NHS
Wolverhampton
Clinical Commissioning Group

A meeting of the Wolverhampton Clinical Commissioning Group Governing Body

will take place on Tuesday 12th July 2016 commencing at 1.00 pm

at Wolverhampton Science Park, Stephenson Room

A G E N D A

		8	Managing Conflicts	Mr P McKenzie	1 - 42
		15	Quality and Safety Committee (Board Assurance Framework)	Dr S Rajcholan	43 - 102
			Date and time of next meeting ~ Tuesday 13 September 2016 ~ Wolverhampton Clinical Commissioning Group Governing Body		

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NHS
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WOLVERHAMPTON CCG

GOVERNING BODY
12 JULY 2016

Title of Report:	**Managing Conflicts of Interest**
Report of:	Corporate Operations Manager
Contact:	Peter McKenzie, Corporate Operations Manager
(add board/ committee) Action Required:	☒ **Decision** ☒ **Assurance**
Purpose of Report:	To recommend a revision to the Policy for Declaring and Managing Interests following changes to the statutory guidance for managing conflicts of interest for CCGs that has been issued by NHS England and to ask the Governing Body to agree in principle to the appointment of an additional Lay Member in response to the Guidance.
Public or Private:	This Report is intended for the public domain
Relevance to CCG Priority:	Developing and Strengthening Leadership Capacity and Capability.
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	Compliance with the new guidance will continue to be a key element of assurance discussions around the CCG's governance arrangements.
• **Domain 3:** Financial Management	The effectiveness of the operational arrangements for managing potential conflicts of interests is a key element of robust financial management procedures, particularly in relation to procurement.
• **Domain 5:** Delegated Functions	The new guidance includes specific provisions in relation to the operation of co-commissioning

	arrangements for Primary Care.

1. BACKGROUND AND CURRENT SITUATION

1.1. At the 31 March 2016 meeting of the NHS England Board, a draft of new statutory guidance on managing conflicts of interests was issued in draft for consultation purposes. A final version of the guidance was published on 30 June 2016.

1.2. The new guidance requires a number of changes to the CCG's policy for Declaring and Managing Interests and makes a strong recommendation that the CCG should recruit an additional Lay Member of the Governing Body.

2. KEY REVISIONS TO STATUTORY GUIDANCE

2.1. The new guidance highlights seven key areas where revisions have been made to the previous statutory guidance from December 2014:-

- A recommendation to increase the number of lay members on the Governing Body to support management of conflict of interest;
- The introduction of a 'conflict of interest guardian' role;
- A requirement to include a robust process for managing breaches within the conflict of interest policy;
- Strengthened provisions around decision making when conflicts of interest arise in Governing Body or committee meetings;
- Strengthened provisions around the management of gifts and hospitality;
- A requirement for annual audit of conflicts of interest management to be reported through the Annual Governance Statement; and
- A requirement for all CCG staff, Governing Body and committee members and GP members to complete mandatory online training on conflicts of interest.

Further detail on each of these key issues is given below.

2.2. **Increasing the number of Lay Members on the Governing Body**

The guidance recognises the key role that lay members play in supporting the CCG in managing conflicts of interest, particularly in being able to provide an independent voice in decision making. This is particularly important in areas where clinical members of the Governing Body face conflicts of interest as a result of their responsibilities in member practices. It also recognises that, as the role of CCGs in commissioning Primary Care services increases, the workload of lay members in such decision making will increase considerably.

As a result, the guidance strongly recommends that CCGs should consider the appointment of an additional lay member. CCGs who choose not to comply with this recommendation will have to account to NHS England for the reasons why through the assurance process. It highlights that a number of CCGs have already appointed additional lay members to their Governing Body and suggests that, where capacity

exists, CCGs should consider whether they could make further appointments. It is suggested that the additional lay member would be able to act as the Vice-Chair of the relevant committee for commissioning primary care.

2.3. Conflict of Interest Guardian

The guidance outlines that, as part of their responsibilities, CCG Audit Chairs should have a defined role in the management of conflicts of interest, acting as a conduit for public concerns, a point of contact for whistleblowing and – with the support of an internal governance lead – support the application of the guidance across the CCG. The guidance describes this as acting as the Conflict of Interest Guardian.

The CCGs existing policy and constitution detail the responsibilities of the Chair of the Audit and Governance Committee in respect of managing conflicts of interest. These align closely with the new requirements in the guidance.

2.4. Robust Process for Managing Breaches

As part of the drive in the new guidance towards greater transparency, there are new requirements to provide greater detail around how breaches of conflict of interest policies will be managed. This includes ensuring that the breach is recorded, investigated, reported both internally and externally to NHS England and the sanctions that will be applied as a result. The guidance also makes it clear that any breaches of the policy must be published on the CCG website.

2.5. Decision Making when conflicts arise

One area in which the current guidance for CCGs has been criticised is that it is not always explicit in describing actions that should be taken when conflicts of interest arise, particularly at meetings. The new guidance addresses this by setting out in greater detail the steps that should be taken, including the fact that the default position should be that those with an interest should not participate in discussions or decision making. To support this process, a checklist has been provided within the guidance to support chairs (who have the ultimate responsibility for determining actions to be taken in response to potential conflicts).

