

No.	Principal objective	No.	Principal Risk	Executive Lead	Operational lead	Source of risk	Potential impact of risk	Assurance (what evidence is there that the risk is being managed?)	Gaps in assurance (Is there a lack of information that remedial actions are being taken?)	Controls (what levers are being used to reduce the risk)	Gaps in controls	Actions with timescales	Comments on risk appetite and risk tolerance	Initial score	Last period	Likelihood of risk becoming real	Impact if risk became real	Current score	Trend
1)	TO ENSURE THAT THE CCG HAS MEDIUM TERM STRATEGIES IN PLACE FOR ITS MAIN COMMISSIONING FUNCTIONS	1.1	Failure to deliver a viable acute commissioning plan.	Chief Officer	Head of Service redesign	Development of a local acute strategy was set aside whilst the CCG worked through the implications of the Better Services Better Value Programme. Following withdrawal from this, an alternative approach is being developed as a matter of urgency through local Transformation Boards.	There is a potential impact on services to patients, standards of care and consequently the CCG's reputation. There are also risks associated with financial sustainability.	Assurance is available from external reports that consistently identify Epsom, Kingston and East Surrey and Sussex Trusts as meeting patient safety requirements in the short term.	The acute strategy is not yet finalised. There is a lack of assurance regarding long term financial sustainability and long term clinical viability of some acute trusts.	Local transformation boards are developing work on clinical standards and long term sustainability.	None known	To develop the acute commissioning strategy alongside the out of hospital strategy and other key areas such as the use of the Better Care fund over the next three months and to review in April 2014.	TREAT. Failure of commissioning is outside the CCG's risk appetite. Tolerance levels are: Providers must work within agreed financial envelopes and must meet quality standards and NHS constitution commitments (including access times). Detail of these tolerances can be found in contractual and related documents.	16	16	4	4	16	Static
		1.2	Out of Hospital Strategy is unsuccessful	Chief Officer	Head of Service Redesign	In order to deliver improvements in patient care and reduce cost, the CCG has an agreed Out Of Hospital Strategy to achieve the necessary strategic sustainable approach to delivery. Failure of the strategy would leave the CCG without a strategic approach.	Un co-ordinated care and significant financial inefficiencies; long term impact on quality of care to patients; longer term potential service failure.	The programme management tool shows key indicators to be mainly at Amber which indicates that the strategy has a grip on areas such as acute activity prior to the detailed programmes being implemented over time.	None known	The fortnightly OOH Programme Board is monitoring the strategy through a Programme Management Approach. Variations around deadlines and KPIs can be measured and management action taken through this approach.	None known	Specific programmes being developed for elective care, urgent care, admission avoidance, discharge processes and referral support. These will be implemented throughout 2014. Review in April 2014.	TREAT. Zero risk tolerance. Should the strategy not be acceptable it would need to be replaced by an alternative strategy whose outcomes around safe care for patients and financially sustainable services could be delivered.	12	12	3	4	12	Static
		1.3	Failure of year 1 Financial Plan	Chief Financial Officer	Head of Finance	Financial control could be undermined by lack of effective strategies for acute, community, CHC and other areas of delivery; or through strategic failures in the management of allocation processes	Failure to achieve financial balance; lack of flexibility to re-allocate resources to strategic programmes	The CCG finance team has been closely monitoring key pressure points as we move to year end. Currently the financial information available suggests the CCG is on track for a £72,000 surplus.	None known	The finance team review latest financial projections on a daily basis. The Executive Team take action to manage key areas of variance and review these in the fortnightly Executive business meetings, which mandates action with suppliers.	There is little or no control over NHSE allocations processes, however these are nearly concluded and risks arising from this are known. Pressures in prescribing activity are subject to reporting lags and are currently an area of high pressure.	End of year agreements are being reached with key suppliers. Intensive activity is in place to reduce prescribing costs. To be concluded by April 2014 in line with Annual Accounts processes.	TREAT. The CCG has a zero tolerance approach to breaching its control total as this would result in starting 2014/15 with a deficit position and have an impact on the confidence of stakeholders in the CCG's ability to manage its resources.	12	16	4	4	16	Static
