Title of paper:	Assurance Framework and Risk Register		
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Meeting:	Governing Body		
Agenda item:	16	**Attachment:**	13
For:	Information		

Executive Summary:

Positive developments

The culture of risk management is now stronger. Managers are more likely to raise the need to reflect issues in the risk register or to refresh existing risks. The bi-monthly refresh for the Governing Body formal meetings shows an increasingly sophisticated understanding of risk and actions to mitigate risk than in the past.

The Governing Body can be assured that risk is visible and regularly reviewed.

Areas for improvement

A number of risks are contained in local risk registers e.g. for CHC, EPRR etc. These are not integrated into the overall corporate risk register although they are linked.

The implementation of Datix has been delayed by the IT migration and subsequent delays in CSU support. Without this system it will not be possible to ensure that there is a totally integrated system of risk management in the CCG.

Assurance framework

The assurance framework has been refreshed for the new year but using the existing six clinical and four non clinical priorities.

Risk register

A number of risks have been refreshed for the new financial year. There are 13 risks rated as red, two of which have deteriorated since the last report. These are:

- Primary Care Co-Commissioning where the CCG has been told to by NHS England to re-apply. This means there is now a degree of strategic uncertainty and a lack of control over primary care contracting that impacts on

overall transformation.

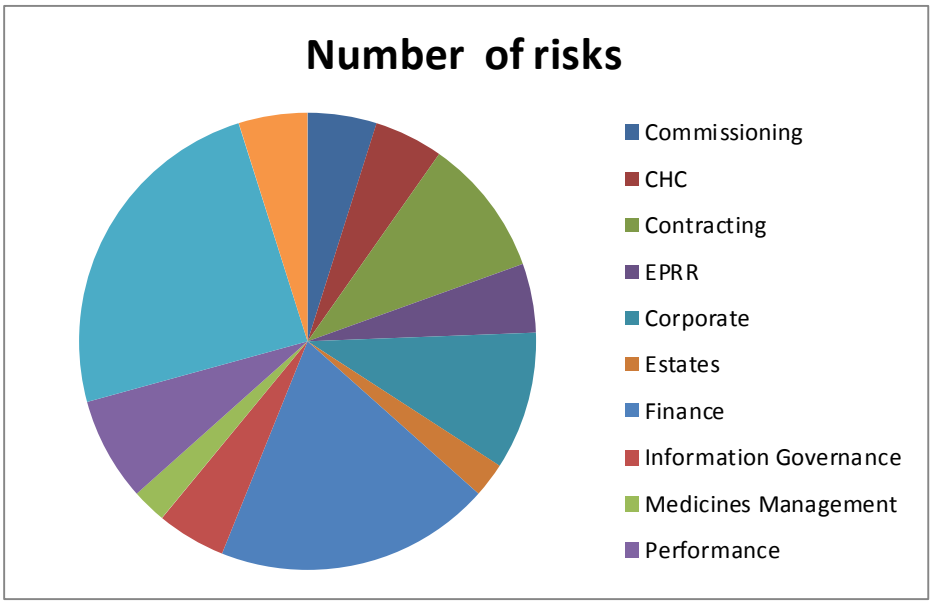
- Constitutional compliance. This should only be red in the short term; a number or amendments were made in line with the co-commissioning proposal but as this has been turned down they need to be reviewed again.

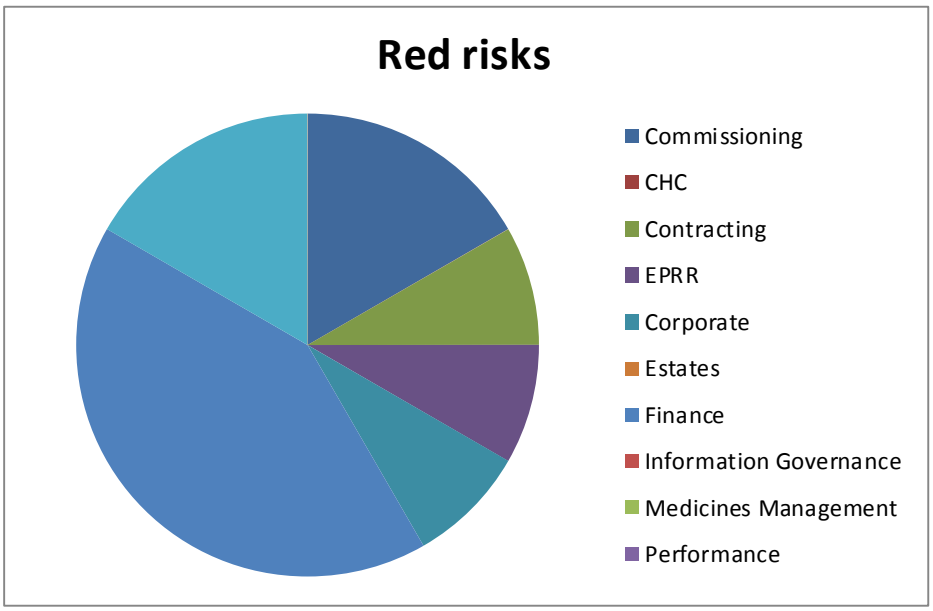
There is a new red risk reflecting staffing at CSH which will remain high until strategies in development can resolve structural workforce issues. The provider is the first line of defence for this risk operationally and the risk is strategic rather than operational.

