NHS
Wiltshire
Clinical Commissioning Group

Presented to:	Governing Body - Public
Date of Meeting:	27 November 2018
For:	Decision

Agenda Reference:	GOV/18/11/10
Title:	Governing Body Sub Committee Items for Approval

Executive summary:

The Audit and Assurance Committee is a standing sub-committee of the Governing Body, with delegated authorities through the Scheme of Delegation.

The following items have been recommended for Governing Body approval:

- Audit and Assurance Committee – Risk Register and Board Assurance Framework
  - Audit and Assurance Committee Terms of Reference
  - Risk Management Strategy

Recommendations:	The Governing Body is asked to approve the documents listed above.
Previously considered by:	Executive Management Team Audit and Assurance Committee Members
Author(s):	Mark Harris – Chief Operating Officer Susannah Long – Governance and Risk Manager
Sponsoring Director / Clinical Lead/ Lay Member:	Mark Harris – Chief Operating Officer

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:	These documents should be treated as public documents and would be available for release under the FOI Act.
Equality & Diversity Assessment:	☐ N/A

Primary & Urgent Care Risk Report

Reference:	P - 16/044
Entry Date:	Jul-16
Review Date:	22/10/2018
Risk Status:	**Accepted**

Risk Rating Abbreviations

L - Likelihood
C - Consequence
T - Total

Movement Symbols
These are contained within the movement drop down list.

ó - No change
ñ - Increase
ò - Decrease

Risk Rating
Refer to risk matrix tab when recording Likelihood and Consequence scores.

	L	C	T	M
Initial Score	4	4	16	
Current Score	4	4	16	⇔
Target Score	2	4	8	

Executive Lead:	Jo Cullen, Director of Primary & Urgent Care
Operational Lead:	TBC
Overseeing Committee:	Local Delivery Board
Risk Source:	

Risk Description (including the effect if the risk):
Urgent care system pressures threaten delivery of constitutional targets for 4hr ED performance, impacting on timely treatment for patients and poorer outcomes. Corresponding impact on Primary Care.

Existing Controls / Assurance:
STP Winter Resilience Plan (including Flu Plan) submitted and ongoing assurance process NHSE/NHSI
Monthly Local A&E Delivery Boards (previously System Resilience Groups) (Wiltshire for SFT, Bath and North East Somerset for RUH and Swindon for GWH) examining strategic level actions and assurance - responsible for ED performance over winter
South system facing - weekly Senior Decision Makers meeting at SFT: developing map of capacity and additional coming on line: developing daily capture tool for capacity
ORCP funding targeted to manage patient flow through the hospital to assist A&E target delivery;
Monthly contract performance review meetings and routine performance management arrangements.
Daily and weekly reports and dashboards on acute performance.
Group Urgent Care Networks.
Quality and Safeguarding Reporting.
Strategic conference calls as required.
System wide escalation process in place - now reflecting new national guidance.

Actions required to mitigate risk:	**Due Date**	**Progress against actions:**
Agreed escalation process in place with CCG Single Point of Contact. Wiltshire Sustainability (winter) plan submitted to NHSE - focus of monthly Local Delivery Boards and final sign off November Length of Stay Improvement PLan with trajectories **Senior Decision Makers call for South System held weekly**	**November 2018**	Winter Resilience Plan v9 submitted and received NHSE/NHSI ongoing assurance responses Weekly Winter Planning leads call (all commissioners and providers across STP) South System focus on weekly Senior Decision Makers meeting; cacpaity mapping: daily capture tool for WHC, Medvivo, Wiltshire Council, Care Homes OPEL response and escalation reporting to NHSE on variation of status at OPEL 3 and 4 in place Monitoring of Trust and system OPEL status in place and escalation processes enacted as necessary Monitoring of DToC position in place with supportive action planning in place to assist patient flow. The WICC created during 2018 winter pressures has assisted in managing patient flow . Home First / Re-ablement Service (WHC and WC) now being mobilised and recruitment on track contributing towards limiting LoS thus reducing pressure in system Ongoing work with Council to understand focus and outcome of iBCF / additional winter funding

Position on previous Governing Body report:	1
Position on current Governing Body report:	1

Primary & Urgent Care Risk Report

Reference:	P - 17/046
Entry Date:	29/08/2017
Review Date:	10/10/2018
Risk Status:	**Accepted**

Risk Rating Abbreviations

L - Likelihood
C - Consequence
T - Total

Movement Symbols
These are contained within the movement drop down list.

ó - No change
ñ - Increase
ò - Decrease

Risk Rating
Refer to risk matrix tab when recording Likelihood and Consequence scores.

	L	C	T	M
Initial Score	4	4	16	
Current Score	4	4	16	⇔
Target Score	2	3	6	

Executive Lead:	Jo Cullen, Director of Primary & Urgent Care
Operational Lead:	Tracey Strachan, Deputy Director of Primary Care
Overseeing Committee:	Clinical Executive/PCCC
Risk Source:	Operational Risk

Risk Description (including the effect of the risk):
Vulnerability of practices - increasing numbers of practices under pressure from vacancies and sickness and unable to recruit. Risk to quality of service to patients and patient safety. Risk of increased activity in secondary care in both planned and urgent care services as knock on effect of use of locums and patient access difficulties.
Continued recruitment issues or withdrawal of CCG support could cause practices to give notice on their contracts. CCG responsibility to ensure services available to patients and may need to tender new contracts and potentially contract for interim cover.

Existing Controls / Assurance:
CCG working with LMC and individual practices to support. Locality plans being developed and proposal for increased project management in localities being drawn up.
Regular review of impact of resilience work in practices. Monthly GPFV/GP Resilience board. Resilience Oversight Panel in place.
Support for practice mergers where agreed.
Joint working with Medvivo to provide Clinical Assessment Service cover to vulnerable practices. Extension and expansion of POD agreed.
Proactive diagnostic work being supported in practices to enable action plans to be drawn up.
Support to Wiltshire GP Alliance development.

Actions required to mitigate risk:	**Due Date**	**Progress against actions:**
Continuous assessment of practice risk.	Next Resilience Oversight Panel Nov 18	Ongoing GPFV/resilience meetings.
Continued support as per agreed principles.		Practice provider organisation being developed.
Development of exit strategy for support - including alternative provision.		Agreed principles and criteria for GP resilience support/funding for 18/19 at Clinical Executive in January 2018.
Development of county wide provider organisation and potential risk sharing.		Review of all schemes and proposals at GP Resilience Oversight Panel 31/07/18
Continued and enhanced support to locality working.		Improved access requirements are likely to have an adverse impact.
		Some Physician Associate recruitment to release GPs.