		1.4	The five year financial plan is not sustainable	Chief Financial Officer	Head of Finance	Lack of control over strategic factors such as allocations, changes in demand, new technologies and NICE Guidance	Potential for CCG financial position to become unsustainable leading to loss of authorisation and difficulties with allocating resources equitably to patient care	Five year plan has been developed.	Process for monitoring and strategic review not yet developed.	Over time, Finance reports to the Governing Body, Executive Committee and Audit Committee will be used to show how the strategy can be improved to make long term finances more resilient.	None known	Five year plan to be refreshed following announcement of 2014/15 and 2015/16 allocations in December 2013. To be completed as part of budget setting by April 2014.	TOLERATE. (for the short term). There is a link to 1.3 but the CCG has yet to define its long term risk appetite and whether high levels of in year-risk might be acceptable to achieve long term sustainability.	15	15	3	5	15	Static
		1.5	Failure of estates strategy	Chief Operating Officer	Programme Manager	Inability to align and prioritise estates to strategic intentions	Care delivered from inappropriate locations; financially inefficient services; poor quality of environment for patients	Draft Business case being developed. Strategy and business case process is in line with the work of the Area Team.	None known	Executive Committee; Governing Body	None known	Draft estates strategy was planned by March 2014 but due to limiting factors around NHS property services this has now been put back to June 2014.	TREAT. Risk tolerance is encompassed within 1.3 i.e. costs must be contained within control total.	12	12	3	4	12	Static
		1.6	The Epsom Local Transformation Board cannot co-ordinate care between agencies	Chief Officer	Head of Service Redesign	Difficulties in aligning efforts and aims of a wide group of stakeholders	Inefficiency of delivery; potentially poor quality of care for patients; impact on CCG strategies for acute and out of hospital services; potential loss of control during surge periods.	The development of strategies for both acute and out of hospital care are being co-ordinated with the Epsom transformation Board and there is strong emerging evidence that the Board is fully engaged in improving care co-ordination and delivery. The CCG has developed a surge plan around the Epsom hub.	None known	The CCG is a member of the Epsom LTB and is working with partners on both acute and community strategies for the area. Areas of poor care co-ordination can be escalated to the Executive. There is also a key role for the Clinical Quality Committee in using patient outcomes and incident reports to highlight any issues with poor care co-ordination and escalate these as appropriate.	As one of several stakeholders on this board the CCG has only limited control	Continued participation in work of the transformation board. Key timescales consistent with Better Care and development of surge and capacity plans. Review in April 2014. The CCG's Transformation Executive meeting has now started to meet on a monthly basis.	TREAT. Risk tolerance is encompassed within 1.1 (failure of acute strategy), 1.2 (out of hospital strategy) and 1.3 (failure of in year financial plan).	12	12	3	4	12	Static
		1.7	The Kingston Local Transformation Board cannot co-ordinate care between agencies	Chief Officer	Head of Service Redesign	Difficulties in aligning efforts and aims of a wide group of stakeholders	Inefficiency of delivery; potentially poor quality of care for patients; impact on CCG strategies for acute and out of hospital services; potential loss of control during surge periods.	The development of strategies for both acute and out of hospital care are being co-ordinated with the Kingston transformation Board and there is strong emerging evidence that the Board is fully engaged in improving care co-ordination and delivery. Kingston CCG has developed a surge plan around the Kingston hub.	None known	The CCG is a member of the Kingston LTB and is working with partners on both acute and community strategies for the area. Areas of poor care co-ordination can be escalated to the Executive. There is also a key role for the Clinical Quality Committee in using patient outcomes and incident reports to highlight any issues with poor care co-ordination and escalate these as appropriate.	As one of several stakeholders on this board the CCG has only limited control	Continued participation in work of the transformation board. Key timescales consistent with Better Care and development of surge and capacity plans. Review in April 2014. The CCG's Transformation Executive meeting has now started to meet on a monthly basis.	TREAT. Risk tolerance is encompassed within 1.1 (failure of acute strategy), 1.2 (out of hospital strategy) and 1.3 (failure of in year financial plan).	12	12	3	4	12	Static