There is also a new red risk around stroke which Governing Body members will be familiar with from the discussions at the last seminar.

Other red risks will be familiar from previous reports and are analysed on the following page.

Risks by category	Number of risks	Red risks
Commissioning	**2**	**2**
CHC	2	0
Contracting	4	1
EPRR	2	1
Corporate	4	1
Estates	1	0
Finance	8	5
Information Governance	2	0
Medicines Management	1	0
Performance	3	0
Quality	10	2
Service Redesign	2	0
Total	39	10





Compliance section Please identify any significant issues relating to the following	
Risk Register and Assurance Framework	See above
Patient and Public Engagement	No significant issues – engagement takes place as appropriate to each risk.
Patient Safety & Quality	Eight of the thirty nine risks have a quality or patient safety component
Financial implications	Eight of the thirty nine risks have a finance component
Conflicts of interest	No significant issues
Information Governance	Two of the risks have an information governance component
Equality and Diversity	There is one risk relating to equality duty
Any other legal or compliance issues	One risk is currently in legal process
Accompanying papers (please list): Latest version of the Assurance Framework; latest version of risk register	
Summary: What is the Governing Body being asked to do and why? To NOTE the changes and overall position with the assurance framework and risk register.	

Organisational Objective	Risk Area	Risk Owner (Executive)	Main responsible committee	Risk Manager	Title of risk	Risk Description: "There is a risk that..."	Source of risk (where does this come from)	Potential effect of the risk (what might happen)	Assurance (What do we know that gives us confidence in meeting the objective)	Gaps in assurance (What don't we know that could undermine achievement)	Controls (what can we do to have a positive impact)	Gaps in Controls (what do we lack control over)	Pre mitigation Likelihood Score	Pre-mitigation Impact Score	Net initial Score	Date of initial score	Date of last update	Updated Likelihood Score	Updated Impact Score	Updated net Score	T Value (Treat, Tolerate, Terminate or Transfer)	If "Treat", set target score at which risk can be tolerated or terminated	If "Treat" set date by which target score will be achieved	Trend	Comments
Clinical Priority 1: Maximise integration of community and primary care based services with a focus on frail older people and those with LTC	Delivery	Chief Op Officer	Quality	**Helen Cook**	Failure to integrate services for key vulnerable groups	The CCG might not be able to integrate primary and community services (including CHC) for key vulnerable groups as an essential part of reforming local delivery.	Currently the lack of integration reduces the quality of care for patients and does not support the CCG's overall strategic programmes e.g. Out Of Hospital strategy	Impact on quality of care and financial sustainability	This priority is programme managed and delivery is assured through the PMO and there is a significant programme for the CHC Transformation Project	Benefits realisation is currently under-developed and the CCG has no dashboard for measuring benefits in some programme areas	Contractual changes to service delivery; actions agreed through transformation boards; actions to reform CHC	The CCG is limited in its ability to direct the actions of other agencies in some areas e.g. nursing homes, community equipment, patient transport	3	4	**12**	01/04/2014	08/04/2015	5	3	**15**	Treat	8	31/03/2015	**Static**	The integration agenda was difficult to progress during 2014-15 due to a lack of investment and dificulties in reconfiguring services. The CCG had planned to use the Vanguard Programme and Co-Commissioning of primary care but despite strong business cases these options are not currently open to the CCG. It is hoped that co-commissioning will be approved in future but there are no timescales at present. The CCG does have an agreed vision for integrated care with Epsom St Helier and CSH Surrey which needs investment and resourcing from alternative sources.
Clinical Priority 2: Provide elective and non-urgent care, specifically primary care, care closer to home and improve patient choice	Delivery	Dir of Comm and Strategy	Quality	**Phillipa Marden**	Failure to provide appropriate access to non-urgent and elective care	Insufficient pathways are reformed for this priority to be considered successful, or the providers and their associated workforce cannot be developed to sufficiently transform services.	Currently elective and non-urgent care is below optimal practice and there is a particular need to develop primary care to support improved care pathways.	Services continue to be developed in outmoded ways and both quality of care and use of resources are sub-optimal.	There is good information on how Surrey Downs CCG benchmarks against other comparable and national CCGs in relation to care pathways and best practice.	Reaction to the primary care offer cannot be easily predicted and is an ongoing development.	Contractual changes to service delivery; actions agreed through transformation boards; actions to reform primary care supply including development of the primary care offer.	Take-up of the primary care offer is not mandatory; contractual reforms may not operate to the timescales that best fit CCG milestones for transformation.	4	4	**16**	01/04/2014	08/04/2015	4	4	**16**	Treat	8	30/03/2015	**Static**	In line with clinical priority 1, this has been difficult to progress due to the difficulties in reconfiguring the system and creating investment for change. The CCG does have a clear vision for how to redesign care locally and this will be taken forward as part of the plan to develop a sustainable health economy. As above, greater influence over primary care will be key.
Clinical Priority 3: Urgent Care; Ensure access to a wider range of urgent care services	Access	Dir of Comm and Strategy	Quality	**Tom Elwick**	Failure to provide access to urgent care	Paqtients will default to emergency acute settings and that A&E will be overwhelmed	Known issues about inappropriate use of urgent care access points and subsequent care pathways	Patients are treated inappropriately or admitted to inappropriate care pathways; significant resources are expended on inappropriate care causing over-activity in acute sector	The CCG has access to a wide range of data sources on best practice and local usage of urgent care services.	There are no know significant gaps in assurance	The CCG can use contractual levers and work through transformation boards and urgent care boards to improve urgent care co-ordination	There are often data lags in information about use of urgent care; work with p[primary care is linked to other initiatives and incentives; urgent care boards can highlight areas for action but not mandate them.	4	3	**12**	01/04/2014	08/04/2015	3	2	**6**	Treat	6	31/03/2015	**Static**	Surrey Downs reeisdents have enjoyed good access to urgent care with winter performance locally exceeding that of comparable systems, i.e. with A&E performance. System Resillience Groups have been effective in co-ordinating care between agencies and additional funds have been deployed effectively. The current score reflects this sucessful emergence from the winter period. This has however led to pressures on other clinical priorities specifically 1 and 2 above where the wider system and the conversion between urgent care and hospital admissions needs improvement.
Clinical Priority 4: Enhanced Support for End of Life Care Patients	Patient Experience	Chief Op Officer	Quality	**TBC**	Failure to improve the end of life care experience	End of Life Care services will be inadequate and people will not be supported to die in their place of choice	Current service provision which can be improved both operationally and in terms of service design	People at the end of their lives and their families have a poor quality of life leading up to their death.	Current levels of service and how they compare to best practice are known as are the deficiencies in information sharing between primary care and other sectors.	There is a lack of qualitative data on patient experience	The CCG can implement improved data sharing with member practices and commission improved night time services	The CCG does not have operational control over other agencies	4	3	**12**	01/04/2014	08/04/2015	2	4	**8**	Tolera te	8	31/03/2015	**Static**	There has been steady improvement in end of liffe care as reflected in the scores but there remain issues with required software solutions and interagency working. There is a high level of integration with clionical priorities 1 and 2 in this respect and further progress wil;l be dependent on wider system reform.
Clinical Priority 5: Improve experience of Children's and maternity services	Patient Experience	Dir of Comm and Strategy	Quality	**Deborah Russell**	Failure to improve maternity and children's Services	Services will not be improved to best practice levels in key areas such as CAMHS, hospital and community paediatrics, and therapies for children	Current service provision which can be improved both operationally and in terms of service design	There could be a significant failure in services (particularly safeguarding) and / or a long term inefficiency in service delivery	Current levels of service and how they compare to best practice are known.	There are no significant gaps in assur4ance (data is good)	Contracts with main providers, work with primary care	A lot of service provision can only be improved with the support of other agencies e.g. Surrey County Council and NHS England which the CCG has no direct control over]	4	3	**12**	01/04/2014	08/04/2015	2	3	**6**	Treat	6	31/03/2015	**Static**	There has been significant progress on children's services throughout the year and this is reflected in the current position. The CCG now has a very robust position on joint working with the leader commissionier and Surrey County Council. There are some limits to CAMHS investment which may emerge as a risk during 2015/16.

