INTEGRATED GOVERNANCE AND RISK MANAGEMENT STRATEGY

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In considering the application of this strategy the CCG will ensure that members, staff or patients will not be discriminated against or treated differently on account of any subjective bias in relation to the pillars of equality and diversity: race, disability, gender, age, sexual orientation, religion/belief, transgender.

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1 Introduction

Integrated governance is defined as ‘Systems, processes and behaviours by which an organisation leads, directs and controls its functions in order to achieve organisational objectives, safety and quality of services’. Integrated governance provides a framework for all governance approaches, it combines the principles of corporate and financial accountability with clinical and management accountability and enables a risk sensitive approach which will enable the delivery of all NHS Halton Clinical Commissioning Group objectives, functions and duties.

It is essential that NHS Halton Clinical Commissioning Group adopts an appropriate structure that supports the safe deliver of care to local people (patients, service users and carers) and reduces the risk to staff and the organisation.

By its very nature the commissioning of healthcare carries risks. The Governing Body accepts the importance of the principles of risk management and recognises the value of taking a strategic, proactive, and comprehensive approach to the assessment and control of risk. Significant benefits can be achieved from this approach, from improving patient care and the safety of the working environment, to reducing levels of financial risk and loss for the CCG as a whole.

The CCG as an authorised body needs a strategy and framework to deal with the hazards and risks associated with its main functions of commissioning high quality healthcare and improving the health of the local population. The strategy defines the commitment of the CCG to developing an open, honest, inclusive and educative ‘fair blame’ culture which encourages identification, reporting and avoidance of risk. It also brings clinical knowledge, understanding and perspectives to the heart of managing risk within the local health system.

2 Purpose, Philosophy & Principles:

This strategy is designed to provide a framework for the development of an integrated governance system which includes a robust risk management system across the CCG and thereby assisting the CCG in achieving its objectives. The organisation will implement a clear system of accountability, governance reporting and decision making as outlined within its Constitution. These processes and systems will have the needs of local people centrally and will ensure that appropriate and open decisions are made.

Each senior manager or clinical lead is expected to systematically identify and assess the risks associated with their key areas of work and manage them to ensure they do not impede the delivery of team or organisational objectives, and to record this activity on the Corporate Risk Register. Major risks identified on the Corporate Risk Registers are integrated into the Board Assurance Framework which the CCG Governing Body recognises is a tool to ensure the delivery of organisational objectives.

The CCG is committed to ensuring robust systems are in place to ensure high standards of risk management. A proactive structured and systematic approach supports informed management decision making by providing a greater understanding of risks and their potential impact. Effective management of risks has the potential for
reducing the frequency and severity of incidents, complaints and claims. The demarcation of risks into clinical, corporate and financial precludes a holistic view so it is proposed that CCG has a unified strategy for managing all risks. This approach should ultimately form an integral part of the business planning process.

2.1 Scope of the Strategy

This strategy relates to the implementation of an integrated governance approach which includes the management of risks faced by the CCG as a commissioner of services.

2.2 Integrated governance

The CCG has included within its Constitution a clear Scheme of Reservation/Delegation and an in depth description of which Governing Body sub-committees will exist and the functions and duties they will deliver. The Committees outlined within the Constitution have been mapped against the functions and duties of the CCG and enable clear escalation, accountability and assurance for the Governing Body. The key roles and functions in relation to Integrated Governance are also outlined within the Constitution and therefore not outlined further in this document. The governance Structure is outlined in Appendix A. (also see NHS Halton CCG Constitution).

2.3 Integrated Governance Objective

The objectives are:

- To provide a high level of assurance in relation to all areas of governance (clinical, quality, safety, finance, research and development) to the Governing Body/Membership of the governance structures within the CCG.
- To describe and ensure the implementation of robust accountability arrangements in the CCG.
- To ensure a co-ordinated approach to the management of integrated governance.
- To provide assurance in relation to quality, safety and patient experience in all services commissioned by the CCG these are delivered assurance via the Quality Committee.
- To provide assurance in relation to compliance with Equality and Diversity, local engagement and the NHS Constitution assurance delivered via the Quality Committee.
- To provide assurance in relation to Information Governance requirements including Caldicott, Freedom of Information etc. providing assurance through the Integrated Governance Committee.
- To ensure the governing body receives high levels of assurance in relation to communication with local people, stakeholders and clinicians.
- To provide assurance in relation to Human Resources, organisational development and staff personal development thereby assuring the Governing Body that the organisation and its staff are fit for purpose Assurance via the HR and OD Committee.
2.4 Risk Management Objectives

It is proposed that the CCG risk management framework should:

- Demonstrate the CCG Governing Bodies support and commitment to the risk management agenda
- Be a fundamental part of the CCG’s approach to integrated governance
- Support the continual development of the Integrated Governance and Risk Management Strategy and ensure communication throughout the CCG.
- Clearly define the stages within the risk management process.
- Ensure compliance with all the relevant statutory and non-statutory standards relating to the assessment and control of risk.
- Manage risks at a corporate and local level.
- Develop and maintain risk registers across the CCG by implementing a comprehensive risk assessment and grading system.
- Provide an effective system to identify and eliminate or mitigate risk by appropriate means.
- Develop and monitor risk management key performance indicators to assure and measure the effectiveness of risk management throughout the CCG.
- Develop a risk aware culture throughout the CCG to help embed the consideration and assessment of risk in all work activities.
- Encourage a culture of ‘fair blame’, being transparent when things go wrong.
- Ensure lessons are learned from good and deficient practice.
- Agree and firmly establish clearly defined roles and responsibilities for the management of risk within the CCG.
- Ensure all staff, constituent members and teams accept their responsibility for managing risk at a local level.

3 Organisation Arrangements and Management of Risk

3.1 Statement of Assurance

The Statement of Assurance (Statement of Internal Control) is a statement of assurance that appropriate strategies and policies are in place and that internal control systems are in place and functioning effectively so that key risks which may threaten the achievement of strategic objectives are identified, recorded and minimised. Any significant issues identified in the SoA are recorded on the Board Assurance Framework and Corporate Risk Register. The CCG will introduce the Datix management system to record and manage the Board Assurance Framework and Corporate Risk Register.

