Presented to:	Governing Body - Public
Date of Meeting:	28 November 2017
For:	Decision

Agenda Reference:	GOV/17/11/10
Title:	Governing Body Sub Committee Items for Approval

Executive summary:

The Audit and Assurance Committee, Quality and Clinical Governance Committee and Remuneration Committee are standing sub-committees of the Governing Body, with delegated authorities through the Scheme of Delegation.

The meetings were quorate and at least three Governing Body Members were present to agree and recommend these papers for approval.

- Audit and Assurance Committee Terms of Reference – agreed by Audit and Assurance Committee on 14 November 2017
- Risk Management Strategy – agreed by Audit and Assurance Committee on 14 November 2017
- Quality and Clinical Governance Committee Terms of Reference – agreed by Quality and Clinical Governance Committee on 7 November 2017
- Remuneration Committee Terms of Reference – agreed by Remuneration Committee on 26 September 2017

Recommendations:	The Governing Body is asked to approve the four items listed above as recommended by the relevant Sub Committee.
Previously considered by:	Each paper has been agreed by the relevant Sub Committee
Author(s):	
Sponsoring Director / Clinical Lead/ Lay Member:	Chair of relevant Sub-committee

Risk and Assurance:	N/A
Financial / Resource Implications:	N/A
Legal, Policy and Regulatory Requirements:	The CCG is required to show that these documents have been approved by the Governing Body in line with the Scheme of Reservation of Duties.
Communications and Engagement:	No further communication will be required.
Equality & Diversity Assessment:	☐

NHS
Wiltshire
Clinical Commissioning Group

Audit and Assurance Committee

Terms of Reference

Date Approved by Audit and Assurance Committee: **14 November 2017**

Date Approved by Governing Body:

1. Purpose

1.1 The Governing Body has established the Audit and Assurance Committee as a standing sub-committee of the NHS Wiltshire CCG.

1.2 The Committee's primary role is to conclude upon the adequacy and effective operation of the internal control systems that underpin the delivery of the organisation's objectives.

2. Membership

2.1 The Committee shall be appointed from amongst the non-executive directors of the CCG and shall consist of not less than three members. At least one Clinical GP Executive will attend, ensuring clinical engagement. The Chair of the CCG should not be a member of the Audit and Assurance Committee, although he/she may be invited to attend meetings. One of the members will be appointed Chair of the Committee by the Governing Body and a non-executive director as Vice Chair will be nominated by the members.

2.2 As a minimum, one member of the Committee must have recent relevant financial experience.

2.3 The Accountable Officer should be invited to attend at least annually to report on identification of risk within the organisation.

2.4 The Chair has been given authority to implement Chair's action under the CCG's Standing Orders – "Emergency Powers and Urgent Decisions". This allows for an emergency or an urgent decision to be exercised by the Chair after having consulted at least one other member. The exercise of such powers by the Chair will be reported to the next formal meeting of the Governing Body in public session for formal ratification.

2.5 The core membership of the Committee will consist of the following or their nominated deputies:

VOTING MEMBERS
Lay Member for Audit and Governance (Chair)
Lay Member for Public and Patient Involvement (Vice Chair)
Secondary Care Doctor
At least one Clinical GP Executive
ATTENDEES
Chief Financial Officer
Chief Operating Officer
Associate Director of Performance, Corporate Services and Head of PMO
Governance and Risk Manager
Representative from Internal Audit
Representative from External Audit
Representative from Counter Fraud or Security
Deputy Chief Financial Officer
The Chair of the Governing Body, Accountable Officer, Commissioning Committee Chair or other Executive Directors and Senior Officers may be invited to attend meetings of the Audit and Assurance Committee as appropriate.

3. Quorum

3.1 Nominated deputies may attend the meeting but business will only be conducted if the meeting is quorate. The Committee will be quorate with a minimum of three Voting Members.

3.2 When the Chair is unavailable, the Vice Chair will deputise.

a. Expectation of Attendance

i. Members are required to attend at least four meetings per year. An attendance record will be maintained.

4. Frequency of Meetings

4.1 Meetings will be held not less than five times a year. The Committee Chair, however, reserves the right to convene additional committee meetings as required to discharge the responsibilities of the committee.

4.2 The External or Internal Auditors may request a meeting, if they consider that one is necessary, and restrict attendance to non-executive members.

a. Meeting Arrangements

i. A work programme and standing agenda will be agreed to guide the work of the Committee, but will allow for flexibility.

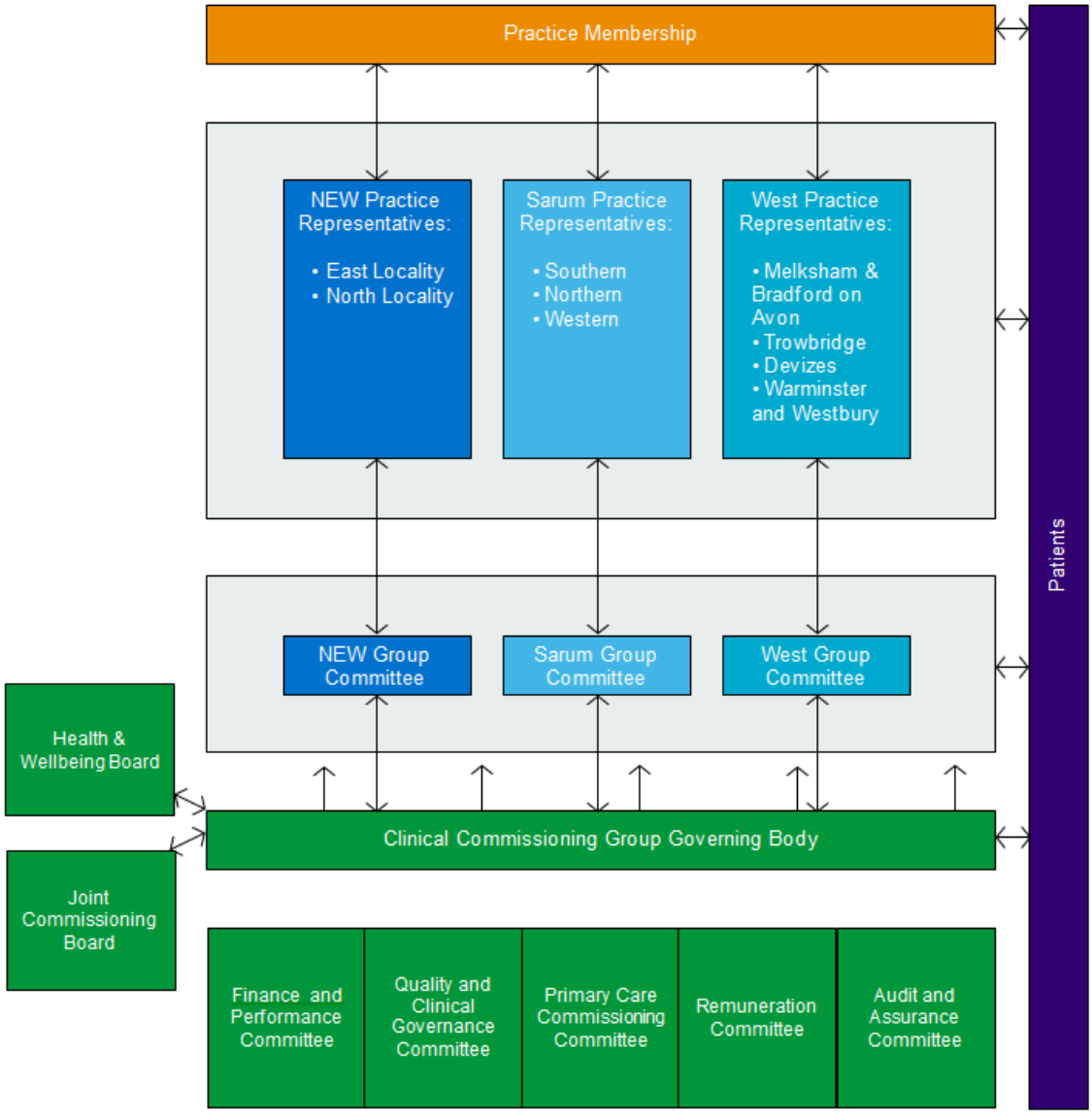
ii. At every meeting, the Committee should meet privately with the External and Internal Auditors without any CCG Executive Members present.

iii. The servicing, administrative and appropriate support to the Chair and committee members of the Audit and Assurance Committee will be undertaken by the Secretary to the Committee, the Board Administrator, who will record formal minutes of the meeting.

5. Accountable To

5.1 The Committee is accountable to the CCG Governing Body.

Figure 1: Clinical Commissioning Group Structure



6. Responsibilities / Authority / Scheme of Delegation

6.1 The Committee is authorised by the Governing Body to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Governing Body to obtain legal or other independent professional advice and to secure the attendance of other appropriate persons with relevant experience and expertise if it considers this necessary.

6.2 The Governing Body will retain responsibility for all aspects of internal control, supported by the Audit and Assurance Committee, satisfying itself that appropriate processes are in place to provide the required assurance.