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Clinical Priority 6: Improving patient experience and parity of esteem for people with Mental Health and Learning Disabilities (including Dementia)	Patient Experience	Chief Op Officer	Quality	**Deborah Russell**	Failure to improve mental health and learning disability services	People with mental health problems and learning disabilities will continue to be marginalised and lack proper access to service; MH may be regarded as lower priority than physical health	Current service provision which can be improved both operationally and in terms of service design; Potential delays in decision-making & action planning for pan-Surrey service improvements	Failure to improve mental health with potential knock-on effect for patients' physical health - potential increase in social isolation and manifesting problems e.g. stigma from MH conditions; suicide; impact on service user mental & physical health	Whole system collaborative groups (incl working groups) are well-established to prioritise MH operational plans. There is some national published data relevant to these programmes – including intelligence tool from MH & dementia networks (Public Health England)	A no of projects are currently only at the mandate stage & there is limited data available for Surrey Downs patients - as these are mostly new projects	Influence the MH & LD Clinical collaborative forum to be action focused rather than just strategy; influence contracts – moving towards more directive, commissioner-led discussions with providers (to increase buyer power), & strengthen working with public health around prevention schemes	A number of pieces of work are joint with other CCGs in Surrey (including initiatives developed in partnership with Surrey H&WB) and can only progress at a jointly agreed pace	4	4	**16**	01/04/2014	08/04/2015	3	4	**12**	Treat	9	31/03/2015	**Static**	Although a joint strategy for emotional health and wellbeing has been agreed, implementation of this will only take place in successive years. This is reflected in the improvement in scores during the year but the position is now unchanged at year end until strategies are operationalised. In addition there are national requirements for investment in mental health services which may not fit with local financial recovery and other priorities.
Non-clinical priority 1: Implement agreed strategies	Strategy	Dir of Comm and Strategy	Executive	**Dir of Comm and Strategy**	Failure of strategy	Failure to implement overarching strategies e.g. Out of Hospital Strategy, Quality Improvement Strategy	CCG's own strategic programmes which are geared towards long term transformation	Although there may not be an in-year risk, the failure to make progress with individual strategies could have a significant impact on the sustainability of the CCG, its QIPP expectations, and longer term improvements for patients.	Strategies are all in CCG's control and are reported on to the Executive Committee	No significant gaps	The CCG has the ability to establish projects to support the delivery of strategies or component parts of strategies.	Most strategies rely to a greater or lesser degree on partner agency co-operation and collaboration	3	4	**12**	01/04/2014	08/04/2015	4	4	**16**	Treat	9	31/03/2015	**Static**	Deteriorating as the impact of financial recovery, the review of community hospitals and primary care commissioning indicate that existing strategies need to be reshaped to address the new local agenda.
Non-clinical priority 2:Improve quality and performance of commissioned services	Quality and Performance	Chief Officer	Quality	**Eileen Clark**	Quality of commissioned services	Quality and key targets for supplier performance do not improve or deteriorate	Breadth and depth of CCG's commissioning responsibilities and diversity of contracting arrangements	This would impact on patient care and patient safety	The CCG has assurance with major suppliers from regular contract meetings and through quality initiatives at local and county level; also from published performance information; initiatives such as visiting programmes; county wide monitoring e.g. of infection control	Performance data often has long time lags meaning it is not up to date; some areas are not commissioned directly by the CCG e.g. specialised services.	Use of contract levers and penalties; joint working on areas of quality improvement; CQUINs	Not always possible to undertake direct action if the contract sits with a host commissioner	4	3	**12**	01/04/2014	08/04/2015	3	4	**12**	Treat	8	31/03/2015	**Static**	In broad terms quality targets are being met although there are specific areas such as Healthcare Acquired Infection where there is ongoing work to resolve less tractable problems. Work is being done with AQP suppliers and the Quality Improvement Strategy continues to be developed.
Non-clinical priority 3:Develop the organisation	Organisational Development	Chief Officer	RNHR	**Chief Operating Officer**	The organisation does not change in ways that deliver the organisation's objectives	Organisational Development will not keep pace with the demands of the CCG or its own stated aims and strategies	This is an inherent risk for all organisations	Potential for gaps in workforce to undermine delivery; structures not aligned to delivery;	Regular review of vacancies with CSU; testing of staff attitudes via staff survey; benchmarking against other CSUs e.g. for sick ness absence; Framework of Excellence programme (see comments).	No significant gaps	Ability to set own organisational structure; ability to work with staff to align workforce to objectives; control over committee terms of reference	Constitution must have NHS England approval	4	3	**12**	01/04/2014	08/04/2015	4	4	**16**	Treat	8	31/03/2015	**Static**	An organisational development plan is currently being prepared by the Chief Operating Officer which will seek to address the changing focus of the organisation around financial recovery and systems transformation. This wil include clinical leadership and the development of staff and the support requried from the CSU. This risk will remain significant until the CCG can demonstrate that the OD changes are having an impact on the CCG's ability to manage its priorities.
Non-clinical priority 4:Achieve financial balance	Finance	Chief Fin Officer	Executive	**Dan Brown**	Achieving financial balance	The CCG fails to achieve financial balance or shifts the impact into one or more subsequent financial years	Inherent risk for all NHS organisations	Direct impact on services provision; loss of flexibility; potential for NHS England to invoke conditions or directions; reputational impact	Monthly finance reports plus local data and intelligence	Time lags in getting activity and finance information on key suppliers	Ability to agree end of year position with major suppliers; contract levers; process for contract challenges.	Key areas such as CHC, specialist services, and medicines are difficult to manage in a "real time " way	4	4	**16**	01/04/2014	08/04/2015	5	4	**20**	Treat	4	31/03/2015	**Static**	The CCG ended 2014/15 with a significant deficit circa £10.5m. As a result the CCG is in discussions with NHS England on a phased recovery plan that is based on transforming the local health economy with partners. The control total for 2015/16 has yet to be finalised with NHS England. The risk will be to failure to achieve the agreed figure for this year rather than financial balance as such which will be achieved over the longer period.