3.2 Board Assurance Framework (BAF)
The BAF is the process by which the CCG can demonstrate that it is doing its reasonable best to manage itself so as to meet its strategic objectives and protect patients, members, staff, visitors and other stakeholders against risk of all kinds.

The framework records the links between strategic objectives, key risks and key controls. It also indicates the sources of evidence or assurance, which support the controls, and identifies any gaps, the BAF will also provide the CCG with a clear understanding of the level of assurance against all strategic risks. The BAF will be reviewed at all business meetings of the Integrated Governance Committee, overseen by the Audit Committee and exceptions identified on the BAF will be reviewed at every public Governing Body meeting, and the full BAF will be reviewed bi-monthly by the Governing Body.

Whilst there are elements of duplication with the Board Assurance Framework and Corporate Risk Register in terms of language and content, the two documents serve different purposes. The BAF is a summary document which brings together a significant amount of information relating to strategic objectives. Its purpose is to provide the CCG Governing Body with assurance that risks to the delivery of organisational objectives have been identified and are being managed. It provides a list of the key pieces of evidence that the CCG Governing Body should use to gain this assurance. There is also an assessment of the strength of evidence provided. The ideal BAF will contain a list of significant assurance evidence with no gaps identified in control or assurance, and all assurances provided rated as 'significant'.

3.3 Corporate Risk Register (CRR)

The Corporate Risk Register may contain high level (red) organisational and escalated operational risks that require active management or review at Governing Body and all risks require management at appropriate Committee level.

The risks contained in the CRR are more wide-ranging than those in the BAF. The purpose of the CRR is to provide the Governing Body with a summary of the principal operational risks facing the organisation with a summary of actions needed and being taken to reduce the risks to an acceptable level. Where risks to achieving organisational objectives are identified within the CRR, they should be added to the BAF. Likewise where gaps in control are identified in the BAF these risks should be added to the CRR. The two documents therefore complement each other providing the Governing Body with assurance and action plans on risk management within the CCG.

The CRR is reviewed on a monthly basis by the CCG Executive Management Team, at every business meeting of the Integrated Governance Committee, overseen by the Audit Committee and every 6 months by the CCG Governing Body.

The process for populating the Corporate and Team Risk Registers can be found in Appendix F.

3.4 Team/Function Risk (these to be included within corporate risk register)
The CCG is developing processes to ensure risks for each key work function are identified. The risks identified are those that would prevent the team delivering its function, or objectives. Risks that are well managed and do not need further treatment shall be recorded on the Corporate Risk Register for regular review until such a time as they can be closed. Major risks on the Corporate Risk Register will be escalated for the attention of the Integrated Governance Committee, of other appropriate committee and ultimately the CCG Governing Body.

Each CCG team will have its own arrangements in place for the monthly review of the Risk Register, agreed and overseen by the Senior Management Team.

### 3.5 The Risk Management Framework

It is proposed that the CCG adopts the risk management framework described in the NHS Executives Controls Assurance risk management standard. This draws on the main components of risk strategy, that is risk identification, risk analysis, evaluation and prioritisation and risk treatment.

#### 3.5.1 Risk Identification

**3.5.1.1 Incident & Near Miss Reporting**

The reporting of incidents and near misses by CCG members and staff is an efficient and effective system for identifying risk. This allows rapid alert to ascertain why and how incidents occurred, and facilitates a fast response in the case of adverse events, which may lead to a complaint or litigation. It enables lessons to be learnt and therefore prevent recurrence. This is best achieved in a supportive management environment where a ‘fair blame’ culture is advocated and makes explicit the circumstances in which disciplinary action may be considered.

All incidents and near misses will be reported and managed using the CCGs incident reporting system in line with the Policy and Procedure for the Reporting and Management of Incidents and Near Misses.

All incidents will be graded at source and as a result of a local investigation, local management when appropriate will ensure controls are put into place and advise Senior
Management of the risk treatment and controls accordingly. Each incident will be assigned to an incident manager who will be responsible for reviewing the grading applied and ensuring that if necessary the Accountable Officer is informed of the incident. Training will be provided to enable staff to grade incidents at source.

### 3.5.1.2 Risk Assessment

In order to anticipate, rather than react to risks identified, a formal mechanism for risk assessment is proposed.

The aim of risk assessment is to determine how to manage or control the risk and translate these findings into a safe system of work that is then communicated to the appropriate level of management.

A risk assessment is a careful examination of what could go wrong. The assessors need to weigh up whether there are sufficient controls in place, if not they must establish the extent of control and ensure that action is proportionate to the level of risk.

Risk assessments are subjective; therefore, a team of no less than three people should undertake the risk assessment, including preferably the relevant senior manager or lead clinician to ensure ownership of the risks within their own area of responsibility.

All risks are graded using the risk grading matrix (appendix B).

### 3.5.2 Risk Grading and Analysis (Acceptable Levels of Risk)

It is accepted that it is neither realistic nor possible to totally eliminate all risk. It is however, feasible to develop a systematic approach to the management of risk so that adverse consequences are minimised, or in some cases, eliminated.

It is proposed that the CCG utilises an accepted system for grading risk (see Appendix B), which takes into account parameters that include probability of occurrence and impact on the organisation. A grading system enables a method of quantification which can be used to prioritise risk treatment at all levels. Incidents and risks are graded according to the CCG’s risk grading matrix which considers the actual consequence of the incident or potential consequence of the risk and the likelihood of occurrence or recurrence. The grading results in a level of risk to the organisation.

