Wandsworth Clinical Commissioning Group

Integrated Risk Management Framework

Version 2.0

Date approved: **22/07/2014**

Date for review: **July 2016**

Lead Director: **Director of Corporate Affairs, Performance and Quality**

Lead Manager: **Business Manager**

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DOCUMENT CONTROL AND AMENDMENT RECORD

Integrated Risk Management Framework

Version	Date	Reason for review/update	Author/ Reviewer	Approving Committee(s)	Date of approval
1.0	Jun-12	Adopted for use by Wandsworth CCG	C White	Board	12/06/12
1.1	Feb-14	Review of document	S Allingham		
1.2	Mar-14	Comments incorporated from IGC	S Allingham		
1.3	Jun-14	Comments incorporated from IGC	S Iskander		
2.0	July 2014	Final version approved	S Iskander	Board	22/07/14

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1. INTRODUCTION

Wandsworth CCG's Board recognises that a key factor in driving its priorities is to ensure that effective risk management arrangements are in place and embedded in the organisation's practices and processes. Effective risk management arrangements will, in addition to helping ensure goals and objectives are met, help ensure compliance with statutory, mandatory and 'best practice' requirements.

The Francis report into the failures at Mid Staffordshire NHS Foundation Trust identified how assurance systems failed to detect and act effectively on address failures in quality. Poor risk assessment and management was explicitly identified as one of the failures of the regulatory system. It emphasises that organisations should draw on a wide range of information to assess risk. Therefore, an effective risk management system is an essential part of ensuring that the CCG effectively anticipates threats and risks, ensures quality issues are identified and takes steps to act on poor practice.

This Integrated Risk Management Framework is owned by CCG senior management, who support its implementation by ensuring a progressive, honest, open and 'just' environment where all types of risks can be identified and managed in a timely, positive and constructive way. Senior management will ensure that all staff are provided with education, training and support, appropriate to their role, to enable them to meet their responsibilities under this Integrated Risk Management Framework.

2. PURPOSE

The purpose of this framework is to describe the arrangements for effective risk management in support of the organisation's vision and objectives, to meet relevant standards imposed by legislation, and with reference to the following guidance and publications:

- Making a Difference – Review of Controls Assurance Gateway Ref. No. 4222
- Building the Assurance Framework: A practical Guide for NHS Boards March 2003. Gate log reference1054
- NHS Litigation Authority – CNST Risk Management Standards
- Governing the NHS: A guide for NHS Boards (2003)
- Integrated Governance Handbook 2006
- Intelligent Commissioning Board (2006 & 2009)
- The Healthy NHS Board: Principles for Good Governance (2010)
- Risk Management Matrix for Risk Managers NPSA, (2008)
- Taking it on Trust – Audit Commission (2009)
- Institute of Risk Management
- Towards Establishment: Creating Responsive and accountable clinical commissioning groups- National Commissioning Board (2012)

Principles and framework contained in the legislation include:

- Health and Safety at Work Act 1974
- Data Protection Act 1998
- Principles contained within the Information Governance toolkit
- ISO 31000 -2009

The framework is designed in accordance with the new international best practice standard *ISO 31000:2009 Risk management – Principles and guidelines*, which requires organisations to clarify their objectives for, and commitment to risk management and to specify the following:

- the links between the risk management policy and the organisation's objectives and other policies;
    - the organisation's rationale for managing risk;
    - accountabilities and responsibilities for managing risk;
    - the way in which conflicting interests are dealt with;
    - the organisation's risk appetite or risk aversion;
    - processes, methods and tools to be used for managing risk;
    - resources available to assist those accountable or responsible for managing risk;
    - the way in which risk management performance will be measured and reported;
    - commitment to the periodic review and verification of the risk management policy and framework and its continual improvement; and
    - the way in which the risk management policy will be communicated to all staff.

Proactive approaches to risk management

- Developing and maintaining the Board Assurance Framework and Risk Registers
- Ensuring a consistent approach to risk assessments through implementation of this framework and the risk register software
- Devising robust system for maintaining policies and procedures across the organisation
- Putting in place policies to ensure achievement of corporate objectives and mitigating risks associated with their achievement
- Ensuring an effective Safety Alerting System
- Ensuring efficient Emergency Planning and Business Continuity Planning
- Ensuring appropriate response to recommendations of NICE guidelines
- Ensuring training and development of staff

Reactive Approaches to risk management

- Near-miss and Incident reporting process
- Serious Incident Reporting
- Complaints and PALS contacts
- Claims management
- Implementing recommendations from National Enquiries, external reviews etc.
- Implementing legislative changes or those resulting from changes in national policy
- Using information in public domain published by the regulatory bodies

3. DEFINITIONS

Risk: ISO 31000:2009 defines **risk** as the "effect of uncertainty on objectives" and states that "Risk is often expressed in terms of a combination of the consequences of an event and the associated likelihood of occurrence."

Risk management: defined in ISO 31000:2009 as "coordinated activities to direct and control an organisation with regard to **risk**."

This risk management framework sets out the activities and coordination mechanisms specific to Wandsworth CCG. Further definitions are contained in Appendix Three and within the risk management and related documents referenced at section 12.

4. ACCOUNTABILITY AND RESPONSIBILITIES FOR MANAGING RISK

4.1 Introduction

This section describes the framework of accountability for managing risk across Wandsworth CCG, which is operationally led by the Accountable Officer and governed by the CCG Board.

4.2 CCG Board and Committees

The CCG Board is responsible for governing the management of risk within Wandsworth CCG. The CCG Board exercises oversight of risk through holding management to account for quality and risk management matters. This includes regularly reviewing the Board Assurance Framework.

The Integrated Governance Committee**,** a formal committee of the CCG Board, gives assurance to the Board that robust governance arrangements are in place to manage risk. It ensures that risks are identified and managed across the CCG and commissioned services, so that emerging issues, tensions and trade-offs are identified and managed effectively. This includes regularly reviewing all risks rated 12 and above. The Integrated Governance Committee is responsible for ratifying the risk management related policies.

The Audit Committee of the CCG is responsible for seeking assurance on the adequacy of internal control systems. It will obtain assurance through the work of the Integrated Governance Committee with reference to risk. The audit committee will review the adequacy of all risk and control related disclosure statements and the systems of internal control.

4.3 Accountable Officer, Senior Information Risk Officer and Management Team

The Accountable Officer is responsible for maintaining a sound system of internal control, which includes effective arrangements for risk management. Each year, the Accountable Officer has to sign, on behalf of the CCG, a Governance Statement that provides an assurance that risk management, control and review processes are in place and their effectiveness has been reviewed.

The Accountable Officer is supported by the Management Team (MT), to review quality and risk matters to ensure that the organisation is safely, and effectively, managed on a day-to-day basis.

The MT is the most senior body concerned with the day-to-day management of risk across the organisation. The MT is responsible for allocating resources at corporate management level to ensure effective management of risk; for dealing with conflicts; for holding managers to account for monitoring the management of risk across the organisation; and for providing assurances relating to risk management performance to the Board.

In addition to the Accountable Officer's ultimate accountability for managing risk, the Director of Corporate Affairs, Performance and Quality carries delegated authority for leading risk management within the organisation, ensuring that robust systems are in place and operating effectively. In addition, the Director of Corporate Affairs, Performance and Quality also carries responsibility as the Board's nominated Senior Information Risk Officer (SIRO).

The Senior Information Risk Officer (SIRO) is responsible for:

- Understanding how the strategic business goals of the CCG may be impacted by information risks; acting as an advocate for information risk on the Board and in internal discussions.
- Ensuring the Board is adequately briefed on information risk issues.
- Overseeing the development of an Information Risk Policy, and a Strategy for implementing the policy within the CCG's Information Governance Framework.
- Reviewing the annual information risk assessment to support and inform the Governance Statement.
- Taking ownership of risk assessment processes for information risks, supported by the Information Governance Manager, Information Security lead (via SLCSS IT), Records Manager and the Caldicott Guardian.
- Reviewing and agreeing action in respect of identified information risks.
- Providing a focal point for the resolution and/or discussion of information risk issues.
- Ensuring that identified information security breaches/threats are followed up and incidents managed.
- Ensuring the CCG's approach to information risk is effective in terms of resource, commitment and execution and that this is communicated to all staff.
- Maintenance, management and escalation of all information related risks on the risk register.