Position on previous Governing Body report:	2
Position on current Governing Body report:	2

Corporate Services Risk Report

Reference:	C - 14/038
Entry Date:	23/02/2015
Review Date:	31/08/2018
Risk Status:	**Action Required**

Risk Rating Abbreviations

L - Likelihood
C - Consequence
T - Total

Movement Symbols
These are contained within the movement drop down list.

ó - No change
ñ - Increase
ò - Decrease

Risk Rating
Refer to risk matrix tab when recording Likelihood and Consequence scores.

	L	C	T	M
Initial Score	4	4	16	
Current Score	4	4	16	⇔
Target Score	2	3	6	

Executive Lead:	Mark Harris, Chief Operating Officer
Operational Lead:	Mark Harris, Chief Operating Officer
Overseeing Committee:	EMT
Risk Source:	Audit of workforce capacity across Health & Social Care system

Risk Description (including the effect if the risk):
Lack of appropriately skilled staff across the health and social care system due to difficulties in recruitment, national staff shortages, transformation of model of care and competitive local market. This could result in the system being unable to cope with demand for services impacting on patient flow and the provision of safe high quality care both now and in the future.

Existing Controls:
1. Each organisation monitors their key workforce gaps and takes remedial action eg recruitment drives. Wiltshire system wide workforce capacity audits undertaken Feb 15, May 16 and Nov 17. Patient outcomes in terms of quality and patient flow data monitored at CQRM meetings and local delivery Board meetings
2 STP workforce work stream (also called Local Workforce Action Board) meets monthly and is developing strategy and action plans for common challenges
3 UWE courses for nonmedical postgraduate education in place and HEE funded places made available to primary and community care in Wiltshire.
4 Wiltshire Workforce Action Group (WWAG) looks at collaborative operational solutions to common challenges, presently concentrating on recruitment of carers/HCA's
5 Strengthened links with Health Education England (HEE) through HEE south west and HEE Wessex
6 Wiltshire Community Education Provider Network (CEPN) established and delivering collaborative initiatives for primary care
7 STP Apprenticeships Network established
8 STP Training leads network established
9 Proud to Care Wiltshire website promoted and advertised

Actions required to mitigate risk:	**Due Date**	**Progress against actions:**
A: Wiltshire Workforce Action Group		**Wiltshire WAG**
2. Use Proud to Care resources at recruitment/career fairs	A2. 30/09/18	Website developed and advertised through leaflets, posters in GP surgeries, leisure centres and attendance at a
3. Continue to promote the care certificate free high quality resources to providers	A3.30/09/18	small number of recruitment fairs. Next steps to promote through social media;
B: Wiltshire CEPN		Ad hoc use at recruitment fairs, next steps to develop a more coordinated plan and have bases for the storage of
1. Develop and promote a Wiltshire Primary Care recruitment website		resources for fairs;
2. Increase the number of student placements in primary care as it is known these often convert to new	B1. 30/09/18	On-going action required to promote quality resources and develop portability of learning to other providers:
employees	B2. 31/03/19	Promotion of Proud to Care Wiltshire website complete.
3. Implement actions arising from national GP Nursing 10 point plan		**Wiltshire CEPN**
4. Promote new roles in primary care to develop a broader staff offer and improve resillience	B3. 30/09/18	www.welcometowiltshire.nhs.uk launched March 2018. Social media marketing campaign commencing April to
5. Work with NHS England, Swindon and B&NES on workforce plans for primary care as part of the GP	B4. 30/09/18	July 2018;
Forward view.	B5. 30/06/18	Wiltshire will share a portion of 2 new educational facilitator posts across the STP. B&NES post recruited Feb 18.
C: STP Workforce Work Streams		Re-advertising for Swindon post at present. Funded by HEE. Also funding for training mentors required to
1. STP Apprenticeship network promotes, shares information and develops high quality apprenticeships		support students in placements and refresher training for those already qualified has been undertaken;
across the network and to smaller employers who have not got the infrastructure and expertise to do so	C1. 30/09/18	Action plan being developed with CEPN funding a number of short term projects to support this development;
at present		Physicians associates, nursing associates, first contact physiotherapists all being promoted;

at present 2. STP Training leads network established common training priorities and developing actions to deliver on those 3. STP Workforce strategy being developed on behalf of the LWAB 4. STP cost control group looking at joint recruitment and also international recruitment of nurses 5. Workforce Lead post – current CCG post holder leaving in early June resulting in a gap before replacement.	C2. 30/09/18 C3. 31/07/18 C4. 30/09/18 C5. 30/09/18	Physicians associates, nursing associates, first contact physiotherapists all being promoted; High level, plans on pages developed and being refined. Applications for international GP recruitment initiative made. **STP Workforce Work Streams** Active network of employers who pay into the Apprenticeship levy. Developing networks for smaller employers to learn and benefit from the procurement of quality training providers by the main network. Procurement of training provider for Nursing Associate role taken place and helping nudge discussions around workforce planning within organisations. Set of metrics being developed; HEE Funded UWE post graduate non-medical modules allocated across STP providers to a value of £165,000 to develop more advanced practitioners; Aim is to have a draft strategy by July 2018; Scope of project being defined. 26.10.18 Inability to sucessfully recruit to CCG vacancy creates delay in providing leadership to further remedial activities including apprenticeships to incentivise staff for domilcillary care work.

Position on previous Governing Body report:	4
Position on current Governing Body report:	3

Primary & Urgent Care Risk Report

Reference:	P - 13/027
Entry Date:	21/10/2013
Review Date:	22/10/2018
Risk Status:	**Accepted**

Risk Rating Abbreviations

L - Likelihood
C - Consequence
T - Total

Movement Symbols
These are contained within the movement drop down list.

ó - No change
ñ - Increase
ò - Decrease

Risk Rating
Refer to risk matrix tab when recording Likelihood and Consequence scores.