Title of risk	Status	Executive Risk Owner	Main responsible committee	Relevant Assurance Framework Area	Risk Description: "There is a risk that..."	Source of risk (where does this come from)	Potential effect of the risk (what might happen)	Date of latest scoring	Likelihood Score	Impact Score	Revised Net Score	Trend (change since last Governing Body report)	T Value (Treat, Tolerate, Terminate or Transfer)	If "Treat", set target score at which risk can be tolerated or terminated	If "Treat" set date by which target score will be achieved	Actions and Comments
Financial Recovery Plan	Awaiting approval	Chief Fin Officer	Executive	10 Financial Balance	Over the lifetime of the recovery plan, there is a risk that the individual programmes will not be sufficient to address the overall deficit	The complex programme management arrangements, the level of deficit, and the uncertain financial environment	At the end of the agreed recovery plan, the CCG may still be in deficit	07/04/2015	3	5	**15**	**Static**	Treat	4	31/03/2018	Discussions in hand with NHSE England and extensive feedback from Deloitte on potential areas for development., Draft recovery plan in place. Still subject to detailed development of projects and programmes. Additional resource to programme management has been put in place.
Staffing in CSH Surrey	Awaiting approval	Dir of Comm	Quality	8 Quality and Performance	Difficulties with staffing in key areas will seriously affect CSH Surrey's Business Continuity arrangements and their ability to deliver services	Shortages of speech and language therapists and nursing staff (in community hospitals)	Patients will suffer due to loss of service,in particular experiencing longer waits or transfers to other locations	07/04/2015	4	4	**16**	**N/A**	Treat	8	30/09/2015	Risk identified in quality committee following concerns about workforce issues in specific areas. Being managed by provider as first line of defence but has strategic impact on i.e. review of community hospitals.
Stroke services	Awaiting approval	Dir of Comm	Quality	8 Quality and Performance	Risk that poor performance at Epsom will continue and that there will be delays in resolving Surrey wide issues with designating specialist sites.	Poor configuration of services in Surrey; need for services to have adequate volumes of patients to maintain clinical skills; workforce supply problems	Direct impact on patients e.g. poor clinical outcomes etc	07/04/2015	4	4	**16**	**N/A**	Treat	4	31/03/2016	Aim is to make stroke pathway an essential element of the integrated care model, so is part of wider system reform as well as being a current performance issue.
Tariff changes	Open	Dir of Comm	Executive	10 Financial Balance	Tariff changes at national level will add to financial recovery requirements	National policy changes	Additional cost pressures	09/04/2015	4	3	**12**	**Static**	Tolerate	N/A		Awaiting outcomes of national discussions but current position is that CCG is exposed to significan risk due to differential tariff operation particularly in London vs locally. CCG has limited control so remains in position of having to tolerate this risk.
Primary Care and Co-Commissioning	Open	Chief Op Officer	PCC	7 Strategy	It may not be possible to exploit co-commissioning with NHS England to the required extent	Co-commissioning is at NHSE discretion and joint arrangements mean that decision making must be bilateral through joint committee arrangements	Agreed arrangements do not support transformation and local provider development	07/04/2015	4	3	**12**	**Deteriorating**	Tolerate	N/A		CCG has been told that it will have to re-apply as its co-commissioning bid for this year is not going forward. Awaiting further guidance from NHS England on timescales and process. Tolerate pending this.
Provider development	Open	Dir of Comm and Strat	Executive	7 Strategy	Providers, particularly community services and primary care networks, may not develop sufficiently to deliver the CCG's strategy	The need to integrate provider activities to develop more cost effective and high quality services in line with the five year forward view	Failure to integrate care and achieve the necessary transformation	09/04/2015	4	4	**16**	**Static**	Treat	8	31/03/2016	This remains high risk as the CCG was unsuccessful with its Vanguard bid although has been successful with the Prime MInisters Challenge Fund bid for Epsom. The aim is to proceed with providers responding to agreed changes in pathways, which will benefit patients and support financial recovery. Investment will be needed to realise this.
Risk to child safeguarding	Open	Chief Op Officer	Quality	5 Children and Maternity	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; significant reputational risk	07/04/2015	1	4	**4**	**Improving**	Tolerate	N/A		No change but final report on work of safeguarding board awaited.
Specialist Equipment in the community	Open	Chief Op Officer	Quality	8 Quality and Performance	The CCG is not assured that certain historically provided specialist equipment being used by healthcare staff in the community is fit for purpose.	There is a central database detailing specialist equipment held by Millbrook (SP), but some old equipment may not be on this system.	Potential risk of harm to patients and operators of the equipment	07/04/2015	3	3	**9**	**Static**	Tolerate	N/A		Needs discussion with providers, starting with CSH. Work ongoing. Constrained by capacity in quality team. Change to 'tolerate' because we are not able to directly influence the situation but are assured that the current process for equipment going forward is robust.
Catastrophic Provider failure	Open	Dir of Comm and Strat	Quality	8 Quality and Performance	An unexpected clinical failure of a Provider takes place 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	07/04/2015	2	4	**8**	**Static**	Tolerate	N/A		No change to net score. Main concerns are with care homes rather than big suppliers. Processes for early warnings are now improved and support a rapid response where needed.16.01.15 update - remain as 'tolerate' no change to score.