All other individual directors and senior managers have responsibility for managing risks within their own span of responsibility.

4.4 Specialist groups, individuals and functions concerned with aspects of risk management

There are several specialist groups, individuals or functions with a Terms of Reference (ToR) or job description that sets out their role, responsibilities, accountability and reporting arrangements in relation to risk management. Reporting relationships for all organisational committees and groups with responsibility for some element of risk management are set out at Appendix One. Details of individuals and functions include, in no particular order:

- Department of Corporate Affairs (including Head of Quality and Clinical Governance and Clinical Governance Facilitator)
- Occupational Health Department via SLCSU
- Director of Infection Prevention and Control
- Fire Safety Officer (via the South London Commissioning Support Unit)
- Information Governance Lead
- Caldicott Guardian
- Senior Information Risk Officer

Risk management processes (including health and safety) will be overseen by the Department of Corporate Affairs, within the risk management function. Additional support is provided by specialist resources including Infection Control, Fire Safety, Information Governance and others. The Risk Management function will collate information on risks within the organisation, monitor new developments in risk management, develop knowledge and expertise through the provision of training, and act as a liaison point for risk management both within the CCG and with external bodies. The Risk Management function, under the leadership of the Director of Corporate Affairs, Performance and Quality, is also responsible for maintaining and developing the organisation-wide risk management system.

4.5 Functions and Directorates

The functions and directorates are led by an executive Director who is responsible and accountable to the Accountable Officer/Management Team for ensuring that their functions properly manage their risks in line with this framework and with related policies, procedures and guidelines.

Senior managers/heads of functions/directorates are responsible for:

– Promoting a continuous process of risk identification within the function/directorate ensuring that all relevant risks are captured on the risk register;
– Adding new risks to the risk register following appropriate review and analysis;
– Supporting local risk management by facilitating the assessment of identified risks bringing together relevant staff/ specialists, as appropriate to the nature of the risk;
– Identifying risks for escalation to the next level of management.

4.6 Staff

It is the responsibility of all staff, including contractors, temporary staff and volunteers, to ensure they are aware of, and comply with this risk management framework and all related policies, procedures and guidelines, to the extent that is necessary to undertake their role.

5. IDENTIFYING, ASSESSING, MANAGING AND GOVERNING RISK

5.1 Introduction

Risk is identified, assessed, managed and governed in line with the widely available standards, guidance and recommendations found in section 12.

5.2 Principles and guidelines

The risk management process in Wandsworth CCG reflects the process outlined in Figure One that NHS organisations in England have been working with since 1999 as follows:

1. the context within which risk is to be managed is properly identified and understood. In this instance, the context is the entire range of activities carried on within Wandsworth CCG, including all activities associated with commissioning patient care and treatment;

2. risks are identified;

3. risks are assessed in terms of their likelihood, or probability, and potential consequences or severity of impact, should they materialise;

4. risks that cannot be accepted (tolerated) are treated, through action plans, so that they are either eliminated, transferred or properly controlled;

5. there is proper communication and consultation with relevant stakeholders about all aspects of risk management; and

6. all aspects of the risk management system are periodically monitored and reviewed to ensure the system is working effectively.

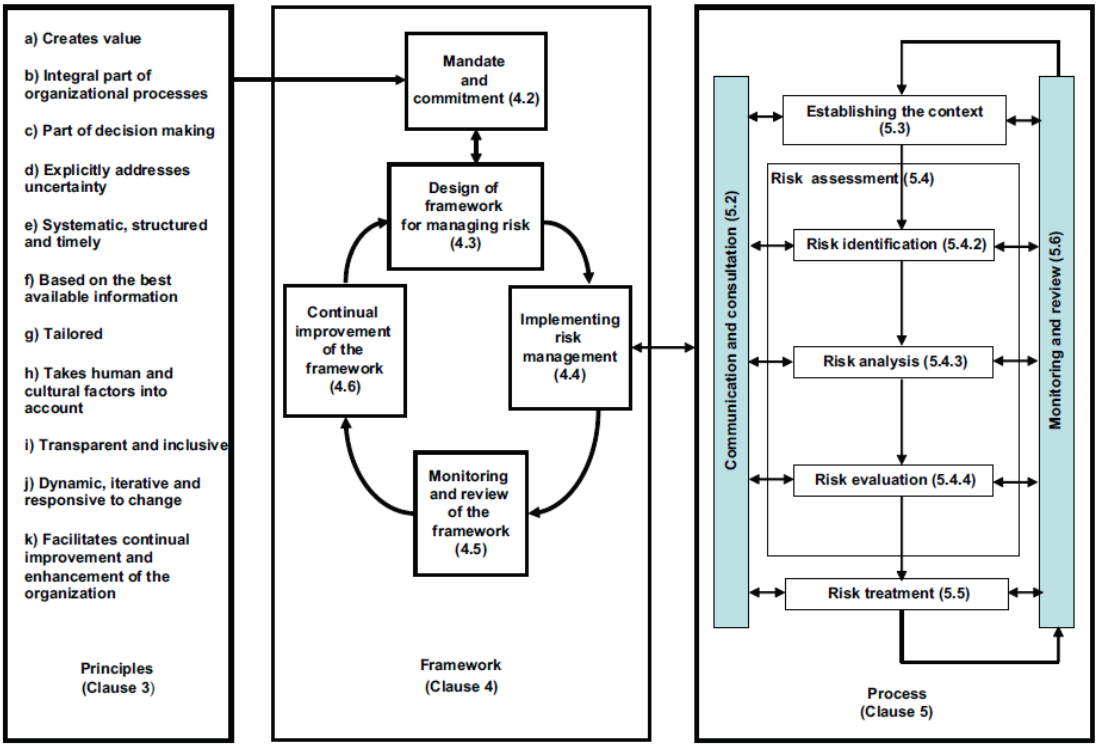

Figure One – Risk management principles, framework and process from ISO 31000:2009

5.3 Risk Register

The key tool used by the CCG for practical implementation of the risk management process outlined in section 5.2, above, is the Risk Register, which is a repository for information on all aspects of risk and used as a management tool both for managing risk and for communicating risk information.

Where necessary, serious risks need to be 'escalated' up the managerial accountability line. Further information on the role of the CCG Board in governing risk is set out in section 5.7.

An on-line risk management software system is used within the CCG.

5.4 Governing Risk

The management of risk is governed at Wandsworth CCG under the auspices of the Board and the Audit Committee. The Board monitors and reviews the Board Assurance Framework and risk register, directly and through the Integrated Governance Committee, taking assurance as to the organisation's management of risk. The Audit Committee is responsible for oversight of the entire system of internal control within Wandsworth CCG and, as part of this responsibility, will provide independent assurance to the Board on the effectiveness of the organisation's system for risk management.

5.5 Board Assurance Framework (BAF)

A key companion to the risk register is the Board Assurance Framework (BAF) (see Appendix Four). The BAF describes the principal risks that relate to the organisation's corporate objectives and is intended to provide assurances to the Board on the management of risks that threaten the ability of the organisation to achieve these objectives.

5.6 Governance Statement

There is a requirement on the Accountable Officer to sign off, on behalf of the Governing Body, an annual Governance Statement (formerly the Statement on Internal Control). This statement is underpinned by the risk management process and, in particular, the organisation's risk register and BAF.

5.7 Process for Board Review of the Risk Register

The Board has overarching responsibility for risk. The Integrated Governance Committee, Audit Committee and Management Team all have specific responsibilities for elements of the risk management system.

The BAF and the red risks (those rated 15 or above) will be presented to the CCG Board on a quarterly basis. Risks rated 12 and above will be presented for review at monthly Integrated Governance Committee meetings, along with information highlighting any changes to the risk register, accompanied by the full risk register for information.