2.6. Gifts and Hospitality

The management of gifts and hospitality – particularly from the pharmaceutical industry – have been an area of concern as the new guidance has been developed. The guidance sets out new requirements in this area to increase transparency by requiring the register of gifts and hospitality for the CCG (including member practices) to be published on the CCG's website. An outline of requirements for this register (which mirror the CCG's current register) are included as an appendix to the guidance.

The guidance also suggests that CCG's reflect on their working relationship with the pharmaceutical industry, including the practice of receiving corporate sponsorship for CCG events. The Audit and Governance committee have discussed this issue and it is an area that may merit further consideration.

2.7. **Annual Audit of Conflict of Interest Management**

Requirements around the auditing of conflict of interest management have also been strengthened. As this will link into NHS England assurance of governance arrangements, a national template for the remit for this audit work is due to be produced. It is suggested that the audit takes place in Quarter 3 or 4 of the year and that the outcomes are reported as part of the end of year assurance assessment by NHS England and included in the annual governance statement. Details of how conflicts of interest have been managed in procurement work and registers of interests will also form part of the annual accounts and be signed off by external auditors.

2.8. **Online Conflict of Interest Training**

The final change highlighted in the guidance is the requirement for training on conflict of interests to be offered to staff, governing body members, committee members and member practices. An online training package is being developed by NHS England that will ensure individuals understand what conflicts of interest are, the importance of managing conflicts, recognising their own interests and how to report concerns that conflicts have not been managed appropriately. Completion of this online training will be mandatory for the individuals concerned and compliance rates must be included in the audit of conflicts of interest management.

3. OTHER CHANGES IN THE GUIDANCE

3.1. As well as the key changes that NHS England have chosen to highlight, the guidance also refines the definitions of both what interests are relevant and who needs to declare them. The new categories are split into 'Financial Interests', 'Non-Financial Professional Interests', 'Non-Financial Personal Interests' and 'Indirect Interests'. This includes the existing definitions (employment, shareholdings etc.) and there are examples given in the other categories to support individuals in making declarations.

3.2. Clarity is also provided around the individuals covered by the policy, particularly within member practices. As outlined in the current policy, all CCG employees, Governing Body Members and individuals acting on the CCG's behalf are required to register their interests and the new guidance sets out that GP Partners (or Directors where the practice is a company) and any staff at member practices involved in CCG decision making must also make a declaration.

3.3. It is suggested that, in developing internal arrangements to manage conflicts of interest, CCGs should reflect on the interests held by individuals prior to making appointments. The CCG has already considered this when making appointments to the Governing Body but can formalise these provisions in response to the guidance. For employees, the guidance also suggests that explicit permission should be sought prior to taking up any secondary employment.

3.4. The guidance explicitly outlines that conflicts of interest must be managed throughout the commissioning cycle, giving brief examples of points where individual's interests could create a conflict. To mitigate against this, the guidance includes provisions that suggest it would be good practice to publish a list of planned procurements in addition to the register of procurement decisions. There is a clear steer in the guidance that the register should be based on a broad definition of procurement decisions, suggesting that decisions such as those to extend existing contracts should be included in the register as well as awards of new contracts.

3.5. The guidance also includes links to case studies and scenarios and NHS England has published a number of summary guides for different audiences (copies of the summaries for GPs and Lay Members are attached for information).

4. NEXT STEPS

4.1. Declaring and Managing Interests Policy

The attached version of the Declaring and Managing Interests policy has been revised in line with the newly issued guidance. Many of the principles outlined in the guidance were already incorporated in the CCG's policies and practices, however elements have been re-emphasised. The new policy includes details of the defined role and responsibilities for the Conflict of Interest Guardian, a process for managing breaches of the policy, details of training arrangements and the revised categorisation of interests are all included in this policy.

Due to the late publication of the guidance by NHS England, the policy has not been subject to review by the Audit and Governance Committee, or any engagement with staff. The Governing Body is therefore asked to approve the Policy in principle, subject to a review by the Audit and Governance Committee and engagement with CCG staff via the Staff Forum. The Governing Body is also asked to delegate responsibility to the Corporate Operations Manager to make any minor and consequential changes to the policy required following these review in consultation with the Conflicts of Interest Guardian. Should any major revisions be required, the policy will be considered at the September Governing Body meeting.

4.2. Lay Member Recruitment

Discussions have taken place to determine the most appropriate response to this element of the guidance for the CCG. The Governing Body will recall that in January, the Finance and Performance Committee agreed to appoint an additional

independent member of the committee to support the on-going development of its assurance and scrutiny role. At that point it was recognised that the independent members of the Audit and Governance Committee both had the requisite skills and experience to perform this new role and it was agreed that, prior to conducting an external recruitment process to appoint an independent member, they should be approached to determine if they were interested in the role.

Following the publication of the draft statutory guidance, the appointment process was paused whilst consideration was given to a number of options for meeting the requirement to appoint an additional lay member. Given the agreed need to strengthen the membership of the Finance and Performance committee, the preferred option was to look at expanding the role description for the Independent Member of this Committee to become a Lay Governing Body member for Finance and Performance. The additional responsibilities this will entail include chairing this committee and becoming a member (and deputy chair) of the Joint Primary Care Commissioning Committee. Alternative options considered included developing an alternative role description for the new Lay Member or expanding the existing role of one of the Lay Members of the Audit and Governance Committee to support management of conflicts of interest.