	L	C	T	M
Initial Score	4	4	16	
Current Score	4	4	16	⇔
Target Score	2	4	8	

Executive Lead:	Jo Cullen, Director of Primary & Urgent Care
Operational Lead:	Emma Smith, Commissioning Lead
Overseeing Committee:	Lead & Joint Commissioners' Group
Risk Source:	Contract Performance W - 13/027

Risk Description (including the effect if the risk):
SWAST monthly and YTD performance continues to be below contracted levels. The increase in response times has the potential to adversely affect clinical outcomes for Wiltshire patients.
Nationally the focus for this coming winter would be on achieving 95% on the four hour A&E target mandating 5 improvement initiatives for LDBs including Ambulance – Dispatch on disposition and code review pilots. The Ambulance Response Programme (ARP)aims to increase operational efficiency whilst maintaining a clear focus on the clinical need of patients. The programme aims to deliver improved outcomes for all 999 patients, with a generally reduced clinical risk through:
- The use of a new pre-triage set of questions to identify those in need of the fastest response at the earliest opportunity (Nature of Call);
- Dispatch of the most clinically appropriate vehicle to each patient within a timeframe that meets their clinical need (Dispatch on Disposition); and
- A new evidence-based set of clinical codes that better describe the patient's problem and response/resource requirement

Existing Controls / Assurance:
Bi monthly contract management and reporting, including delivery by SWAST of consolidated action plan;
Review of SWAST Winter Plans and ARP Performance - through LDB.

Actions required to mitigate risk:	**Due Date**	**Progress against actions:**
Continuing engagement with SWAST and monitoring of contract via lead and joint commissioners group. SWAST member of Wiltshire LDB	**Q4 2018/19**	• ARP has now been adopted as the national benchmark, and a suite of national documents have been published addressing ambulance transformation and sustainability (Carter review, Spring Review, Commissioning Framework) • SWAST have seen some improvements in Cat 1 performance at Month 6, and have met the national Cat 1 mean target of 7 mins and achieved 90th percentile target for 2 consecutive months. However Cat 1 performance for Wiltshire is still not meeting national 7 minute mean. • Cat 2 performance is still not being achieved across SWAST and nationally there is no targets for cat 3 or Cat 4 • Wiltshire activity is currently 1.64% expected contractual volumes and activity increase is particularly driven from patients calling 999 directly. Acute Trusts are experiencing an increase in conveyed patients to ED and this remains a discussion point at local delivery boards. • SWAST initially identified a significant funding gap at a point in time and a business case was shared with commissioners. SWAST and Commissioners have re-commissioned ORH to model to understand the current funding gap to meet with expected demand and impact of commissioner joint action plan to refresh the underlying business case. This is expected to be completed by the end of the year. WCCG have already committed to additional funding for 2018/19 of £157,235 with 2.3% recurrent uplifts both in 2019/20 and 2020/21 but awaiting to see outputs of the financial modelling. • SWAST have implemented a number of internal actions including management restructure, rota review, fleet procurement and recruitment. • Commissioners have developed a joint STP action plan covering 6 keys areas including, Handovers, Frequent attenders, HCP callers, 111 activity, Frailty and Falls, Mental Health, Alternative Pathways; which is seen to improve performance with consistency being adopted across the SWAST area. • Wiltshire CCG has prioritised 111 activity, frailty and falls as key areas to work on (being confirmed) • Commissioners continue to work with SWAST to implement all workstream actions of the joint STP action plan to achieve performance by April 2021 • Internally, SWAST are registering their risk as significant in regard to their performance for call stacking. CCG

Position on previous Governing Body report:	3
Position on current Governing Body report:	4

Maternity, Children & Mental Health Risk Report

Reference:	M - 18/001
Entry Date:	24/10/2017
Review Date:	23/10/2018
Risk Status:	**Action Required**

Risk Rating Abbreviations

L - Likelihood
C - Consequence
T - Total

Movement Symbols
These are contained within the movement drop down list.

ó - No change
ñ - Increase
ò - Decrease

Risk Rating
Refer to risk matrix tab when recording Likelihood and Consequence scores.

	L	C	T	M
Initial Score	3	5	15	
Current Score	3	5	15	⇔
Target Score	1	5	5	

Executive Lead:	Lucy Baker
Operational Lead:	Myfanwy Champness
Overseeing Committee:	EMT
Risk Source:	Transfer from Community & Joint Commissioning Risk Register (CJ - 17/050)

Risk Description (including the effect if the risk):
There is a risk that -The lack of compliance with the Children's Continuing Care national framework and process for families, providers and commissioners to follow at key stages in the process such as referral, assessment, decision making around eligibility and establishment of care packages could adversely affect patient outcomes and the CCG's reputation. CCG is failing in its responsibility to commission and oversee packages of 'continuing care' to meet the needs of its patients. Should a commissioned package of care not meet a patient's needs and this impacts on the safety or wellbeing of the patient, the CCG would be responsible and accountable. Delegation of assessment to the provider has resulted in an unacceptable degree of 'distance' between commissioners and the packages of care which are ongoing and any new referrals coming in.

Existing Controls / Assurance:
CCG clinical staff have been included within the complex needs panel in order to give robust clinical challenge and assurance. An options paper has been produced to consider ways in which the CCG might respond to this risk and develop a compliant children's CHC commissioning model in the future.
Quality & Clinical Governance Committee review.

Actions required to mitigate risk:	Due Date	Progress against actions:
CHC to review existing packages of care to ensure that they are appropriate and that the CCG has the necessary oversight to assure itself that patients are receiving care of the correct standard.	Oct 18	CHC have commissioned an external organisation to review the process
Process and care package documentation to be developed which is compliant with the continuing care framework.	Oct 18	To begin following recruitment of additional staff to manage children's CHC for which a business case is required to approve this recruitment. Swindon CCGs policy has been sourced for reference and to begin work on adapting for WCCG. Await outcome of above review
CCG to recruit to the children's nurse assessor role and associated admin support role as previously agreed in the options paper.	Oct 18	Case for recruitment to be developed by safeguarding lead - await outcome of above review
Formal review and options appraisal for Childrens CHC to be recieved by EMT.	Nov 18	

Position on previous Governing Body report:	5
Position on current Governing Body report:	5

Acute Commissioning Risk Report

Reference:	A-18/073
Entry Date:	Jun-18
Review Date:	19/10/2018
Risk Status:	**Action Required**

Risk Rating Abbreviations

L - Likelihood
C - Consequence
T - Total

Movement Symbols
These are contained within the movement drop down list.

ó - No change
ñ - Increase
ò - Decrease

Risk Rating
Refer to risk matrix tab when recording Likelihood and Consequence scores.

	L	C	T	M
Initial Score	4	4	16	
Current Score	3	5	15	⇧
Target Score	2	2	4	

Executive Lead:	Mark Harris, Chief Operating Officer
Operational Lead:	Andy Jennings, Head of Acute Commissioning
Overseeing Committee:	
Risk Source:	

Risk Description (including the effect if the risk):
There ia a risk that no bids are received for the PTS tender which is now live. This will result in a need to run a second procurement exercise and will require a further extension of the incumbent provider at potentially greater cost. There will be additional workload for the CCG Leads to manage.