6. CONSULTATION AND COMMUNICATION WITH STAKEHOLDERS

The key internal stakeholders, for the purposes of this risk management framework, are the staff and functions/directorates, Management Team and the Board. It is the responsibility of the Director of Corporate Affairs, Performance and Quality to ensure proper consultation and communication processes are in place between key internal stakeholders.

The key external stakeholders, for the purposes of this risk management framework, are NHS England and External Audit. It is the responsibility of the Director of Corporate Affairs, Performance and Quality to ensure proper consultation and communication processes are in place with key external stakeholders.

7. APPROVAL AND RATIFICATION

This Framework has been approved by the Board and any associated policies have been ratified as suitable for implementation across the CCG by the Integrated Governance Committee through delegated responsibility from the Board.

8. REVIEW AND REVISION

This framework and associated policies will be reviewed in line with the Framework for the Development and Management of Policy and Procedural Documents policy; the standard length of time for review is three years.

However, changes within the organisation affecting this process, together with any changes in legislation or the requirements of external regulators /accreditation organisations may prompt the need for revision before the three year natural expiry date.

9. DISSEMINATION AND IMPLEMENTATION

The general process for dissemination is as described in the Management and Development of Procedural Documents policy.

Staff training on risk management is central to the successful implementation of this framework. Risk management training needs, in relation to the responsibilities outlined in section 4, will be mapped out and included in the Wandsworth CCG training needs analysis currently in development.

10. ARCHIVING

The risk management framework, associated policies and guidelines, will be held in the CCG database and archived in line with the arrangements in the Management and Development of Procedural Documents and Records Management policies.

11. MONITORING COMPLIANCE

This framework, and associated policies, are monitored using (a) audit of the standards contained within and underpinning the framework and associated policies and will be reported by the Director of Corporate Affairs and Performance to the Integrated Governance Committee annually; and (b) the Risk Management Key Performance Indicators at Table One below. Key Performance Indicators (KPIs) will be included quarterly in the Integrated Report.

For each group and committee identified as being responsible for elements of risk management, an annual review will be completed by the Chair of that group or committee to assess the achievement of its terms of reference, including the Integrated Governance Committee's and the Board's review of the risk register and Board Assurance Framework. This will include reviewing duties in relation to risk management.

The results of the review must be considered by the relevant group or committee and members will be asked to approve the findings and the conclusion drawn, before forwarding a copy to the Risk Management lead, under the management of the Director of Corporate Affairs and Performance, for inclusion in the quarterly summary. At a governance level, the CCG Board is responsible for reviewing compliance.

Table One: CCG Risk Management KPIs

Key Indicator	Purpose	Construction	Use of the indicator / action required	Person Resp	Frequency of review	Review body(ies)
BEING PRO-ACTIVE: IDENTIFYING AND MANAGING RISK *Note: Mandatory fields within the risk register ensure that the Trust process for assessing risks of all types is followed (min. data set in accordance with NHSLA requirements)* ***(NHSLA Criterion 1.5 a)***						
Total number of risks on register	Provides a quantification of the number of risks that are subject to control which can be 'benchmarked' with other management units etc.	Sum of all risks on the unit risk register.	Compare with other management units and if the number is considered low in comparison then establish whether the process of risk identification needs improving	Director of Corporate Affairs, Performance and Quality	Quarterly	Integrated Governance Committee
Number of risks opened in the reporting period	Provides a quantification of the number of risks that were identified within the reporting period which can be benchmarked against other management units	Sum of all risks with open date falling in the reporting period	Compare with other management units and with relevant performance data (incident/ complaints/claims/ audit/ targets etc) and if number is considered low in comparison establish whether process of risk identification needs to be strengthened	Director of Corporate Affairs, Performance and Quality	Quarterly	Integrated Governance Committee
% training in risk management carried out as identified in training needs analysis	Provides a quantification of compliance with the risk management training needs analysis which can be benchmarked against the target (indicator of risk management capability)	Number of staff trained as a % of the total number who require to be trained	Compare with target and if performance falls below expected levels establish reasons for impaired performance and record plan for improvement	Director of Corporate Affairs, Performance and Quality	Quarterly	Integrated Governance Committee

Key Indicator	Purpose	Construction	Use of the indicator / action required	Person Resp	Frequency of review	Review body(ies)
% of risk management actions completed on time	Provides a quantification of the number of planned controls which have been implemented on time (in accordance with planned timescales) which can be benchmarked against target	Sum of all actions completed on time as a percentage of the total number of actions due for closure in the reporting period (actions which are carried forward in breach from the previous reporting period are included in the calculation)	Compare with target and if performance falls below expected levels establish reasons for impaired performance and record plan for improvement	Director of Corporate Affairs, Performance and Quality	Quarterly	Integrated Governance Committee
Movement in risk scores	Provided indication that identified actions and controls established are effective in mitigation of risks	Reduction in risk scores to achieve the tolerance risk score identified for individual risks	Compare with the tolerance score and establish reasons for non-reduction in risk score	Director of Corporate Affairs, Performance and Quality	Quarterly	Integrated Governance Committee

12. References

- Making a Difference – Review of Controls Assurance Gateway Ref. No. 4222
- Building the Assurance Framework: A practical Guide for NHS Boards March 2003. Gate log reference1054
- NHS Litigation Authority – CNST Risk Management Standards
- Governing the NHS: A guide for NHS Boards (2003)
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- Institute of Risk Management
- Towards Establishment: Creating Responsive and accountable clinical commissioning groups- National Commissioning Board (2012)

Principles and framework contained in the legislation including:

- Health and Safety at Work Act 1974
- Data Protection Act 1998
- Principles contained within the Information Governance toolkit
- ISO 31000 -2009

13. Associated Documents

Policy for the Reporting, Management and Investigation of Incidents (including Serious Incidents).

Complaints Policy (under development for the CCG)

Framework for the Development and Management of Policy and Procedural Documents

14 Equality Analysis

Equality analysis was undertaken and no issues identified. The equality analysis will be published on the Wandsworth website.

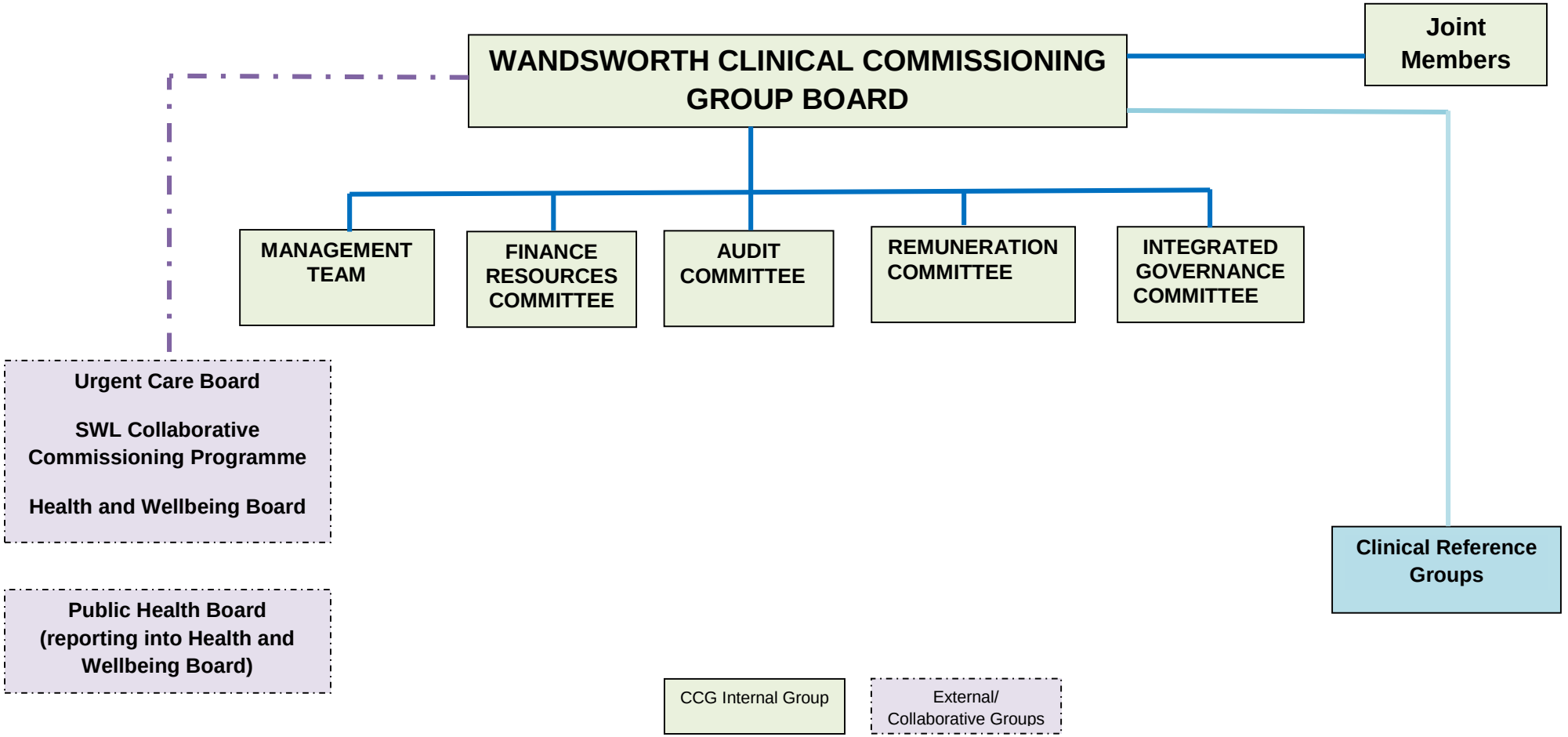
15 Information Security Risk Management Process