Infection Control	Open	Dir of Comm and Strat	Quality	8 Quality and Performance	Significant failings with commissioned services in relation to Health Care Acquired Infection	Local Providers may fail to meet agreed quality standards around Health Care Acquired Infection practice with the subsequent risk to patient safety and experience. Also lack of in depth expertise and capacity in this area across Surrey CCGs to enable robust monitoring. DH requirements for investigation of incidents.	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.	07/04/2015	4	3	**12**	**Static**	Treat	6	31/03/2016	CCG continues to work collaboratively acros Surrey to identify effective ways to share capacity and resource. Local targets failed for 2014/15 - Operational risk around 2015/16 remains high. Quality team seeking additional resource to work with providers on resolving issues.
Safeguarding Adults	Open	Chief Op Officer	Quality	8 Quality and Performance	Potential for preventable harm to Surrey Downs (and 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; reputational risk to the NHS.	07/04/2015	1	4	**4**	**Improving**	Tolerate	N/A		There is now a new health sub group meeting regularly to look at Adult Safeguarding.
Care home failures	Open	Chief Op Officer	Quality	8 Quality and Performance	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. Reputational risks to the NHS and joint agencies.	07/04/2015	4	2	**8**	**Static**	Tolerate	N/A		This is an ongoing risk which may escalate dependent on the development of the wider market for care homes. Reviewed in care homes forum.
Quality of care in Care Homes	Open	Chief Op Officer	Quality	8 Quality and Performance	The nursing care provided in care homes and care homes with nursing in Surrey Downs (and Surrey) is not of a suitable standard to ensure the safety and well-being of residents	Variable standards of care from a range of small and large providers highlighted by - Safeguarding referrals - Serious incident reporting - Complaints - Soft intelligence - CQC reports	Actual harm to individuals. Reputational risks to the NHS and joint agencies.	07/04/2015	4	3	**12**	**Static**	Treat	6	31/03/2015	Ongoing review and monitoring at this stage with escalation around in dividual homes where there are identified concerns.
Failure to achieve quality premium	Open	Dir of Comm and Strat	Quality	8 Quality and Performance	Quality premium payments are directly linked to achievement of supplier standards and targets and CCGs are effectively penalised for not achieving these	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	07/04/2015	4	4	**16**	**Static**	Tolerate	N/A		Quality premium lost in 14/15 - Discussed in quality committee and in Exec - outside possibility of some rebate. Risk has been renewed from 1st April for new financial year.
Major incident preparedness	Open	Chief Op Officer	Executive	Other / operational	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 / public safety and use of resources. Reputational impact of failing to respond appropriately.	07/04/2015	3	5	**15**	**Static**	Treat	10	02/01/2015	Net score unchanged. No significant development this quarter. Recent staff turnover will mean requirement for additional training in Q1 of 2015/16
Potential failure of Information Governance	Open	Chief Officer	Executive	Other / operational	Surrey Downs CCG will be adversely affected by failure to meet high standards of information governance (NHS IG Toolkit)	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	07/04/2015	1	4	**4**	**Improving**	Tolerate	4		IG Toolkit self assessment for 2014/15 was at level 2 for second year running. IG steering group now in place. This risk effectively mitigated but will increase as toolkit scores are reviewed in year for 2015/16.