Existing Controls / Assurance:
Agreement from CCGs to make the contract offer / tender as attractive as possible in light of weak provider market, by reducing variation and complexity between CCGs and increasing funding envelope.

Actions required to mitigate risk:	**Due Date**	**Progress against actions:**
Apply a funding envelope to the financial offer values. Reduce complexity in the tender so far as reasonable. Reduce variation between different CCG elements of the tender so far as reasonable.	*Tender process is currently live.*	Funding envelope approach agreed by all 4 CCGs. complexity and variation reduced where possible. Additional 10% value by CCGs of funding put into tender following feedback from potential bidders. Deadline for bids 31/10/18. Through procurement process it is mlre likely that bid(s) will be received.

Position on previous Governing Body report:	6
Position on current Governing Body report:	6

Acute Commissioning Risk Report

Reference:	A - 14/025a
Entry Date:	11/05/2015
Review Date:	19/10/2018
Risk Status:	**Action Required**

Risk Rating Abbreviations

L - Likelihood
C - Consequence
T - Total

Movement Symbols
These are contained within the movement drop down list.

ó - No change
ñ - Increase
ò - Decrease

Risk Rating
Refer to risk matrix tab when recording Likelihood and Consequence scores.

	L	C	T	M
Initial Score	4	4	16	
Current Score	5	3	15	⇧
Target Score	3	3	9	

Executive Lead:	Mark Harris, Chief Operating Officer
Operational Lead:	Mark Harris, Chief Operating Officer
Overseeing Committee:	RTT Steering and Delivery Meetings. Escalation to CRM Meetings
Risk Source:	Planned Care Programme - 14/025

Risk Description (including the effect if the risk):
There is a risk, that as a CCG we will not achieve the NHS Constitutional target for patients to be treated within 18 weeks of referral for elective care which impacts on performance, clinical risk and and constitutional risk.

Existing Controls / Assurance:
Monitoring arrangements:
1. Provider / CCG RTT WG monthly. Escalates issues as required to CRMs.
2. CRMs monthly with each provider.
3. CSU contacts any non local providers that report a 52 week wait to ensure a 'to come in' (TCI).
4. Remedial Action Plan in place with GWH.
5. Remedial Action Plan in place with RUH.
6. Demand escalation framework at RUH to flag emerging issues.
7. Deep dives by specialties as required continue.
8. SFT RTT steering group now well established.
9. Review of monthly performance as published by CSU Reporting & Performance Team.

Actions required to mitigate risk:	**Due Date**	**Progress against actions:**
1. Continued monitoring of remedial action plans & trajectories in place for RUH and GWH via monthly dedicated assurance meetings with each provider. 2. Increased focus on waiting list size and shape at IS providers including RTT pathway.	31/03/2019	1. All continue as planned. 2. RTT September 91.65% target. Note : National direction is focus delivery of the waiting list size, not 92% target.

Position on previous Governing Body report:	7
Position on current Governing Body report:	7

Quality Risk Report

Reference:	Q - 18/039
Entry Date:	18/10/2018
Review Date:	
Risk Status:	**Accepted**

New

Risk Rating Abbreviations

L - Likelihood
C - Consequence
T - Total

Movement Symbols
These are contained within the movement drop down list.

ó - No change
ñ - Increase
ò - Decrease

Risk Rating
Refer to risk matrix tab when recording Likelihood and Consequence scores.

	L	C	T	M
Initial Score	4	3	12	
Current Score	4	3	12	⇔
Target Score	1	1	1	

Executive Lead:	Dina McAlpine, Director of Nursing & Quality
Operational Lead:	Rachel Hobson, Formulary Pharmacist
Overseeing Committee:	Q&CG
Risk Source:	Transfer from Acute Commissioning Risk Register (A - 18/072)

Risk Description (including the effect if the risk):
Blueteq implementation - achievement of WCCG significant QIPP saving (£809K) associated with Blueteq is at risk due to inability of acute trusts to fully engage with the required roll out; and other BSW STP CCGs to lead in their respective clinical areas

Existing Controls / Assurance:
Blueteq STP meetings (regularly)
Feedback to CAG
Feedback to QIPP review meetings
Updates to Finance & Performance Committee

Actions required to mitigate risk:	**Due Date**	**Progress against action**
1. Encourage trusts and other CCGs to fulfill their responsibilities.	31/03/2019	- CCG wide pharmacist started in post on 7.8.18, though data issue at SFT needs to be overcome, as Blueteq can not be used fully until this data issue is resolved. - Gastro has gone live. - Re-phasing of savings currently being undertaken with probable reduction in potential savings in 18/19 - STP Blueteq meeting 26.9.18.

Position on previous Governing Body report:	8
Position on current Governing Body report:	8

Quality Risk Report

Reference:	Q - 15/034
Entry Date:	28/04/2016
Review Date:	22/10/2018
Risk Status:	**Action Required**

Risk Rating Abbreviations

L - Likelihood
C - Consequence
T - Total

Movement Symbols
These are contained within the movement drop down list.

ó - No change
ñ - Increase
ò - Decrease

Risk Rating
Refer to risk matrix tab when recording Likelihood and Consequence scores.

	L	C	T	M
Initial Score	3	3	9	
Current Score	3	4	12	⇔
Target Score	2	3	6	

Executive Lead:	Dina McAlpine, Director of Nursing & Quality
Operational Lead:	James Dunne, Associate Director of Safeguarding, CHC, SPP, s117
Overseeing Committee:	Q&CG
Risk Source:	Operational

Risk Description (including the effect if the risk):
Currently, there are 6 cases (5 LD and one physical disability) which the Local Authority has agreed are not eligible for CHC but have refused to transition these over to Social Care funding and has refused offer of funding, without prejudice, for the health interventions which the Local Authority believe should be funding by the CCG. Consequently, the CCG continues to fund, without prejudice, full cost at significant financial risk to the CCG despite the agreement that all 6 cases are not CHC.

Existing Controls / Assurance:
Legal advice taken with Beachcrofts LLP for individual cases.
All 6 cases have a 'cease funding' letter issued by the CCG after 28 days reflecting the unanimous decision by both Health and Social Care that they are not eligible for CHC.
Interim Chief Officer letter to LA DAS to confirm next steps (Aug'18).

