Agenda item 11
Attachment 06

NHS
Surrey Downs
Clinical Commissioning Group

Title of paper:	**Governing Body Assurance Framework and Risk Register**
Meeting:	Governing Body, 13th June 2014
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Purpose	To Agree	
	To Advise	✓
	To Note	

Summary

The Governing Body Assurance Framework and Risk Register are produced in conjunction with Heads of Service and other managers and reviewed by the Executive Committee. The Assurance Framework enables the Governing Body to understand the risks to the principal objectives of the organisation and direct the Executive accordingly.

The risk register is closely aligned to the Assurance Framework but sets out a range of more operational risks within the organisation.

As the 2014/15 year has now closed this is effectively the closing position for the assurance framework and a number of recommendations are made for whether these risks should carry forward into 2014/15.

There is one new category (medicines management) and two new risks, both in this new category in the risk register.

The Governing Body is asked to discuss the attached and if necessary make recommendations to the Executive Committee about the assurance framework and risk register going forward.

Development

Since the last meeting the risk register and the 2013/14 assurance framework have been reviewed by all four of the Governing Body's principal committees, both for individual risks and to ensure that there is an integrated approach to risk

management and assurance.

As part of the year end annual reporting process, the internal and external auditors have both confirmed that the CCG's approach to risk management and internal controls is robust. There is now a need to develop this during 2014/15.

2015/16 Assurance Framework

The Governing Body meeting in July will receive a draft Assurance Framework for the new operating year. This will be built around the CCG's six clinical priorities and four enabling themes.

Attached is an outturn report on the 2013/14 Assurance Framework which sets out recommendations for which risks can be terminated, which transferred to the risk register, and which ones should be incorporated into the new assurance framework.

Risk Training

At the time of writing, a risk management training session for manager is scheduled for the 12th June. This is being run by TIAA (the CCG's internal auditors).

Narrative for the risk register – June 2014

The following is a summary of the risk register by category.

Continuing Health Care

These risks are covered in detail in the Chief Officer's report and pending continuous good progress it may be possible to downgrade them by the time of the next Governing Body.

Corporate

There are no new risks. Equality Duty and Information Governance both have structures for taking actions and will be monitored as part of business as usual. Major incident preparedness is being improved through training offered by the Local Resilience Forum (LRF) which is running three repeat training days between now and February 2015 and which we have asked all on-call managers to attend. We are also in discussion with the MI team at Surrey County Council with a view to them running a Major Incident simulation for us. This will also inform the risk on business continuity.

Contracting

There are no new risks. The EDICS arbitration outcome should be known for the Governing Body meeting in July.

Finance

The financial risk around CHC retrospectives has been carried forward into the new financial year.

Medicines Management

There are two new risks, relating to Patient Group Directions and Community Prescribing both of which relate to uncertainty in the wider policy environment. They are both “tolerate” in risk terms as the CCG has little option but to wait for a national resolution. An update is being sought on the 9th May deadline mentioned in the second risk.

With respect to community prescribing there are also some financial risks if homecare dispensing is taken back "in-house" – as acute drug costs attract VAT (the exception is SASH which has a subsidiary community pharmacy they could potentially use).

Performance

The SECAmb risks remain on the risk register; a detailed briefing on recent developments will be provided in Part II of the June meeting.

Quality

The safeguarding training risk is recommended for closure for the reasons set out in the risk register entry.

Child safeguarding issues are actively discussed at the quality committee and a policy will be coming to the July meeting.

A review of the community equipment risk is planned for this month and will be reported as part of the risk register update at the July Governing Body.

The potential for a catastrophic supply failure is unchanged.

Adult safeguarding capacity has been discussed at Quality Committee and is being resolved through different ways of working with the main lead professional acting in an advisory and facilitative capacity given the low level of resource.

There is a new risk around care home failures which links to the adult safeguarding agenda.