6.3 The Governing Body delegates the following to the Committee:

Delegations by the Governing Body to the Audit and Assurance Committee	
Body/Individual	**Delegation**
Audit and Assurance Committee	a) Ensuring there is an effective internal audit function established by management, that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Accountable Officer and Governing Body; b) Reviewing the work and findings of the external auditor and considering the implications of and management's responses to their work; c) Reviewing the findings of other significant assurance functions, both internal and external to the organisation, and considering the implications for the governance of the organisation; d) Ensuring that the systems for financial reporting to the Governing Body, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Governing Body; e) Reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgements; f) Reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives; g) Monitoring compliance with Standing Orders and Standing Financial Instructions; h) Reviewing schedules of losses and compensations and making recommendations to the Governing Body; i) Reviewing schedules of debtors/creditors balances £5,000 and over six months old and explanations/action plans; j) Review and approval of the annual report and financial statements prior to submission to the Governing Body for ratification focusing particularly on; (i) the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee; (ii) changes in, and compliance with, accounting policies and practices; (iii) unadjusted misstatements in the financial statements; (iv) major judgmental areas;

	(v) significant adjustments resulting from audit. k) Reviewing the external auditors report on the financial statements and the annual management letter; l) Conducting a review of the CCG's major accounting policies; m) Reviewing any incident of fraud, bribery or corruption or possible breach of ethical standards or legal or statutory requirements that could have a significant impact on the CCG's published financial accounts or reputation; n) Reviewing any objectives and effectiveness of the internal audit services including its working relationship with external auditors; o) Reviewing major findings from internal and external audit reports and ensure appropriate action is taken; p) Reviewing 'value for money' audits reporting on the effectiveness and efficiency of the selected departments or activities; q) Reviewing the mechanisms and levels of authority (e.g. Standing Orders, Standing Financial Instructions, Delegated limits) and make recommendations to the CCG; r) Reviewing the scope of both internal and external audit including the agreement on the number of audits per year and approving audit plans; s) Investigating any matter within its terms of reference, having the right of access to any information relating to the particular matter under investigation; t) Reviewing waivers to Standing Orders; u) Reviewing hospitality and sponsorship registers; v) Reviewing the information prepared to support the controls assurance statements prepared on behalf of the Governing Body and advising the Governing Body accordingly. w) Undertaking the procurement of the external audit contract through the establishment of an auditor panel, and then advising the Governing Body on the contract award. x) Approval of procedures, policies and strategies relevant to the committee's terms of reference.
	Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Governing Body. Exceptionally, the matter may need to be referred to the Department of Health.

The Committee will be responsible for:

6.4 Governance, Internal Control and Risk Management

The Committee shall review the establishment and maintenance of an effective system of integrated governance, internal control and risk management across the whole of the organisation's activities (financial, non-financial, clinical, non-clinical and information) that supports the achievements of the organisation's objectives. It will review the CCG risk register at every meeting.

The Committee will primarily utilise the work of Internal and External audit and other assurance functions but will not be limited to these functions. It will also seek reports and assurances from Directors and managers as appropriate concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced by the Committee's use of an effective CCG Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

In particular, the Committee will review the adequacy of:

- All risk and control-related disclosure statements (including the Annual Governance Statement) together with any accompanying Head of Internal Audit Opinion Statement, External Audit opinion or other appropriate independent assurances prior to endorsement by the Governing Body;

- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks, and the appropriateness of the above disclosure statements;

- The policies for ensuring compliance with relevant statutory, regulatory, legal and code of conduct requirements, and the operational effectiveness of policies and procedures which are brought to the attention of the Audit and Assurance Committee by Internal and External Auditors;

- The policies and procedures for review and performance management of all work related to fraud, bribery and corruption are set out in the NHS Standard Contract and the Standards for Commissioners: Fraud, bribery and corruption.

6.5 Internal Audit

The Committee shall ensure there is an effective internal audit control function which provides appropriate independent assurance to the Audit and Assurance Committee, Accountable Officer and Governing Body. The Committee's function is to:

- Consider the appointment and provision of the internal audit service, the audit fee, review of audit appointments and tenders and any questions of resignation or dismissal;
- Oversee the effective operation of Internal Audit and ensure that Internal Audit is appropriately resourced and has appropriate standing within the CCG;
- Review, contribute to, and approve the Internal Audit strategy and plans and more detailed programme of work ensuring that they are consistent with the audit needs of the organisation as identified in the CCG Assurance Framework, and with the requirement for External Audit to place reliance on Internal Audit work;
- Consider major findings of Internal Audit reports, management and Director responses, follow-up reports and CCG summary reports and subsequent action;
- Evaluate the extent to which the Internal Audit service complies with the mandatory audit standards and the guidelines set out in the Public Sector Internal Audit Standards;
- Ensure there is an annual review of the effectiveness of internal audit.

6.6 External Audit

The committee shall review the work and the findings of the External Auditor appointed by the CCG and consider the implications and management's response to their work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor in relation to the CCG contract;
- Discussion and agreement with the External Auditor of the nature and scope of the external audit programme of work as set out in the annual plan prior to commencement and ensure co-ordination, as appropriate, with other External Auditors within the local health economy;

- Discussion with auditors of their local evaluation of audit risks and assessment of the CCG;
- Review of all external audit reports before submission to the Governing Body, and any work carried out outside the annual audit plan, together with the follow-up reports and responses from management and Directors;
- Discussion of any issues and reservations arising from the work of the External Auditor and any matters the External Auditor may wish to raise (in the absence of Executive Directors and other management of the CCG, where necessary).

The Audit and Assurance Committee will seek to enhance and receive assurance that effective and co-ordinated relationships exist between Internal and External audit, and with the Local Counter Fraud Officer, to optimise audit resources.

6.7 Counter Fraud

- To appoint the Counter Fraud Management service, the fee and terms and conditions of engagement;
- Oversee the effective operation of Counter Fraud and to ensure that the Counter Fraud Service is appropriately resourced and has appropriate standing within the CCG;
- Review the Counter Fraud Policies, Strategies/Plans and to consider major findings of Counter Fraud reports, management's response and subsequent action;
- Ensure compliance with the NHS Counter Fraud Authority Standards for Commissioners: fraud, bribery and corruption.

6.8 Security Management Service

- To appoint the Security Management service, the fee and terms and conditions of engagement;
- Oversee the effective operation of Security Management and to ensure that the Security Management Service is appropriately resourced and has appropriate standing within the CCG;
- Review the Security Management Policies, Strategies/Plans and to consider major findings of Security Management reports, management's response and subsequent action;
- Ensure compliance with the NHS Counter Fraud Authority Standards for Commissioners: security management.

6.9 Financial Reporting and Control

a) The Audit and Assurance Committee will recommend approval of the Annual Governance Statement, Annual Accounts, Financial Statements, and Annual Report before submission to the Governing Body for adoption. Particular focus is to be made on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
- Changes in, and compliance with, accounting policies, standards and practices;
- Unadjusted misstatements in the financial statements;
- Major judgmental areas;
- Significant adjustments resulting from the audit.

b) The Committee should also ensure that the systems for financial reporting to the Governing Body, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Governing Body. In addition it should review financial and information systems, monitor the integrity of financial statements, and review significant financial reporting judgements.

6.10 Other Assurance Functions

a) The Audit and Assurance Committee will review the findings of other significant assurance functions, both internal and external, and consider the governance of the organisation. These will include, but will not be limited to, any reviews by the Department of Health bodies' regulators/inspectors (e.g. Healthcare Commission, NHS Litigation Authority); staff surveys; professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

b) In addition, the Committee will oversee and review the work of other committees within the organisation which can provide relevant assurance on the implementation of integrated governance arrangements. The Committee shall request and review reports and positive assurances from Directors and Managers on the overall arrangements for governance, risk management and internal control. They may also request specific reports from individual functions within the organisation.

c) Any material objections to the Internal Audit plans and associated assignments that cannot be resolved through negotiations will be notified to the Chief Financial Officer immediately.

d) If matters cannot be resolved to the satisfaction of the Head of Internal Audit he/she has a right of access to all Audit and Assurance Committee members, the Chair and Accountable Officer of the CCG. This process is in line with the CCG Constitution and Standing Financial Instructions.

7. Accountable For

7.1 The Committee is authorised to create such working groups as are necessary to fulfil its responsibilities within its Terms of Reference. The Committee may not delegate executive powers (unless expressly authorised by the Governing Body) and remains accountable for the work of any such group.

7.2 The Information Governance Group reports to the Committee.

8. Duties

8.1 In addition to the list of delegations shown in 6.3, the Committee will:

- Advise the Governing Body on internal and external audit services;
- Review the establishment, maintenance and adequacy of an effective system of integrated governance, internal controls and risk management, across the whole of the organisation's activities (financial, non-financial, clinical, non-clinical, and information), that supports the achievement of the organisation's objectives;

- Establish and maintain effective systems to consider risks, complaints, patient feedback and untoward incidents;
- Review of National Reports and Guidance;
- Monitor compliance with and waiver of the financial policies and scheme of delegation;
- Review every decision to suspend the Scheme of Reservation and Scheme of Delegation;
- Review the schedule of losses and compensations and make recommendations to the CCG;
- Review the annual financial statements prior to submission to the Governing Body.

9. Reporting

9.1 The Committee will establish an annual work programme which:

- Reflects its accountabilities and responsibilities;
- Reflects strategic risks arising from the Assurance Framework.

9.2 The minutes of the Audit and Assurance Committee shall be formally recorded by the secretary and the final and approved minutes submitted to the subsequent Governing Body. The Chair of the Committee shall draw to the attention of the Governing Body any issues that require disclosure to the full Governing Body, or require executive action. Any items of specific concern or which require Governing Body approval will be the subject of a separate report.

9.3 The Committee will report to the Governing Body annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the extent to which risk management has been embedded in the organisation and the integration of governance arrangements. The Audit and Assurance Committee will produce an annual report, in line with best practice, which sets out how the Committee has met its Terms of Reference during the preceding year.

10. Monitoring

10.1 The Audit and Assurance Committee will review its Terms of Reference and work programme on an annual basis as a minimum. Any changes to the Terms of Reference must be approved by the CCG Governing Body.

NHS
Wiltshire
Clinical Commissioning Group

RISK MANAGEMENT STRATEGY 2015 to 2018

Please be aware that this printed version of the Strategy may NOT be the latest version. Staff are reminded that they should always refer to the Intranet for the latest version.