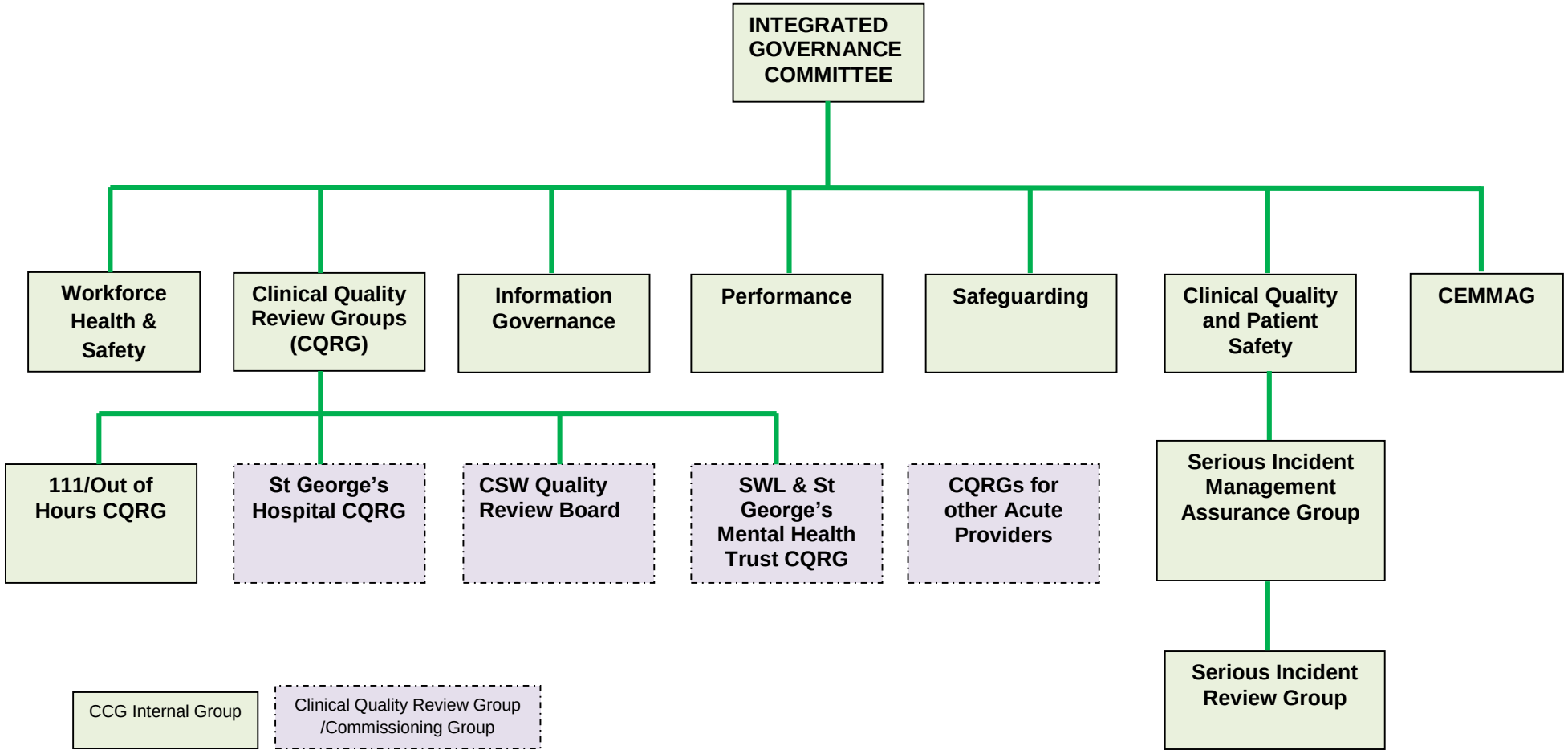
The CCG will use the process outlined below, to monitor information security risks:

Information Security Risk Management Process

Domain	High Level Controls	High Level Management
Staff Recruitment	▪ Confidentiality clauses in contracts for Permanent Staff ▪ Confidentiality agreement signing for temporary staff prior to engagement ▪ CRB vetting procedures as per CRB criteria ▪ Management of Starters and leavers Process	▪ Bi –Monthly Information Governance Steering Group meetings(or more as required) ▪ Monthly assurance update to Integrated Governance Committee ▪ Monthly verbal SIRO and Caldicott Updates by IG lead ▪ Information Governance Risk register which feeds to the Corporate risk register for risks above a score of 12 ▪ Regular risk review reports by IGSG ▪ Advice , guidance and support from, local and national bodies such as HSCIC,DH, NHSE, ICO
Information Assets	▪ Yearly identification & mapping of Key Information assets ▪ Allocation of IAO & IAA for each asset ▪ Assessment of Risk, access control & Business continuity of each key asset ▪ Risk identified on each asset to be logged on CCG IG risk register for management ▪ Process for feedback of issues from IAA/IAO to SIRO	
Procurement and New Projects	▪ IG vetting at PQQ stage for all providers ▪ Standard NHS contract for clinical services ▪ Consultancy service agreement with/without PCD access ▪ Data Controller/Processor agreements as required ▪ Privacy Impact Assessment for Individual projects - Risks managed through risk registers ▪ IG checklist for managers during procurement	
PCD Information Flows	▪ Mapping inbound and outbound PCD flows ▪ Risk assessment of each flow & logging Identified risks on IG risk register and /or corporate risk register as appropriate ▪ Process for approving all new PCD flows ▪ Management & monitoring ASH safe haven models	
Incidents	▪ SIRI management in line with HSCIC guidance ▪ Low grade Incidents recorded as per incident process	
Training	▪ Yearly training for all staff ▪ Specialist training for IG manager, CG, SIRO and IAO	
Communication	▪ All staff communication using various methods	
Audit/ Monitoring	▪ Internal audits which vary in format ▪ External audits ▪ Monitoring provider for IG compliance in line with CCG audit process	

Appendix One: Committee Structure




INTEGRATED GOVERNANCE COMMITTEE
Workforce Health & Safety
Clinical Quality Review Groups (CQRG)
Information Governance
Performance
Safeguarding
Clinical Quality and Patient Safety
CEMMAG
111/Out of Hours CQRG
St George's Hospital CQRG
CSW Quality Review Board
SWL & St George's Mental Health Trust CQRG
CQRGs for other Acute Providers
Serious Incident Management Assurance Group
Serious Incident Review Group
CCG Internal Group
Clinical Quality Review Group /Commissioning Group