The existing members of the Audit and Governance Committee have been approached to determine whether they would be interested in the expanded role. Mr Peter Price has expressed an interest, in line with the principles for appointment of Lay Members for CCGs and ensuring that such appointments are made on merit, Mr Price has met with the Lay Member for Audit and Governance, the Clinical Lead for Finance and Performance and the Chief Finance and Operating Officer and consideration has been given to Mr Price's considerable experience of NHS Finance and performance matters and his contribution to the work of the Audit and Governance Committee during his membership. On this basis, Mr Price has demonstrated his suitability to fill this post and the Governing Body is asked to agree to appoint him to the post, to be formally effective once the Constitution is varied to reflect the change in Governing Body Membership. Mr Price will take up his duties in shadow form pending this being formalised through the NHS England processes.

4.3. **Internal Audit**

The Audit and Governance committee have agreed an annual work plan for internal audit that includes an audit of conflicts of interest management. This is in line with the new requirement and the internal audit team will conduct the audit in line with template terms of reference that are due to be issued by NHS England in due course.

4.4. **Training**

Once the revised policy for Declaring and Managing interests is approved, the Corporate Operations Manager will develop a training programme for staff, Governing Body members and member practices to highlight the relevant changes.

In addition, NHS England will be producing online training materials in the Autumn that will be mandatory for CCG staff. All staff will need to complete this training by 31 January and training compliance rates must be reported through the internal audit.

5. CLINICAL VIEW

5.1. Not applicable.

6. PATIENT AND PUBLIC VIEW

6.1. Not applicable.

7. RISKS AND IMPLICATIONS

Key Risks

7.1. There is a risk that an ineffective approach to managing potential conflicts of interest would leave the CCG's decisions open to challenge. Adopting the revised policy and appointing an additional lay member will mitigate this risk.

Financial and Resource Implications

7.2. The CCG will be required to appoint an additional Lay Member of the Governing Body to comply with the revised guidance which will have an impact on running costs. The other requirements in the guidance will be met within existing resources.

Quality and Safety Implications

7.3. There are no quality and safety implications relating to this report.

Equality Implications

7.4. There are no equality implications arising from this report.

Medicines Management Implications

7.5. There are no medicines management implications relating to this report.

Legal and Policy Implications

7.6. The CCG's Policy for Declaring and Managing Interests and sections of the constitution that refer specifically to Standards of Business Conduct and the relevant sections of Standing Orders must comply with the statutory guidance.

8. RECOMMENDATIONS

That the Governing Body

- **Agrees in principle** to approve the revised policy for declaring and managing interests, subject to review by the Audit and Governance Committee and staff engagement
- **Delegates authority to the Corporate Operations Manager** (in consultation with the Conflicts of Interest Guardian) to make any minor and consequential amendments to the policy arising from the Audit and Governance Committee review.
- **Agrees** to appoint Mr Peter Price to the new position of Lay Governing Body Member for Finance and Performance, subject to the CCG's constitution being varied to give effect to this change.

Name	Peter McKenzie
Job Title	Corporate Operations Manager
Date:	July 2016

ATTACHED:

Revised Policy for Declaring and Managing Interests
Summary of Conflict of Interest Statutory Guidance – GPs involved in commissioning
Summary of Conflict of Interest Statutory Guidance – Lay Members
Lay Member for Finance and Performance Role Description

RELEVANT BACKGROUND PAPERS

CCG Constitution
Managing Conflicts of Interest, Statutory Guidance for CCGs, NHS England June 2016
https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/06/revsd-coi-guidance-june16.pdf

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View	N/a	
Public/ Patient View	N/a	
Finance Implications discussed with Finance Team	Discussed requirement for additional Governing Body lay member with Claire Skidmore	04/04/16
Quality Implications discussed with Quality and Risk Team	N/a	
Medicines Management Implications discussed with Medicines Management team	N/a	
Equality Implications discussed with CSU Equality and Inclusion Service	N/a	
Information Governance implications discussed with IG Support Officer	N/a	
Legal/ Policy implications discussed with Corporate Operations Manager	Report author	05/07/2016
Signed off by Report Owner (Must be completed)	**Peter McKenzie**	**05/07/2016**

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NHS
Wolverhampton
Clinical Commissioning Group

Declaring and Managing Interests

Including Managing Conflicts of Interest

DOCUMENT STATUS:	**Approved**
DATE ISSUED:	**March 2016**
DATE TO BE REVIEWED:	**March 2017**

AMENDMENT HISTORY

VERSION	DATE	AMENDMENT HISTORY
1.1	November 2014	First Revision
1.2	December 2014	Revised following comments by Jim Oatridge
1.3	December 2014	Reviewed to incorporate revised guidance from NHS England
2.0	**January 2015**	**Reviewed following comments from the Audit and Governance Committee**
2.1	October 2015	Revision by Peter McKenzie
3.0	July 2016	Revision Following changes to NHS England Statutory Guidance

REVIEWERS

This document has been reviewed by:

NAME	TITLE/RESPONSIBILITY	DATE	VERSION
Peter McKenzie	Corporate Operations Manager	November 2014	1.1
Jim Oatridge	Lay Member for Audit and Governance	December 2014	1.1
Peter McKenzie	Corporate Operations Manager	October 2015	2.1

APPROVALS

This document has been approved by:

GROUP/COMMITTEE	DATE	VERSION
Governing Body	13 January 2015	1.3
	9 March 2016	2.1
Audit and Governance Committee	20 January 2015	2.0
	23 February 2016	2.1

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Contents

1. Introduction and Purpose

1.1. This policy is a key element of the Group's Business Conduct Policies[1] and is available on the group's website at www.wolvescityccg.nhs.uk. It sets out how NHS Wolverhampton Clinical Commissioning Group (CCG) will manage conflicts of interest arising from the business of the organisation and should be read alongside the constitution (including the standing orders in Appendix E) and the Codes of conduct for staff and Governing Body Members and clinical leads.