Purpose of Agreement	The organisation is committed to the implementation of a strategy that develops and maintains an open and proactive culture associated with all aspects of risk management.
Document type	Strategy
Reference Number	
Version	~~5.0~~ 5.2
Name of Approving Committee/Groups	NHS Wiltshire CCG Governing Body
Operational Date	October 2015
Document Review Date	~~September 2017~~ September 2018
Document Sponsor (Name & Job)	~~David Noyes, Director of Planning, Performance and Corporate Services~~ Mark Harris, Chief Operating Officer
Document Manager:	Susannah Long, Governance and Risk Manager
Document developed in consultation with	Chief Operating Officer, Audit & Assurance Committee
Intranet Location	Risk Management
Website Location	Publications
Keywords (for website/intranet uploading)	Risk Management, Risk Assessment

Amendments Summary:

Amend No.	Page(s)	Subject	Action Date
1	6 10 18	Update to Strategic Objectives Role of Director of Planning, Performance & Corporate Services Update use of Risk Register	Sep'13
2	6 10 10 & 11 11 & 12 18 18 & 19	Update to Strategic Objectives Removal of NHSLA assessments Further detail on roles and responsibilities Removal of support provided by CSCSU Introducing use of 'Top 10' for reporting to the Governing Body Removal of role of CSCSU in reporting	Sep'14
3	8 14	Inclusion of voluntary & third sector (to achieve risk management objectives) Clarification of monitoring of clinical adverse events	Sep'14
4	7	Addition of risk management objective for transparency and partnership working.	Sep'15
5	6 11 14 18	Update to strategic objectives Update to CSU name Clarification of SIRI section Addition to risk register layout	Sep'16
6	6 11 12 13 15 22	Update to 2017/18 strategic objectives Governance & Risk Manager no longer core member of Q&CG Detail of services provided by our contractors, addition of TIAA and removal of reference to the Datix system. Removal of reference to the Datix system. Removal of reference to the Datix system. Removal of reference to Adverse Event Reporting Policy as this is covered by the Risk Management Policy.	Oct'17
7			

Review log:

Version number	Review date	Lead name	Approval process	Notes
1	Sep'13	S.Long	Gov Body	
2	Sep'14	S.Long	Gov Body	Amendment 3 undertaken at request of Gov Body
3	Sep'15	S.Long	Gov Body	Full three year review
4	Sep'16	S.Long	Gov Body	Also reviewed by Emily Shepherd and Dr Richard Sandford-Hill
5	Oct'17	S.Long	Gov Body	Review with Chief Operating Officer

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Risk Management Strategy

This document aims to provide an overarching strategy for the management of internal and external risk by the CCG. It provides the framework for the continued development of risk management processes throughout the organisation and describes levels of accountability, processes and frameworks.

The Risk Management Strategy aims to deliver a pragmatic and effective multidisciplinary approach to risk management, which is underpinned by a clear accountability structure.

This Risk Management Statement and the effectiveness of the risk strategy will be subject to on-going review and, where necessary, amendment.

This strategy must be read in conjunction with the CCG Constitution.

1. INTRODUCTION

The organisation has a statutory responsibility to patients, staff and the public to ensure that it has effective processes, policies and people in place to deliver its objectives and to control any risks that it may face in achieving these objectives.

The Governing Body recognises that sound risk management in the CCG and its partner organisations is essential for meeting objectives and identifying and managing future opportunities, by ensuring risk management forms a fundamental element of its business rather than a separate programme. The Governing Body is committed to ensuring that risk management is embedded throughout the organisation and is part of every day practice.

The purpose of this strategy is to set out the overall aims, objectives and rationale for risk management within the organisation and when working in conjunction with stakeholders in recognition of the changing NHS environment.

2. RISK MANAGEMENT OVERVIEW

Risk refers to uncertainty, the possibility of incurring misfortune or loss or missing opportunities. This is measured in terms of the likelihood of something happening and the impact of the possible consequences. In the CCG a risk may be looked upon as anything which has the potential to damage or threaten the achievement of the strategic objectives or the reputation of the CCG.

For the purposes of this strategy:

- **Clinical risk** is any issue that may have an impact on the provision of high quality, safe and effective clinical care for patients;
- **Organisational risk** is any issue that may have an impact on organisational objectives, business continuity or the organisation's reputation;
- **Financial risk** is any issue that may have an impact on financial objectives or arrangements.

The task of the organisation is to effectively identify, analyse and respond to these risks so as to maximise the likelihood of the organisation achieving its vision and in doing so ensure the best use of resources.

Within health care some exposure to risks or risk taking will be necessary, fundamental and tolerated. However, this must be under a clear risk management methodology that enables:

- the facilitation of identification, recording and management of risk at all levels within the CCG;
- consistent risk measurement so that risk priorities can be identified through a combination of impact and likelihood;
- an understanding of the type of risk and level of risk exposure that can be tolerated by the CCG, particularly where clinical risk is concerned, in undertaking its activities and allocating resources, and defines the risk appetite of the CCG;
- mitigation and control that is proportionate to the level of risk;

- appropriate mechanisms to ensure that risks can be escalated to a level of management that can effectively respond to them;
- the on-going monitoring of the effectiveness of mitigation and control; and
- the provision of assurance to responsible committees.

The Risk Management Framework should be suitably robust and transparent to support the on-going business of the organisation whilst being proportionate and reasonable to facilitate innovation in the commissioning of high quality health care.

The establishment of effective risk management is recognised as being fundamental to ensuring good governance and is reported as part of the Annual Governance Statement (AGS) in the Annual Report of the CCG and is included in the Financial Statements. The AGS is a public report that confirms the on-going effectiveness of the internal control in the management of all type of business risk, both clinical and non-clinical.

3. STRATEGIC OBJECTIVES

The CCG has agreed its vision and values and from these has identified strategic objectives. An effective risk management framework is an essential part of corporate governance to support delivery of these strategic objectives. Risks will be identified to outputs to clearly programme appropriate risk mitigation. It should not be forgotten that the same principles of risk management can be equally effectively used to identify opportunities. It is therefore a highly effective tool for guiding resource allocation and service mix within the commissioning framework. Hence a strategic approach to risk will support delivery of the following strategic objectives:

- To ~~drive towards~~ continue delivering a clinically led model providing an enhanced range of ~~which delivers integrated~~ high quality and integrated patient services within the community based upon neighbourhood teams to provide providing 'wrap around' care at or close to home, e.g. High intensity care in the community and the development of urgent care treatment centres.

- Commission and transform appropriate services to meet the needs of the local population and ~~national priorities, delivered in the right place (ideally in a primary and community care setting) and accessible at the right times identifying and addressing health inequalities~~ implementing NHS England's Five Year Forward View focusing on urgent and emergency care, primary care, mental health and cancer services.

- Engage effectively with the local population to enable patients and ~~practices~~ carers to influence the services that we commission increasing our engagement with hard to reach groups.

- Enhance and assure the quality, ~~and~~ safety and experience of services by ensuring effective mechanisms are in place to set quality standards, ~~assess~~ monitor performance, address concerns and ~~drive~~ embed a culture of continuous quality improvement.

- Achieve a sustainable (in terms of performance and finance) health and care economy across Wiltshire and the Sustainability and Transformation Partnership footprint optimising appropriate use of resources for the delivery of effective services to address the efficiency, ~~efficient and effective healthcare~~ quality and health and well-being gaps.

- Develop an effective and responsive clinically led commissioning organisation, working collaboratively with partner organisations and with Wiltshire Council increasing our focus on integrated commissioning and delivery of services.

- Encourage and support the Wiltshire population in managing and improving their health and wellbeing, wherever possible increasing the ability of people to manage their own care and to make their own choices.

- To support the resilience of primary care across Wiltshire through the implementation of our local GP Forward View Plan and delegated responsibilities of primary medical services.

- To work with partners to develop our vision for an Accountable Care System across Wiltshire.

- To ensure that the CCG workforce remains focussed and motivated by providing clear and consistent leadership, applying our objective and appraisal system, reacting appropriately to staff survey action points and feedback from the Staff Partnership Forum and investing in staff training, development and wellbeing.

4. RISK MANAGEMENT OBJECTIVES

The following objectives have been identified which form the basis of the risk management strategy. These objectives will be achieved through various mechanisms that are outlined in the strategy and associated programmes of work and documents:

- Promote awareness of risk management and embed the approach in all functions and management throughout the organisation;

- Ensure the CCG has and maintains the required level of risk management support to successfully manage its risks;

- Seek to identify, record, measure, control, report and monitor any risk that will undermine the achievement of objectives, both strategically and operationally, through appropriate analysis and assessment criteria;

- Protect the services, patients, staff, reputation and finances of the organisation through application of sound risk management;

- Be transparent in our arrangements for risk management and our risk exposure to foster confidence in our operations and when working with partners;

- Provide the Governing Body with assurance that risk is being effectively managed through the establishment of appropriate risk management escalation mechanisms for the purposes of decision making, coupled with proportionate monitoring and compliance with agreed processes;

- Utilise risk management proactively as a tool for business planning, resource allocation and service improvement as part of the Project Management Office (PMO) arrangements.

Ultimately it is the role of Governing Body to ensure that risk is identified and appropriately mitigated on a day to day basis. The Accountable Officer is accountable for Risk Management. The Governing Body delegates the management of risk to the Audit & Assurance Committee which will provide assurance to the Governing Body on the effectiveness of the risk management framework.

The objectives will be achieved through:

- Leadership and commitment from the top, supporting a culture of risk awareness and personal, professional and corporate responsibility and accountability;
- Providing a clear system and framework within which risks and adverse events may be identified, reported, analysed, managed and monitored;
- Sharing good practice, effective risk management actions and audit recommendations which reduce exposure to risk;
- Providing appropriate training to ensure staff have the correct knowledge and skills;
- Complying with legislation, regulations and standards;
- Reducing the impact of adverse events and learning from adverse events, complaints and claims;
- Working in collaboration with healthcare providers, Wiltshire Council and the voluntary and third sector to sustain the provision of high quality and effective healthcare that demonstrates value for money and sound CCG risk management.

5. RISK MANAGEMENT FRAMEWORK

The following elements make up the Risk Management Strategy:

- Approach
- Roles and Responsibilities
- Processes
- Risk Identification
- Risk Assessment and Measurement
- Risk Appetite and Treatment
- Reporting and Monitoring

5.1 RISK MANAGEMENT APPROACH

The organisation's approach to risk management will encompass the breadth of the organisation by considering financial, organisational, reputational and project risks, both clinical and non clinical and for all parts of the organisation involved. Please see the CCG Constitution for the organisation's committee structure. This will be achieved through:

- having an appropriate risk management framework delegating authority, seeking competent advice and seeking assurance
- Having a clear risk culture, philosophy and resources for risk management
- Integration of risk management into all strategic and operational activities and discussing risk appetite
- Identification and analysis, active management, monitoring and reporting of risk across organisation
- Ensuring appropriate and timely escalation of risks
- Excellent communication encouraging the sharing of experiences and learning in a fair blame/non-punitive culture
- Consistent compliance with relevant standards, targets and best practice
- Business continuity plans and recovery plans established and regularly tested.

5.2 ROLES & RESPONSIBILITIES

This section of the strategy identifies the roles and responsibilities of key individuals and committees, highlighting accountability levels. A detailed account of individual and committee responsibilities is provided in the CCG Risk Management Policy and Procedure, job descriptions and committee terms of reference.