The risk grading system also covers the different grades of incidents. The level of authority required for managing the different grades of incidents will be described in detail in the incident reporting policy. The following table indicates the authority levels required to act in accordance with the quantification of risk.
3.5.3 Risk Evaluation and Prioritisation

The criteria used to evaluate risk covers the following:

- Acceptance criteria within the organisation, i.e., operational standards
- Cost benefit analysis, i.e., balance of cost against the potential benefits
- Human issues, i.e., pain and suffering
- Legislative constraints, i.e., meeting statutory requirements

3.5.4 Risk Treatment

During the process of risk assessment, analysis and evaluation it is possible to identify controls in place or required to reduce or eliminate risk. These control strategies cover a number of possible solutions, as described below:

- Risk avoidance – discontinuing a hazardous operation/activity
- Risk retention – retaining/accepting risks within financial operations
- Risk transfer – the conventional use of insurance premiums
- Risk reduction – prevention/control of any remaining residual risk

Once controls, in place or required, have been identified the risk must be re-graded in order to establish whether the action proposed is adequate and will reduce the residual risk to an acceptable level. These controls and further treatments may be cost neutral or require action that requires investment. At this point it is imperative that action plans are submitted as part of the CCG’s usual process for service planning.

Risks should continue to be monitored by the relevant Team to ensure that the controls remain effective, once the actions have been implemented and the risk has been eliminated the risk may be closed on the risk register and the reasons for the closure recorded in the narrative of the risk register to provide an auditable trail. The CCG recognises that in some cases high risks may be long standing which cannot be reduced to an acceptable level for a number of reasons, and even having been reviewed and accepted by the Governing Body, these risks shall remain upon the Corporate Risk Register and exception reported to the Governing Body to serve as a reminder that the risks are still significant. Process for populating risk registers and escalating risk is outlined in appendix F.
3.5.5 Risk Management and Review

Through a process of audit and monitoring the CCG will undertake a review of the risk control measures regularly. It is anticipated that risk control and monitoring measures will include some or all of the following:

- Statistical and trend reporting of incidents, complaints and claims to the CCG Governing Body and relevant committees
- Audit of implementation of the range of risk management policies, procedures and guidelines throughout the organisation.
- On-going review of Corporate Risk Register and updating of the risks and actions.
- Annual review of the Integrated Governance and Risk Management Strategy
- Bi-annual review of the Risk Management Performance Indicators
- Monitoring of the Audit committee and other minutes
- Audits undertaken by Internal and External Auditors

3.5.6 Communication and Consultation

Expert advice is available internally through the Chief Nurse and externally from specialist advisers dependent upon the type of risk being considered. A list of internal specialist advice is available under Section 4 of this policy. For advice regarding external advice, this is available through the Chief Nurse. Consideration should be given as to who needs to be informed of the Risk. Internally this process should follow the process detailed within Appendix G. Consideration should also be given as to whether any external stakeholders should also be informed as the impact may affect the achievement of their objectives. i.e. Halton Council.

3.6 Risk Prevention

It is proposed that the CCG adopts proactive and reactive approaches to risk. The population of risk registers with the further development of appropriate action plans will provide the CCG with greater knowledge of where our risks lie. As our systems and processes become further defined, the CCG will become more sophisticated in its approach to essential risk prevention.

3.7 Legal Liabilities and Property Losses

NHS Halton CCG is a member of the Clinical Negligence Scheme for Trusts (CNST), Liabilities to Third Parties (LTPS) and Property Expenses Scheme (PES) that are administered by the NHS Litigation Authority (NHSLA). Funding is on a pay as you go basis and contributions are based on a range of criteria such as NHS income, numbers of staff and property values.

Commissioned services such as secondary care providers, independent contractors and their employees are not directly employed by the CCG and therefore are required to make their own indemnity arrangements. However, the CCG will have a responsibility to
ensure that governance principles and risk management systems are being developed and applied by all providers. It is therefore possible for negligence proven in the course of a claim to in part be attributed to CCG commissioning the care if the CCG has failed to take reasonable steps to assure itself of the quality of standards of its provider. In these circumstances it is important that the CCG is able to demonstrate that it has taken all reasonable steps, i.e., monitoring performance, to assure itself of the quality of care provided. To this end during the Chief Nurse has developed links between the risk and clinical quality agenda, in conjunction with colleagues in CMCSS to ensure that the CCG fulfils its obligations as a Commissioner and any areas of concern highlighted through contract performance monitoring inform the wider CCG through risk management framework.

4.0 Roles and responsibilities for risk management:

All those working within the CCG have a responsibility to contribute, directly and indirectly to the achievement of the CCG’s objectives through the efficient management of risk. It is also important to make explicit how the responsibility of the individual contributes to the lines of management accountability through to the CCG Board.

However within the CCG itself the following system is being established.

There are four identifiable tiers within the CCG:

- Board Level Management
- Senior Management
- Clinical Leads/ Head of Commissioning /Managers
- All Members and Staff

4.1 Board Level Management

4.1.1 Chief Officer

The Chief Officer will have, on authorisation, ultimate responsibility for risk management, for meeting all statutory requirements and adhering to guidance issued by the Department of Health / NHS England in respect of governance. As such, the Accountable Officer must take assurance from the systems and processes for risk management. The CCG will ensure that reporting mechanisms clearly demonstrate that the Accountable Officer is informed of significant risk issues. The reporting mechanism will include the presentation of minutes and reports to the CCG by the Audit Committee.

It is the responsibility of the Chief Officer and Executive Management Team to ensure that the standards of risk management are applied at all levels within the CCG and that assurance mechanisms are in place to assure the CCG Board that risk is being managed effectively.

4.1.2 Chief Nurse
The Chief Nurse will be a member of the CCG Governing Body and have clear responsibility for governance and risk management. They will ensure the development of a comprehensive system of integrated governance across the CCG and that risk management arrangements are controlled and monitored through robust audit processes. The Chief Nurse and the Chief Finance Officer are the key contacts for the auditors. The Chief Nurse is a member of the Integrated Governance Committee and Audit Committee (TOR in Appendix C and D).

4.1.3 Chief Finance Officer

The Chief Finance Officer has overall fiscal responsibility in the CCG and is responsible for ensuring that the CCG carries out its business within sound financial governance and that risk management arrangements are controlled and monitored through robust accounting mechanisms that are open to public scrutiny on an annual basis. They will seek the Chief Internal Auditors opinion on the effectiveness of internal financial control. The Chief Finance Officer is a member of Audit Committee and the Integrated Governance Committee. In addition they will be ultimately responsible for any financial implications of plans to minimise risk and the method for incorporating these into business planning.