Actions required to mitigate risk:	**Due Date**	**Progress against actions:**
JD to approach Local Authority to ask for explanation as to why 2 are considered elligible and 1 is considered to be joint funded.	30/11/18	High level meeting with Local Authority partners in December 2016 agreed that joint Health and Social Care care plans would be completed on these 6 cases to determine any ongoing health needs. 13/4/18: Wiltshire Council has reviewed the 6 jointly written care plans but does not agree with the findings of the CCG. A meeting was held on 17 April between NHSE, Wiltshire Council and the CCG looking at a process for resolution. In advance of this the CCG liaised with NHSE and the other 2 CCGs in the STP to suggest which interventions should be health and which should be social care funded.It is intended that the three CCGs with their relevant local authorities will discuus the suggestions with support from NHSE and ADASS. Meeting held with Wiltshire Council on 28 June 2018. Wiltshire Council has written to CCG Interim Chief Officer agreeing to transition 3 of the cases to Local Authority funding. They suggest that 2 cases need a CHC review due to changes in health needs and 1 requires a joint approach. Interim Chief Officer will be talking to DAS regarding next steps. The CCG retains its opinion that all 6 should be transitioned to Local Authority funding with new checklist assessments carried out where necessary if the LA consider that the care needs have changed to warrant a re-review. Oct'18: JD meeting with Finance 22/10. Immediate transition required on the 3 agreed as not CHC with finances back to April'18. Onus placed on LA to explain why 2 further are illegible and 1 joint as letter from Jerry Wickham agrees to transition all six.

Position on previous Governing Body report:	11
Position on current Governing Body report:	9

Quality Risk Report

Reference:	Q - 15/029
Entry Date:	04/08/2015
Review Date:	22/10/2018
Risk Status:	**Action Required**

Risk Rating Abbreviations

L - Likelihood
C - Consequence
T - Total

Movement Symbols
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ñ - Increase
ò - Decrease

Risk Rating
Refer to risk matrix tab when recording Likelihood and Consequence scores.

	L	C	T	M
Initial Score	2	3	6	
Current Score	3	4	12	⇔
Target Score	3	2	6	

Executive Lead:	Dina McAlpine, Director of Nursing & Quality
Operational Lead:	James Dunne, Associate Director of Safeguarding, CHC, SPP, s117
Overseeing Committee:	Q&CG
Risk Source:	Operational

Risk Description (including the effect if the risk):
Lack of agreement regarding eligibility recommendations for six CHC cases with Local Authority, of which four are LD, have lead to formal disputes and continuing CCG funding dating back to 2015 in some cases. This holds significant financial risk for the CCG. The LA does not agree with the current dispute process for resolving disagreements regarding CHC eligibility. Consequently the CCG has been unable to progress six cases to the dispute panel and has continued to fund, without prejudice, at a significant financial pressure.

Existing Controls / Assurance:
Robust use with MDT approach;
Existing dispute process.

Actions required to mitigate risk:	**Due Date**	**Progress against actions: Joint review planned.**
Creation of Joint Programme Board with three defined programmes - Adult CHC, Childrens CHC and Section 117	30/9/18	A series of meetings have taken place with Local Authority partners. This is being escalated with the expectation that dispute panels will then be scheduled and heard.
Redrafted dispute process will form part of the programme board actions to agree a joint protocol.	31/10/18	Local Authority have provided a draft procedure, Director of Nursing and Quality has reviewed draft and this cannot be accepted in its current form. Further collaboration with the local authority is required to reach agreement. Director of Nursing & Quality to liaise with newly appointed interim Director of Adult Social Care, Tracy Daszkiewicz. Meeting held with Local Authority on 28 June 2018. Paper presented to JCB by DM proposing a Joint Programme Board between the Local Authority and the CCG to cover Adult CHC, S117 and Childrens' CHC with the intention to commence as soon as possible. An outcome from the Board would be an agreed dispute process. Oct'18: Programme Board to ratify Dispute Resolution Policy. Policy then to be tested on these six cases.

Position on previous Governing Body report:	12
Position on current Governing Body report:	10

NHS Wiltshire Clinical Commissioning Group - Board Assurance Framework & Action Plan November 2018