1.2. The policy has been drafted in accordance with relevant legislation and guidance including:-

- NHS England Code of Conduct: "Managing conflicts of interest where GP practices are potential providers of CCG-commissioned services" (October 2012)
- NHS England: "Managing conflicts of interest: Statutory Guidance for CCGs" (June 2016)
- The National Health Service (Procurement, Patient Choice and Competition) Regulations 2013, SI 2013/257
- Royal College of General Practitioners' ethical commissioning guidance (October 2011)
- The four principles set out in the NHS England Towards Establishment: Creating responsive and accountable CCGs, Technical appendix 1:-
  - Doing business properly
  - Being proactive not reactive
  - Assuming that individuals will seek to act ethically and professionally, but may not always be sensitive to all conflicts of interest
  - Being balanced and proportionate

1.3. The CCG is responsible for the stewardship of vast public resources and the commissioning of healthcare services for the community. It is therefore determined to inspire confidence and trust by demonstrating integrity by acting in accordance with the principles of Good Governance set out in paragraph 4.5 of the constitution. These include nationally recognised standards such as the Nolan Principles governing standards of behaviour in public life, the Good Governance Standard for Public Services[2], the seven key principles of the NHS Constitution and the Equality Act 2010. Locally, the development of this policy is based on these principles and helps to ensure all of the group's decisions are taken and demonstrably seen to be taken for the right reasons and in line with the following principles:-

- The interests of patients remain paramount at all times;
- The Group's business is conducted in an impartial and honest manner;
- Public funds are used to the best advantage of the service, always ensuring value for money;
- No employees or appointees abuse their position for personal gain or to the benefit of their family or friends;
- No employees or appointees seek to advantage or further private or other interests in the course of their duties.

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[1] Paragraph 8.1.2 of the group's constitution

[2] The Good Governance Standard for Public Services, The Independent Commission on Good Governance in Public Services, Office of Public Management (OPM) and The Chartered Institute of Public Finance & Accountability (CIPFA), 2004

1.4. This ethos underpins this policy, by setting out steps to avoid any potential or real situations where there could be suggestions of undue bias or influence in the decision making of the CCG throughout the 'Commissioning Cycle'. This means that efforts will be made to ensure that:-

- Service design and specification is informed by appropriate patient and public engagement and the views of relevant providers and expert clinicians;
- Procurement decisions (and other decisions with financial consequences) are in line with the the CCG's responsibilities under The National Health Service (Procurement, Patient Choice and Competition) Regulations 2013[3], which stipulate that the Group:
    - when procuring health care services, must treat providers equally and not treat a provider or type of provider more favourably, in particular on the basis of ownership - Regulation 3(2)(b);
    - must not award a contract for the provision of health care services where conflicts or potential conflicts between commissioning and providing the services affect or appear to affect the integrity of that contract award – Regulation 6(1);
    - must maintain a record of how it managed any such conflicts of interest in relation to each such contract that it has entered into – Regulation 6(2);
    - must provide Monitor with any specified information in its possession for the purposes of an investigation into any complaint received by Monitor regarding the Group's failure to comply with the above – Regulation 13(4).

2. Scope of Policy

2.1. This policy applies to:-

- CCG Member practices;
- Governing Body Members and members of the Group's committees;
- Employees of the group; and
- Any individuals contracted to work on the group's behalf or otherwise provide services or facilities to it.

2.2. In addition, anyone engaging with the Group in relation to the actual or potential provision of services or facilities to it will be required to comply with this policy as regards the declaration of any relevant actual or potential conflict of interest.

2.3. A conflict of interest is defined as a situation in which:-

- There is a real possibility that any interest will lead an individual to act in a way that is not impartial and independent in carrying out their duties on behalf of the group;
- There is a real possibility that any interest held by somebody with whom an individual has a close association (such as a close relative, friend or business associate) will lead an individual to act in a way that is not impartial and independent in carrying out their duties on behalf of the group;

[3] SI 2013/257

- A fair minded and informed observer would conclude that one of the above interests exists and that there was a real possibility that the interest could lead the individual to act in a way that is not impartial or independent in carrying out their duties on behalf of the group.

2.4. As highlighted above, when considering conflicts of interest, there may be circumstances when it is not necessary for an actual conflict to exist. It may be sufficient that there is a perceived conflict, where there is a reasonable perception that the individual is influenced or could be open to influence.

2.5. The definition of a close relative includes spouses, civil partners, partners, parents, children (adult and minor) and siblings. It also includes other people living in the same household as the individual. For the avoidance of doubt, GPs on the Governing Body, other GPs in their practice will be considered to be business associates for the purpose of this policy.