Appendix Two: Frequency and Purpose of Local Review of Risk Registers

I. The individual Directors should meet monthly with the Business Manager to monitor and maintain their individual directorate risks. They should:

- Ensure that the risk register is appropriately populated, capturing risks from a range of sources. – *"Any new risks this month?"*
- Review new risks on the register to ensure that the risk assessment is robust, challenging as appropriate the risk scoring, proposed risk treatment plan and monitoring arrangements in place. – *"Is this new risk assessment robust?"*
- For existing risks, ensure that treatment (action) plans are progressing in accordance with due dates and that the current risk score is updated to reflect progress in managing the risk. – "*Are we making the progress we expected in managing individual risks?"*
- Identify risks for escalation to the next level of management. – *"Are there any risks which are, in part of wholly, outside of our control to manage, and if so, who has the authority and resources to manage the risk?"*
- Review and agree risk priorities and ensure that these are accounted for within wider business planning and commissioning processes. – *"How can we deploy our efforts and resources to greatest effect?"*
- Consider the tolerance risk score for individual risks to provide an indication of the level at which the CCG would consider the risk to be at an acceptable level.

Monthly risk reports will be provided by the Business Manager to support the Directors.

Other reports, such as audits, Serious Incident reports, incident trend analysis reports etc, should be utilised as sources of potential risk.

II. The Risk Review Group, made up of key representatives from each of the directorates, should meet, monthly to monitor the risk register in totality. The group should:

- Identify any new significant risks for inclusion on the register, drawing on information from a wide range of sources, including but not limited to: CQC inspection reports, service reviews, performance information (internal and external reports), internal and clinical audit findings, serious incident reports, staff and patient surveys, benchmarking data etc.
- Scrutinise all risks on the register to ensure that the risk assessment is robust, challenging as appropriate the risk scoring, proposed risk treatment plan and monitoring arrangements in place.
- For existing risks, ensure that actions are progressing in line with expectations.
- Identify risks that, having achieved the tolerance risk score, can be removed from the risk register.
- Identify risks for escalation to the Integrated Governance Committee.

Appendix Three: Definitions / Glossary of Terms

Risk – effect of uncertainty on objectives where an effect is a deviation from the expected – positive and/or negative

Inherent risk - is the exposure arising from a specific risk before any action is taken to manage it

Risk appetite – amount or type of risk that an organisation is willing to pursue or retain

Risk assessment – the overall process of risk identification, risk analysis and risk evaluation

Risk analysis – process to comprehend the nature of risk and to determine the level of risk

Risk criteria – terms of reference against which the significance of a risk is evaluated

Risk evaluation – process of comparing the results of risk analysis with risk criteria to determine whether the risk and/ or its magnitude is acceptable or tolerable

Residual risk – risk remaining after risk treatment (action completed, controls in place and effective)

Risk retention – acceptance of the potential gain, or burden of loss, from a particular risk (includes the acceptance of residual risks)

Risk tolerance – organisation's willingness to bear the risk after risk treatment in order to achieve its objectives (Note: risk tolerance can be limited by legal and/ or regulatory requirements)

Risk treatment – process to modify risk

I. Avoiding the risk by deciding not to start or stop the activity giving rise to the risk
II. Taking or increasing the risk in order to pursue an opportunity
III. Removing the risk source
IV. Changing the likelihood
V. Changing the consequence
VI. Sharing the risk with another party or parties (contracts and financing arrangements)
VII. Retaining the risk by informed decision making

Strategic risk – risk concerned with where the organisation wants to go, or how it plans to get there, and how it can survive (BAF)

Appendix Four: Board Assurance Framework Template

INTRODUCTION

The Integrated Risk Management Framework was approved in June 2012 by the CCG Board. The framework is detailed in the Risk Policy and Procedure. The risk process and framework is now fully established across the CCG. Risks at all levels are identified, assessed, scored, reported, owned and recorded. Some risks will be identified by the Board; others will be raised by managers and staff as part of their day-to-day work. Each risk is assessed in terms of both its potential likelihood and impact. Those two dimensions are each given a score between 1 and 5 (in line with the National Patient Safety Agency's Model 2 Risk Matrix). The risk score is calculated by multiplying those two numbers. Controls are put in place to reduce the likelihood or the impact of each risk.

The Board Assurance Framework has been developed from the organisation's key objectives and principal risks to those objectives (identified by the Board). The Board Assurance Framework is the main process through which the Board receives assurance on the management of risks to the achievement of the strategic objectives.

Higher scoring operational risks are also reported and escalated within the wider system of risk across the organisation. This provides the Board with an overview of the totality of the high level risks which face the organisation together with the action plans to address them. The detailed review and scrutiny of the Board Assurance Framework ensures that appropriate controls and assurances are in place to manage the mitigation of these risks. Analysis identifies any objectives that are at a greater risk and provides opportunities for remedial action which will increase the level of assurance.

This Board Assurance Framework attached details the Principal Risks as ***** that may prevent the CCG from achieving its strategic objectives. Information included in the report identifies:

- Controls that have been put in place to manage the risks;
- Assurances that have been received to demonstrate if the controls are having the desired impact;
- Performance against Key Performance Indicators;
- Details of any gaps in the assurance; and
- Comments and further actions required.

There are currently ***** BAF risks, ***** is rated very high (15-25), ***** rated as high (8-12), and ***** moderate (4-6). To date the strategic objectives most at risk is/are ***** with risk scores totalling 42. The highest level individual risk is (R***) ***** which has a risk score of **.

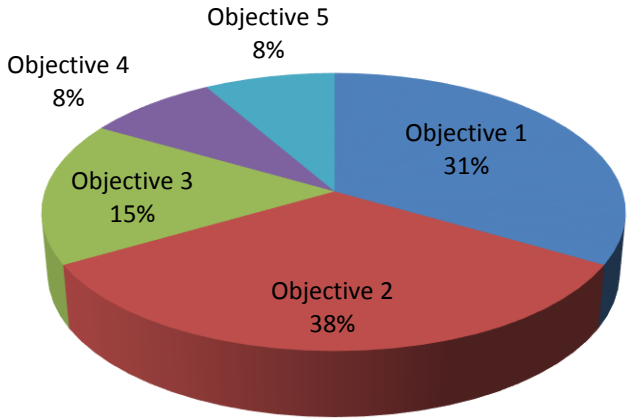
All risks and their actions are regularly reviewed and scrutinised. The review process involves the teams within the CCG and the Management Team. The scrutiny process involves the Risk Review Group, the Integrated Governance Committee, and the CCG Board. The Principal Risk scores will be tracked during the financial year, which will enable monitoring of the effectiveness of the actions, controls and assurances.

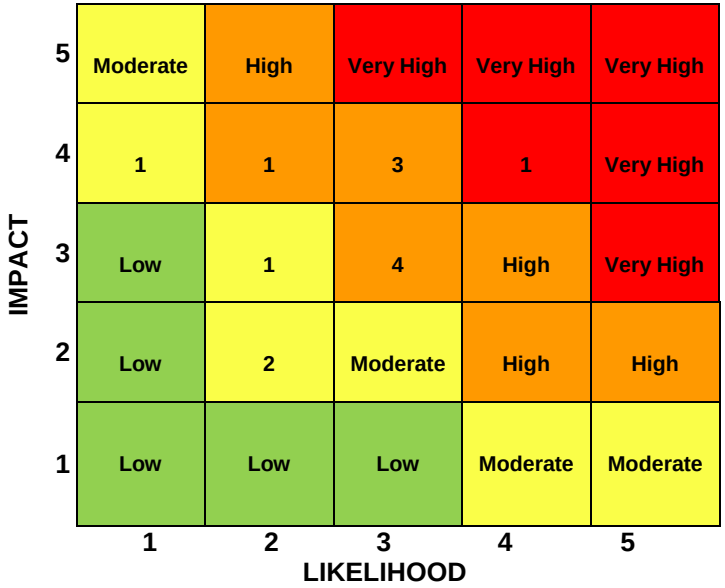
The dashboard below summarises the Corporate Objectives and lists the principal risks that relate to them.