4.1.4 Early Warning System (Executive Management Team)

The CCG operates an ‘Early Warning System’, which enables any issue with the potential to post a significant risk to the CCG, to be brought immediately to the attention of the Executive Management Team (EMT) without using the formal committee route. The decision to use this route must be approved by a member of the EMT.

4.1.5 CCG Governing Body

The CCG Governing Body recognises that risk management is a fundamental part of good governance and to be effective it is essential that risk management processes are integral to the CCG’s culture. The Governing Body is therefore committed to ensuring that risk management forms an integral part of the CCG’s philosophy, practices and business plans. Risk management is not viewed or practised as a separate programme and responsibility for implementation is accepted at all levels of the CCG.

The CCG Governing Body ultimately carries responsibility for monitoring and overseeing risk that is relevant to the nature of its duties and responsibilities; however, the CCG Governing Body has delegated responsibility to the Audit Committee to take an overview of all risk and report directly to the Governing Body. This approach was commended by the Audit Commission in their guidance ‘Governing the NHS (June 2003). The CCG will ensure that all Governing Body members receive risk management training both as part of their induction training and refresher training.

4.1.6 Audit Committee
The Audit Committee has delegated authority from the CCG Governing Body to ensure that risk management is embedded throughout the CCG, including monitoring of all specialist groups with responsibility for risk. Under the chairmanship of a the Lay Advisor Board Member with a lead for Governance, with lead clinician input and high level representation from the CCG management team, the Committee is charged with the responsibility for ensuring effective risk management systems are in place across the CCG. The Committee will have the option to establish specialist risk management groups to consider specific areas of risk in more detail on the Committee’s behalf if it wishes to do so. The Audit Committee also reports to the Governing Body in terms of information the Audit Committee may wish to consider when deciding on audit forward plans.

The Audit Committee is also responsible for providing the CCG Governing Body with assurance that an effective system of integrated governance, risk management and internal control, across the whole of organisation’s activities which supports the achievement of the organisation’s objectives is in place. In particular the Committee reviews the adequacy of all risk and control related disclosure statements, particularly the Statement of Internal Control, and the underlying assurance processes which indicate the degree of the effectiveness of the management of principle risks.

For further information regarding the role of the Audit Committee please refer to appendix D.

4.2 Senior Management Support

Whilst most management of risk in delivered internally by the CCG the CCG Chief Nurse will commission effective management support for risk from C&MCSU as appropriate.

4.2.1 C&MCSU Support

The Chief Nurse has overall operational responsibility for delivery and review of the risk management strategy, however the C&MCSU team will be commissioned to support the delivery of some of the systems and policies within the CCG as part of the Core Offer. The Governance team in the CCG will provide advice and support regarding the analysis and evaluation of risk, ensuring that all risk registers across the organisation are ‘dynamic’ reflecting the changing risk profile of the organisation. The CCG Governance team will ensure systems are in place to achieve and improve compliance with external assessments and for monitoring all internal audit activity on behalf of the Audit Committee, ensuring that gaps in assurance and associated action plans identified through risk based reviews are completed. They also have responsibility for the risk education programme across in the CCG.

C&MCSU will support the Chief Nurse by preparing for external inspections and accreditations.

The C&MCSU will provide the Chief Nurse with regular information on Serious Untoward Incidents reported from commissioned services across Halton.
They will also support the Chief Nurse around patient safety issues, and health and safety & security. They will also manage the Incident Reporting System for both CCGs in Halton and report regularly to the Governing Body via the Chief Nurse. C&MCSU will provide Integrated Governance KPI reporting for the Integrated Governance Committee (KPIs are outlined in Appendix E)

4.2.2 Other Specialist Expertise:

Expertise in specific areas of risk may be obtained from a number of sources, both internal and external, such as:

- Health and Safety Lead from C&MCSU
- Occupational Health Manager
- Local Counter Fraud Specialist
- NHS Litigation Authority
- Health & Safety Executive

4.3 Clinical Leads/ Managers

They will ensure that:

- The Integrated Governance and Risk Management Strategy is implemented within their area of control and promote risk management as a key management responsibility.

- Risk management responsibilities are properly assigned and accepted at all levels.

- All risks associated with their area of responsibility are risk assessed and the results of these assessments and resulting control mechanisms are recorded on the Risk Registers. Control procedures will be periodically reviewed for continued effectiveness.

- A periodic review of the effectiveness of risk management within their area of responsibility is undertaken and action taken to eliminate deficiencies.

- Information, instruction and training are delivered to members / staff appropriate to the findings of risk assessments.

- Safe systems of work are in place and that effectiveness is periodically monitored.

- Outcomes of risk assessments are used as part of the service planning process to assist with planning and resource allocation.

- Information captured by complaints, litigation and incident reporting is used as a means of continuous monitoring and review, leading to risk reduction in services within their area.
• Bringing any significant risks which have been identified, and where local controls are considered to be potentially inadequate to the attention of the Integrated Governance Committee or EMT via the inclusion on the Risk Register.

• All staff within attend mandatory risk management training in line with the CCG’s mandatory training policy.

4.4 All CCG Members and staff

• Risk management will form part of their daily duties. All will be able to identify and assess risk; take action to reduce risks to an acceptable level and inform appropriate lead clinicians and managers of unacceptable risks.

• All will be required to participate in activities, which are commensurate with the CCG’s risk management arrangements and statutory requirements.

• All have a responsibility to report incidents, which is a key source of information for clinicians and managers on the nature and level of adverse activity within their sphere of responsibility.

• Be aware of emergency procedures e.g., resuscitation, evacuation and fire precaution procedures.

• Will attend risk management training as relevant to their role set out in the CCG’s Mandatory Training Policy.