2.6. Further details on the interests that must be registered is given in Section 3 of this policy, but in general potential conflicts of interest may arise from:-

- **Financial Interests –** where an individual or somebody with whom they have a close association may financially benefit from the consequences of group decision (for example, a decision to commission a provider of services);
- **Non-Financial Professional Interests** – where an individual or somebody with whom they have a close association may obtain a non-financial professional benefit from the consequences of a group decision, such as increasing their professional reputation or status or promoting their professional career;
- **Non-Financial Personal Interests –** where an individual or somebody with whom they have a close association may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit (for example, a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual's house);

2.7. Failure to comply with this policy is taken very seriously by the group and may have significant consequences. Details are given in Section 9 of this policy on how breaches of the policy will be managed but could include investigations under the disciplinary policy for employees or as a breach of the code of conduct for governing body members. Failure to comply with this policy by member practices will be treated as a dispute in line with paragraph 7.10 of the Constitution.

3. Key Roles and Responsibilities

3.1. The Accountable Officer has overall responsibility for how the CCG manages conflicts of interest and every individual to whom this policy applies is responsible for acting in accordance with its requirements. Beyond this, there are specific roles for ensuring that this policy operates effectively.

3.2. **Conflicts of Interest Guardian**
The Governing Body Lay Member for Audit and Governance is designated as the CCG's Conflict of Interest Guardian. The CCG's constitution sets out their role in

ensuring arrangements are in place to manage conflicts of interests[4] and to have an oversight of how effectively they are operating (in conjunction with the Audit and Governance Committee).

In line with the 2016 Statutory Guidance, their role also includes:-

- Acting as a conduit for GP practice staff, members of the public and healthcare professionals who have any concerns with regards to conflicts of interest;
- Being a safe point of contact for employees or workers of the CCG to raise any concerns in relation to this policy;
- Supporting the rigorous application of conflict of interest principles and policies
- Providing independent advice and judgment where there is any doubt about how to apply conflict of interest policies and principles in an individual situation; and
- Providing advice on minimising the risks of conflicts of interest.

3.3. **Corporate Operations Manager**

In recognition that the role of Conflict of Interest Guardian is strategic, the Corporate Operations Manager has day to day responsibility for managing conflict of interest matters and queries. This includes:-

- Maintaining the CCG's registers of Interests and Gifts and Hospitality;
- Supporting the Conflict of Interest Guardian to enable them to fulfil their role effectively;
- Providing advice, support and guidance on how conflicts of interest should be managed;
- Ensuring that appropriate administrative processes and training are put in place.

3.4. **Governing Body and Committee Chairs**

The nature of the CCG's decision making arrangements mean that conflicts of interest may well occur during formal meetings. The Chairs of such decision making forums will have responsibility for ensuring that the requirements of this policy are met at meetings. This will include (with appropriate advice) determining whether a conflict of interest exists, the action to be taken in response and that the outcome is clearly recorded in the record of the meeting.

4. Registration of Interests

4.1. It is the responsibility of all individuals to whom this policy applies to ensure that they are not placed in a position which creates a potential conflict between their private interests and their CCG duties. The CCG needs to be aware of all situations where individuals' interests may have the potential to cause a conflict so all persons covered by the policy are required to declare any relevant interest held by themselves or any person defined by paragraph 2.5 above using the Declaration of Interest Form (Appendix A).

4.2. For the purposes of paragraph 3.1, the individuals from Member practices to whom this policy applies are defined as:-

- GP Partners (or where the practice is a company, each director); and

[4] Paragraphs 8.4.2 to 8.4.4, Sections 4 and 5 are approved by the Lay Member as the Group's arrangements under these paragraphs

- Any individual directly involved with the business or decision-making of the CCG.

4.3. Individuals should consider their personal circumstances very carefully when completing the declaration form. Whilst not intended to be a comprehensive list, relevant interests that may impact on the work of CCG that should be declared may include:-

Financial Interests

- Roles and responsibilities held within member practices
- Directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies) which may seek to do business with the CCG (or, where relevant, its providers)
- Ownership or part ownership of companies, businesses or consultancies which may seek to do business with the CCG (or, where relevant, its providers)
- Significant share holdings (more than £25,000 or 1% of the nominal share capital) in organisations which may seek to do business with the CCG (or, where relevant, its providers)
- Employment with (or provision of consultancy services to) an organisation which currently does or may seek to do business with the CCG (or, where relevant, its providers)
- Receipt of research funding/ grants from the CCG (or, where relevant, its providers)
- Interests in pooled funds that are under separate management (any relevant company included in this fund that has a potential relationship with the CCG must be declared)
- Current contracts with the CCG in which the individual has a beneficial interest
- Any payments (e.g. honoraria, one off payments, day allowances or travel or subsistence) from an organisation which currently does or may seek to business with the CCG
- The receipt of individual Gifts and Hospitality worth over £25 or several gifts worth over £100 in a 12 month period from a single source (see Section 6 for more details)

Non-Financial Professional Interests

- Roles acting as an advocate for a particular group of patients
- Clinical areas of special interest for GPs
- Membership of particular specialist professional body
- Advisory roles with organisations such as the Care Quality Commission or National Institute for Health and Care Excellence

Non-Financial Personal Interests

- Roles acting as a voluntary sector champion for a provider
- Voluntary roles within organisations which currently or may seek to do business with the CCG
- Membership of or a position of trust in a charity or voluntary organisation in the field of health and social care
- Suffering from a particular condition that requires individually funded treatment
- Formal interest with a position of influence in a political party or organisation
- A member of a lobby or pressure group with an interest in health.