Service Redesign

The capacity and surge risk has not yet been reviewed in the light of recently issued guidance, this will be updated for the July Governing Body.

The GP IT infrastructure risk is low. There was a meeting on the 4th June when all CCGs were able to present their proposals and bids for GP infrastructure improvement to NHS England, the outcome of which is awaited.

Attachments / References:

- 2013/14 Assurance framework outturn summary
- Surrey Downs CCG Risk Register June 4th 2014

Implications for wider governance

Quality and patient safety: Quality and Patient safety risks will be reviewed by the Clinical Quality Committee in April
Patient and Public Engagement: None specific
Equality Duty: There is a risk on the risk register regarding achievement of the CG's Equality Duty.
Finance and resources: Finance and resource are reviewed by the Executive Committee.
Communications Plan: A revised version of this paper will be available on the CCG web site.
Legal or compliance issues: The Assurance Framework and Risk Register are a part of the Annual Governance Statement and the overall system of internal controls. A number of individual risks relate to statutory duties.
Risk and Assurance: The CCG's approaches to risk management and risk tolerance are still maturing. There also remains a need to achieve a better understanding or risk throughout the organisation, with managers using risk assessment tools as part of everyday work rather than risk just being perceived as a compliance exercise.

Risk ID	Risk Area	Risk Owner (Executive)	Main responsible committee	Risk Manager	Title	Risk Description	Source of risk	Effect of the risk	Assurance	Gaps in assurance	Controls	Gaps in Controls	Actions with timescales	Comments on risk appetite	Pre-mitigation Impact Score	Pre mitigation Likelihood Score	Net initial Score	Apr-14			Trend
CHC01	Clinical	Chief Operating Officer	Clinical Governance, Clinical Quality and Safety Committee	Head of Continuing Care	Continuing Care Retrospective Reviews and potential claims	Risk that Continuing Healthcare team will not be able to meet the demands for retrospective assessments ands payments	Management of applications for retrospective payments	Patients and family may wait for a long time for the result of their application and payment	CHC Review has now been implemented and efforts are being made to find better ways of meeting the reprtospective workload	None known	Transformation of Service arising from review	Ability to recruit appropriately skilled staff due to model of service	Move to localised working and other actions from review action plan by April 2014	**TREAT** as set out in actions with timescales - target score 8	4	4	16	4	4	16	Static
CHC02	Clinical	Chief Operating Officer	Clinical Governance, Clinical Quality and Safety Committee	Head of Continuing Care	Failure to deliver CHC assessments within nationally mandated imescales	Risk that the nature and scale of normal continuing care applications cannot be managed	Unpredictable nature of levels of applications; capacity of team to meet demand, and methods of working	Impact on patients and carers. potential serious financial pressures and further backlogs and delays, including impact on acute hospital activity	CHC Review has now been implemented and efforts are being made to find better ways of meeting the ongoing CHC workload	New database not yet procured which inhibits ability to manage and report performance.	Recruitment of additional / replacement staff; prioritisation of claims for people who are still alive and requiring support.	None known	Transformational change programme as set out in review; action plan by April 2014. Database to be in place and operational July 2014.	**TREAT** as set out in actions with timescales - target score 8	4	4	16	4	4	16	Static