Committees

5.2.1 The Governing Body

The Governing Body will be responsible for:

- Having overall accountability for the management of governance, risk and assurance, determining the strategic approach to risk and setting the risk appetite for the organisation;
- Ensuring and approving the structure and framework for risk management;
- Consideration of whether the organisation has implemented an effective system of internal control, including appropriate risk management arrangements, with reference to available assurance;
- Regularly receiving the Board Assurance Framework (BAF) and the High Level Risk Register which contain the most significant risks that can impact on the achievement of the strategic objectives;

- Monitoring management of significant risks and seeking assurance that management decisions balance performance within appropriate limits defined by the Group committees.

The Governing Body delegates operational responsibility for the delivery of risk management to the Audit & Assurance Committee.

5.2.2 Audit & Assurance Committee

The Audit & Assurance Committee will be responsible for:

- Providing assurance to the Governing Body on the effectiveness and adequacy of the processes for managing principle risks and risk management framework;

- Challenging the way in which risk is managed, particularly where there is uncertainty or concerns over the effectiveness of existing arrangements. This could include requesting attendance at meetings for the purpose of providing relevant information for assurance purposes;

- Ensuring that arrangements for risk management are regularly included in the cycle of independent audits;

- Being accountable for providing the Governing Body with overall assurances that the management of risk is effective;

- Overseeing and monitoring governance and performance, including corporate, information, clinical and non-clinical governance and risk management and quality (clinical governance and quality is the responsibility of the Quality and Clinical Governance Committee). It will report regularly to the Governing Body on these areas;

- Overseeing the operation of the risk management framework to ensure that the organisation is appropriately managing risks, including operating safely and legally and exploiting potential opportunities, providing assurance of its effectiveness to Governing Body;

- Programming work related to external and internal assessments of the organisation's risk management arrangements;

- Receiving and reviewing the High Level Risk Register and Board Assurance Framework at each meeting;

- Challenging the progress made by responsible Directors in the mitigation of identified risks;

- Approving, on behalf of the organisation, those policies that fall within the remit of the committee's terms of reference.

5.2.3 Quality & Clinical Governance Committee (Q&CG)

The Q&CG will be responsible for:

- Identifying clinical and quality facets of risk, through their work and the work streams of its subordinate groups;
- Challenging the appetite for and management of clinical risk throughout the organisation.

The Governance & Risk Manager will ~~be a core member of~~ attend this committee to ensure a consistent approach to the identification and management of clinical risk.

Individuals

5.2.4 Accountable Officer

The Chief Officer is ultimately accountable for all risks relating to the operations of the organisation and will lead on determination of the strategic approach to risk, establishing and maintaining the structure for risk management. The Chief Officer will ensure that leadership and expertise in the field of risk management is available to the organisation.

The Accountable Officer is responsible for the governance framework within the CCG and is the lead for Risk Management.

5.2.5 Chief Financial Officer

The Chief Financial Officer is accountable for internal financial control and sound financial governance through the development of sound systems and processes and through the identification and management of financial risks.

5.2.6 Director of Nursing and Quality

The Director of Nursing and Quality is responsible for the identification and management of clinical and quality related risks within the CCG and those identified risks within provider organisations that may impact on the quality and safety of patients' care commissioned by the CCG.

~~5.2.7 Director of Planning, Performance and Corporate Services~~

~~The Director of Planning, Performance and Corporate Services is responsible for the governance framework within the CCG and is Lead Director for Risk Management.~~

5.2.8 ~~Locality~~ Commissioning/Group Directors

~~Locality~~ Commissioning/Group Directors are responsible for the identification and management of risks during the commissioning process and for the duration of the contract periods with providers. These risks are likely to have components of financial risk, clinical risk and organisational risk.

5.2.9 Governance & Risk Manager

The Governance & Risk Manager is responsible for ensuring that the Board Assurance Framework (BAF) is developed, reviewed and reported to the Audit & Assurance Committee and Governing Body as appropriate. The BAF must adequately reflect the analysis of assurances around significant risks to the organisation's strategic objectives.

The Governance & Risk Manager will retain an overview of the risk register and assist Directors with their management of directorate risk registers and prepare the High Level Risk Register for presentation to the Audit & Assurance Committee.

5.2.10 Associate Director of Performance, Corporate Services and Head of PMO

The Associate Director will ensure that business continuity and disaster recovery plans are established and are regularly tested.

5.2.11 Risk Management Support

The CCG retains responsibility for management of risk within the organisation. Aspects of Risk management advice and support ~~is~~ are provided by NHS South, Central and West Commissioning Support Unit (CSU). Where risk management support will be made available to:

- ~~Provide the DATIX system on which to record adverse event (incidents/near misses) reports, including Information Governance breaches, for analysis to identify issues and opportunities for learning;~~
- ~~Receive and disseminate alerts,~~ monitor actions and undertake central reporting ~~particularly~~ in regard to Information Governance;
- ~~Ensuring~~ Assess compliance with Health and Safety legislative requirements in regard to risk assessments, appropriate control measures, raising outstanding concerns, staff training, ensuring safe working procedures / practices are in place and continued monitoring and revision of these. These responsibilities extend to cover anyone affected by the organisation's operations including sub-contractors, members of the public and visitors;
- ~~Provide specialist advice in support of risk management;~~
- Provide Human Resources advice and assistance.

The CCG will monitor the CSU performance through ~~its internal audit arrangements and~~ regular contract meetings.

The CCG is also supported by TIAA for Counter Fraud and Security Management advice.

5.2.12 Directors and Senior Managers

Directors and senior managers will provide leadership for the risk management agenda and ensure that responsibilities to identify, record, analyse, control and communicate risk issues (via processes such as Risk Assessment, Adverse Event Reporting and Risk Registers) are undertaken.

Directors and Senior Managers will:

- Ensure that staff receive training in line with the Training Needs Analysis and mandatory updates are completed;

- Undertake a workstation assessment with each direct report on at least a three yearly basis or earlier should there be relevant changes;

- Ensure that all employees who require health surveillance according to risk assessments are identified; ensuring that where health surveillance is required no individual carries out specific duties covered by the surveillance until they have attended the Occupational Health Service;

- Making adequate provision to ensure that fire and other emergencies are appropriately dealt with, including Personal Emergency Evacuation Plans where required, and business continuity arrangements are in place;

- Ensure compliance with all Information Governance requirements through the Connecting for Health IG Toolkit, staff training, subsequent plans and associated policies.

5.2.13 Staff

All staff have a responsibility to understand, accept and implement the mechanisms in this Strategy. Staff have a responsibility for actively identifying and addressing risk and for undertaking their roles with full appreciation for the risks and the potential consequences of their actions or omissions.

All staff have a responsibility in relation to health and safety risks, to take action to protect themselves and others. Organisational policies and the Training Needs Analysis (TNA) detail the required training that is provided in each risk area. Staff must take responsibility to ensure that they attend training as required.

All staff are responsible for:

- Ensuring that identified risks and adverse events are dealt with swiftly and effectively, and reported via the risk register or ~~DATIX~~ adverse event reporting process, as appropriate, to ensure further action/learning may be taken as necessary;

- Adherence to their professional codes and the NHS Code of Conduct;

- Complying with all approved policies and Standard Operating Procedures;

- Reporting inefficient, unnecessary or unworkable risk controls;

- Neither intentionally, nor recklessly interfering with nor misusing any equipment provided for the protection of safety and health;

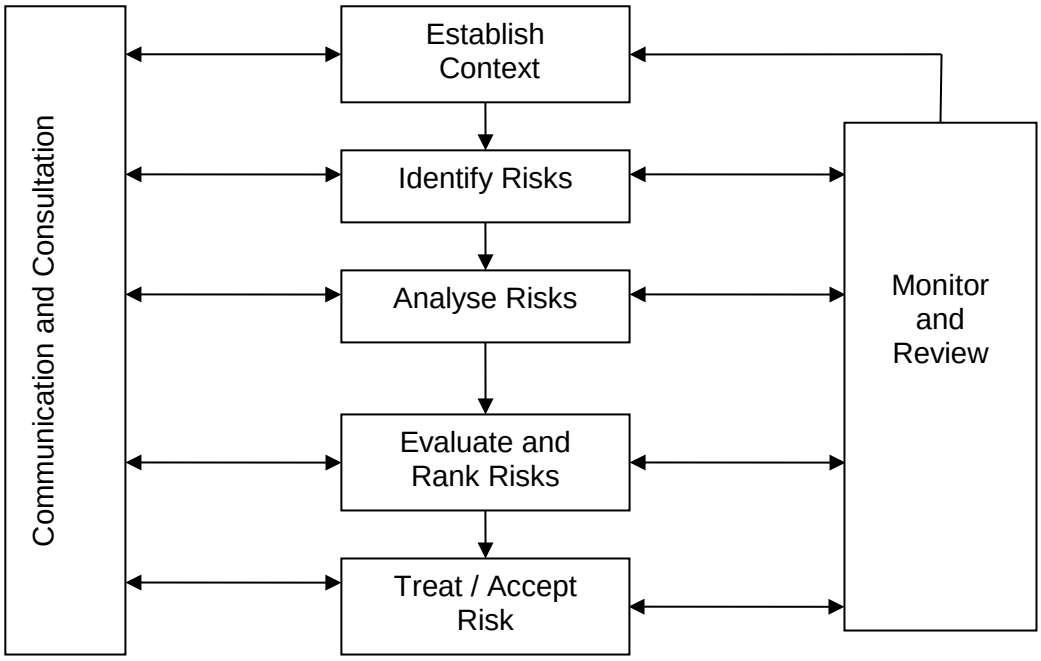
- Being aware of relevant emergency procedures e.g. first aid, evacuation and fire precaution procedures, relevant to their location and role;

- Co-operating with management on adverse event investigations;

- Providing assistance as reasonably requested in times of crisis.

5.3 RISK MANAGEMENT PROCESS

Risk Management is the responsibility of everyone in the organisation. The risk management process is a continuous cycle, taking a systematic approach to all risks, as illustrated below:



5.4 RISK IDENTIFICATION

Risk management is an integral part of the culture of the organisation with leadership from the Governing Body and a structure that permits staff to identify and report risk at all levels.