4.4. As outlined in the constitution, the arrangements for appointing members to the Governing Body will include a requirement to declare any potential conflicts of interest. The Accountable Officer (in consultation with the statutory Lay Members of the Governing Body) will then assess whether any identified conflicts would prevent the individual concerned making a full and proper contribution to the governing body. If such significant conflicts do exist, the individual concerned will be excluded from the appointment process.

4.5. Induction arrangements for staff, Governing Body Members and committee members will include training on the arrangements for managing conflicts of interest. In addition, advice on the registration of interests is available to all individuals covered by this policy from the Corporate Operations Manager. This will include any clarification of the categories listed above and advice on whether situations not covered by the above categories should be registered.

4.6. The Group will use these declarations to maintain and publish on its internet site Registers of Interests for:

- the members of the Group;
- the members of its Governing Body;
- other members of any committees or sub-committees;
- other employees and anyone else required to declare interest under a contract for their services.

The registers will include details, where appropriate, of how any specifically identified conflicts of interest will be managed. All individuals will be made aware that information included in the register will be published and open to public inspection.

4.7. If an individual feels that information relating to an interest that must be registered is sensitive they can request that the information not be included the public register. Such requests must be made in writing to the Conflicts of Interest Guardian, who will determine whether the request is valid and maintain a separate register of any information not included on the public version.

4.8. For the purposes of paragraph 3.6, information is considered to be sensitive if making it open to public inspection is prohibited by law or could lead to the individual or a close personal relation suffering harm or distress.

4.9. On at least a six monthly basis, all those persons covered by this policy will be formally reminded of the need to declare interests and to confirm the accuracy of the interests already registered against their name. The Registers will also be reviewed quarterly by the Corporate Operations Manager to ensure that they accurately reflect all of the declarations of interest submitted or withdrawn since the previous such review.

4.10. Any person covered by this policy who becomes aware that they have a relevant interest because:

- their personal circumstances change;
- they become aware, either in the course of any transaction (including conversations between two or more individuals, e-mails, correspondence and other communications) on behalf of the Group or when they find out about a

decision to be made by the Group that they have a relevant interest that they had not previously recognised and declared;

must inform the Corporate Operations Manager of the change in their interests, as soon as practicable after they become aware of it to ensure that this interest is registered within 28 days.

5. General Principles for Managing Potential and Actual Conflicts of Interest

5.1. As highlighted above, the CCG's constitution sets out the responsibility of the Conflict of Interest Guardian to ensure arrangements are in place to manage conflicts of interests[5]. All individuals covered by this policy must comply with the arrangements outlined below and any instructions given to them under those arrangements.

5.2. When an actual or potential conflict of interest is identified, the individual with the conflict of interest will normally be instructed to withdraw from any activity, transactions or meetings relating to the conflict on a permanent basis. Where the conflict only becomes apparent in the course of activity, transactions or meetings, the individual must withdraw at the point the conflict is identified and their interest communicated to all relevant parties.

5.3. As a consequence of paragraph 5.2, individuals with a conflict of interest should also not be party to any information relating to the matter in which they have a conflict other than information that is publicly available. This means that, if they are a member of a committee or governing body, they should not receive copies of any private papers relating to the matter in which they have a conflict of interest.

5.4. For decisions that affect all of the practices in the Group, any individual with a resulting conflict of interest can be involved in developing relevant proposals and their discussion at Committees and Governing Body level. They will not be able to vote on the decision and another non-conflicted party must be involved in formally putting recommendations to any Committee or the Governing Body.

5.5. In addition, in regard to conflicts as regards any decision required of the Group with regard to services actually or potentially provided by the members of the group the Group will follow the NHS England Code of Conduct and use the template in Appendix B for all relevant commissioning decisions. In particular the Group will:

- arrange for access to robust, independent advice and support with regard to procurement and contract management;
- publish the details of all contracts, including their value, on the Group's website as soon as they are agreed;
- publish on the Group's website the types of services being commissioned though Any Qualified Provider and the agreed price for each service;
- liaise with NHS England when commissioning any service from a primary care provider that is related to the services that some or all GP practices provide under the GP contract

[5] Paragraphs 8.4.2 to 8.4.4, Sections 4 and 5 are approved by the Lay Member as the Group's arrangements under these paragraphs

5.6. A register of all procurement decisions made by the Group will be maintained and published on the Group's website and made available for inspection at the Group's offices. This register will include the details of the decision, who was involved in making the decision (including whether this involved the Governing Body or a Committee) and a summary of any conflict of interests that were declared and how they were managed.

5.7. Where, due to the specific nature of the interests involved, a different approach is required, the Conflict of Interest Guardian (or their nominee) will communicate the arrangements for managing the actual or potential conflict of interest to all relevant parties within 7 days of a conflict being identified[6].

5.8. As outlined in the constitution, alternative arrangements may include the following actions:

- referring the matter to the group's governing body to progress;
- inviting one or more of the following, who do not have the conflict of interest, to attend the relevant meeting to provide additional scrutiny to the matter and advice to those who can participate:
  - A practice representative;
  - A member of a relevant Health and Wellbeing Board;
  - A member of a governing body of another clinical commissioning group.