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		1.8	The Surrey and Sussex Local Transformation Board cannot co-ordinate care between agencies	Chief Officer	Head of Service Redesign	Difficulties in aligning efforts and aims of a wide group of stakeholders	Inefficiency of delivery; potentially poor quality of care for patients; impact on CCG strategies for acute and out of hospital services; potential loss of control during surge periods.	The development of strategies for both acute and out of hospital care are being co-ordinated with the Surrey and Sussex transformation Board and there is strong emerging evidence that the Board is fully engaged in improving care co-ordination and delivery. East CCG has developed a surge plan around the SASH hub.	Uncertainty over SASH FT pathway	The CCG is a member of the East Surrey LTB and is working with partners on both acute and community strategies for the area. Areas of poor care co-ordination can be escalated to the Executive. There is also a key role for the Clinical Quality Committee in using patient outcomes and incident reports to highlight any issues with poor care co-ordination and escalate these as appropriate.	As one of several stakeholders on this board the CCG has only limited control	Continued participation in work of the transformation board. Key timescales consistent with Better Care and development of surge and capacity plans. Review in April 2014. The CCG's Transformation Executive meeting has now started to meet on a monthly basis.	TREAT. Risk tolerance is encompassed within 1.1 (failure of acute strategy), 1.2 (out of hospital strategy) and 1.3 (failure of in year financial plan).	12	12	3	4	12	Static
		1.9	Potential for H&WB Board and H&WB Strategy to be ineffective	Clinical Chair	Head of Service Redesign	There are significant numbers of stakeholders in the H&WB and the potential exists for strategies and operational requirements to diverge and / or be ineffective in achieving the remit of the board.	Failure to achieve statutory responsibilities (i.e. failure to develop an inclusive Joint Strategic Needs Assessment; failure to integrate care).	To date the H&WB has been effective in bringing stakeholders together; the strategy has widespread support. There are Regular H&WB Board meetings and feedback; reports to Governing Body. Clinical Chair reports to Executive Committee.	Lack of systematic appraisal of the H&WB's effectiveness	CCG input into H&WB	As one of several stakeholders on this board the CCG has only limited control	Continued participation in the H&WB Board; no other specific actions at this stage.	TOLERATE. The CCG, as one of a number of stakeholders, has limited control and can mitigate risk through other mechanisms. These are contained within other elements of the assurance framework i.e. 1.6, 1.7, 1.8 (care co-ordination) and 5.7 (Better Care and other partnership funding)	12	12	3	4	12	Static
2)	TO ENSURE THAT THE CCG HAS SUFFICIENT CAPACITY AND CAPABILITY TO DELIVER ITS BUSINESS	2.1	Failure of Leadership or general workforce strategy	Chief Officer	Chief Operating Officer	CCGs are competing for people in leadership roles and skilled staff; in addition the environment is complex with staff in-house, in CSU and in hosted services	Failure to achieve operational objectives; loss of operational control	The CCG has had considerable success in recruiting staff; the CSU is now fully operational; and hosted services are increasingly structured and accountable	Detail of collaboration for some hosted services is still being worked through	Remuneration and Nominations Committee; Executive Committee; CCG Collaborative meetings; Chief Officer's meetings	None known	Chief Finance Officer and new service redesign staff now appointed, other posts being reviewed.	TREAT. The CCG has shown a strong risk appetite in this area, specifically: willingness to accept vacancies in senior positions in order to recruit talented individuals for the long term; willingness to use short term premium approaches in specific posts to ensure the organisation is effective during its startup year.	12	6	2	3	6	Static