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CORP01	Operational	Chief Operating Officer	Executive Committee	Governing Body Secretary	major incident preparedness	Risk that Surrey Downs CCG will be unable to discharge its responsibilities as a Category 2 responder in the event of a Major Incident or surge in demand, and will not have generally robust on-call arrangements	As a statutory body the CCG has responsibilities for a range of commissioned services and a duty to collaborate with NHS and other organisations to ensure that health services are maintained under abnormal circumstances (e.g. severe winter weather) and in the event of an actual major incident.	Impact on patient safety and use of resources.	The CCG has on-call arrangements and a surge and capacity plan and has attended major incident simulations run by the South of England. Surge and Capacity plans have been approved by NHS England.	The CCG major incident plan is now in place but not yet finalised and approved.	The CCG has established a monthly heads of service meeting with emergency planning and business continuity on the agenda. Review / look back exercise on business continuity issues leading to action plan. Managers in the in-call rota are also attending MI training between August 2014 and Feb 2015 run by Surrey County Council	None known	By end of June - complete and approve the major incident plan and embed operationally. By end of July - provide a major incident table top exercise for senior staff.	**TREAT - target risk score 8**	5	3	**15**	**4**	**4**	**16**	**Static**
CORP02	Operational	Chief Operating Officer	Executive Committee	Governing Body Secretary	Potential failure of Information Governance	Risk that Surrey CCG will be adversely affected by failure to meet high standards of information governance.	Uncertainty over arrangements for data security, management of records and other elements of the I G Toolkit for managing information safely, securely and effectively	Potential loss of patient identifiable information; poor management of data leading to impact on business; reputational impact; in severe cases, fines and legal action by the information commissioner	The CCG is working with the South CSU on actions to maintain IG level 2 status and improve if possible.	None known	Progress on implementing IG toolkit with Heads of Service and their staff.	None known	None at this stage	**TREAT via IG action plan - target risk score 8**	4	4	**16**	**4**	**3**	**12**	**Static**
CORP03	Operational	Chief Operating Officer	Executive Committee	Governing Body Secretary	Equality Duty	Risk that Surrey CCG will fail to comply with the 2010 Equality Act	Statutory nature of the CCG's equality duty which is reiterated in the NHS constitution	The CCG may fail to discharge its commissioning and / or employer functions in line with the law. This would mean that it was not meeting the needs of protected groups e.g. people with disabilities, age specific groups, faith, gender etc.	Policies and objectives in place and monitored by the Quality Committee	Inadequate information on workforce in terms of protected group characteristics (employer duty); more systematic feedback required from stakeholders; policies need improving]	Implementation of Equality Objectives; use of EDS2 to measure and improve CCG's equality action plan	None known	Establish E&D Steering Group; Implement EDS2 by end of September 2014; Report twice a year to Governing Body (September and March) undertake consultation with wider stakeholders (by end of May 2014)	**TREAT** as set out under actions with timescales	4	4	**16**	**4**	**3**	**12**	**Static**

CORP04	Operational	Chief Operating Officer	Executive Committee	Governing Body Secretary	Business continuity	Risk that a major business continuity incident could cause the organisation to lose the ability to function effectively	Adverse incidents such as weather, fire, terrorist incident, pandemic illness impacting on day to day running of the organisation	Loss of buildings and IT; unable to access records and communicate with other organisations; loss of services to patients e.g. CHC. IFR and RSS; if prolonged, inability to pay contractors in a timely way and to maintain commissioning functions	Business continuity policy and plans in place; some staff training conducted	Lack of testing of policies and plans; no measures of wider staff awareness of business continuity issues	Heads of service tasked with ensuring business continuity mechanisms are in place on a team by team basis	Lack of control over landlord actions in relation to premises; low control over e.g. pandemic flu and weather that could impact on staffing	Previous actions re business continuity [plans now completed further work required particularly revisiting BC plans and staff training	**TREAT** as set out under actions with timescales	5	3	**15**	**4**	**3**	**12**	**Static**