This list is not exhaustive, and any arrangements will be recorded and communicated in line with the requirements of paragraph 5.7 above and paragraph 8.4.10 of the Constitution.

6. Declarations of Interests at Meetings

6.1. The agenda for meetings of the Group, the Governing Body and their Committees and Locality Boards will contain a standing item at the commencement of each meeting, requiring members and other invited attendees to declare any interests relating specifically to the agenda items being considered.

6.2. Participants must be specific when declaring interests. They should state which agenda item their interest relates to, the nature of the interest and whether or not their interest creates a potential conflict of interest.

6.3. If a member or other invited attendee becomes aware of an interest during the course of the discussion on a particular item they must declare it as soon as they become aware of it and, if it has not previously been included in the register of interests, take the steps outlined in paragraph 3.9 to ensure the interest is registered.

[6] This may include circumstances covered by paragraphs 8.4.9 and 8.4.10 of the constitution when a quorum of the Governing Body or a Committee cannot be reached due to the existence of conflicts of interest.

6.4. Where the interest declared constitutes an actual or potential conflict of interest, the participant in question will leave the room prior to the item being discussed and not take part in the discussion or any vote that takes place[7].

6.5. If there is any doubt as to whether an interest that has been declared constitutes a conflict of interest advice should be sought from the Corporate Operations Manager. In general terms, it is often safest to assume that a conflict does exist and act accordingly, particularly where the interest relates to a decision to be made at the meeting.

6.6. The Chair will follow the checklist set out at Appendix C for ensuring that the arrangements outlined this policy are rigorously applied at meetings. If the Chair has to make a ruling on any potential or actual conflicts during the meeting, including determining the action to be taken, their ruling will be final.

6.7. If the application of paragraph 5.4 above means that a meeting cannot be quorate for any decision, that matter will be deferred until the meeting is quorate or dealt with under paragraphs 8.4.9 to 8.4.10 of the constitution as necessary.

6.8. Paragraphs 8.4.9 and 8.4.10 of the constitution cover situations where a quorum could never be reached due to actual or perceived conflicts of interest. It sets out the responsibility of the chair of the meeting to consult with the Lay Member for Audit and Governance on alternative actions that could be taken.

6.9. If a part of a meeting of the Governing Body cannot be quorate due to conflicts of interest, standing order 3.6.2 will apply and the relevant parts of such meetings will be chaired by the Deputy Chair or, in their absence, another non-conflicted member selected from among and by the non-conflicted members present. Those members allowed to vote will do so having ensured that they have received independent advice[8], either before or at the relevant meeting.

6.10. All declarations of interest, any subsequent action taken and any other relevant information – including any advice given will be recorded in the minutes of the meeting.

7. NHS England Delegated Functions

7.1. In general, the arrangements set out above in sections 5 and 6 will apply when the CCG is discharging functions delegated to it by NHS England. This includes the commissioning of Out of Hours services and Primary Medical Services.

7.2. Specific arrangements have been made in the NHS England guidance for co-commissioning of Primary Medical services, including ensuring that:-

[7] Unless alternative arrangements have been put in place by the Lay Member for Audit and Governance under paragraphs 8.4.3 or the Chair under Paragraphs 8.4.9 and 8.4.10 of the Constitution

[8] In line with paragraph 8.4.10(b) of the constitution

- The Deputy Chair of the CCG Governing Body Chairs the committee responsible for commissioning Primary Medical Services;
- A Lay Member of the Governing Body acts as the deputy chair of the committee responsible for commissioning Primary Medical Services;
- The committee responsible for commissioning Primary Medical Services will have a Lay and Executive majority;
- NHS England representatives on the committee responsible for commissioning Primary Medical Services will be required to comply with the CCG's arrangements for managing conflicts of interest; and
- A representative of Local Healthwatch and a Local Authority representative from the Health and Wellbeing Board are invited to observe meetings of the Committee responsible for commissioning Primary Medical Services to provide assurance that conflicts of interest are adequate managed.

8. Gifts and Hospitality

8.1. In general terms, in order to support the broad aims of this policy, offers of gifts and hospitality beyond those defined in paragraph 6.4 should be politely but firmly declined as accepting such offers could lead to similar claims of undue influence as with other conflicts of interest. It is an offence under the Bribery Act 2010 for anyone to request, agree to receive or receive any financial or other advantage as an inducement to or reward for improper behaviour by them or anyone else.

8.2. For the purposes of this policy, the offer of a discount that would not normally be available to the individual is to be considered the offer of a gift.

8.3. All relevant offers of gifts or hospitality should be declared to the Corporate Operations Manager, who will maintain a register of gifts and hospitality both received and declined and who will advise individuals when the receipt of gifts or hospitality becomes a relevant interest as defined in paragraph 4.3 above. The register of gifts and hospitality will be published on the CCG's website.

8.4. Gifts of low intrinsic value (less than £25 per item) such as pens, diaries, calendars and mouse mats need not be refused and do not need to be declared in most cases. However if several such gifts are received from the same or related source over any 12-month period and their cumulative value exceeds £100, they should be declared.

8.5. Any personal gift of cash or cash equivalents (e.g. vouchers, tokens, offers of remuneration to attend meetings whilst in a capacity working for or representing the CCG) must always be declined, regardless of value. The offer which has been declined must be reported to the Corporate Operations Manager.