		2.2	Information / reporting failure	Chief Financial Officer	Head of Planning and Performance	The CCG does not develop in-depth (i.e. from Governing Body down to locality) reporting of performance, quality and other operational matters due to organisational or technical business intelligence reasons	Lack of internal engagement; lack of assurance of progress on organisational objectives; potential failure of objectives	Internal reporting has a more focused approach with the appointment of a planning and performance lead; business intelligence support now fully recruited to	Further evidence required that reports to Governing Body are fit for purpose	Governing body oversight; Executive Committee weekly reporting; Audit Committee review; internal audit;	Internal reporting of finance, activity and performance requires further development.	Activity reporting is continuously improving under the efforts of the CSU and the PMO.	TREAT. The CCG has a low tolerance of risk in this area. Whilst some gaps or quality issues with information are accepted at this stage, the CCG is actively seeking to address these particularly with suppliers who are not providing information or are providing information that is not up to date.	12	8	2	4	8	Static
		2.3	There is a lack of ownership of projects, targets and budgets	Chief Operating Officer	Heads of Service	New and complex organisations need to establish regimes for engaging staff in critical tasks and make sure these are maintained	Failure to deliver organisational objectives; poor staff morale	Weekly team briefing being used to ensure clarity of purpose; Executive team is operationally reviewing effectiveness of structures and levels of engagement	Workforce statistics and reporting need further development however see 2.1 above.	Executive committee oversight; Remuneration and Nominations Committee review of staff indicators; exit interviews	None known	The new Programme Management Office (PMO) is bringing structure to key tasks such as the Delivery Plan and the Out of Hospital Strategy. A reporting tool for the delivery plan was developed during Oct 2013. Reports to the Governing Body March 2014.	TREAT. The CCG has a low tolerance of risk in this area. The scheme of delegation requires that there is complete accountability for budgets and this is also being extended to significant projects and targets.	9	6	2	3	6	Static
		2.4	It is not possible to develop a distinct Surrey Downs culture	Chief Operating Officer	Heads of Service	Surrey Downs CCG still less than nine months old and purpose and direction still being established; new staff still joining the organisation; need to knit together member practices with wider organisation and create identity at both levels	Failure to deliver organisational objectives; poor staff morale	Weekly team briefing being used to develop culture; SDCCG as an organisation with its own geographical identity and sense of purpose is achieving greater clarity; regular written communications to GP practices and staff; Council of Members meetings have been held. Appraisal systems now in place.	Need more systematic feedback from staff; more work needed with Council of Members to achieve ownership and engagement	Remuneration and Nominations Committee; Executive Committee; feedback from localities	Lack of a formal staff forum needs to be addressed. Equality Delivery Systems suggest that the CCG should undertake some form of systematic staff survey on an annual basis.	The distinctive culture of the organisation has emerged more fully since the move to Cedar Court and recruitment to key posts that provide cohesion. No further action at this stage. This will be formally evaluated as part of the year end controls process.	TOLERATE The Governing Body has reflected on Organisational Development over the first nine months at its Dec 2013 Seminar and it is clear that the organisation has developed strong culture and leadership.	8	4	1	4	4	Static
		2.5	The Governing Body fails to develop in order to deliver its responsibilities.	Chief Operating Officer	Governing Body Secretary	Surrey Downs CCG still less than nine months old and purpose and direction still being embedded; systematic permanent appointments to external clinical members only just completed; Governing Body still in need of a development plan	Clear body of evidence that poorly developed boards produce poorer organisational outcomes, which could impact on everything from financial control to quality of services for patients	Governing Body has had several seminars and formal meetings and there is strong evidence emerging of cohesiveness of purpose and good relationships and shared ambitions; lay members consulted on induction programmes.	Lack of a systematic approach with timetables for Governing Body development.	Governing body self review; feedback from authorisation	None known	Formalise a Governing Body development programme for 2014 by end April 2014 (originally Dec 2013).	TREAT as set out under actions with timescales.	12	12	3	4	12	Static