Equality Duty	Open	Chief Op Officer	Executive	9 Organisational Development	Risk that Surrey Downs CCG will fail to comply with the 2010 Equality Act and face regulatory action	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. both as a commissioner and employer	07/04/2015	2	4	**8**	**Static**	Tolerate	N/A	31/03/2015	Draft annual report published - programme of work planned for 2015/16 - score reduced from 3x4 to 2x4 but will need to be revisited in the autumn if the CCG cannot demonstrate that it has made progress e.g. with EDS2. Recommend tolerating risk at this level until next review. Information now being co-ordinated on our patient population. Recruitmenty timetable in place to replace Patient Engagement manager which is key post in moving these issues forward.
Business continuity	Open	Chief Op Officer	Executive	Other / operational	Inadequate business continuity plans will mean that the CCG is incapable of functioning or that there will be an extended recovery time before normal service is resumed.	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	07/04/2015	2	4	**8**	**Improving**	Tolerate	8	30/11/2015	Net score unchanged. Business continuity policy and plans approved by Exec 27/01/15. Heads of service briefed on need for robust approach to business continuity during the winter period. Target score amended from 6 to 8 to reflect practical difficulties of eliminating this risk given Cedar Court flood plain location.
Information Security Issues in South CSU	Awaiting closure	Chief Op Officer	Executive	Other / operational	Weaknesses may exist in the CCG's IT Security that could impact on CCG networks and data	Information Security risks identified in the CSU by auditors and through the IG toolkit	Loss of data; loss of patient identifiable information.	07/04/2015	1	1	**1**	**Improving**	Tolerate	N/A		Weaknesses were in former CSU security, recommend that this risk is now closed and incorporated in the existing year-on-year IG toolkit risk.
Risks arising from transfer of CSS	Awaiting closure	Chief Fin Officer	Executive	9 Organisational Development	Business critical services will fail / under-perform during the transition to a new Commissioning Support Service	CSS Transition Program July - April 2014 / 2015	Loss of or impact on any of the following functions: IG, Contracting, Finance, IT, HR Services, Serious Incident Reporting	07/04/2015	1	3	**3**	**Static**	Tolerate	N/A		All Commissioning services have transitioned to SECSU or CCG from SCS. Only remaining issue is to finalise SLA. Recommended for closure.
Constitution	Open	Chief Fin Officer	Executive	9 Organisational Development	Risk of the constitution not being fit for purpose	Inherent risk in all CCG's governance	Risk that decisions of the Group, Governing Body or its constituent parts might be invalidated; risk of judicial review; reputational risk	07/04/2015	4	4	**16**	**Deteriorating**	Treat	N/A	31/07/2015	There is a heightened short term risk whilst the CCG introduces new governance structures which means that these need to be incorporated into a revised constitution for submission to NHS England. It is expected that this risk will be mitigated substantially over the next few weeks. Operationally the issues are being managed and roles are clear.
Governing Body and Committee effectiveness	Open	Chief Fin Officer	Audit	Other / operational	The Governing Body and Principal Governing Body Committees are ineffective or fail to co-ordinate their assurance roles	Inherent risk in all CCG's governance	Loss of strategic and operational control; inability to comply with the requirements of the annual governance statement; potential impact on ongoing authorisation	07/04/2015	4	3	**12**	**Deteriorating**	Treat	8	31/07/2015	Full review of scheme of delegation and committee terms of reference largely completed. Analysis of results from self-assessment tool completed to help committees and the GB assess effectiveness. This will be used in conjunction with the ITT for external facilitation, for which three responses have been agreed. New finance and performance and primary care committees established.
CHC impact on Financial balance in 215/16	Open	Chief Fin Officer	Executive	10 Financial Balance	Risk that SDCCG inherits an unforeseen deficit as a result of the ongoing issues and risks around historic (i.e. pre April 2013) CHC retrospective claims	History of retrospective claims arising from transition period	The CCG could have to deal with a significant non-recurrent cost pressure	09/04/2015	3	3	**9**	**Static**	Tolerate	N/A	01/04/2016	2014/15 risk refreshed for 2015/16. Level of risk for this financial year cannot be quantified at this stage - will need to be reviewed.
Homecare medicines safety	Open	Dir of Comm and Strat	Executive	8 Quality and Performance	Risk that community patients may not receive a safe service in specific clinical areas.	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	09/04/2015	4	3	**12**	**Static**	Tolerate	N/A		No gaps in assurance from providers since last report - providers have provided required assurance and are working with homecare companies but this does remain a risk that needs to be kept under review.
Secamb Cat A Performance	Open	Dir of Comm and Strat	Quality	3 Urgent Care	Risk that SECAMB cannot ensure acceptable performance in relation to Category A response times.	SECAMB published performance information	Risk of potential harm to patients; impact on NHS reputation	09/04/2015	4	3	**12**	**Static**	Tolerate	N/A	31/03/2016	Risk refreshed for 2015-16. Red 1 (defib required) is being met Red 2 all (other) is not being met. A review of harm to patients where standards not met is done and an analysis of this is being discussed at quality committee. No further actions possible whilst outcomes of host commissioner actions is awaited.
SECAMB Patients transport	Open	Dir of Comm and Strat	Quality	8 Quality and Performance	Risk that SECAMB cannot achieve acceptable performance in relation to Patient Transport response times.	SECAMB Patient Transport performance is currently below expectations.	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)	09/04/2015	3	3	**9**	**Static**	Tolerate	N/A		Performance has improved marginally. This service is now being reprocured but a one year extension is being negotiated to give more time to do this properly. SCC have led a Surrey wide model to develop a future specification and will lead on this with a procurement plan. Tolerance set at current level pending completion of procurement. Trust continues to try and improve operational performance.