Principal strategic objective	Issue impacting on achievement of strategic objective	Key controls and systems supporting issue management	Positive assurances of controls (the available evidence on the effectiveness of the controls / systems)	Gaps in controls and systems (or weak controls and systems)	Gaps in assurance (poor evidence of effectiveness of controls and systems)	Date of Last Review	Director Lead	Action Plan	By when	Status	Comments/Updates
A: To improve the quality of healthcare and outcomes and reduce inequalities											
A.01	Range of risks associated with business continuity across local community and including the CCG as a separate organisation including: Severe weather; Disruption to transport infrastructure (incident/fuel supply); Disease pandemic; Telecommunications infrastructure failure.	Participation in Local Health Resilience Partnership at executive and working group level; Contributing through LHRP to risk management through LHR Forum; LRF Joint plans (e.g. Fuel, Telecommunications); Health Protection Unit; LRF Warning & Informing Strategy; LRF Major Incident & Recovery Plan; Refreshed CCG Business Impact Assessments (BIA); Interdependencies with CSU and NHS PS identified; Action cards for most Priority 1 business continuity in place.	LHRP workplan and meetings; Community Risk Register; Involvement with EPRR exercise; Internal Audit of Business Continuity arrangements Feb'18. Compliance with Core Standards for EPRR.	Action cards for service continuity. Remote access 'token' prioritisation. Resilient telephony in SGH	None	19/10/2018	**Chief Operating Officer**	Action Cards for remaining Priority 1 business continuity to be developed. Develop alternative solution to remote access 'token' arrangement. Replacement telephone system in SGH	Jan 19 Mar 19 Mar 19	Amber	CSU/NHSPS business continuity plans provided to CCG.
A.02	Provider organisations failing to provide harm free care to Wiltshire residents.	Contracts for commissioned services with quality schedule (for NHS and non-NHS providers); Clinical Quality Review Meetings (for NHS and non-NHS providers); Incident reporting requirement and mechanisms; CQC registration and review; Safety thermometer; Quality & Clinical Governance Committee; Oversight by Q&CG of CQC reports and safety notices; Quality visits.	Monthly Integrated Performance Report to Governing Body including patient safety information; Monitoring of SI data at Q&CG; CCG participating in surveillance for highlighted providers. Routine Contract Review Meetings of Provider performance through CSU Annual process of confirm and challenge meetings with providers to ensure compliance with EPRR including their business continuity arrangements	None	None	19/10/2018	**Director of Quality**	No further action needed		Green	
A.03	Objective setting process is not adhered to in all directorates which could lead to personal development requirements failing to be identified and cross CCG training not being purchased to address needs. Staff may be unable to effectively undertake their role and/or any training purchased may not be purchased in the most cost effective manner.	Appraisal and objective setting timetable 6 Monthly Workforce report received by AAC L&D Policy L&D Panel recives applications for support Appraisal/PDP monitoring tool available to managers on ConsultOD	Previous Internal Audit of appraisal and objective setting process.	Reports on ConsultOD indicate low compliance	None	19/10/2018	**Interim Accountable Officer**	No further action needed		Amber	Timetables for objectives and appraisals reset and reissued.
A.04	Public Sector Equality Duty requires more focus within the CCG	Lay member for PPI on Governing Body EIA process in place for decisions at Governing Body Equality Champions in place Annual E&D Compliance report	Compliance Report agreed at AAC	CCG E&D Strategy due for review	None	19/10/2018	**Interim Accountable Officer**	Establish Patient &Public Involvement Committee	Jan-19	Amber	
A.05	Strategic decisions about the future of commissioning/provision in the NHS and local system consume the capacity of the leadership and effect the delivery of commissioning activities	CCG involvement in STP leadership and programmes TOR agreed for commissioning at scale work Governing Body agreed integrated governance arrangements with Wiltshire Council, BaNES CCG and Swindon CCG Staff meeting briefings with Executive Directors and through bulletins produced jointly with partner CCGs Executive Directors' portfolios defined and shared Oct'18	Minutes of Governing Body meetings	None	None	19/10/2018	**Interim Accountable Officer**	No further action needed		Green	
B: To improve the patient's experience of local health services											
B.01	Failure to fully engage with communities to influence service development. Non compliance with Commissioner Duty to Consult where and when necessary.	CCG Communication and Engagement Strategy; Lay Member role; Website; Governing Body meetings held in public at various locations around Wiltshire; Active involvement of Healthwatch; Acknowledgement of petitions; Equality & Diversity Strategy; Stakeholder Event June 2017; PPG forum established and working well.	Locality Stakeholder days; Area Board attendances; Public consultations, surveys and conversations as required on developments; Healthwatch feedback; Centre for Independent Living feedback; Internal audit of stakeholder engagement presented to AAC & Gov Body Nov'16. Comms & Engagement plan established and actions undertaken to support Commissioning Alliance and GP Alliance and associated initiatives	Communications and Engagement Plan for STP is established, but will evolve as System evolves. (See positive assurances: Comms & Eng plans exist for Commissioning Alliance and GP Alliance)	None	19/10/2018	**Interim Accountable Officer**	Continued consistent messaging to staff and stakeholders re emerging System. Continued public messaging and consultations regarding initiatives arising from joint working within system.	Dec'18	Green	CCG involvement and comms leadership in System leadership and programmes

NHS Wiltshire Clinical Commissioning Group - Board Assurance Framework & Action Plan November 2018

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C: To work collaboratively with Wiltshire Council and partner organisations on integrated commissioning and delivery of services											
C.01	The definition for an Integrated Care System and how it works across STPs is still unclear. This might lead to incorrect assumptions, wasted effort and/or lack of progress.	Limited guidance	None	None	None	19/10/2018	**Interim Accountable Officer**	No further action needed		Green	STP Leadership Group agreement to definitions and boundaries of ICS and Integrated Care Alliances in place. Governing Bodies of BaNES, Swindon and Wiltshire CCGs agreed to establish joint governance and management arrangements on 4 Oct 18.
C.02	Achieving integrated commissioning to support the strategic objectives of CCG, the 5 Year Strategy and Better Care Fund.	Governing body reports; Joint Commissioning Board; Director of Integration; Integrated Performance Report; Engagement with Sustainable Transformation Partnership (STP) Board; S75 agreement; Emergent Sustainable Transformation Plan (Dec'16); Joint working Group (agreed ToR). Interim joint structure for Community, Mental Health, learning Disabilities and Childrens Commissioning.	Governing Body minutes; Positive relationships at Health & Wellbeing Board; Assessment of Integrated Team performance summer 2016.	None	None	19/10/2018	**Interim Accountable Officer**	No further action needed		Green	Governing Bodies of BaNES, Swindon and Wiltshire CCGs agreed to establish joint governance and management arrangements on 4 Oct 18.
C.03	Failure of partner organisations in commissioning of services on behalf of CCG in regard to financial expenditure and patient safety.	Signed Memorandum of Understanding Service Specifications Monthly performance meetings between CCG Lead and Wiltshire Council Lead Joint Business Agreement agreed by JCB; Better Care Plan governance arrangements; Outcome reports for commissioned services; Director of Integration post. Updated s75 agreement approved by Wiltshire Council and CCG at Health & Wellbeing Board; Internal audit of Better Care Plan Q4 16/17.	JCB as an assuring body; Performance risk assessed, detail included in JBA; Findings of follow-up audit of Better Care Plan.	None	None	19/10/2018	**Chief Finance Officer / Director of Quality / Director of Community & Joint Commissioning**	No further action needed		Green	
C.04	Key partner/contractors/providers may be unable to provide commissioned services.	Contracts for commissioned services with KPI; Contract performance arrangements (CSU support); Contract Managers; Integrated Performance Report; Systems Resilience Group; Provider licensing by NHS Improvement EPRR assurance against core standards	Governing Body members receive Integrated Performance Report on a monthly basis. Monthly Contract Governance Forum with CSU.	None	None	19/10/2018	**Director of Primary Care & Urgent Care / Community & Joint Commissioning Director / Acting Director of Acute Commissioning / Chief Operating Officer**	No further action needed		Green	Annual round of EPRR assurance completed with positive assurances received
C.05	Lack of available workforce in the local health system to support transformation agenda.	Each organisation monitoring key workforce gaps and taking remedial action eg overseas recruitment; Health Education England workforce planning; UWE courses for community and primary care staff in place; Wiltshire Institute of Health & Social Care; Workforce Action Group (system wide) looking at operational collaborative solutions concentrating on efficiency, learning & development and recruitment; Monitoring of provider vacancy rates at contract performance meetings; Workforce key work stream in STP and monitored at STP LWAB; Analysis of GP staffing; CCG Workforce Lead.	None	CCG Workforce Lead vacancy	None	19/10/2018	**Group Directors**	Complete second round of advertising for workforce lead	Dec'18	Amber	

NHS Wiltshire Clinical Commissioning Group - Board Assurance Framework & Action Plan November 2018