4.5 Commissioned services, Independent Contractors and their Employers

Whilst there is no obligation to adopt the CCG Integrated Governance and Risk Management Strategy, if they do commissioned services will be contributing to the reduction of risk across the area as a whole, and to the improvement of patient and staff safety. In addition, following these procedures will assist in complaint handling, reduce litigation and may assist in the defence of any claims should they arise.

5. Definitions

5.1 Risk management:

Risk management is a framework for the systematic identification, assessment, treatment and monitoring of risks. Its purpose is to prevent or minimise the possibility of recurrence of risks and their associated consequences, which have potentially adverse effects on the quality of care, both directly provided and commissioned, and safety of patients, staff and visitors, and the financial management of the organisation. It
encompasses culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.

5.2 Risk

The possibility of incurring misfortune or loss or failing to take advantage of potential opportunities.

Risk = consequences x likelihood

5.2.1 ‘Acceptable’ risk

It is not feasible to eliminate or avoid all risks and there are some risks identified which require the CCG to go beyond reasonable action to reduce or eliminate. Where the ‘cost’ to the organisation to reduce the level of risk outweighs the adverse consequences of the risk occurring, the risk would be considered ‘acceptable’ to the CCG.

5.2.2 ‘Manageable’ risk

Some risks identified can be realistically managed, or reduced, within a reasonable, acceptable timescale through cost-effective measures; these are considered ‘manageable’ risk.

5.2.3 ‘High’ risk

These are risks which if they occur will have a serious impact on the CCG and threaten the achievement of its objectives. Risks identified as ‘high’ should always be reported on the Corporate Risk Register, if necessary they should also be highlighted to the EMT via the Early Warning System.

6. Consultation, approval and ratification process

The policy has been developed, based on good practice in the area of risk management and is presented to the CCG Governing Body for approval. The strategy will then be discussed in more detail by the Audit and Integrated Governance Committees and any amendments will be presented to the Governing Body in a revised version.

7. Review and revision arrangements

The strategy will be considered and reviewed by the CCG Governing Body annually and / or when there are changes in NHS requirements or best practice.
8. **Dissemination and Implementation:**

For the strategy to be effective the CCG will:

- Review annually its Integrated Governance and Risk Management Strategy to ensure it meets the needs of the CCG and the changing environment.

- Ensure the risk management services provided meet the needs of the organisation and develops in line with changing requirements.

- Continue the development and delivery of an education and training programme which assists members and assist in identifying and managing risk and in complying with the CCG risk management policies. Attendance records will be kept for all risk management training and evaluation forms completed and held by the Workforce Department at C&MCSU department.

- Ensure the C&MCSU systems capture data effectively.

- Monitor risk management key performance indicators, such as those suggested listed in Appendix F, to measure the performance of the CCG’s risk management process. The efficacy and usefulness of these indicators will be reviewed by the Chief Nurse and the Integrated Governance Committee. Consequently they will continue to be refined and developed.

- Encourage the flow of information via risk registers, and disseminate good practice in this regard, within and across the CCG.

- Develop a risk aware culture amongst members and staff through CCG briefings, literature, induction programmes, mandatory training and use of the CCG intranet site.

- The Chief Nurse will ensure that the Strategy is communicated throughout the CCG via the CCG website and intranet, bulletins, newsletters and in induction and mandatory training/ Core skills sessions.

8.1 **Education and Training**

The following training will be provided by C&MCSU on behalf of the CCG on an ongoing basis:

- Risk management mandatory training to promote ownership of the risk management element of this Strategy, including providing guidance on incident reporting, root cause analysis, risk assessment and the risk registers, and based upon the training needs analysis of all staff.

- Risk management is included in induction training.

- On an ad hoc basis as identified in personal development plans.
• Providing support in response to information notices, i.e., CAS alerts.

The Integrated Governance Committee will review progress against the implementation of the strategy. The review will be based on information available from the Board Assurance Framework, risk registers, Audit Commission’s Use of Resources assessment and Internal Audit’s risk based reviews. In addition the Audit Committee also reviews the efficiency of risk management systems across the CCG on behalf of the CCG Governing Body; this is primarily done by the work of internal and external audit.

9. Document Control

The Chief Nurse is responsible for storing current, and archiving, versions of the Risk Management Strategy.

10. Monitoring compliance with and effectiveness of the policy

The success of risk control measures must be monitored in an appropriate manner to provide information to guide future developments. There are various ways in which the CCG assesses and monitors risk supported by systems managed by C&MCSS. Reactive monitoring occurs through the incident and near miss reporting and monitoring of complaints and claims. Proactive monitoring of adherence to procedures occurs through audit, workplace inspections, staff surveys and performance indicators.

The CCG committee structure will provide a vehicle for monitoring risk management activity.

The Integrated Governance Committee is responsible for managing areas of concern on the Corporate Risk Register and will receive information from the incident reporting system and consider policy changes as a result of information from incident reporting. It will also monitor the risk management performance indicators on a 6-monthly basis.

Senior Managers shall hold staff to account for ensuring compliance with the strategy within their locality / service area. An effective way of ensuring the strategy is adopted into the culture of the CCG is via the appraisal process when reviewing performance e.g. against the Knowledge and Skills Framework outline

11. Associated documentation

The Integrated Governance and Risk Management Strategy is to be followed within the context of the CCG’s overarching strategy. A range of documents from predecessor organisations will be reviewed, amended and if appropriate adopted by the CCG Governing Body. Such policies will include:-
- Policy & Procedure for the Reporting and Management of Incidents & Near Misses
- Policy & Procedure for the Management of Claims
- Complaints Comments & Concerns Policy
- Policy & Procedure for the Root Cause Analysis of Incidents, Complaints and Claims
- Health and Safety Policy
- Moving and Handling Policy
- Lone Workers Policy
- Control of Substances Hazardous to Health (COSHH) Policy
- Management of Violence and Aggression Policy
- Information governance Strategies and Policies
- StEIS reporting procedure
- Whistleblowing Policy
- Serious Untoward Incidents Policy
- And any other relevant document

These policies will be published the CCG Intranet site once adopted.
NHS Halton Governance Arrangements