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CONTR01	Operational	Chief Finance Officer	Executive Committee	Head of Contracting	EDICS - contractual arbitration	Suffering a financial loss as a result of the determination of costs relating to EDICs	Poorly designed original specification and contract arrangements	Unacceptably poor value for money and costs in excess of budget	The contract is now expired and an adjudicated outcome is awaited.	None known	Executive Committee oversight, contract meetings. CCG presentation of arbitration case has been highly robust.	None known	Arbitration case was prepared in January and we now await outcome of adjudication panel expected by July 2014.	**TOLERATE**	4	2	**8**	**4**	**2**	**8**	**Static**
CONTR02	Delivery	Chief Finance Officer	Clinical Governance, Clinical Quality and Safety Committee	Head of Contracting	Quality of Estate	Risk of a disruption to commissioned services due to a rapid deterioration in the estate at New Epsom and Ewell Cottage Hospital and / or The Poplars at West Park	Current state of buildings at New Epsom and Ewell Cottage Hospital and The Poplars at West Park	Potential need to close services at short notice	The supplier's estates team has put in place mitigating structural work to ensure the buildings can remain open without physical risk or risk to business continuity. NHS Property services have now commenced work on a long term solution.	None known	Executive Team oversight, contract meetings with suppliers. Propoco undertaking remedial work.	None known	Remedial work commenced in December 2013, end date TBC. However there is a need to manage infection control risks on an ongoing basis.	**TREAT -** target risk score 4	4	2	**8**	**3**	**2**	**6**	**Static**

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FIN01	Financial	Chief Finance Officer	Audit, Corporate Governance and Risk Committee	Head of Finance	Financial balance in 2014-15	Risk that SDCCG inherits an unforeseen deficit as a result of the ongoing issues and risks around CHC retrospective claims	History of retrospective claims arising from transition period	The CCG could have to deal with a significant non-recurrent cost pressure	Minimal assurance available based on PCT final accounting processes	Lack of specific and credible financial reporting in the final period of 2012-13, and conflicting policy statements during 2013/14	The CCG has minimal control over this issue other than to escalate the understanding of the impact to NHS England.	Control mechanisms within NHS England are not clear	The CCG has been actively seeking oversight of accruals to understand position. However, the final position is still not known and remains a risk until concluded. There are no further actions the CCG can take at this time. See comments on risk appetite.	**TOLERATE -** Guidance and a level of successful claims continues to change. Revisit when further information is available.	4	3	**12**	**4**	**3**	**12**	**Static**

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MEDMAN1	Operational	Chief Operating Officer	Executive Committee	Head of Medicines Management	Patient Group Directions	Risk that Patient Group Directions that have expired following the transition period will not be subject to proper governance	The national position is unclear. DH/NHSE and MHRA have sought legal advice re PGD authorisation. Unfortunately, formal notification of the outcome of these discussions has yet to be published	It may not be possible to identify who should authorise vaccinations in areas such as hepatitis	There is continuous dialogue ion this issue between the area team, NHS England nationally and other bodies to resolve the situation. There is no indication that PGDs are unsafe but the situation does need a long term resolution.	As set out opposite - lack of clarity on ultimate responsibility for PGDs	Minimal pending resolution.	See controls.	Ongoing dialogue - no timeline as yet for when a resolution will be achieved.	**TOLERATE** at this stage but move to treat as guidance becomes available.	4	3	**12**	**4**	**3**	**12**	**Static**
MEDMAN2	Operational	Chief Operating Officer	Executive Committee	Head of Strategic Pharmaceutical Commissioning / Lead Commissioning Pharmacist (Liz Clark)	National Patient Safety Alert - Homecare medicines	Risk that community patients may not receive a safe service in specific clinical areas. Mainly rheumatology, dermatology and IBD. Clinical risks from late/omitted doses are not very high with the exception of IBD.	Medicines are increasingly managed at home rather than via acute trusts as this provides the best and most cost effective service. However there have been instances of supplier failure that potentially leave patients in an unsafe position.	Clinical risk (potential for harm) to patients	We are seeking confirmation that the recommendations in the alert will be completed by 9th May deadline and that asking how risk assessments will be carried out and what contingency plans are in place. Contact has been made with South London CSU commissioning pharmacist to ensure joint work around ESHUT and Kingston hospitals.	Still waiting to hear back from some providers. ESHUT and Kingston say they are aware of alert and are in process of implementing.	Dependent on the providers - the CCG role is to gain assurance from them but not to implement the safety alert directly/	See controls.	Deadline for implementation is 9th May	**TOLERATE** at this stage but move to act as updates become available form DoH and acutes	4	3	**12**	4	3	**12**	**Static**