Risk identification establishes the organisation's exposure to risk and uncertainty. There is no one correct way to identify risks and, in practice, the use of multiple methods by different staff groups, is more successful. The risk identification processes used by the organisation will include, but is not limited to:

- Risk assessment process
- Adverse Event Report (AER), including trends and data analysis
- Serious Incidents ~~Requiring Investigation~~ (SI~~RI~~)
- Claims and complaints data
- Business decision making and project management
- Strategy and policy development analysis
- External/Internal audits findings and external advisors.

5.4.1 Risk Assessment Process

The organisation has a structured risk assessment process. The Governance & Risk Manager provides support to this process.

Directors and Senior Managers are responsible for managing action planning against identified risks and for escalating risks with additional resource implications or implications for other parts of the organisation. Identified risks must be recorded, analysed and monitored using the risk assessment tool. The Governance & Risk Manager centrally records risk assessments to identify commonalities for organisational risk treatment. Risks will be added to the Risk Register where this is appropriate.

5.4.2 Adverse Event Report (AER) trends and data analysis

All staff are required to report non-clinical incidents and near misses using the ~~on-line~~ Adverse Event Report (AER) process ~~form linked to the DATIX system accessed~~ via the Governance & Risk Manager. Line Managers and Service Managers use these reports to identify risks and take immediate and/or planned risk management action. Risks may also be included on the Risk Register. The Governance and Risk Manager identifies trends and risk issues.

5.4.3 Serious Incidents ~~Requiring Investigation~~ (SI~~RI~~)

Provider SI~~RI~~: The organisation receives reports regarding the most serious incidents that occur in Provider services in line with the criteria set out in the NHS England 2015 Serious Incident Framework. The organisation has the responsibility to consider and close these incidents and monitor associated actions as appropriate. SI~~RI~~ data and reports is an important source of information for the commissioning process. The Quality Team will report relevant information regarding Provider SI~~RI~~ to the Quality and Clinical Governance Committee.

Other SI~~RI~~: SI~~RI~~ may also occur outside Provider services for example in nursing homes, private providers or as part of other commissioning services. The CCG will be involved with the reporting and monitoring of these SI~~RI~~ where appropriate. These other organisations are responsible for investigating and embedding learning associated with the SI~~RI~~. Clinical adverse events occurring outside Provider services are monitored by Wiltshire Council.

The CCG Quality Team will manage the STEIS reporting system on behalf of the CCG.

5.4.4 Claims

By analysing any trends from claims and by looking at the particulars of each, risks to the objectives of the organisation may be identified.

5.4.5 Complaints and concerns

By analysing the content and any trends from complaints and concerns made to the CCG, risks to the objectives of the organisation may be identified. Contracted NHS Provider organisations are also required to share complaints information with the commissioning CCG. NHS Wiltshire CCG Quality Team oversees the Complaints process.

5.4.6 Business decision making and project planning

Risk identification is an essential part of business planning to identify those risks that could impact on achievement of the organisation's strategic objectives and risks that would be present if objectives are not achieved. Risk identification will be used to seek business opportunities to exploit and as a fundamental supporting assessment of all proposed and ongoing projects documented in Project Workbooks. This will include joint working arrangements with partner organisations.

5.4.7 Strategy and policy development analysis

Developments in strategy and policy can and do have considerable impact on business activities, plans, organisational form and staff. Senior Managers will look to their own field and specialism to identify potential risks and opportunities to be added to the risk register and to inform the BAF.

5.4.8 External/Internal audit findings and external advisors

By commissioning internal and external audit, issues of control may come to light. Other external findings may also be available from sources such as NHS Counter Fraud Authority ~~Protect~~, the Local Counter Fraud Service, the Local Security Management Service and the Fire Officer.

5.5 RISK ASSESSMENT & MEASUREMENT

Once risks are identified further evaluation is required to establish the exposure of the organisation or service to risk and uncertainty. The result of risk analysis can be used to rate the significance of the risk and to prioritise risk treatment. The organisation will use the National Patient Safety Agency 5 by 5 likelihood and impact matrix to assign a risk score.

In all cases it is important to set the risk into context for evaluation. Unfortunately, some types of incident are more commonplace than others and may be linked to a particular service or client group. This does not mean that certain incidents should be tolerated but it could mean that risk treatment may take a different form.

It is also important to consider how the identified risk may impact on other tasks, functions or services. The risk itself may be of low significance but dependencies may raise the profile of the risk.

The organisation will adopt the following approach:

- Apply a scale of 1 to 5 to measure the impact and the likelihood to determine the score by multiplication and classify or prioritise the risk by this means. Please see the risk matrix below.

In order to assess the risk:

- Ask what the consequences would generally be if it occurs?
- Ask how likely is it to occur?
- Multiply the consequences by likelihood using the matrix to define the level of risk severity.

This process can and should be used for all types of risk, eg clinical, non-clinical, strategic, financial, operational, information governance etc. Matrices to aid with the assessment of risks within these specific areas can be found at Appendix 1.

Risk Matrix (Likelihood x Impact)

		Likelihood of Occurrence				
		1 Rare	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Certain**
Impact	**5 Catastrophic**	**5**	**10**	**15**	**20**	**25**
	4 Major	**4**	**8**	**12**	**16**	**20**
	3 Moderate	**3**	**6**	**9**	**12**	**15**
	2 Minor	**2**	**4**	**6**	**8**	**10**
	1 Negligible	**1**	**2**	**3**	**4**	**5**

5.6 RISK APPETITE AND TREATMENT

5.6.1 Risk appetite refers to the level of risk on the scale outlined above that the organisation is willing to tolerate or expose itself to as risks arise or when embarking on new projects. An organisation may accept different levels of risk appetite for different types of risk, or in relation to different projects. For example, it might be highly averse to clinical risk but willing to accept a level of financial loss.

The organisation's risk appetite ensures that risks are considered in terms of both opportunities and threats and are not confined to the financial consequences of a risk materialising. Risks also impact on the capability of the organisation, its performance and its reputation. Risk appetite is influenced by the objectives set, individual programmes of work and the NHS landscape.

The Governing Body acknowledges that risk is a component of change and improvement and, therefore, does not expect or consider the absence of risk as a necessarily positive position. The organisation will, where necessary, tolerate levels of risk where action is not cost effective or reasonably practicable.

The organisation will not normally accept levels of risk rated extreme (red) which are scored between 15 and 25 using the risk scoring matrix. The organisation will ensure that plans are put into place to lower the level of risk whenever an extreme risk has been identified.

5.6.2 The organisation requires that all staff take responsibility for the treatment of identified risks. Identifying and reporting a risk does not end the responsibility of the individual staff member. A major part of risk treatment is control and the control to mitigate the risk may be easily put in place, for example by cleaning up a spillage.

The organisation expects that all reported and registered risks will be considered for risk treatment options. Risk treatment includes implementing controls, removing the risk completely, reducing the risk, transferring the uncertainty of the risk (for example by insurance) or making a decision to tolerate the risk in line with level of authority.

The organisation believes that the majority of risks will need to have controls implemented to reduce the likelihood or severity of the risk. The cost-benefit of the control needs to be considered to ensure that the risk reduction benefits outweigh the cost of the control and achieves the desired outcome.

Existing control mechanisms/activities and the level of confidence in these existing controls will be considered when identifying options for additional control measures. Potential dependencies between controls will also be considered.

The organisation has clear lines of delegation and authority.

Level	Authority / Ownership	Action
Low risk 1-3	Individuals and Team Managers	Managed through normal local control measures. Acceptable level of risk.
Moderate risk 4-6	Managers	Review control measures through formal risk assessment, record on the Risk Register
High risk 8-12	Senior Manager	Consider for risk treatment, identify mitigating actions, record on the Risk Register
Extreme risk 15-25	Director	Intolerable level of risk. **Immediate action** must be taken and the risk will generally be communicated via the High Level Risk Register to the Governing Body.

1-3: Low Risk

Individuals should manage low risks by maintaining routine procedures and taking proportionate action to implement any additional new control measures to reduce risk where possible. Individuals must escalate higher levels of risk

4-6: Moderate Risk

Managers must ensure that an action plan is identified to treat the risk. The risk must be entered on the risk register. Managers must escalate higher levels of risk.

8-12: High Risk

Senior Managers must prepare an action plan for high risks. There must be appropriate management, to oversee the action plan to reduce the risk. This may be an emerging risk which could rapidly escalate. Senior Managers must consider developing implications of the risk and report to the Audit & Assurance Committee if appropriate. The risk must be reported on the risk register.

15-25: Extreme Risk

Management action is required to ensure immediate risk treatment, in line with the context of the risk. Action plan must be overseen by a responsible lead who will ensure that the risk is reported on the Risk Register. The risk will be monitored at the Governing Body where it falls within the 'Top 10' risks of the organisation.

The format and process of the organisational Risk Registers has been approved by the Governing Body and includes the following –

- Description of the risk
- Initial Risk score (likelihood and severity)
- Current controls
- Further mitigating actions required (with owners)
- Progress on actions
- Current risk score
- Status – open, accepted, closed
- Date of review
- Overseeing committee (committee where risk area is discussed)

5.7 RISK REPORTING AND MONITORING

5.7.1 Risk Reporting

The organisation will operate a risk register that will record all identified risks. Maintaining the Directorate risk register as a complete document is the responsibility of the relevant Director and Senior Managers, providing ownership and leadership for their teams. The Directorate Risk Register must comprehensively reflect the risks identified by the Directorate. Support for this process is available from the Governance & Risk Manager. A mechanism is in place to escalate risks to the attention of the Audit & Assurance Committee and the Governing Body. A risk register is not a static record but should be viewed as a communication tool and an action plan giving details of current controls and, where appropriate, auditable actions for risk treatment. Risks should be clearly detailed to identify the cause of the risk, what the risk is and the potential impact of the risk. Defined actions should be specific, measurable, achievable, relevant and time-bounded (SMART).

The Quality Team will present a statistical report of Serious Incidents ~~Requiring Investigation~~ (SI~~RI~~) recorded on the STEIS system to the Quality and Clinical Governance Committee.

5.7.2 Risk Monitoring

The organisation will review its risk performance at a strategic and corporate level and in relation to risk management action plans. This will be achieved through regular review of the Risk Register and Board Assurance Framework (BAF). The organisation is required to maintain a comprehensive BAF.