- **Governing Body** (monthly)
  - Membership Forum (quarterly)
    - Dr Cliff Richards
  - Dr Cliff Richards

- **Audit Committee** (quarterly)
  - David Merrill

- **HR and OD Committee**
  - Remuneration Committee
  - Ingrid Fife

- **Quality Committee** (monthly plus three working groups)
  - Jan Snoddon

- **Integrated Governance** (quarterly)
  - Simon Banks

- **Finance and Performance** (ten times per year)
  - Simon Banks

- **Service Development**
  - Dave Sweeney

- **Urgent Issues Committee**
  - Executive Management Team

---

Appendix A
Risk Grading Matrix

<table>
<thead>
<tr>
<th>Consequence Likelihood</th>
<th>1 Insignificant</th>
<th>2 Minor</th>
<th>3 Moderate</th>
<th>4 Major</th>
<th>5 Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Almost Certain</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>4 Likely</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>3 Possible</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>2 Unlikely</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>1 Rare</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk</th>
<th>Score</th>
<th>Colour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insignificant</td>
<td>1 – 3</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>4 – 6</td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>8 – 12</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>15 – 25</td>
<td></td>
</tr>
</tbody>
</table>

Significant Risk

A risk which attracts a score of 8 or above on the risk grading matrix constitutes a significant risk and must be recorded on the Team Risk Register.
INTEGRATED GOVERNANCE COMMITTEE

Terms of Reference

This Committee will report to NHS Halton CCG Governing Body on the development, implementation and monitoring of all areas of integrated governance by providing assurance on the systems and processes by which the CCG leads, directs and controls its functions in order to achieve organisational objectives.

The Committee is established in accordance with NHS Halton Clinical Commissioning Group’s (the CCG) Constitution, Standing Orders and Scheme of Delegation.

These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Committee.

1. Membership

- Chief Officer (Chair)
- 1 Lay Member (Vice Chair)
- Chief Nurse
- Operational Director Integrated Commissioning or delegated representative
- Head of Corporate Services
- Chief Finance Officer

In Attendance

- Commissioning Support Unit representation: Information Governance, Health & Safety, Risk, and Equality & Diversity Governance
- Other senior officers may be invited to attend as appropriate

2. Quorum

A quorum will be three members including Chair or Vice Chair.

3. Remit and responsibilities

3.1 Risk Management

- Promote good risk management and ensure effective governance, both clinical and non-clinical processes across all commissioned services.
- Approve the Integrated Risk Management Strategy and any other appropriate policies and strategies.
Oversee key assurance and risk systems, ensuring processes are in place to enable the CCG to comply with their statutory requirements.

Challenge risk assessment and risk assurances provided by Corporate Risk Register (CRR) and Board Assurance Framework (BAF) to ensure that robust controls are evident throughout the organisation. This should include scrutiny of entries contained within all areas of the BAF and CRR.

Agree and coordinate an Assurance Framework which allows integration of the governance activities that focus on continually improving the patient experience and ensure safe practice, efficiency and effectiveness through risk management.

Oversee the development and embedding of CCG systems and processes in relation to internal control and risk management.

Oversee the continuing development of the BAF and management of the CRR to enable the identification of any areas where internal or external controls need strengthening to support on-going assurance and decision making in respect of risk management to achieve strategic objectives.

Identify specific risks contained within the BAF and CRR which relate to the duties of the Committee. Ensure that those identified risks are managed effectively and that sufficient detailed assurance is gained from the risk owner.

The Committee will also hold an overview of corporate risks managed via other Committees, for example ensuring appropriate mitigation and monitoring of potential risks to quality and safety.

Ensure the risks in relation to QIPP are identified and managed appropriately as part of the commissioning programme.

Provide appropriate support to lead managers with specific responsibility for risk identification and mitigation.

Ensure that risk co-ordinators, managers and staff within the CCG are provided with appropriate training.

Ensure there are appropriate arrangements in place in respect of incident reporting, investigation and learning.

Provide assurance for the Governing Body with regard to the CCG responsibilities in relation to Equality and Diversity law.

3.2 Information Governance (IG)

To ensure that the practices within the CCG have established and maintained policies and procedures to comply with the Data Protection Act, Freedom of
• To carry out formal review and agree risk mitigation plans for all information related risks reported to the Committee.

• To monitor, review and contribute to the Asset and Risk Management Programme across the organisation.

• To approve, implement and maintain the joint IG Strategy and IG Policy and as appropriate operational IG procedures with review mechanisms.

• To ensure that IG is reflected in Corporate Policy documents as appropriate within the organisation with appropriate review mechanisms.

• To prepare the annual IG Toolkit assessment for sign off by the Governing Body.

• To develop and monitor progress on an established IG work programme.

• To ensure that the agreed approach to information handling is communicated to all staff and made available to the public.

• To coordinate the activities of staff with Data Protection, Confidentiality, Security, Information Quality, Records Management and Freedom of Information responsibilities.

• To monitor all information handling activities across CCG Cluster to ensure compliance with the Law, NHS and Social Care guidance.

• To ensure that the organisation conducts joint training needs analysis of differing staff groups and provides the appropriate IG training as required and that post training assessments of their understanding are made.

3.3 Fire Health and Safety/Local Security Management Service (LSMS)

• Ensure there are appropriate arrangements in place to ensure compliance with statutory responsibilities in respect of health and safety including policies, procedures and training, approving appropriate policies and reviewing compliance.

• Ensure that there are appropriate arrangements for the management of staff safety issues via the Local Security Management Specialist.

• Ensure the delivery of the appropriate support via the local LSMS action plan in line with national requirements.

3.4 Other
• To approve appropriate policies and plans to ensure compliance with emergency planning duties outlined in the Civil Contingencies Act 2004.

• Provide assurance of compliance with the NHS Constitution in all areas of commissioning and assurance of compliance by all providers.

• Be accountable for the performance and reporting of other Sub-Committees and functions as delegated by the Governing Body.

• Provide assistance to the Audit Committee in respect of internal control assurance.