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PERF01	Performance	Chief Finance Officer	Clinical Quality Committee	Head of Performance	Secamb Cat A Performance	Risk that SECAMB cannot recover existing poor performance and sustain acceptable performance in relation to Category A response times.	SECAMB Published statistics show they are not meeting the required standard	Risk of potential harm to patients; impact on NHS reputation	Published statistics; feedback from patients' representatives; shared intelligence from new joint commissioner's meetings	Commissioners do not have visibility of Trust action plans	Contractual levers	CCG is associate commissioner and cannot take unilateral action	Work with new commissioners (NW Surrey CCG) to address performance deficits; review implementation of 19 action points recommended by recent review; ongoing scrutiny in Quality Committee.	TREAT - The CCG is committed to requiring the supplier to meet this target. Target risk score 8.	4	3	**12**	**4**	**3**	**12**	**Static**
PERF02	Performance	Chief Finance Officer	Clinical Quality Committee	Head of Performance	SECAMB Patients transport	SECAMB Patient Transport performance is currently below expectations.	SECAMB Poor performance in relation to patient transport	This impacts on patients and carers and can also impact on acute trusts and others where patients miss appointments or cannot be discharged in a timely fashion. Potential financial impact from mismatch between expected and actual demand (cost pressure on budget)	Published statistics; feedback from patients' representatives; shared intelligence from new joint commissioner's meetings; minutes from SECAMB and Acute Trust monthly meetings	None known	Contractual levers	CCG is associate commissioner and cannot take unilateral action	Need to use Urgent Care Boards to lever co-ordinated actions around each local acute hub, using feedback from trust / SECAMB monthly operational meetings. From February onwards. Also actions as per PERF01 above.	TREAT - The CCG is committed to improving performance.	4	3	**12**	**4**	**3**	**12**	**Static**