Corporate Objective	Potential Principal Risk	Initial Score	Current Score	Tolerance Score	Movement from previous review	Date of last Review
Objective 1: Commission high quality services which improve outcomes and reduce inequalities *(additional 9 operational risks and one programme risk recorded)*						
Objective 2: Make the best use of resources, continually improve performance and deliver statutory responsibilities *(additional 6 operational risks recorded)*						

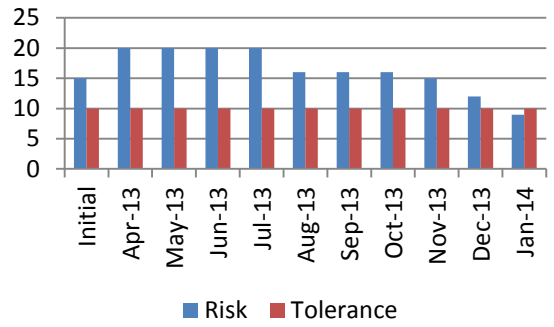
Objective 3: Continually improve delivery by listening to and collaborating with our patients, members, stakeholders and communities *(additional 5 operational risks recorded)*						
Objective 4: Transform models of care to improve access, ensuring that the right model of care is delivered in the right setting *(additional 5 operational risks and 1 programme risk recorded)*						
Objective 5: Develop the CCG as a continuously improving and effective commissioning organisation *(additional 3 operational risks recorded)*						

BAF Risk Profile Summary February 2014



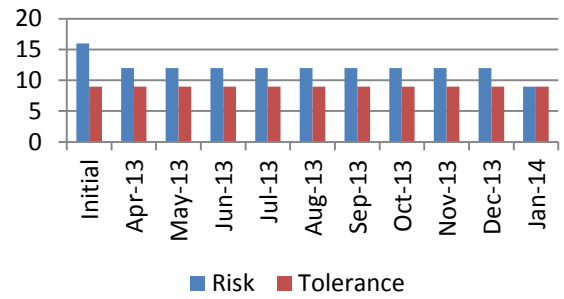


Objective				Very High
1: Commission high quality services which improve outcomes and reduce inequalities	0	0	0	0
2: Make the best use of resources, continually improve performance and deliver statutory responsibilities	0	0	0	0
3: Continually improve delivery by listening to and collaborating with our patients, members, stakeholders and communities	0	0	0	0
4: Transform models of care to improve access, ensuring that the right model of care is delivered in the right setting	0	0	0	0
5: Develop the CCG as a continuously improving and effective commissioning organisation	0	0	0	0

Objective 1: Commission high quality services which improve outcomes and reduce inequalities		
Risk ** -		**Director Lead:** **Date last reviewed:**
Risk Rating: (likelihood x consequence) Initial: Current: Tolerance rating:	**Risk History**  	**Rationale for current score:**
Main controls in place: *(What are we currently doing about the risk?)* •		**Internal Assurances:** *(How do we know if things we are doing are having an impact?)* **External Assurances:**
Gaps in Assurances and Controls: *(What additional assurances should we seek?)* •		**Further actions required:** *(What more should we do?)* •
Current Performance: *(What will progress be measured against?)*		**Additional comments:** *(With these actions taken, how serious is the problem?)*

<table>
<tr><td colspan="3">Objective 2: Make the best use of resources, continually improve performance and deliver statutory responsibilities</td></tr>
<tr><td colspan="2">Risk ** -</td><td>Director Lead:

Date last reviewed:</td></tr>
<tr><td>Risk Rating:
(likelihood x consequence)

Initial:
Current:
Tolerance rating:</td><td>Risk History
 
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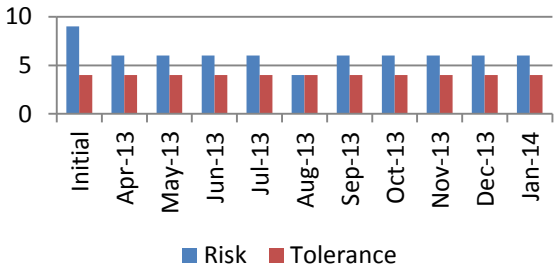
<tr><td colspan="2">Main controls in place: (What are we currently doing about the risk?)
•</td><td>Internal Assurances: (How do we know if things we are doing are having an impact?)

External Assurances</td></tr>
<tr><td colspan="2">Gaps in Assurances and Controls: (What additional assurances should we seek?)
•</td><td>Further actions required: (What more should we do?)
•</td></tr>
<tr><td colspan="2">Current Performance: (What will progress be measured against?)</td><td>Additional comments: (With these actions taken, how serious is the problem?)</td></tr>
</table>

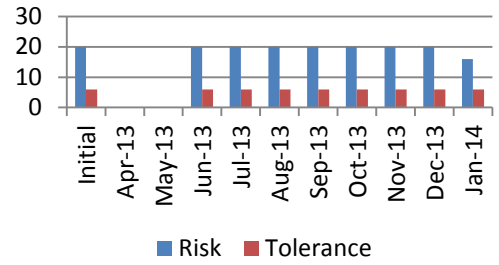
Objective 3: Continually improve delivery by listening to and collaborating with our patients, members, stakeholders and communities	
Risk ** -	**Director Lead:** **Date last reviewed:**

Risk Rating: (likelihood x consequence) Initial: Current: Tolerance rating:	**Risk History**  	**Rationale for current score:**

Main controls in place: *(What are we currently doing about the risk?)* •	**Internal Assurances:** *(How do we know if things we are doing are having an impact?)* • **External Assurances**
Gaps in Assurances and Controls: *(What additional assurances should we seek?)* •	**Further actions required:** *(What more should we do?)* •
Current Performance: *(What will progress be measured against?)*	**Additional comments:** *(With these actions taken, how serious is the problem?)*

<table>
<tr><td colspan="3">Objective 4: Transform models of care to improve access, ensuring that the right model of care is delivered in the right setting</td></tr>
<tr><td colspan="2">Risk ** -</td><td>Director Lead:

Date last reviewed:</td></tr>
<tr><td>Risk Rating:
(likelihood x consequence)

Initial:
Current:
Tolerance rating:</td><td>Risk History
 
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•

External Assurances
•</td></tr>
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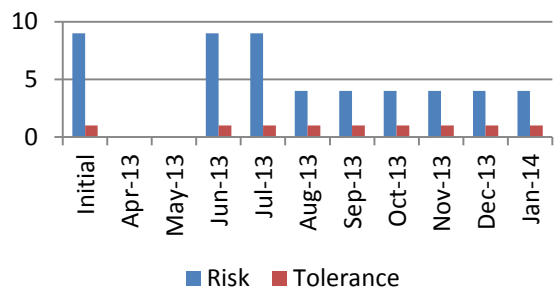
<table>
<tr><td colspan="3">Objective 5: Develop the CCG as a continuously improving and effective commissioning organisation</td></tr>
<tr><td colspan="2">Risk ** -</td><td>Director Lead:

Date last reviewed:</td></tr>
<tr><td>Risk Rating:
(likelihood x consequence)

Initial:
Current:
Tolerance rating:</td><td>Risk History
 
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</table>

The following detailed Operational Risks are currently rated 15 or above: *(to be inserted as appropriate)*

Appendix Five: Risk Rating Matrix

Table 1 Consequence (Severity) scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence (severity) score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	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	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
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million

Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L)
What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur,possibly frequently

Note: the above table can be tailored to meet the needs of the individual organisation.

Some organisations may want to use probability for scoring likelihood, especially for specific areas of risk which are time limited. For a detailed discussion about frequency and probability see the guidance notes.

Table 3 Risk scoring = consequence (severity) x likelihood (S x L)

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
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

Note: the above table can to be adapted to meet the needs of the individual trust.