Capacity and surge planning	Open	Dir of Comm and Strat	Executive	Other / operational	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, 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.	07/04/2015	3	4	**12**	**Static**	Treat	12	31/12/2015	Significant issues since last report but system as a whole continues to cope well. Remains a significant risk. Teleconferences with Area Team continue and linked closely to monitoring of performance. Holding risk at current levels pending May bank holidays and further assuirance on 111 services.
GP IT infrastructure	Open	Chief Op Officer	Executive	Other / operational	Ageing computers, peripherals and network connections could fail or have insufficient capacity to manage practice workload.	Limited resources available and the uncertain year-on-year nature of the allocation process for the South of England.	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.	07/04/2015	2	3	**6**	**Improving**	Tolerate	N/A		Risk not material at this stage - will need to be re-assessed early in 2015/16 financial year. Existing programme is being rolled out, new capital allocation will be known shortly. New position is that all equipment will be no more than five years old as a result of technology refresh.
Continuing Care Retrospective Reviews team capacity	Open	Chief Op Officer	Executive	1 Integration of care	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	09/04/2015	3	4	**12**	**Static**	Treat	9	31/12/2015	The programme of retrospectives should be completed by December, three months ahead of schedule
Failure to deliver CHC assessments within nationally mandated timescales	Open	Chief Op Officer	Executive	1 Integration of care	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	09/04/2015	3	4	**12**	**Improving**	Treat	8	30/09/2015	Improving - risk reduced from 16 to 12 - but there remain ongoing staffing risks. Although the localities are at 80% the re are still issues in the hub team and the Previously Unallocated Periods Of Care (PUPOC) team.
EDICS - contractual arbitration	Open	Chief Fin Officer	Audit	10 Financial Balance	Suffering a financial and reputational loss as a result of the determination of costs relating to EDICs	Cessation of EDICs contract July 2013	Significant financial risk circa £0.5 - £2.5m	08/04/2015	4	3	**12**	**Static**	Tolerate	N/A		No change. Still in arbitration process.
Contract sign off	Open	Chief Fin Officer	Executive	Other / operational	There is a failure to sign off 2015/16 contracts and their associated CQUINs	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	08/04/2015	4	3	**12**	**N/A**	Treat	4	31/05/2015	Risk renewed for 2015-16. Significant issues with national timetables and local ssurance related to the CCG's draft financial recovery plan which is under discussion with NHS England mean that contract sign off at this stage is likely to be subject to delay, however impact can be managed during the negotiation period in conjunction with providers.
Contract planning cycle	Open	Chief Fin Officer	Executive	Other / operational	The 2015/16 Annual Contract planning and monitoring cycle is poorly managed	This will be the first annual planning cycle wholly owned by organisations in the new system. In addition there are mid year changes to CSU arrangements.	Poor commissioning in 2015/16; potential loss of financial control and control over other areas e.g. contract quality.	08/04/2015	3	4	**12**	**N/A**	Treat	4	31/09/2015	Key phases fore the planning cycle will be June through to September - CCG will aim to be ahead of timetable compared to previous years to successfully mnitigate this risk fully.
Contract database	Open	Chief Fin Officer	Executive	Other / operational	The contact database fails to adequately capture all contracts and aligned payments	Adequate contract database arrangements are a prime component of overall business and financial control	Loss of financial control	08/04/2015	3	3	**9**	**Static**	Treat	4	05/09/2015	Database now functioning but extension to smaller contracts needs to be monitored before further review of this risk and risk score.
Failure to achieve 2015-16 QIPP - impact on Financial balance in 2015-16	Open	Chief Fin Officer	Executive	10 Financial Balance	Risk that the CCG cannot deliver QIPP schemes of sufficient value to support achievement of financial balance	QIPP programs involve a mixture of transformational and cost reduction activities mainly with commissioned suppliers. The risk arises from the difficulties in co-ordinating actions and delivering target QIPP levels across these. Additionally, £3.3m of the planned QIPP programmes remain unidentified at the end of Quarter 1	Significant potential impact on the CCG's ability to achieve financial balance and knock on effect to future investment strategies.	09/04/2015	4	4	**16**	**Static**	Treat	8	31/03/2015	Risk refreshed for 2015-16. QIPP delivery is an essential component of financial recovery and delivery of agreed contracts. Audit report (March 2015) will be used to identify improvements in QIPP process going forward.
Destruction of old IT Equipment	Open	Chief Op Officer	Executive	Other / operational	Risk that old equipment will not be properly disposed of resulting in a data loss	Complex IT destruction / disposal arrangements; outsourcing of function and need for secondary assurance	Loss of patient data; distress to individual patients; damage to organisational reputation; ICO fine and attendant financial impact	07/04/2015	3	3	**9**	**Static**	Treat	2	31/01/2015	Actions from IG steering group on 06/02/15 relating to this and disposal of old mobile (blackberry) handsets. Should be capable of resolution by end of May as a disposal plan has been agreed with the new CSU.