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QUAL1	Clinical	Chief Operating Officer	Quality Committee	Head of Clinical Quality	Safeguarding Adults	As host commissioner and Surrey lead for the Adult Safeguarding, the CCG is not assured that the current level of training in Safeguarding Adults within member practices and provider services meets that required by the regulators of primary care, the Care Quality Commission (CQC)	The training is regulatory under CQC, not mandatory, therefore commitment to undertake appears to be less No complete database exists to track training needs so the size of the problem is unknown. Poor uptake of Level 1 and 2 training.	Individuals (patients, employees and members of the public) may not be adequately protected from harm or able to recognise situations where others maybe at risk. Potential impact on member practices' CQC registration. .	Training packages developed and delivered at Level 1 for all Surrey CCG Governing Body members (at 31st March 2013). CQC inspections providing some information. Training packages at Level 1 and 2 developed and circulated to all GP practices. Major uptake of training in SDCCG since January 2014.	No database to properly record attendance at training; known issues with poor training attendance; lack of information about what level and frequency of training that practices are providing to their staff	NHS England Area Team – role in co-ordinating and funding safeguarding training for GPs. CCG has the ability to put on training for its own GPs.	CCG cannot mandate training attendance and can only influence.	Earlier actions completed now maintenance work ongoing to ensure training levels maintained.	**RECOMMENDED FOR CLOSURE AS TRAINING NO LONGER A MAJOR ISSUE**	4	3	**12**	**3**	**2**	**6**	**Static**
QUAL2	Clinical	Chief Operating Officer	Quality Committee	Head of Clinical Quality	Safeguarding Children	Risk that Child Safeguarding arrangements will not be adequate.	Child Safeguarding structures are hosted by another CCG and there are complex multi-agency arrangements in place which have the potential to break down.	Potential risk of harm to vulnerable children.	The host commissioner provides regular reports to the CCG which sets out the main issues and risks relating to child safeguarding. SD CCG also has representation on the Health Sub-group and Area Safeguarding Groups which provide assurance.	None identified.	The CCG has a Service Level Agreement with Guildford and Waverley CCG (as hosts of this service) to lead on Safeguarding Children. There are also established multi-agency structures and processes in place across Surrey which can be used to initiate action where a concern exists.	None identified	No further specific actions required.	**TOLERATE at the current score. Review if any changes.**	4	3	**12**	**3**	**3**	**9**	**Static**
QUAL3	Clinical	Chief Operating Officer	Quality Committee	Head of Clinical Quality	Specialist Equipment in the Community	The CCG is not assured that certain specialist equipment being used by healthcare staff in the community is fit for purpose.	There is no central database detailing specialist equipment, its location or maintenance schedule.	Potential that unsafe equipment is in use Potential risk of harm to patients and operators of the equipment	Some databases of equipment in use. Feedback from health and social care staff working directly with patients.	No assurance on providers processes / insufficient information about historical equipment still in use.	Contractual levers for monitoring equipment in use in the community.	No controls over old equipment that is not on anyone's inventories.	To be systematically reviewed in June with providers.	**TOLERATE. Pending outcome of review.**	3	3	**9**	**3**	**3**	**9**	**Static**
QUAL4	Clinical	Chief Operating Officer	Quality Committee	Head of Clinical Quality	Catastrophic supply failure	Risk of an unexpected clinical failure of a supplier that reveals and is attributable to either a lack of early warning systems or cultural issues within the organisation that conceal significant quality issues.	Following the issues at Mid Staffordshire, all health economies run the risk that there is a potential unexpected failure of an organisation-wide nature.	Harm to patients, global reputational issues for the health economy	The CCG monitors a basket of indicators including mortality rates through contract meetings and other mechanisms; Governing Body Oversight; monitoring of serious incidents and other early warning signs; Surrey wide patient safety committee	None known	Ongoing site visits and direct interaction with suppliers to test organisational culture. Intervention through contracts.	None known	Continuing systematic oversight of quality as set out in controls. No specific further actions at this stage.	**TOLERATE**	4	4	**16**	**4**	**2**	**8**	**Static**

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QUAL5	Clinical	Chief Operating Officer	Quality Committee	Head of Clinical Quality	Infection Control	Significant failings with commissioned services in relation to Health Care Acquired Infection	Local Providers are failing to meet agreed quality standards around Health Care Acquired Infection practice with the subsequent risk to patient safety and experience.	Actual or potential harm to patients. In addition, the CCG will fail to achieve the standards required to receive part of the quality premium payment attached to these standards.	Clinical Quality Review Meetings with Providers; Surrey-wide overview and advice from the infection control prevention lead in Public Health and quarterly meeting of Providers and Commissioners. Ongoing antibiotic prescribing audit and follow up with GP practices (Medicines Management Team); Heat map showing incidence across Surrey in acute, community and primary care providers to identify 'hot spots' completed October 2013.	None known	Contract meetings and contract levers; prescribing audits	None known	Continuous monitoring and review through contracts and audit. Development of an infection risk plan by July 2014.	**TREAT - target score of 6**	4	4	**16**	**3**	**4**	**12**	**Static**
QUAL6	Clinical	Chief Operating Officer	Clinical Quality Committee	Head of Clinical Quality	Safeguarding Adults	Potential for preventable harm to Surrey residents and patients due to lack of clarity over adult safeguarding roles and resources	Surrey is a complex county with six commissioning CCGs and only one person in the host organisation to co-ordinate activities.	Actual harm to individuals.	The adult safeguarding board provides oversight of all agency activities; the CCG quality committee produces regular minutes identifying issues and actions relating to adult safeguarding.	None known	Surrey CCG Quality Leads discuss Safeguarding issues six-weekly where the 2013/14 work plan is monitored. Bi-monthly meeting of NHS Adult Safeguarding Leads across Providers in	None	Ongoing worth with the CCG Collaborative to ensure that resources are adequate to support this agenda. Regularly reported at Quality Committee - next major update in June.	**TREAT - target score of 6**	4	3	**12**	**3**	**3**	**9**	**Static**
QUAL7	Clinical	Chief Operating Officer	Clinical Quality Committee	Head of Clinical Quality	Care home failures	Potential for residential and nursing homes in the local area to experience difficulties and / or fail.	The care home market is a volatile one and there are issues with recruitment of staff and maintenance of standards.. Monitoring and compliance regimes are still underdeveloped.	Actual harm to individuals.	Homes are subject to registration by the CQC. GP practices are often aware of concerns and can pass these to the local authority.	Lack of systematic and well co-ordinated intelligence.	Surrey CCG Quality Leads discuss Safeguarding issues six-weekly where the 2013/14 work plan is monitored. Regular intelligence sharing forum being developed between CCG Quality Leads, SCC QA team and CQC to focus on providers. Bi-monthly meeting of NHS Adult Safeguarding Leads across Providers.	None	Ongoing worth with the CCG Collaborative to ensure that resources are adequate to support this agenda. Regularly reported at Quality Committee - next major update in June.	**TREAT - target score of 6**	4	3	**12**	**3**	**4**	**12**	**Static**