		2.6	Locality sub committees are ineffective in delivering local change	Chief Operating Officer	Locality Chairs with Head of Service Redesign	Surrey Downs CCG still less than nine months old and roles and relationships between localities and groups still emerging; levels of delegated authority still being clarified	Lack of equity in terms of impact; potential failure to deliver strategy at local level.	Localities report weekly to Executive Committee - strong evidence of strategic engagement and working with local transformation boards and local services; locality performance reports	None known	Executive Committee; reports to Governing Body;	None known	The Executive has reviewed this and made changes to ensure a focus on core business and commissioning intentions through revised locality arrangements and locality reporting. However more work is ongoing to define future role of localities in Executive. Report to February Governing Body Seminar.	TREAT as set out under actions with timescales.	9	9	3	3	9	Static
		2.7	Collaborative commissioning arrangements are ineffective or inefficient	Chief Operating Officer	Heads of Service	Six CCGs working together in Surrey - highly complex arrangements for hosting and joint working	Potential failure in a number of areas: safeguarding; continuing healthcare; capacity and surge planning. Potential impact on patients as a result.	Monthly collaborative meetings and Chief Officers meetings; specialist review of CHC	None known	Executive Committee; reports to Governing Body;	None known	Review of 2013/14 delivery in progress; CSU SLA being reviewed. To be concluded by end of March 2013.	TREAT. The CCG is not prepared to tolerate risk in relation to patient safety or loss of financial control, therefore safeguarding and Continuing Health Care are key areas of focus.	12	12	3	4	12	Static

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3)	TO DELIVER SPECIFIC AND DEFINED QUALITY IMPROVEMENTS	3.1	The CCG fails to develop soft intelligence from direct contact with service providers	Chief Operating Officer	Head of Clinical Quality	Need for commissioners to see services at first hand and to receive direct feedback from patients and staff on their experience	Failure to see a potential "Mid Staffs" type service failure that is not evident from quantitative business intelligence and consequent patient harm and loss of reputation.	Examples of suppliers raising issues with CCG as commissioner in first six months; lay members report regularly on soft intelligence concerns; Programme of walkabouts developed; work in hand with PALS and Complaints to use this information in a more structured way.	Structured feedback not yet available	Lay member input to weekly Executive Committee; feedback from complaints; CCG "walk around" style visits; Clinical Quality Committee co-ordinating known concerns	None known	PALS and complaints work should be completed by the end of April 2014 (originally December 2013).	TREAT. The CCG has zero tolerance of harm to patients but where incidents occur will seek to learn from any incidents or Never Events.	12	12	3	4	12	Static
		3.2	Failure of quality reviews	Chief Operating Officer	Head of Clinical Quality	Quality Review meetings (QRMs) are not comprehensive and / or do not result in remedial action to address poor quality of suppliers	Potential impact on patient care - potential actual harm and reputational impact	QRMs are taking place and being minuted	Need longer term body of evidence to assess QRM effectiveness	QRMs minuted and reviewed by Clinical Quality Committee; locality clinical leads engaged in QRMS and report direct to Executive Committee	Lack of control over contracts where the CCG is only an associate commissioner	Review of effectiveness of all QRMS to be completed by the end of April 2014 (originally December 2013). Links to work on new quality strategy.	TREAT. The CCG has zero tolerance on developing an effective QRM process as this is key to the success of overall quality management	6	6	2	3	6	Static
		3.3	Clinical audit programmes are ineffective in improving Quality and patients safety	Chief Operating Officer	Head of Clinical Quality	Poorly designed clinical audits or audits not targeted at the right areas can fail to provide assurance regarding the clinical quality of services	Potential impact on patient care - potential actual harm and reputational impact	Supplier clinical audits have been reviewed by the Clinical Quality Committee	Need longer term body of evidence to assess clinical audit effectiveness	Clinical Quality Committee; Contract reviews and QRMs	None known	Quality Strategy to be developed by end March 2014 (originally end of Jan 2014).	TREAT. The CCG has low tolerance of failure by suppliers to complete their clinical audit programmes but this cannot be defined further at this stage.	6	6	2	3	6	Static