Failure to control the acute portfolio - impact on Financial balance in 2015-16	Open	Dir of Comm and Strat	Executive	10 Financial Balance	Risk that acute hospital spend cannot be controlled leading to significant a year end deficit	The CCG contracts with three local and a large number of more distant (i.e. London) providers with a history of over-performance that generates significant financial pressure.	Significant potential impact on the CCG's ability to achieve financial balance and knock on effect to future investment strategies.	09/04/2015	4	4	**16**	**Static**	Treat	8	31/03/2016	Net score unchanged. Risk now rolled over into 2015/16. Acute over-activity is now a significant contributor to CCG financial position and a recovery plan is being put in place for 2015/16 as this is the major factor in the CCG's ability to continue as a going concern.
Failure to control prescribing costs - impact on Financial balance in 2015/16	Open	Chief Fin Officer	Executive	10 Financial Balance	Risk that prescribing spend cannot be controlled leading to significant a year end deficit	Historically this has been a difficult area of spend to control, and is dependent on the behaviour of a large number of clinicians who have the power to prescribe.	Significant potential impact on the CCG's ability to achieve financial balance and knock on effect to future investment strategies.	09/04/2015	2	3	**6**	**Static**	Tolerate	N/A	28/02/2015	To be monitored at end of quarter 1. Tolerate unless there are indications that risk is rising quarter on quarter.
Cancer wait 62 days	Open	Dir of Comm and Strat	Executive	8 Quality and Performance	Risk of not meeting 62 day cancer performance target	There is an issue involving some cancers specialities between Epsom and the tertiary provider.	Potential harm to patients; reputational risk.	09/04/2015	4	3	**12**	**Static**	Treat	4	30/06/2015	Risk refreshed for 2015-16. Any patient who breaches 100 days should be subject to an RCA and any 62 day breach subject to an investigation.
Impact of transfer of specialist commissioning liability on Financial balance in 2015-16	Open	Chief Fin Officer	Executive	10 Financial Balance	Risk that specialist commissioning liabilities will impact significantly and negatively on the CCG's ability to achieve its control total	National programme of apportioning increased specialist commissioning costs to CCG commissioners	Impact could be significant for individual CCGs - no accurate estimates as yet.	09/04/2015	4	4	**16**	**Static**	Tolerate	N/A		Net score unchanged. Risk is real circa £4.7m in year. T score changed to tolerate as this risk in practical terms is not capable of mitigation as the CCG has no influence over the central allocation of the liability.
HQ usage - impact of high occupancy levels	Awaiting approval	Chief Op Officer	Executive	Other / operational	The operational use of Cedar Court will compromise health and safety and / or business continuity	Number of staff and electronic devices in the office space	Increased frequency of accidents; impact on staff morale; excessive impact on power and aircon systems and other utilities causing a potential business continuity problem if systems fail; additional parking problems	09/04/2015	3	2	**6**	**N/A**	Tolerate	N/A		The actions listed under controls are planned to take place and then mitigation will be reviewed.
Individual Funding Request service	Open	Chief Op Officer	Executive	8 Quality and Performance	The service could fail in its responsibilities for providing a service on behalf of the Surrey CCGs and two Sussex CCGs and to patients making applications through the service.	Staff Establishment is five WTEs however: Head of IFR on long-term sick leave since Dec 2013 and is due to retire. Operational continuity largely dependent on a junior manager acting up to a senior role and her being available to process incoming cases whilst out of the office or on Annual Leave. Unstable team due to the number of non-substantive staff in post. Lack of capacity for senior level manager oversight and dependence on staff in other functions over a prolonged period.	The service fails to meet it's responsibilities for processing interventional and drug IFRs on behalf of all Surrey and some Sussex CCGs, and maintaining up to date policies and procedures. Reputational risk for SD CCG Delay to treatment with impact on quality of care and patient safety	07/04/2015	3	3	**9**	**Static**	Treat	6	31/03/2015	Capacity being reviewed in April.