The BAF:

- is a high-level management assessment process and record of the primary risks to the delivery of strategic objectives assessing the strength of internal controls;
- identifies sources of assurance and evaluates them for suitability. By receiving and reviewing actual assurances and using findings, the adequacy of internal control can be tested, confirmed and/or modified.

The Board Assurance Framework is regularly reviewed at the Audit & Assurance Committee and Governing Body and is fully updated annually in line with strategic objectives.

The organisation will maintain a comprehensive risk register. This is a principle tool that can be described as "*a log of all the risks that may threaten the success of the Trust in achieving its declared aims and objectives*". The Risk Register is a record that aims to illustrate the current complete risk profile of the CCG by reflecting the extent to which the objectives of the organisation are threatened by the uncertainty that risk represents. The CCG does not differentiate between risks and issues in this process. The Risk Register is linked directly to the Board Assurance Framework to ensure that the organisation can demonstrate where evidence is available to give assurance that all significant risks to the business of the organisation are being appropriately managed.

The organisation-wide risk register is used to inform the Governing Body, the Audit & Assurance Committee and other relevant parties of the risks held by the organisation and is reviewed, as a minimum, every two months. Directors and Senior Managers are responsible for reviewing their risks on the risk register as part of their routine management and governance activities and providing accurate status reports on implementation of actions in line with deadlines. Directors and Senior Managers are encouraged to use the risk register as a business decision making and communication tool.

An Annual Risk Management Report by Internal Audit will be presented to the Audit & Assurance Committee and will inform the Annual Governance Statement of the CCG.

6. TRAINING

Training to ensure competency at all levels is recognised as one of the most cost effective controls for good risk management. The organisation is committed to a system of corporate induction for all new starters and those returning to work after a long absence. Risk management related training is on-going for all staff. Systems are in place to ensure attendance for training and report training statistics to the appropriate committee.

The organisation recognises that senior managers will need governance and risk management training which is more suited to their role, level of accountability and authority. This training will be specified by the CCG and will be formally recorded.

7. COMMUNICATION & CONSULTATION

The BAF and High LeveI Risk Register will be public documents published on the CCG website as part of Governing Body papers.

In addition to the regular monitoring, annual review and reports to the Governing Body and its committees, key issues and actions arising from risk management, audit reports and related processes will be communicated to staff, patients, the public and other relevant stakeholder groups where necessary. If appropriate and/or required these key risk issues and actions will be communicated to external performance management/review bodies.

The Communications Manager will raise general staff awareness of particular risk issues by including briefings in the staff newsletter '14 days'.

This strategy will be made available to contracted bodies on request.

This strategy will be published on the organisation's website and intranet, and staff will be made aware through training sessions, where applicable, and via '14 days'.

8. REVIEW

This Risk Management Strategy is a rolling three year document. The Strategy will be reviewed on at least an annual basis or earlier where there has been a significant change to the organisation or the organisation's objectives. The review will involve a clinician.

The strategy will be submitted to the Governing Body for ratification on an annual basis.

9. MONITORING COMPLIANCE

The Audit & Assurance Committee will be responsible for ongoing monitoring of this strategy, to ensure that the framework described is working effectively.

Independent assurance will be gained when required, by means of the Internal Auditors, to assess the operation of the risk management framework of the organisation. Internal Audit support may also be requested to assess specific controls, areas or risks identified through these processes.

10. SUPPORTING DOCUMENTATION

The organisation intends to implement this strategy by means of the following key policies/documents. Further advice and support may be requested from the Governance & Risk Manager.

- Health & Safety Policy
- ~~Adverse Event (Incident) Reporting Policy~~
- Significant Incidents ~~Requiring Investigation~~ (SI~~RI~~) Policy
- Security Management Policy
- Counter Fraud and Bribery Policy
- Complaints Policy
- Learning & Development Policy – Training Needs Analysis
- Whistleblowing Policy
- Information Governance Framework
- Standards of Business Conduct Policy

11. REFERENCES AND LINKS TO OTHER DOCUMENTS

- The Risk Management Process, Federation of European Risk Management Associations (FERMA), 2005
- A Risk Management Standard, The Association of Insurance and Risk Managers, (AIRMIC), 2002
- International Organisation for Standardisation (ISO) / IEC Guide 73:2002 Risk Management
- Risk Management Model (HSG65), Successful Health & Safety Management, HSE Books, 1997
- Five Steps to Risk Assessment, HSE, 2006
- Corporate Manslaughter and Corporate Homicide Act, 2007
- A Risk Matrix for Risk Managers, NPSA, January 2008
- Department of Health (2003) Building the Assurance Framework: A Practical Guide for NHS Bodies London: Department of Health
- Consequence Grading Matrix (from A Risk Matrix for Risk Managers Jan 2008 – NPSA)

- ISO 31000 ‘Risk management – Principles and guidelines’
- ‘A structured approach to Enterprise Risk Management (ERM) and the requirements of ISO 31000’, Airmic, Alarm, IRM
- The Management of Health and Safety at Work Regulations 1999 and the Workplace (Health, Safety and Welfare) Regulations 1992 (As Amended 2002)
- Corporate Manslaughter and Corporate Homicide Act 2007
- The Data Protection Act 1998
- The Freedom of Information Act 2000
- Bribery Act 2010

APPENDIX 1

Description of the application of the NPSA matrix

Score	Description	Broad descriptor	Time-framed descriptor	Probability descriptor
5	Certain	The event is expected to occur in all circumstances	Expected to occur at least daily	>50%
4	Likely	The even will occur in most circumstances	Expected to occur at least weekly	10-50%
3	Possible	The event should occur at some time	Expected to occur at least monthly	1-10%
2	Unlikely	The event could occur	Expected to occur at least annually	0.1-1%
1	Rare	May happen in exceptional circumstances	Not expected to occur for years	<0.1%

Impact on organisation

Choose the most relevant risk descriptor and use this to measure the impact of the risk.

Descriptor	Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Impact Heading: Safety **Injury (physical & psychological) to patient / visitor/ staff**	Minimal injury requiring no/minimal intervention or treatment	Minor injury or illness requiring minor intervention	Moderate injury requiring medical treatment and/ or counselling Agency reportable, e.g. Police (violent and aggressive acts) An event which impacts on a small number of patients	Major injuries / long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling	Incident leading to death or major permanent incapacity An event which impacts on a large number of patients

Descriptor	Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Impact Heading: Service Delivery **Human Resources / Organisational development / Staffing & Competence**	Short tem low staffing level temporarily reduces service quality (<1 day). Short term low staff level (>1 day) where there is no disruption to patient care	Ongoing low staffing level reduces service quality Minor error due to ineffective training / undertaking of training	Late delivery of key objective / service due to lack of staff. Unsafe staffing level or competence (>1 day). Low staff morale Poor staff attendance for mandatory / key training. Ongoing problems with staffing levels.	Uncertain delivery of key objective / service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory / key training	Non-delivery of key objective / service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training / key training on an ongoing basis.
Impact Heading: Service Delivery **Statutory duty / inspections**	No or minimal impact or breach of guidance / statutory duty Small number of recommend ations which focus on minor improving quality issues	Breach of statutory legislation Reduced performanc e rating if unresolved Recommen dations made which can be addressed by low level of manageme nt action	Single breach in statutory duty Challenging recommend ations that can be addressed with appropriate action plan / improvemen t notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report

Descriptor	Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Impact Heading: Reputation **Adverse Publicity/ Reputation**	Rumours, no media coverage but potential for public concern Little effect on staff morale	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met. Minor effect on staff morale / public attitudes.	Local media coverage – long-term adverse publicity Significant effect on staff morale and public perception of the organisation	National media / adverse publicity, less than 3 days Service well below reasonable public expectation Public confidence in the organisation undermined Use of services affected	National / International media / adverse publicity, more than 3 days MSP/MP concern (Questions in Parliament) Court Enforcement Public Inquiry/ FAI Service well below reasonable public expectation Total loss of public confidence
Impact Heading: Service Delivery **Business objectives / projects**	Insignificant cost increase/ schedule slippage, reduction in scope or quality	<5% over project budget; minor reduction in scope, quality or schedule	5-10% over project budget; reduction in scope or quality of project; project objectives or schedule.	Non compliance with national 10-25% over project budget; significant project over-run; key objectives not met	Incident leading to >25% over project budget; Inability to meet project objectives; reputation of the organisation seriously damaged

Descriptor	Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Impact Heading: Financial **Financial (including damage / loss/ fraud / bribery) and Claims**	Negligible organisational / personal financial loss (less than £10K) Small loss risk of claim remote	Minor organisational / personal financial loss (£11k to £50K) Claim(s) less than £10,000	Significant organisational / personal financial loss (£51k to £100k) Claim(s) between £10,000 and £100,000	Major organisational / personal financial loss (£101k to £250k) Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Severe organisational / personal financial loss. (£251k plus) Failure to meet specification / slippage Loss of contract / payment by results Multiple claims or single major claim > £1 million
Impact Heading: Service Delivery **Services / Business Interruption Environmental impact**	Interruption in a service which does not impact on the delivery of pt care or the ability to continue to provide service Minimal or no impact on the environment	Short term disruption to service with minor impact on patient care Minor impact on the environment	Some disruption in service with unacceptable impact on patient care. Temporary loss of ability to provide service. Moderate impact on the environment	Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked Major impact on the environment	Permanent loss of core service or facility Disruption of facility leading to significant 'knock-on' effect Catastrophic impact on the environment

Descriptor	Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Information Governance/ Records Management	Damage to an individual's reputation. Possible media interest, e.g. celebrity involved	Damage to a team's reputation. Some local media interest that may not go public	Damage to a services reputation/ Low key local media coverage.	Damage to an organisation's reputation/ Local media coverage.	Damage to NHS reputation/ National media coverage.
	Potentially serious breach. Less than 5 people affected or risk assessed as low, e.g. files were encrypted	Serious potential breach & risk assessed high e.g. unencrypted clinical records lost. Up to 20 people affected	Serious breach of confidentiality e.g. up to 100 people affected	Serious breach with either particular sensitivity e.g. sexual health details, or up to 1000 people affected	Serious breach with potential for ID theft or over 1000 people affected

Adapted from NPSA 'A risk matrix for risk managers' January 2008

NHS
Wiltshire
Clinical Commissioning Group

Quality and Clinical Governance Committee

Terms of Reference

Date Approved by Quality and Clinical Governance Committee: 7 November 2017

Date Approved by Governing Body:

1. Purpose

1.1 The Quality and Clinical Governance Committee will deal with key clinical governance responsibilities of the organisation as set out in the CCG Constitution. It will help the Governing Body to develop and understand service quality issues, as led by the quality and safety agenda, providing assurance to the Governing Body on these matters. It will promote clinical discussion about quality and patient safety, ensuring continuous quality improvements. It will provide the forum to undertake performance review of service and clinical issues with particular reference to action plans emerging from Serious Incidents Requiring Investigation (SIRI), Serious Case Reviews (SCR) and Care Quality Commission (CQC) inspections for which the committee will be responsible and will include.