		3.4	Failure to achieve quality premium	Chief Operating Officer	Head of Clinical Quality	Quality premium payments are directly linked to achievement of supplier standards and targets and CCGs are effectively penalised for not achieving these	Impact on patients; loss of income to the CCG; reputational damage	Supplier actions relating to Quality Premiums are actively monitored by the quality team and Clinical Quality Committee; enhanced performance reporting is being introduced	None known	Clinical Quality Committee; Executive Committee	None known	Achievement of premium being pursued via individual premium linked targets. No timescales.	TOLERATE. Q1 premium not 100% achieved and some elements of Q2 (HCAI related) will be at risk. The CCG has set a tolerance level for specific targets. There is little more the CCG can do at this stage on 2013/14 Quality Premium targets.	16	16	4	4	16	Static
4)	TO IMPLEMENT SPECIFIC AND DEFINED SERVICE PATHWAY/PROVISION CHANGES	4.1	The improvement of standards in Primary Care is low and as a result does not support the CCG's commissioning reforms	Chief Operating Officer	Service redesign managers	CCG is responsible for Local Enhanced Services but will be deploying them differently to the former PCT	GPs could disengage; LESs may not link to wider reform strategy of the CCG	Service review process now in place. Virtual clinical review group established. Clinical networks in place.	None known	Executive Committee, Governing Body, locality meetings	None known	The Executive Committee has sponsored an Out of Hours Programme board with work focused on agreeing primary care standards. This is linked to the work of the Area Team. Next review April 2014.	TREAT as set out under actions with timescales.	12	9	3	3	9	Static
		4.2	Admission avoidance programmes are inadequate and do not support the objectives of the out of hospital strategy	Chief Operating Officer	Service redesign managers	CCG has set itself a target or reducing unnecessary admissions and this forms part of its quality and financial strategies	Failure to achieve QIPP targets; impact on end of year financial forecasts; loss of reputation with stakeholders	Executive committee review of performance	None known	Out of Hospital Strategy reports; Executive Committee; locality sub-committees; Governing Body oversight	None known	Out of Hospital Strategy; RSS now live. Review as part of out of hospital strategy April 2014.	TREAT as set out under actions with timescales.	12	12	4	3	12	Static
		4.3	Urgent Care System reforms do not have the required impact on the local health system	Chief Operating Officer	Service redesign managers	CCG has set itself a target or improving urgent care and this forms part of its quality and financial strategies	Failure to achieve QIPP targets; impact on end of year financial forecasts; loss of reputation with stakeholders	Programmes just being implemented - no evidence base as yet for whether they are being achieved	None known	Out of Hospital Strategy reports; Executive Committee; locality sub-committees; Governing Body oversight	None known	UC Board will oversee the urgent care system and improvements required for A&Es, in partnership with Kingston and SASH. No timescales as yet.	TREAT as set out under actions with timescales.	12	12	4	3	12	Static
		4.4	Reform of Elective Care systems does not achieve the necessary objectives	Chief Operating Officer	Head of Service Redesign	CCG has set itself a target or improving elective care and this forms part of its quality and financial strategies and supports admission and discharge objectives	Failure to achieve QIPP targets; impact on end of year financial forecasts; loss of reputation with stakeholders	Programmes just being implemented - no evidence base as yet for whether they are being achieved. Referral support systems are being put in place rapidly by October 2013.	None known	Out of Hospital Strategy reports; Executive Committee; locality sub-committees; Governing Body oversight	None known	Membership engagement on development of referral management system to ensure patient choice and optimisation of referrals. No timescales as yet.	TREAT as set out under actions with timescales.	12	12	4	3	12	Static
		4.5	Local transformation Boards fail to improve discharge pathways	Chief Operating Officer	Head of Service Redesign	CCG has set itself a target or reducing unnecessary admissions and this forms part of its quality and financial strategies	Failure to achieve QIPP targets; impact on end of year financial forecasts; loss of reputation with stakeholders	Programmes just being implemented - no evidence base as yet for whether they are being achieved	None known	Out of Hospital Strategy reports; Executive Committee; locality sub-committees; Governing Body oversight	None known	Ward walk around and bed audit to identify key changes in the discharge pathway, with joint working with Surrey Council, in view of future integration funds. No timescales as yet. An Epsom operational board is now in place.	TREAT as set out under actions with timescales.	12	12	4	3	12	Static