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SERVRED01	Operational	Chief Operating Officer	Executive Committee	Head of Service Redesign	Capacity and surge planning	There is a risk of potential failures of service quality, financial stability, or business continuity that impact on patients and may cause harm if periods when there is a surge in demand (such as winter, heatwaves or during a pandemic) are not adequately planned for.	Severe weather, high levels of demand, seasonal 'flu or other conditions, and norovirus can impact on the demand for services and also interrupt the supply and delivery of commissioned care.	Services are unavailable or subject to long waits; cancellation of elective treatment; significant impact on A&E departments, community hospitals, primary care and patient transport. Can also impact adversely on the CCG's financial and performance outturn at the end of the year if remedial action is not taken.	All health economies have published winter surge and capacity plans. The flu plan was published in July 2013 and has been followed locally. The NHS England Area team has been reviewing local arrangements since early autumn and provides a system wide monitoring role.	None known	Urgent Care Board arrangements flexed arrangements for community beds to support discharge and manage system pressures. The CCG has established an internal group to co-ordinate winter planning and this has given a focus in addition to the locality information on demand and capacity in local systems. Additional investment has been played in to support	The CCG is one of several organisations at local level and does not have complete control over system wide interventions, particularly the role of the ambulance service.	None currently as the CCG has emerged from the winter and Easter periods without significant issues. The CCG's own resilience is also much improved as a result of the experiences over the last six months.	TOLERATE at this stage but move to treat at a later stage as e.g. heatwave guidance is issued.	4	4	16	3	3	9	Improving
SERVRED05	Operational	Chief Operating Officer	Executive Committee	Head of Service Redesign	GP IT infrastructure	Ageing computers, peripherals and network connections could fail or have insufficient capacity to manage practice workload.	Limited resources available and the allocation process for the South of England was unclear.	Ageing or non-functioning IT equipment could lead to failings with patient record keeping, and the ability to communicate between services. This could have both operational and clinical consequences. Strategically, out of date GP IT will not support CCG strategies for Out of Hospital care and programmes sponsored by Transformation Boards that seek to modernise health care. GP IT could lag behind that of other stakeholders.	Baseline of equipment needs is now in place	Lack of clarity about future NHS England processes and timescales.	Rollout of IT refresh programme	None known	CCG has successfully lobbied for investment and a substantial sum has been allocated for 2014/15. However this does not eliminate the longer term risk and a strategic approach is required. To be reviewed in June 2014.	TOLERATE pending review in June	4	3	12	3	2	6	Static