• Approve relevant Corporate Policies on behalf of the Governing Body

4. Frequency of meetings

The Committee shall meet four times per year.

5. Reporting

The Committee will submit a Key Issues report to the Governing Body. This Committee will also prepare reports at the request of the Governing Body.

6. Responsibility of Committee Members and Attendees

Members of the Committee have a responsibility to:

• Attend meetings, having read all papers beforehand.

• Act as ‘champions’, disseminating information and good practice as appropriate.

• Identify agenda items to the Secretary at least fifteen working days before the meeting.

• Submit papers at least eleven working days before the meeting.

• Make open and honest declarations of their interests at the commencement of each meeting notifying the Committee Chair of any agreed management arrangements, or to notify the Committee Chair of any actual, potential or perceived conflict in advance of the meeting.

• Uphold the Nolan Principles and all other relevant NHS Code of Conduct requirements.

7. Administrative Arrangements
The Committee will be supported by an appropriate Secretary that will be responsible for supporting the Chair in the management of the Committee’s business.

The Secretary will ensure:

- Correct minutes are taken and once agreed by the Chair, distributing minutes to the members within five working days of the meeting taking place.
- A Key Issues report is produced following the meeting and submitted to the next meeting of the Governing Body.
- An Action Log is produced following each meeting and any outstanding actions are carried forward until complete.
- The agenda and accompanying papers are distributed to members at least five working days in advance of the meeting date.
- They provide appropriate support to the Chair and Committee members.
- The papers of the Committee are filed in accordance with NHS Halton CCG policies and procedures.

The Work Plan will be agreed at the start of each financial year and will be approved by the Governing Body.

8. Date and Review

These Terms of Reference were accepted as part of NHS Halton CCG Constitution approval on 3rd October 2013.
AUDIT COMMITTEE

Terms of Reference

The Audit Committee (the Committee) is established in accordance with Halton Clinical Commissioning Group’s (the CCG) Constitution. 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 Constitution and Standing Orders.

1. **Membership**

   - Chair of the Committee (who shall be a Lay Member of the Governing Body with significant financial experience)
   - Three Lay Members of the Governing Body (one of whom will be appointed as Vice Chair).

   **In attendance**

   - Internal Audit Representative
   - External Audit Representative
   - Counter Fraud Representative
   - Chief Finance Officer
   - Chief Nurse

Other senior staff may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Officer. Representatives from NHS Protect may be invited to attend meetings.

At least once a year the Committee should meet privately with the external and internal Auditors. Regardless of attendance, external audit, internal audit, local counter fraud and security management (NHS Protect) providers will have full and unrestricted rights of access to the Audit Committee.

The Clinical Commissioning Group Chair will be invited to attend one meeting each year in order to form a view on, and understanding of, the Committee’s operations.
2. **Quorum**

The Audit Committee Chair (or Vice Chair) and 1 Other Member.

3. **Remit and responsibilities**

The duties of the Committee will be driven by the priorities of the Clinical Commissioning Group, as identified by the CCG, and the associated risks.

3.1 **Integrated governance, risk management and internal control**

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Clinical Commissioning Group’s activities that support the achievement of the CCG’s objectives.

In particular the Audit Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any appropriate independent assurances, prior to endorsement by the CCG.

- The underlying assurance processes that indicate the degree of achievement of Clinical Commissioning Group objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

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

- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.

In carrying out this work the Committee will utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from Officers and Governing Body members as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.
The above will be evidenced through the Committee’s use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

The Committee will approve the Detailed Financial Policies of the CCG and its arrangements for discharging the financial duties.

3.2 Internal audit

The Committee shall ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Officer and CCG. 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 assurance framework.

- Considering the major findings of internal audit work (and management’s response) and ensuring 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 Clinical Commissioning Group.

- An annual review of the effectiveness of internal audit.

- Approving the appointment of the internal auditors.

3.3 External audit

The Committee shall review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the performance of the external auditors, as far as the rules governing the appointment permit.

- Discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensuring 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 Clinical Commissioning Group and associated impact on the audit fee.

- Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the CCG and any work
undertaken outside the annual audit plan, together with the appropriateness of management responses.

- Selection of external auditors once freedom to appoint is given to the CCG.

3.4 Other assurance functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external and consider the implications for the governance of the Clinical Commissioning Group.

These will include, but will not be limited to, any reviews by Department of Health arm’s length bodies or regulators/inspectors (for example, the Care Quality Commission, NHS Litigation Authority, etc.) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies, etc.)

The Audit Committee will also review the circumstance and reason behind any suspension of the Constitution.

3.5 Counter fraud

The Committee shall satisfy itself that the Clinical Commissioning Group has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the arrangements for counter fraud and the associated work programme.

3.6 Management

The Committee shall request and review reports and positive assurances from senior staff on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the Clinical Commissioning Group as they may be appropriate to the overall arrangements.

3.7 Financial reporting

The Audit Committee shall monitor the integrity of the financial statements of the Clinical Commissioning Group and any formal announcements relating to the Clinical Commissioning Group’s financial performance.

The Committee shall ensure that the systems for financial reporting to the CCG, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the CCG.

The Audit Committee, under delegated powers from the Governing Body, shall approve the Annual Report and Financial Statements focusing particularly on:
- The wording in the Governance Statement and other disclosures relevant to the terms of reference of the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements
- Significant judgements in preparing of the financial statements
- Significant adjustments resulting from the audit
- Letter of representation
- Qualitative aspects of financial reporting

4. **Frequency of meetings**

   The Audit Committee shall meet on at least 4 occasions during the financial year. Internal Audit and External Audit may request a meeting if they consider one necessary.

   Members shall be notified at least 10 days in advance that a meeting is due to take place.

5. **Reporting**

   The ratified minutes of Audit Committee will be submitted to the Governing Body. An annual report will be produced by the Audit Committee which will set out the Committee’s work programme for the year ahead. Exception reports will also be submitted at the request of the Governing Body.