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C.06	Capacity and capability of CCG staff to deliver against the 5 year plan	Objective setting, PDP and appraisal system and timetable; Learning & Development Policy; Central oversight of requests for staff development from April 2016 at L&D Panel; Project Governance Framework; Workforce report received by AAC; Staff Survey and action plan.	Staff survey results; Workforce report (turnover, sickness absence and objective setting data) to Governing Body on six monthly basis.	Staff survey action plan	None	19/10/2018	**Chief Operating Officer**	Finalise staff survey action plan	Dec'18	Amber	Executive Directors' portfolios defined and shared Oct'18
D: To encourage and support people to be responsible for managing and improving their own health and wellbeing											
D.01	The greater involvement of the CCG in the health promotion agenda is contingent on engagement with Wiltshire Council Public Health.	Health & Wellbeing Board; Memorandum of Understanding (MoU) with Public Health - Refreshed 16/17; STP workstream; CCG public campaigns.	Minutes of Health & Wellbeing Board. Public Health attendance at Clinical Exec meeting	None	None	19/10/2018	**Chief Operating Officer**	No further action needed		Green	
E: To support the resilience of primary care across Wiltshire											
E.01	Full delegated commissioning of Primary Care wef April 2017 with no transfer of staff or resources from NHSE which impacts on multiple areas of the CCG (Primary Care, Finance, Quality & Communications).	Primary Care Commissioning Committee; NHSE documented transitioning arrangements; Ongoing support available from NHSE; Additional staff member recruited; Internal Audit of Delegated arrangements in 2017; Monitoring of risks at PCCC.	Internal Audit findings of governance and budget monitoring processes.	Delegation Agreement.	None	22/10/2018	**Director of Primary Care & Urgent Care**	No further action needed		Amber	Ongoing discussion to develop shared SOP for STP
E.02	A number of GP practices across Wiltshire are at risk due to the ongoing availability og GPs and practice staff. This may lead to poor service to registered population, possible closures and increased pressure on neighbouring practices and urgent care.	Monitoring of GP practice provision. Locum arrangements. GP Practice contracts. GP Forward View GP Commissioning Alliance and 'Grouping Zones' for locality working GP Resilience Board Clinical Assessment Service	None	None	None	22/10/2018	**Director of Urgent and Primary Care**	Continuous assessment of vulnerable practices and identification of actions. Support to GP Alliance development.	Ongoing Ongoing	Amber	
F: To contribute towards a financially sustainable and responsive health and care economy											
F.01	Implementation of the General Data Protection Regulations by 2018.	Information Governance Group; Primary Care Information Governance Group; SCW CSU Information Governance support; Existing Information Governance Framework; Information Governance Toolkit; PwC assessment of GDPR readiness (Jan'18); GDPR action schedule; DPO in place.	Information Governance Toolkit annual compliance assessment. PwC readiness assessment findings IAO,DC & IAA Handbook and training agreed at IGG Sep 18	National NHS Guidance Complinace with new DSP toolkit	None	19/10/2018	**Chief Finance Officer / Director of Quality**	Actions to be undertaken on various aspects of GDPR (see separate action plan). Assignment of IAO, DC and IAA roles and training. KPMG internal audit of DSP Toolkit progress. Completion of DSP toolkit	Mar 19 Nov 18 Dec 18 Mar 19	Amber	
F.02	The CCG is unable to deliver on all QIPP targets	Regular monitoring of QIPP delivery at Governing Body by means of Integrated Performance Report; Finance & Performance Committee (every two months); Detailed project workbooks.	Governing Body members receive Integrated Performance Report on a monthly basis; Finance & Performance Committee monitoring.	Uptake in directorates of PMO discipline Internal arrangements for oversight of performance	None	19/10/2018	**Chief Finance Officer / Chief Operating Officer / Director of Primary Care & Urgent Care / Community & Joint Commissioning Director / Acting Director of Acute Commissioning**	Confirmation of project management requirements to be shared as a result of annual planning, implementation of Directors' portfolios and joint CCG management arrangements.	Mar-19	Green	
F.03	CCG unable to meet the financial targets	Financial Strategy; 5-year Strategy/2yr Operational Plan: Financial management systems; Finance & Performance Committee; Audit & Assurance Committee; Integrated Performance Report; Internal Audit; External Audit; Organisational QIPP Plan; Contracts for commissioned services; Secondary Uses Service (SUS) data correctly attributed to CCG or NHSE; Signed Provider contracts 17/18; Financial Plans for 17/18.	Governing Body members receive Integrated Performance Report on a monthly basis; Finance & Performance Committee monitoring.	Limited Transformational QIPP plans especially for Urgent Care to support savings required in 19/20	None	19/10/2018	**Chief Finance Officer / Chief Operating Officer / Director of Primary Care & Urgent Care / Community & Joint Commissioning Director / Acting Director of Acute Commissioning**	Development of investment strategy as directed by Finance & Performance Committee.	Mar-19	Amber	

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F.04	CCG unable to deliver against NHS Constitution	5-year Strategy/2yr Operational Plan: Integrated Performance Report; Finance & Performance Committee; Quality Report at Q&CG Committee; Contract quality schedules to hold providers to account for performance; STP development; RTT delivery group/steering board.	Governing Body members receive Integrated Performance Report on a monthly basis; Finance & Performance Committee monitoring; CRM meetings reviewing providers performance data; Q&CG discussion of provider performance against targets; Reports from RTT delivery group/steering board; NHSE assurance framework.	Integrated performance management arrangements	None	19/10/2018	**Director of Primary Care & Urgent Care / Community & Joint Commissioning Director / Acting Director of Acute Commissioning / Director of Quality / Director of Integration / Chief Operating Officer**	Constitution requirements as part of Directors' portfolios	Jan-19	Green	

NHS
Wiltshire
Clinical Commissioning Group

Audit and Assurance Committee

Terms of Reference

Date Approved by Audit and Assurance Committee: 13 November 2018

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 on an annual rotational basis
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
Representative from 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.