		4.6	The review of Continuing Health Care and a new CHC specification are unsuccessful	Chief Operating Officer	Head of Continuing Care	All stakeholder CCGs have identified the need to improve CHC systems and processes	Significant impact on patients and carers; loss of financial control; reputational impact; loss of confidence by other CCG's in SDCCG's ability to host	Significant work done - external review in progress - programme going forward as a result of this	None known	CHC Reference Group; Executive Committee fortnightly reporting; regular performance reports	CCG collaborative not yet signed up to outcomes of the review process	The Outcome of the review will be implemented between April 2014 and July 2015	TREAT as set out under actions with timescales.	16	16	4	4	16	Static
5)	TO ESTABLISH OPERATIONAL CONTROL OF SERVICES, CONTRACTS & BUDGETS	5.1	There is a failure to sign off 2013/14 contracts and their associated CQUINS	Chief Finance Officer	Head of Contracting	Contracting is a prime function of the CCG that impacts across domains of quality, finance and performance	Loss of control over finance and performance of any supplier without a contract	All main contracts and CQUINS for SDCCG signed	CCG does not yet have contracts in place for all suppliers.	Programme of review of out of hospital suppliers	None known	Ongoing contract review process	TREAT as set out under actions with timescales.	12	12	3	4	12	Static
		5.2	The 2014/15 Annual Contract planning cycle is poorly managed	Chief Finance Officer	Head of Contracting	This will be the first annual planning cycle wholly owned by organisations in the new system	Poor commissioning in 2014/15; potential loss of financial control	Planning for 2014/15 planning already commenced, current focus on business intelligence and adequate supporting data	None known	Executive Committee; Audit Committee; CCG Collaborative	None known	Report to Board and subsequent actions between now and March 2014	TREAT as set out under actions with timescales.	12	8	2	4	8	Static
		5.3	The contact database fails to adequately capture all contracts and aligned payments	Chief Finance Officer	Head of Contracting	Adequate contract database arrangements are a prime component of overall business and financial control	Loss of financial control	Contract database being developed in finance team	None known	Executive Committee; Audit Committee	None known	Contract database now nearly complete, non-clinical contracts still to be done	TOLERATE. Non clinical contracts database will be picked up in due course.	12	8	4	2	8	Static

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		5.4	Contracting and Commissioning Intentions are not in place for all contracts	Chief Finance Officer	Head of Contracting	Adequate statements of commissioning intent are a prime component of overall business and financial control	Loss of financial control	Contract position is known and a contract database is established	None known	Executive Committee; Audit Committee; Governing Body; locality meetings	None known	Work ongoing between now and February	TREAT as set out under actions with timescales.	12	12	4	3	12	Static
		5.5	The contract Review process is not adequate to support quality and effectiveness of services	Chief Finance Officer	Head of Contracting	Contract reviews are a primary mechanism for monitoring suppliers and ensuring they take remedial action around poor performance in relation to quality and financial performance.	Negative impact on quality, performance and financial control	Contract review meetings happening and minuted; remedial actions taken as a result of poor contract performance	None known	Executive Committee, Governing Body, locality meetings	None known	Contract review process to be reviewed at end of year for effectiveness over first 12 months	TREAT as set out under actions with timescales.	12	9	3	3	9	Static
		5.6	Primary Care Contracts within the CCG's remit (LES and GPSI) are poorly managed	Chief Operating Officer	Service Redesign Managers	CCG is responsible for Local Enhanced Services but will be deploying them differently to the former PCT	GPs could disengage; LESs may not link to wider reform strategy of the CCG	LESs have been discussed at Executive Committee during August, proposals being worked up for September	None known	Executive Committee, Governing Body, locality meetings	None known	Prioritised within delivery plan and programme of work in place. No timescales as yet.	TREAT as set out under actions with timescales.	12	12	3	4	12	Static
		5.7	The Better Care fund and Partnership funding generally are not utilised in line with the CCG's strategic objectives	Chief Operating Officer	Head of Contracting	Partnership funding is a key element of the CCG's ambitions to reform the local health care system and achieve more integration of care	Potential impact on strategic objectives (out of hospital strategy) and financial sustainability	Has been discussed in Executive Committee - issue for 2014/15 planning	None known	Executive Committee, Governing Body, locality meetings	None known	Forum now established with Social Care, discussions ongoing. To be concluded by March 2014.	TREAT as set out under actions with timescales.	12	16	4	4	16	Static