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 – 6	Moderate risk
8 – 12	High risk

15 –25 Extreme risk

Instructions for use

1 Define the risk/s explicitly in terms of the adverse consequence/s that might arise from the risk.

2 Use table 1 (page 24) to determine the consequence (severity) score/s (S) for the potential adverse outcome/s relevant to the risk being evaluated.

3 Use table 2 (above) to determine the likelihood score/s (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

4 Calculate the risk score the risk multiplying the consequence by the likelihood: S (consequence/severity) x L (likelihood) = R (risk score)

5 Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

Source: NPSA (modified)

Appendix Six: Terms of Reference: CCG Board; Audit Committee; Integrated Governance Committee

WANDSWORTH CLINICAL COMMISSIONING GROUP

Governing Body – Terms of Reference

1. Aim and Purpose

The main function of the Governing Body is to ensure that Clinical Commissioning Group (CCG) has appropriate arrangements in place to ensure it exercises its functions effectively, efficiently and economically and in accordance with any generally accepted principles of good governance that are relevant to it.

The Governing Body shall carry out the duties and responsibilities set out in the CCG's Constitution and should ensure business is conducted in accordance with Standing Orders (SOs) and Standing Financial Instructions (SFIs).

These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Governing Body.

2. Authority

The Governing Body may establish sub-committees to assist with the delivery of its delegated responsibilities and to progress its work as appropriate. Such sub-committees do not have executive powers, unless this has been agreed in advance by the Governing Body.

The Governing Body will establish appropriate reporting arrangements for Sub-Committees.

The Chair of the Governing Body will work to establish unanimity as the basis for decisions. If, exceptionally, the Governing Body cannot reach a unanimous decision, the Chair will put the matter to a vote, with decisions confirmed by a simple majority of those voting members present, subject to the meeting being quorate. In the case of equality of votes the Chair will have the casting vote.

3. Relationship with Professional Executive Committee for 2012/13 only

The Governing Body subsumes the statutory obligations of the Professional Executive Committee (PEC) and in recognition that Wandsworth Primary Care Trust is the statutory body for 2012/13. The PEC chair will be a voting member of the Wandsworth Clinical Commissioning Group Governing Body for 2012/13 only, before PEC, as a statutory PCT function ceases on 1st April 2013.

4. Duties

The role of the Governing Body is to commission health services, affect health inequalities and to deliver the vision and strategic goals of the CCG as specified in the Constitution. This includes any duties outlined in the Health and Social Care Act 2011 and in any subsequent amendments to the Act or as requested by the National Commissioning Board.

Specific responsibilities include:

- Exercise its functions in relation to the provision or securing the provision of healthcare.

- Ensure effective systems are in place for ensuring the quality and effectiveness (including cost-effectiveness) of commissioned services.
- Put in place proposed structures and systems to safeguard transparency, accountability and good governance.
- Ensure accountability, probity and openness of its business at all times in line with the NHS Code of Conduct.
- Lead strategic direction and setting of corporate objectives
- Be responsible for the delivery of financial balance and performance indicators.
- Be responsible for the Board Assurance Framework
- Review risks rated 15 and above and ensure effective mitigations are in place.
- Ensure strong and effective clinical involvement in all aspects of commissioning.
- Receive and note reports and minutes from subgroups.

5. Membership and Quoracy

The Governing Body will comprise the following voting members, which reflects a clinical majority:

- CCG Chair (Chair)
- 4 x GP Locality Leads
- Chief Officer
- Chief Financial Officer
- Lay Member for Governance
- Lay Member for Patient and Public Involvement
- Secondary Care Doctor
- Registered Nurse

The Governing Body will be chaired by the Clinical Lead.

The Vice-Chair of the Governing Body will be the Lay Member with responsibilities for Governance.

In addition, the following are non-voting roles:

- Local Authority (nominated as the Director of Adult Social Services)
- Joint Director of Public Health
- Director of Delivery and Development
- Director of Commissioning and Planning
- Director of Corporate Affairs and Performance
- Wandsworth HealthWatch

Additional non-voting members may be co-opted on to the Governing Body from time to time at the discretion of the Chair. Part II of the meeting will be attended by all voting members, and others may be invited to attend at the discretion of the Chair.

The quorum will be six members of which three will be GPs and at least one Lay Member and one voting Director (either the Chief Officer or the Chief Financial Officer). No business shall be transacted at a meeting unless the following are present:

Chief Financial Officer or the Chief Officer; and

Chair or Vice Chair.

6. Frequency

The meetings will be held monthly with the exception of August and January.

The principle to be adopted is that the meetings will be held in public with, where necessary, a Part II in private for confidential items.

At any meeting of the Governing Body or a sub-committee, the Chair of the Governing Body or sub-committee, if present, shall preside. If the Chair is absent from the meeting, the Vice Chair shall preside.

If the Chair is absent temporarily (i.e. for a specific agenda item) on the grounds of a declared conflict of interest the Vice Chair, if present, shall preside. If both the Chair and Vice Chair are absent, are disqualified from participating, or there is neither a Chair or Vice Chair, a member of the Governing Body, shall be chosen by the members present, or by a majority of them, and shall preside for that agenda item only. The quoracy arrangements described above apply for meetings as a whole.

The Governing Body will arrange for an Annual General Meeting to be held each year, which will be open to members of the public.

Members are expected to maintain regular attendance at meetings. If circumstances make this impossible, this will be addressed by the Chair with the individual member concerned and alternative arrangements will be determined.

7. Conduct of the committee

The Committee will conduct its business in accordance with the codes of conduct set out for all Governing Body members and good governance practice as laid out in the Constitution.

Members of the Governing Body are required to adhere to the Wandsworth CCG Conflicts of Interest Policy.

The Governing Body will keep a Register of Members' interests, and interests relevant to items under discussion will be declared at each meeting as required in line with Standing Orders.

8. Administration

The meeting will be administered by the Business Manager. The Business Manager will draft the Agenda for approval by the Chair. All Agenda items and relevant papers will be published one week prior to CCG meetings. The Business Manager will maintain Minutes of all meetings and a log of decisions made. Meetings will be held in public in an accessible venue within Wandsworth. Papers for discussion will be made available on the CCG website at least five working days in advance of the meeting. Papers should be considered by Management Team or a sub-committee of the Governing Body before being submitted to the Governing Body.

9. Review

The terms of reference for the Governing Body will be reviewed at least annually, and may be reviewed before that date to reflect changes in national or local policy or guidance as required.

WANDSWORTH CLINICAL COMMISSIONING GROUP

Audit Committee – Terms of Reference

1. Aim and Purpose

The Wandsworth Clinical Commissioning Group (CCG) has established a Committee of the CCG Board known as the Audit Committee (the Committee). The Committee is a non-executive committee of the CCG Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Authority:

The Committee is authorised by the CCG Board 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 CCG Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

3. Duties

The responsibilities of the Committee are categorised as follows:

3.1 Internal Control

3.1.1 The Committee shall seek assurance on the adequacy of internal control systems, across the whole of the organisation's activities that supports the achievement of the CCG's objectives. Assurance will be obtained through the work of the Integrated Governance Committee, particularly regarding corporate and clinical governance, risk, safety, quality and performance of commissioned services, and Safeguarding systems; and the Finance Resource Committee, particularly regarding allocation of resources, strategic and operational financial plans, and financial systems.

3.1.2 The Committee will specifically review the adequacy of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the CCG Board.

- 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 systems of internal control, ensuring they are subject to review and adequate assurance is received on their operation.

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements.

- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect.

3.1.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances on the overarching systems of integrated governance, risk management and internal control.

3.1.4 This will be evidenced through the Committee's use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

3.2 Internal Audit

3.2.1 The Committee shall ensure that there is an effective internal audit function established that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Officer and the CCG Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.
- Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework.
- Consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources.
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.
- Annual review of the effectiveness of internal audit.

3.3 External Audit

3.3.1 The Committee shall review the work and findings of the External Auditor appointed through due process and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor, as far as the External Audit rules permit.
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy.
- Discussion with the External Auditors of their local evaluation of audit risks and assessment of the organisation and associated impact on the audit fee.
- Review all External Audit reports, including agreement of the annual audit letter before submission to the CCG Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

3.4 Other Assurance Functions

3.4.1 In addition, the Committee will review the work of other committees within the organisation, to provide assurance to the CCG Board that responsibilities are being fulfilled.