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, through the annual assessment of performance in line with the Audit Committee Handbook and checklist, 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 20~~15~~18 to 20~~18~~21

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	~~6.0~~ 6.1
Name of Approving Committee/Groups	NHS Wiltshire CCG Governing Body
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Document Manager:	Susannah Long, Governance and Risk Manager
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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	7 10 20 21 21 22 22 24	Update to 2018/19 strategic objectives Addition of Governance Handbook Listing of target risk score Definition of RAG scores for BAF – audit recommendation Identification of strategic component of risks to inform BAF – audit recommendation ConsultOD added Removal of '14 Days' and addition of 'Latest news' feed Addition of GDPR and amendment to DPA	Nov'18

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
6	Nov'18	S.Long	Gov Body	Full three year review incorporating additions from KPMG internal audit recommendations

Contents

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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 continue delivering a clinically led model providing an enhanced range of 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 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 carers to influence the services that we commission increasing our engagement with hard to reach groups.~~

- ~~Enhance and assure the quality, safety and experience of services by ensuring effective mechanisms are in place to set quality standards, monitor performance, address concerns and 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, 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.~~

- To improve the quality of healthcare and outcomes and reduce inequalities;

- To improve the patient's experience of local health services;

- To work collaboratively with Wiltshire Council and partner organisations on integrated commissioning and delivery of services;

- To encourage and support people to be responsible for managing and improving their own health and wellbeing;

- To support the resilience of primary care across Wiltshire;

- To contribute towards a financially sustainable and responsive health and care economy.

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, 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 and Governance Handbook 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, committee terms of reference and the Governance Handbook.

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 attend this committee to ensure a consistent approach to the identification and management of clinical risk.

Individuals

5.2.4 Accountable Officer

The Accountable 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 Accountable 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 Commissioning/Group Directors

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.

5.2.8 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, being responsible for the preparation of the High Level Risk Register for presentation to the Audit & Assurance Committee.

5.2.9 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.

5.2.10 Risk Management Support

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

- Monitor actions and undertake central reporting in regard to Information Governance;
- 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 Human Resources advice and assistance.

The CCG will monitor the CSU performance through regular contract meetings.

The CCG is also supported by TIAA for Counter Fraud and Hampshire and Isle of Wight Fraud and Security Management Service for Security Management advice.

5.2.11 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.

5.2.12 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 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;

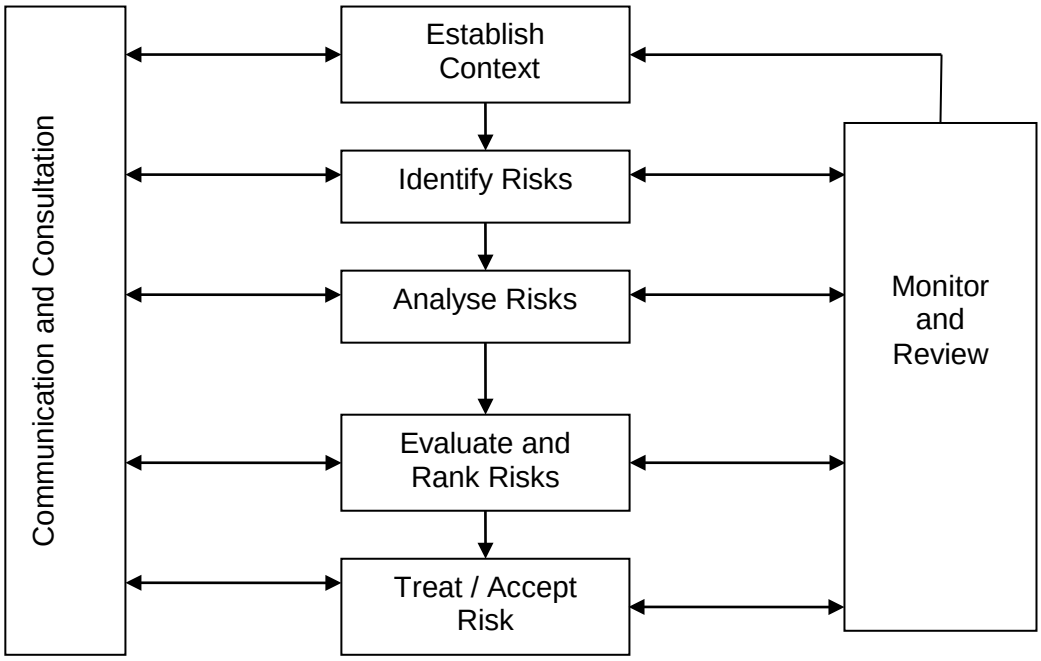
- Being aware of relevant emergency procedures e.g. first aid, evacuation and fire precaution procedures, relevant to their location and role;

- 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 (SI)
- Contract management
- 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 Adverse Event Report (AER) process 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 any trends and risk issues.

5.4.3 Serious Incidents (SI)

Provider SI: 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 data and reports is an important source of information for the commissioning process. The Quality Team will report relevant information regarding Provider SI to the Quality and Clinical Governance Committee.

Other SI: SI 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 where appropriate. These other organisations are responsible for investigating and embedding learning associated with the SI. 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 Contract management

The CCG regularly monitors provider contract performance against Key Performance Indicators (KPI) and quality schedules. Identified issues will be discussed with providers for remedial action and may result in Contract Performance arrangements. Risks will be discussed at committees and added to the risk register as appropriate.

5.4.5 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.

5.4.6 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 and a complaints report is presented to the Quality & Clinical Governance Committee.

5.4.7 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.

5.4.8 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.

5.4.9 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, 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)
- Target risk score for closure of the risk.

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 (SI) recorded on the STEIS system and a Complaints Report 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.

Items registered on the BAF are scored using a RAG rating. This clearly highlights to the Audit and Assurance Committee and the Governing Body where further effort needs to be directed to improve controls or to seek assurances that controls are appropriate and performing appropriately. The RAG rating is applied as follows:

RAG	Definition
Red	There are gaps in controls that need to be addressed.
Amber	There may be some gaps in control that the CCG would look to address; and/or There is an absence of assurance of controls that needs to be addressed.
Green	Appropriate controls are in place and the CCG has mechanisms operating which provide sufficient assurance of these controls.

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. Directors and Senior Managers must consider any strategic component of risks for inclusion on the BAF and examination of the assurances of controls in place.

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 published 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. The CCG publishes a Training Needs Analysis (TNA) to clearly identify the training to be undertaken by staff. The TNA informs ConsultOD which provides a portal for accessing and recording training. Reminders are sent to staff when refresher training is due. 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 in various subjects 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 Level 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 Governance & Risk Manager will raise general staff awareness of particular risk issues by including briefings in the staff newsletter ~~'14 days'~~ 'Latest news' feed on the intranet and in the '7 Day Roundup'.

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'~~ the 'Latest news' feed.

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 approval/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
- Significant Incidents (SI) 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)
- The General Data Protection Regulations 2016
- The Data Protection Act ~~1998~~ 2018
- 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