- Safeguarding Children
- Safeguarding Adults at Risk
- SIRIs and clinical incidents
- Medicines management and governance
- Review and authorisation of clinical policies and NICE guidance, and ratify the decision taken through the Clinical Advisory Group
- Workforce *(from a quality and safety aspect)*
- Assurance of any patient safety and experience issues arising from commissioning new, re-commissioning and decommissioning of services

1.2 This list is not exhaustive or exclusive and the committee will be asked to consider other relevant issues on an ad hoc basis.

2. Membership

2.1 The core membership of the Committee will consist of the following or their nominated deputies:

VOTING MEMBERS
Secondary Care Doctor (Chair)
Clinical Chair of the CCG (Vice Chair)
Director of Nursing and Quality / Registered Nurse on Governing Body
Lay Member for Patient & Public Involvement
Accountable Officer (Director of Strategy and Interim Deputy Chief Officer as Deputy)
GP representative from NEW
GP representative from West
GP representative from Sarum
ATTENDEES
Associate Director of Quality (Deputy to Director of Quality)
Associate Director of Safeguarding, CHC and Special Placements
Public Health Representative from Wiltshire Council
Governance and Risk Manager
Medical Advisor

3. Quorum

3.1 When the Secondary Care Doctor is unavailable to Chair, the Clinical Chair will deputise.

3.2 To be quorate there is a requirement for a minimum of four Voting Members from the CCG, which includes the Chair or Vice Chair.

a. Expectation of Attendance

i. Members are expected to attend all meetings, unless previously agreed with the Chair, and where unable a deputy is required.

4. Frequency of Meetings

4.1 A formal meeting will be held bi-monthly.

4.2 Extraordinary meetings may be called by the Chairman with seven working days' notice as required.

a. Meeting Arrangements

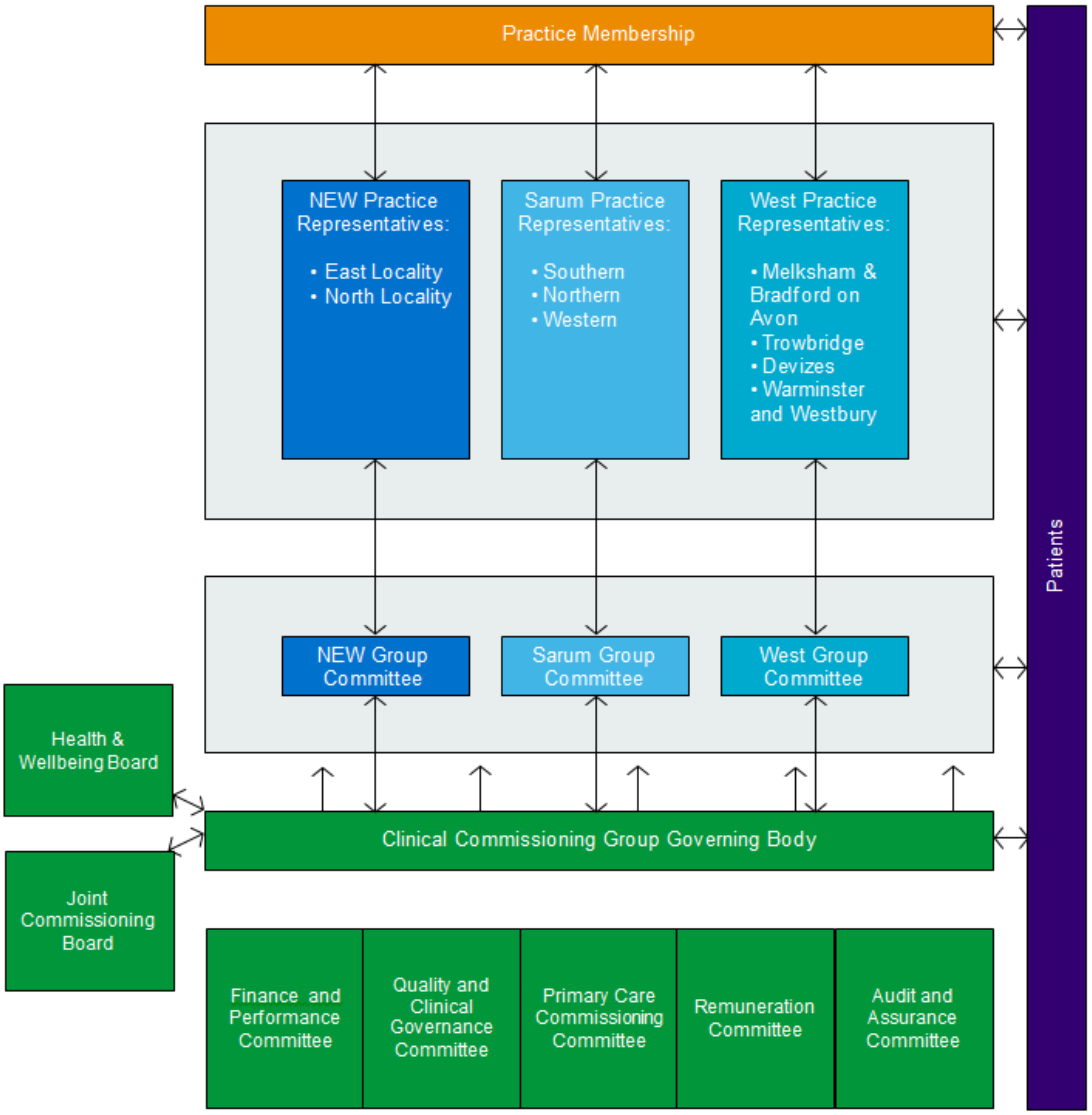
i. A detailed work programme and standing agenda will be agreed to guide the work of the committee, but will allow for flexibility.

ii. Detailed guidance and front sheets for reports to the Committee, and the frequency of reporting requirements, are available from the Board Administrator and the Director of Nursing and Quality.

5. Accountable To

5.1 The Committee is accountable to the CCG Governing Body.

Figure 1: Clinical Commissioning Group Structure



5.2 Provide assurance to the Audit and Assurance Committee and the CCG Governing Body regarding the quality and safety of commissioned services.

5.3 Provide the Governing Body with evidence that patient safety issues are fully considered, risks identified and reduced or mitigated and that exceptions are reported as necessary.

6. Responsibilities / Authority / Scheme of Delegation

6.1 The Committee is authorised by the CCG Governing Body to undertake activity within its terms of reference.

6.2 Members of the Committee are responsible for communicating decisions made by them through their management lines.

6.3 The Governing Body delegates the following to the Committee:

Delegations by the Governing Body to the Quality and Clinical Governance Committee	
Body/individual	**Delegation**
Quality and Clinical Governance Committee	a) Ensure that the Governing Body mainstreams consideration of service and clinical issues b) Identify and manage risks to quality c) Act against poor performance d) Implement plans to drive continuous improvement, including the focus on patient feedback and its direct relationship to commissioning decisions e) Seek assurance through the contracting arrangements from all Provider services that their governance and patient safety systems are robust and measurable f) Monitor incidents and Action Plans linked to key areas of responsibility where Wiltshire CCG: - is Lead Commissioner - has statutory responsibility - or where responsibility falls directly to Wiltshire CCG g) Develop and implement processes for identifying issues that affect patient safety and monitor the implementation of changes and developments to prevent re-occurrence h) Monitor compliance of commissioned services with the Care Quality Commission regulations / standards and with the quality standards within the contracts with providers. i) Approval of procedures, policies and strategies relevant to the committee's terms of reference.

7. Accountable For

- Clinical Advisory Group (CAG)
- Wiltshire Children's Safeguarding Committee

8. Duties

8.1 The Committee will take reports on matters including: Patient and Public Engagement and Experience, PALS, Complaints, Claims and trends in, for example, Freedom of information requests linked to patient quality.

8.2 In addition to the list of delegations shown in 6.3, the Committee is to:

- Promote a culture within the CCG that focuses on Patient Safety and Continuous Quality Improvement;
- Invite providers to meetings as and when appropriate to report on performance and services;
- Invites patients to meetings when appropriate to hear their story and experience
- Provide evidence and, through exception reporting, an overview and a monitoring function for all governance and patient safety issues for Wiltshire CCG;
- Provide a forum for representatives from the CCG to work collaboratively with members of the Committee to implement the quality and clinical governance agenda;
- Ensure that appropriate advice is shared with CCG Groups, through the Director of Nursing and Quality, to enable appropriate patient safety standards and indicators to be agreed with service providers and monitored, as lead commissioner.

8.3 Review by exception reports on Provider quality via the contracting and performance management framework. The committee recognises that these reports may vary in format as they will have been generated by other organisations. The Committee will expect the Group, responsible for the management of the Provider contract, to provide explanation of the reports and the remedial action that is in place to address any issues.

9. Reporting

9.1 The Committee will provide assurance to the Governing Body for both organisational learning and the fulfilment of its statutory responsibilities.

9.2 The Committee will provide, at least annually, a report to the Audit and Assurance Committee and the Governing Body and by exception in the remaining quarters.

9.3 The final and approved minutes of this meeting will go to the Governing Body.

9.4 Updates will be presented in a composite format to include areas of learning and areas of concern.

10. Monitoring

10.1 Review Quality monitoring scorecards and exception reports will enable the Committee to monitor its performance.

10.2 The Terms of Reference will be reviewed on an annual basis. Any changes to the Terms of Reference must be approved by the CCG Governing Body

NHS
Wiltshire
Clinical Commissioning Group

Remuneration Committee

Terms of Reference

Date Approved by Remuneration Committee: **26 September 2017**

Date Approved by Governing Body:

In accordance with requirements of the NHS Codes of Conduct and Accountability, Standing Orders (S4) and Standing Financial Instructions (S20.1), the CCG Governing Body shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

1. Purpose

1.1 The Remuneration Committee will provide a strategic overview of remuneration packages and advise the CCG Governing Body about appropriate remuneration, the appointment, termination and terms and conditions of the Accountable Officer, Executive Directors, Clinical Leads and other senior managers with locally determined contracts described by the NHS Very Senior Managers Pay Framework.