6)	TO ESTABLISH EFFECTIVE GOVERNANCE	6.1	The SDCCG Constitution is not maintained and developed and fails to be a live tool of Governance	Chief Operating Officer	Governing Body Secretary	The constitution sets the ground rules by which the whole organisation is governed, including the relationship between the Council of Members, Governing Body, Committees, and localities.	If the constitution is not fit for purpose it can lead to loss of control, lack of clarity as to where responsibilities and accountabilities lie and could damage the organisation's ability to govern itself. This could lead in turn to poor outcomes, loss of public confidence and potentially continued authorisation.	Constitution is a live document - reviewed and amended with the agreement of NHS England (Version 3 effective from end of August 2103). Further review and amendments submitted 1st November 2013.	None known	Audit Committee; Council of Members; Governing Body review.	None known	Awaiting feedback from NHS England on changes submitted in November. Scheme of Delegation to be reviewed by end of January.	TREAT as set out under actions with timescales.	8	8	2	4	8	Static
		6.2	Principal Governing Body Committees are ineffective or fail to co-ordinate their assurance roles	Chief Operating Officer	Governing Body Secretary	Committees have extensive delegated authority for assurance of principle objectives and core business - all committees must be strong in governance terms in order to meet this delegated responsibility and contribute to the overall effectiveness of the organisation	Loss of strategic and operational control; inability to comply with the requirements of the annual governance statement; potential impact on ongoing authorisation	Governing body committees have developed extensively over the last eight months - reviewed terms of reference as part of amendments to the constitution - all have effective chairs and membership arrangements. A joint meeting of the Audit and Quality Committees in Oct 2013 highlighted the need for a joined up approach.	None known	Audit Committee review and oversight; Governing Body oversight. Internal audit review. Committees review of own effectiveness as part of their terms of reference	None known	Joint Chairs of Committees meeting planned for January 2014 to review effectiveness and plan for formal evaluation at year end.	TREAT as set out under actions with timescales.	12	8	2	4	8	Static
		6.3	The Governing Body Assurance Framework is not adequate to enable the group to assess its risks to its principle objectives	Chief Operating Officer	Governing Body Secretary	The GBAF is at the centre of the CCG's system of internal controls along with the risk management strategy and the risk register and needs to be effective in keeping the governing body focused on principal objectives and risks	Loss of strategic and operational control; inability to comply with the requirements of the annual governance statement; potential impact on ongoing authorisation	GBAF has been developed in line with discussion at GB seminar, discussion at Audit Committee and input from auditors	None known	Audit Committee review and oversight; Governing Body oversight. Internal audit review.	None known	The Governing Body Assurance Framework has been updated following discussions at Audit Committee and in the Governing Body however there is a continuing need to improve ownership and value of the GBAF as a tool and to develop discussion on risk appetite and risk tolerance. Further discussion at January Audit Committee. A review of the effectiveness of risk mechanisms was carried out in December 2013 and this will be circulated for discussion.	TREAT as set out under actions with timescales.	8	6	2	3	6	Static
		6.4	SDCCG fails to discharge its remaining authorisation conditions or has new conditions placed upon it	Chief Operating Officer	Transition Manager	CCG was authorised with seven conditions from 1st April 2013	Reputation; CCG subject to continued scrutiny; resources required for core business diverted to meeting review process conditions	Delivery Plan implementation and Assurance Framework will give assurance that there is no significant threat to continuing authorisation.	None known	Executive Committee; Governing Body	None known	Final Conditions removed October 2013. In order to maintain its authorisation the CCG needs to perform satisfactorily to avoid conditions being re-imposed. No timescales required.	TOLERATE. May be reviewed if signs emerge of deterioration in performance.	8	4	1	4	4	Static