3.5 Management

3.5.1 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 as they may be appropriate to the overall arrangements, for example, scrutinising a decision made by the CCG Board to ensure adherence to its key principles as established in the Constitution.

3.6 Financial Reporting

3.6.1 The Committee shall review the Annual Report and Financial Statements before submission to the CCG Board, focusing particularly 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 and practices.
- Unadjusted mis-statements in the financial statements.
- Major judgemental areas.
- Significant adjustments resulting from the audit.
- Letter of representation.
- Qualitative aspects of financial reporting.

3.7 Identification of Risks

3.7.1 The Committee shall identify any areas of risk to be considered for inclusion on the CCG's Risk Register.

4. Membership:

The membership of the Committee will consist of four members: two Lay Members of the CCG Board and two additional Associate Lay Members. The Associate Lay Members will not be members of the CCG Board. A quorum shall be two members, including at least one CCG Board Lay Member. The Lay Member with responsibility for Governance will be appointed Chair of the Committee by the CCG Board. The Chair of the CCG Board shall not be a member of the Committee.

5. Attendance:

The Chief Finance Officer (CFO) and appropriate Internal Audit, External Audit and Counter Fraud representatives shall normally attend the meetings. At least once a year the Committee shall meet privately with the Internal and External Auditors.

The Chief Officer and Chair must be in attendance at least once a year, to review the Year End accounts plus the Annual Governance Statement.

The Chief Officer (CO), as the Accountable Officer, and other directors shall be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director.

The CO shall be invited to attend, at least annually, to discuss with the Committee the process for assurance that supports the Annual Governance Statement.

The CFO will provide appropriate support to the Chair and Committee members.

The Chair of the CCG Board may be invited to form a view on Committee operations.

Members are expected to maintain regular attendance at meetings. If circumstances make this impossible, this will be addressed by the Chair with the individual member concerned and alternative arrangements will be determined.

6. Frequency

Meetings shall be held not less than four times a year. The Head of Internal Audit or External Auditor may request a meeting if they consider that one is necessary.

The Committee Chair has discretion to call additional meetings if there is sufficient business to transact.

7. Reporting

The Minutes of the Committee meetings shall be formally recorded and submitted to the CCG Board. The Chair of the Committee shall draw to the attention of the CCG Board any issues that require disclosure or require executive action.

The Committee will report to the CCG Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, and the integration of governance arrangements.

8. Conduct of the committee

The Committee will conduct its business in accordance with the codes of conduct set out for all CCG Board members and good governance practice as laid out in the Constitution.

9. Administration

The Committee shall be supported administratively by the Business Manager, whose duties in this respect will include:

- Agreement of Agenda with Chair and attendees and collation of papers.
- Taking the Minutes and keeping a record of matters arising and issues to be carried forward.

The Chief Finance Officer will advise the Committee on pertinent areas.

10. Review

The Committee will review its performance, membership and Terms of Reference annually. Any resulting changes would need to be approved by the CCG Board.

WANDSWORTH CLINICAL COMMISSIONING GROUP

Integrated Governance Committee – Terms of Reference

1. Aim and Purpose

Integrated Governance Committee (the Committee) has been established as a subcommittee of the Clinical Commissioning Group (CCG) Board. The Committee has no executive powers, other than those specifically delegated in these Terms of Reference. These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the committee and shall have effect as if incorporated into the CCG's Constitution and Standing Orders.

The Committee is required to give assurance to the Board that robust governance and management processes are in place to manage performance and risk (including patient safety, clinical effectiveness, quality of care, financial and corporate risks) across the full range of services commissioned by the CCG; to report regularly; and to bring to the attention of the Board any significant emerging issues.

The Committee supports the Board in the following areas:

1. ensuring that robust governance and management arrangements are in place to secure and improve patient safety, clinical effectiveness and the quality of care across all services commissioned by the CCG

2. ensuring that risks and performance issues are identified and managed across the CCG and its commissioned services as a whole, so that emerging issues, tensions and trade-offs are identified and managed effectively

3. ensuring that the CCG's overall governance and assurance structures and procedures remain fit for purpose and effective

The Committee is authorised to direct urgent action on behalf of the Board where necessary to address emerging risks or concerns.

Authority

- The Committee is directly accountable to the CCG Board and is authorised by it to investigate any activity within its Terms of Reference.

- The Committee 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 to seek any information it requires from providers and other commissioned or hosted services should concerns be raised.

- The Committee is authorised to work in collaboration with partner agencies in areas of common interest, and to request reports on joint working as required.

- The Committee is authorised to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2. Duties

The Committee is responsible for providing assurance to the Board in the following areas relating to both the CCG's internal governance arrangements and to the quality of our commissioned services:

- Patient safety and service quality in commissioned services, including organisational culture.
- Performance of commissioned services and the delivery of the CCG Assurance Framework.
- Serious Incidents and Never Events processes and any compliance issues or learning raised.
- Adult and child Safeguarding systems of internal control and shared accountability processes with partners.
- Patient experience, as illustrated through complaints, surveys, Make A Difference alerts and other hard and soft intelligence.
- CCG corporate governance arrangements including review and updating the Board Assurance Framework.
- Risk management, including reviewing all risks rated 12 and above.
- Impact of financial position on quality, safety, performance and governance.
- Information governance arrangements.
- Processes for promoting and encouraging primary care performance and quality.

The Committee will seek assurance on these areas through reviewing key information, which will be included in the monthly Integrated Report. The Integrated Report will include quantitative and qualitative information and will support the process of triangulation. The Committee will also seek assurance through reports such as exception reports, action plans and risk assessments provided by the following sub-committees:

- Information Governance Committee
- Safeguarding Committee
- Serious Incident Review Group and Serous Incident Management Group
- Clinical Quality Review Groups
- Risk Review Group
- Workforce Committee

Issues raised at the sub-committees can be escalated to the Committee and the Committee can request that sub-committees investigate issues and provide reports.

3. Membership and Quoracy

The membership of the Committee will be as follows:

- CCG Lead (Chair)
- Nurse Member on the CCG Board (Deputy)
- Lay Member with lead for Governance
- Chief Officer
- Director of Corporate Affairs, Performance and Quality

- Director of Commissioning and Planning
- Director of Delivery and Development
- 2x Locality Clinical Leads
- Chief Financial Officer
- Lay Member with lead for Patient and Public Involvement (PPI)
- Associate Lay Member
- Secondary Care Clinician
- Head of Clinical Governance and Patient Safety

A quorum shall be three members, to include the Chair or Deputy Chair, one voting Board Member, and one other Director. This must include at least one clinician and one Lay Member or Associate Lay Member.

4. Attendance

Additional members of staff may be required to attend meetings in order to present papers or provide additional information in support of discussions.

5. Frequency

Meetings shall be held on a monthly basis. Members are expected to maintain regular attendance at meetings. If circumstances make this impossible, this will be addressed by the Chair with the individual member concerned and alternative arrangements will be determined.

6. Reporting

The Committee will report directly to the CCG Board. High-level summaries of discussions from meetings will be submitted to the CCG Board for review and any necessary action. If any confidential or sensitive information does need to be reported to the CCG Board, this will go to Part 2 of the Board meeting. The Committee will provide the Board with an annual report of its activities and achievements. The sub-committees will provide reports to the Committee.

7. Conduct of the committee

The Committee will conduct its business in accordance with the codes of conduct set out for all CCG Board members and good governance practice as laid out in the Constitution.

8. Administration

The Committee shall be supported administratively by the Business Manager, whose duties in this respect will include:

- Agreement of Agenda with Chair and attendees and collation of papers.
- Taking the Minutes and keeping a record of matters arising and issues to be carried forward.

Agenda items and relevant papers will be published one week prior to meetings. The Business Manager will maintain Minutes of all meetings and a log of decisions made.

9. Review

These Terms of Reference will be reviewed annually to ensure that the Committee is carrying out its functions effectively.