6. **Responsibility of Committee Members and Attendees**

   Members of the Committee have a responsibility to:
   - Attend meetings, having read all papers beforehand.
   - Act as ‘champions’, disseminating information and good practice as appropriate.
   - Identify agenda items to the Secretary at least fifteen working days before the meeting.
   - Submit papers at least eleven working days before the meeting.
   - Make open and honest declarations of their interests at the commencement of each meeting notifying the Committee Chair of any agreed management arrangements, or to
notify the Committee Chair of any actual, potential or perceived conflict in advance of the meeting.

- Uphold the Nolan Principles and all other relevant NHS Code of Conduct requirements.

7. **Administrative Arrangements**

The Committee will be supported by an appropriate Secretary that will be responsible for supporting the Chair in the management of the Committee’s business.

The Secretary will ensure:

- Correct minutes are taken and once agreed by the Chair, distributing minutes to the members within five working days of the meeting taking place.
- A Key Issues report is produced following the meeting and submitted to the next meeting of the Governing Body.
- An Action Log is produced following each meeting and any outstanding actions are carried forward until complete.
- The agenda and accompanying papers are distributed to members at least five working days in advance of the meeting date.
- They provide appropriate support to the Chair and Committee members.
- The papers of the Committee are filed in accordance with NHS Halton CCG policies and procedures.

The Work Plan will be agreed at the start of each financial year and will be approved by the Governing Body.

8. **Date and Review**

These Terms of Reference were accepted by NHS Halton CCG Governing Body as part of the Constitution approval on 3rd October 2013

Version No. [1]
Review date [September 2015]
## Risk Management Performance Indicators

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Lead for compiling data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Incident Reporting</strong></td>
<td></td>
</tr>
<tr>
<td>No. of incidents &amp; near misses reported this period compared to previous periods</td>
<td>CMCSS</td>
</tr>
<tr>
<td>% of directorates reporting incidents &amp; near misses</td>
<td></td>
</tr>
<tr>
<td>No. (%) of incidents with actions recorded</td>
<td></td>
</tr>
<tr>
<td>No. (%) of incidents closed with no action recorded</td>
<td></td>
</tr>
<tr>
<td>No. (%) of incidents ongoing for more than 3 months</td>
<td></td>
</tr>
<tr>
<td>Average severity rating of incidents and near misses</td>
<td></td>
</tr>
<tr>
<td>No. (%) of patient safety incidents uploaded to the NPSA NRLS</td>
<td></td>
</tr>
<tr>
<td><strong>Risk Register</strong></td>
<td></td>
</tr>
<tr>
<td>No. of risks added to the Risk Registers</td>
<td>Chief Nurse</td>
</tr>
<tr>
<td>No. of risks closed on the Risk Registers</td>
<td></td>
</tr>
<tr>
<td>No. (%) of red risks on the Risk Registers</td>
<td></td>
</tr>
<tr>
<td>No (%) of Team with ‘live’ Risk Registers (ie reviewed on monthly basis)</td>
<td></td>
</tr>
<tr>
<td><strong>Risk Management Training</strong></td>
<td>Workforce via CMCSU</td>
</tr>
<tr>
<td>% of Staff who are up to date with their mandatory risk management training</td>
<td></td>
</tr>
<tr>
<td><strong>Complaints</strong></td>
<td></td>
</tr>
<tr>
<td>No. of formal complaints relating to Commissioned Services received (NOTE – as of 1 April 2009 any verbal complaints not resolved within 24 hours are now logged as a formal complaint)</td>
<td>Report from CMCSU</td>
</tr>
<tr>
<td>No. (%) of complaints acknowledged within 3 working days</td>
<td></td>
</tr>
</tbody>
</table>
No. (%) of complaints answered within an agreed timescale
No. (%) of complaints with an initial incident reporting form
No. (%) of complaints referred to the Ombudsman

**Claims**
- No. of claims
- No. (%) of claims in which an initial incident form was completed
- No. (%) of letters of claim acknowledged within 14 days

**Central Alert System (CAS)**
- No. of alerts received within this period
- No. (%) of alerts responded to within the timescales

**STEIS (Serious Untoward Incidents)**
- No. of STEIS incidents reported to the CCG
- No. (%) of STEIS incidents acknowledged within 3 days
- No. (%) of completed investigation reports received within agreed timescales
- No. (%) of investigation reports reviewed within 10 working days

**Quality Performance all providers**
- Quality metrics
- CQUINNS
- Patient experience
- Safeguarding Adults and Children

---

**Populating the Corporate Risk Register**

Staff member identifies risk through an incident, audit, complaint, etc

Risk assessment completed and discussed with line manager

Can the risk be managed within the team/ i.e., they have the skills, resources and authority to make the implement the treatment plan

- **Yes**
  - Update the action plan, review & update the Risk assessment form once completed and file.

- **No**
  - Present risk assessment and proposed action plan to Team Manager. Can the risk be managed (reduced to an acceptable level) within the Team?

---

Appendix F
Enter onto the Corporate Risk Register to be reviewed by Audit Committee on a bi-monthly basis, and the Board on a 6 monthly basis. Can the Board authorise risk treatment, allocate funding?

No

Acknowledge and accept the risk on the Corporate Risk Register to monitor and review, reporting any change in risk rating. Consider for inclusion on the Board Assurance Framework.

Yes

Update the action column on the Corporate Risk Register. Monitor completion of the treatment plan, reporting any delay in action. Close on the Corporate Risk Register once the risk has been eliminated or, once it has been reduced to an acceptable level.

Enter onto the Corporate Risk Register. Present the risk to the appropriate group or committee for advice. Present the business case, if applicable to the Chief Nurse. Can the Risk now be managed (reduced to an acceptable level)?

No

Enter onto the Corporate Risk Register. Present the risk to the appropriate group or committee for advice. Present the business case, if applicable to the Chief Nurse. Can the Risk now be managed (reduced to an acceptable level)?

Yes

Update the action column on the Corporate Risk Register. Monitor completion of the treatment plan, reporting any delay in action. Close on the Corporate Risk Register once the risk has been eliminated or, once it has been reduced to an acceptable level.