Assurance Framework 2013/14 – Outcomes and recommendations for 2014/15

1.1	Failure to deliver a viable acute commissioning plan.	Good progress made during the year but remains a significant issue for 2014/15
1.2	Out of Hospital Strategy is unsuccessful	Carry forward to 2014/15 – focus on benefits realisation particularly in relation to long term financial strategy
1.3	Failure of year 1 Financial Plan	Close but re-open as risk for new financial year
1.4	The five year financial plan is not sustainable	Good progress made during the year but remains a significant issue for 2014/15
1.5	Failure of estates strategy	Carry forward to 2014/15
1.6	The Epsom Local Transformation Board cannot co-ordinate care between agencies	Carry forward to 2014/15
1.7	The Kingston Local Transformation Board cannot co-ordinate care between agencies	Carry forward to 2014/15
1.8	The Surrey and Sussex Local Transformation Board cannot co-ordinate care between agencies	Carry forward to 2014/15
1.9	Potential for H&WB Board and H&WB Strategy to be ineffective	Carry forward to 2014/15
2.1	Failure of Leadership or general workforce strategy	Probably only year one risk – can be removed

2.2	Information / reporting failure	Carry forward to 2014/15
2.3	There is a lack of ownership of projects, targets and budgets	Probably only year one risk – can be removed
2.4	It is not possible to develop a distinct Surrey Downs culture	Probably only year one risk – can be removed
2.5	The Governing Body fails to develop in order to deliver its responsibilities.	Carry forward to 2014/15
2.6	Locality sub committees are ineffective in delivering local change	Dependent on discussions about changes to localities and structure
2.7	Collaborative commissioning arrangements are ineffective or inefficient	Carry forward to 2014/15
3.1	The CCG fails to develop soft intelligence from direct contact with service providers	Probably risk register rather than assurance framework
3.2	Failure of quality reviews	Probably risk register rather than assurance framework
3.3	Clinical audit programmes are ineffective in improving Quality and patients safety	Probably risk register rather than assurance framework
3.4	Failure to achieve quality premium	Probably risk register rather than assurance framework
4.1	The improvement of standards in Primary Care is low and as a result does not support the CCG's commissioning reforms	Carry forward to 2014/15

4.2	Admission avoidance programmes are inadequate and do not support the objectives of the out of hospital strategy	Probably risk register rather than assurance framework
4.3	Urgent Care System reforms do not have the required impact on the local health system	Carry forward to 2014/15
4.4	Reform of Elective Care systems does not achieve the necessary objectives	Carry forward to 2014/15
4.5	Local transformation Boards fail to improve discharge pathways	Carry forward to 2014/15
4.6	The review of Continuing Health Care and a new CHC specification are unsuccessful	Carry forward to 2014/15
5.1	There is a failure to sign off 2013/14 contracts and their associated CQUINs	Probably risk register rather than assurance framework
5.2	The 2014/15 Annual Contract planning cycle is poorly managed	Probably risk register rather than assurance framework
5.3	The contact database fails to adequately capture all contracts and aligned payments	Probably risk register rather than assurance framework
5.4	Contracting and Commissioning Intentions are not in place for all contracts	Carry forward to 2014/15
5.5	The contract Review process is not adequate to support quality and effectiveness of services	Probably risk register rather than assurance framework or remove

5.6	Primary Care Contracts within the CCG's remit (LES and GPSI) are poorly managed	Replace with more explicit risk around primary care offer
5.7	The Better Care fund and Partnership funding generally are not utilised in line with the CCG's strategic objectives	Carry forward to 2014/15
6.1	The SDCCG Constitution is not maintained and developed and fails to be a live tool of Governance	Probably risk register rather than assurance framework
6.2	Principal Governing Body Committees are ineffective or fail to co-ordinate their assurance roles	Probably risk register rather than assurance framework
6.3	The Governing Body Assurance Framework is not adequate to enable the group to assess its risks to its principle objectives	Very much a year one concern - remove
6.4	SDCCG fails to discharge its remaining authorisation conditions or has new conditions placed upon it	Very much a year one concern - remove