2. Membership

2.1 The Committee will comprise:

VOTING MEMBERS
Lay Member for Audit and Governance (Chair)
Lay Member for Public and Patient Involvement (Vice Chair)
The Chair of the CCG
The Accountable Officer (or their nominated Deputy)
Registered Nurse (Director of Nursing and Quality)
Secondary Care Doctor
1 x GP representative from a CCG Group
Chief Financial Officer
ATTENDEES – NON VOTING MEMBERS
A representative from Human Resources

(Except when conflicted or discussions about their own personal position, remuneration or terms of service are taking place)

2.2 Should any matter be put to a vote, all voting committee members present shall have a single vote to cast. In the event that for and against are equal, the Chair of the meeting shall have a second or casting vote.

3. Quorum

3.1 Business will only be conducted if the meeting is quorate. A quorum shall be the Chair (or in exceptional circumstances, Vice Chair) and any 2 Non-Executive Members.

3.2 When the Chair is unavailable, the Vice Chair will deputise.

a. Expectation of Attendance

i. Members are expected to attend at least two meetings per year.

ii. Human Resources to attend all Committee meetings

4. Frequency of Meetings

4.1 The Committee will be convened as and when required by the Chair, the Accountable Officer or the Chief Financial Officer.

4.2 It is anticipated that there will be three Committee meetings per annum, with a minimum of two.

a. Meeting Arrangements

i. The Chair, the Accountable Officer and the Chief Financial Officer shall be responsible for agreeing the agenda.

ii. The agenda and any related papers will be circulated to members at least a week in advance of the meeting. Committee members who are unable to attend should provide their comments to the Chair prior to any meeting.

iii. The Chair shall be responsible for ensuring appropriate and timely proposals are submitted for consideration, and for ensuring Committee decisions are enacted.

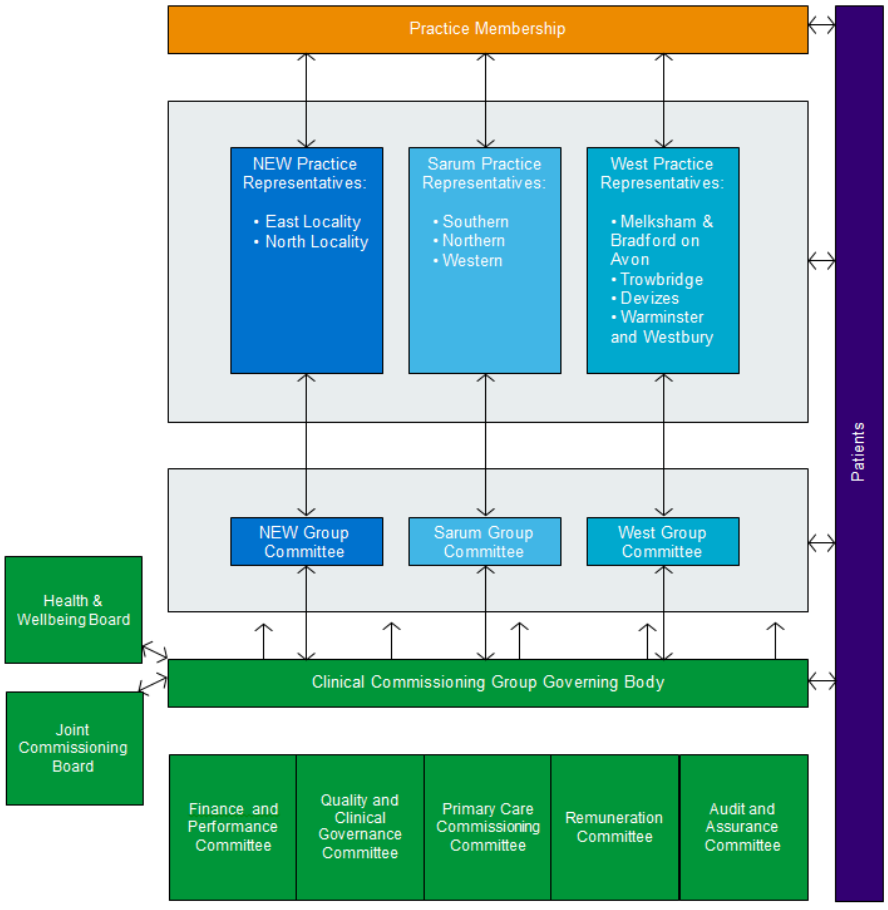
iv. Formal and confidential minutes will be recorded from each meeting of the Committee, which state the issues considered, decisions and resolutions made and the rationale for these decisions. These shall be maintained by the Board Administrator.

v. No senior manager will be present for discussions about their own remuneration.

5. Accountable To

5.1 The Committee is accountable to the CCG Governing Body for its decision making. The Chair will liaise closely with the Accountable Officer and shall only report to the CCG Governing Body such details of Committee decisions as are necessary for the Accountable Officer and CCG Governing Body to exercise proper stewardship of management costs and associated financial risks.

Figure 1: Clinical Commissioning Group Structure



6. Responsibilities / Authority / Scheme of Delegation

6.1 The Committee is authorised by the CCG Governing Body to undertake activity within its Terms of Reference.

6.2 At all times the Committee will:

a) observe the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds and the management of the bodies concerned;
b) maximise value for money through ensuring that services are delivered in the most efficient and economical way, within available resources, and with independent validation of performance achieved wherever practicable;
c) be accountable to Parliament, to users of services, to individual citizens, and to staff for the activities of the bodies concerned, for their stewardship of public funds and the extent to which key performance targets and objectives have been met;
d) comply fully with the principles of the *Citizen's Charter* and the *Code of Practice on Access to Government Information*, in accordance with Government policy on openness; and
e) bear in mind the necessity of keeping comprehensive written records of their dealings, in line with general good practice in corporate governance.

6.3 The Committee may:

a) Seek advice from whatever source it deems appropriate;
b) Incur reasonable expenditure in the furtherance of its work;
c) Authorise the Accountable Officer and Chief Financial Officer to implement remuneration packages approved by the Committee.

6.4 The Governing Body delegates the following to the Committee:

Delegations by the Governing Body to the Remuneration Committee	
Body/individual	**Delegation**
Remuneration Committee	a) Advising the Governing Body on all aspects of salary (including performance related pay elements, bonuses and allowances), provision for other benefits including pensions and lease cars (where applicable) not covered by Agenda for Change. b) Advising the Governing Body on arrangements for termination of employment (including compulsory and voluntary redundancy payments and mutually agreed severance payments) and other contractual terms and conditions. c) Advising the Governing Body on the remuneration, allowances and terms of service of senior managers covered by the Very Senior Managers pay framework ensuring that the terms and conditions of service, remuneration and pay awards are in line with nationally agreed guidance. d) Monitoring and evaluating the performance of individual Executive Members. e) Advising and overseeing appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking into account such national guidance

as appropriate.

f) Advising the Governing Body on the remuneration, allowances and terms of service for the Chairs and Members of the Group.
g) Reporting to the Governing Body that it has met and performed its function, within recognised national guidelines.
h) Establishing Sub-Committees to assist in discharging delegated responsibilities of the Committee as set out in its Terms of Reference as agreed by the Governing Body (as required).
i) Making relevant policy decisions within the functions of the Committee as set out in its Terms of Reference as agreed by the Governing Body.

7. Accountable For

There are no formal sub-committees which report directly to the Remuneration Committee.

8. Duties

8.1 In addition to the list of delegations shown in 6.4, the Committee will:

- Advise the Governing Body about appropriate remuneration, allowances and terms of service for the Accountable Officer, Clinical Leaders and those Senior Managers with locally determined contracts, described within the Pay Framework for Very Senior Managers:
    a. All aspects of salary;
    b. Contractual arrangements for such staff including the proper calculation and scrutiny of termination of employment payments, taking account of national guidance as appropriate.
- Make such recommendations to the Governing Body on the remuneration, allowances and terms of service and employment of Officer members of the Governing Body and other senior employees to ensure that they are fairly rewarded for their individual contribution to the CCG (whilst having proper regard for the CCG's circumstances and performance, and to the provisions of any national arrangements for such members and staff where appropriate).
- Annually monitor and evaluate, with the Accountable Officer and the Chair, the performance of the Clinical Leaders, Executive Directors, and those Senior Managers with locally determined contracts, described within the Pay Framework for Very Senior Managers.
- With the Chair of the CCG, annually monitor, evaluate and confirm the satisfactory performance of the Accountable Officer.
- In keeping with NHS guidance, decisions concerning pay and contractual matters shall take into account all aspects of salary, non-pay benefits, length of notice period and termination payments, other contract provisions, the scale and complexity of employment challenge, the performance of individuals and the circumstances of the organisation.
- Pay and contractual advice to inform Committee decision shall be secured from informed, impartial sources. Where a matter concerns the Accountable Officer, the Committee shall commission and receive the advice directly. The Remuneration Committee will take advice on any matters it believes to be outside its area of knowledge.
- Remuneration of Lay Members is not decided by the Remuneration Committee, but is decided by the Chair, Accountable Officer and Chief Financial Officer locally, as guided appropriately by wider national guidance, where it exists.

9. Reporting

9.1 The Chair of Committee will approve the minutes. Once approved, the minutes will be shared with Committee Members and Human Resources where appropriate. Should the minutes relate to a member of the Committee, sharing of minutes will be restricted. The minutes will be available to the External Auditors upon request.

9.2 Any items which require Governing Body approval will be the subject of a separate report.

9.3 In line with the Pay Framework for Very Senior Managers, it may be necessary to obtain NHS England ratification, which will be after the Remuneration Committee has approved any proposals.

10. Monitoring

10.1 The Committee will review its Terms of Reference on an annual basis as a minimum. Any changes to the Terms of Reference must be approved by the Governing Body.