8.6. Hospitality provided to individuals in connection with events, meetings or working visits at another organisation is acceptable without being declared, provided it is similar to the scale of hospitality which the Group would be likely to offer to a representative of another organisation attending one of its events or visiting the Group for similar reasons.

8.7. Where the Group receives or solicits offers of sponsorship for meetings, training events or publications this Policy requires that:-

- the sponsor's involvement must be made public without giving their advertising or promotional material undue significance;
- nothing said or issued during a meeting or training event or written in the publication must give any explicit or implicit suggestion that the Group is endorsing the products or services of the sponsor;
- receipt of the sponsorship must be declared and recorded in the gifts and hospitality register;
- sponsorship should not be sought from and should be declined if offered by any organisation if it is known or considered likely that they will be submitting a competitive bid to the Group within three months either side of the sponsored event or publication.

8.8. Employees of the group should only accept sponsorship to fund their attendance at relevant conferences, courses or work-related visits with the prior approval of their line manager, who needs to ensure there can be no perception of a conflict of interest in relation to the motives of the organisation making the offer. All such offers, whether accepted or not, should be declared and recorded in the gifts and hospitality register.

8.9. The Group might wish to sponsor (i.e. contribute part of the funding for) local events or publications in which they have no other involvement but which contribute to the aim of the Group. This must be done such that the Group is not seen to be endorsing everything said at the event or in the publication and with due regard to the timing of the event/publication and any actual or potential commercial relationship between the Group and the organisation being sponsored.

8.10. If an employee or representative of the Group is asked to contribute on behalf of the Group to a conference or other event arranged by another organisation, the invitation is accepted as part of the individual's job or role with the Group and the contribution delivered during time for which they are already being paid, it is not appropriate for them to be paid for doing so. The Group may wish to reimburse any related expenses, particularly any overnight accommodation and related meals, if they are not funded by the organisers of the event. Anyone accepting such an invitation needs to ensure that doing so does not create any potential conflict with any other relationship between the Group and the event organisers. Expenses and hospitality directly associated with contributing to an event in this way need not be declared, provided that the event takes place in the UK.

8.11. Such an offer can also be accepted by an individual in their own right, to be carried out in their own time and with any views expressed to be explicitly those of the individual, not necessarily the Group. It is then acceptable for them to be paid for their contribution provided that this does not create any conflict of interest with their role within the Group or any potential relationship with the other organisation. All related expenses must be met by the individual or the event organisers; if the latter, any such expenses, except reimbursement of travel expenses within the UK, should be declared and recorded in the gifts and hospitality register.

8.12. The Group and its members must follow the toolkit issued by the Department of Health and Association of the British Pharmaceutical Industry (ABPI)[9] whenever any joint working is undertaken with pharmaceutical companies. This defines the difference between sponsorship (where pharmaceutical companies simply provide funds for a specific event or work programme) and joint working, where goals are agreed jointly by the NHS organisation and company, in the interest of patients, and shared throughout the project. Whenever the group engages in any joint work with a pharmaceutical company a working agreement must be drawn up and management arrangements conducted with participation from both parties in an open and transparent manner.

9. Training

9.1. The Corporate Operations Manager will be responsible for providing training to all individuals covered by this policy. The training will cover the following key areas:-

- What is a conflict of interest?
- Why is conflict of interest management important;
- What are the responsibilities of the organisation you work for in relation to conflict of interests?
- What should you do if you have a conflict of interest relating to your role, the work you do or the organisation your work for? (who to tell, where it should be recorded, what actions to take and the implications for your role);
- How conflicts of interest can be managed;
- What to do if you have concerns that a conflict of interest is not being declared ot managed appropriately;
- What are the potential implications of the CCG's rules and policies for Managing conflicts of interest.

9.2. In addition to this training, all CCG staff will be required to complete online training provided by NHS England by **31 January** of each year. This training will support raising of awareness of the risks associated with conflicts of interest and support staff in managing conflicts of interest in practice. Compliance rates will be recorded as part of the annual conflict of interest audit.

10. Raising Concerns and breaches

10.1. If any person within the scope of this policy has concerns about its administration or the management of conflicts of interests within the CCG, including any non-compliance they must report it. Such reports can be made to:-

- The Conflict of Interest Guardian;
- The Accountable Officer;
- The Chief Finance and Operating Officer;
- The Governing Body Chair;

[9] Moving Beyond Sponsorship, 2010, underpinned by important pieces of Guidance. "Best Practice Guidance for Joint Working between the NHS and the Pharmaceutical Industry" was issued by the Department of Health in February 2008. "The ABPI Code of Practice for the Pharmaceutical Industry" and "Guidance Notes on Joint Working between Pharmaceutical Companies, the NHS and Others for the Benefit of Patients"

- The Corporate Operations Manager
- Line Manager

10.2. If an employee makes a report under this policy, they will be afforded the same legal protections as those defined under the CCG's Whistleblowing Policy. All other reports from other parties will be managed in accordance with the principles underpinning the Whistleblowing principles.

10.3. When a report is made that constitutes an allegation of a breach of this policy, the following procedure will apply:-

i. The person to whom the report has been made will notify the Corporate Operations Manager of the details of the alleged breach.
ii. The Corporate Operations Manager will investigate the alleged breach. The investigation will focus on determining whether a breach has occurred and whether the breach is serious to merit any further action either under CCG policies (such as the disciplinary policy for employees or the CCG's Counterfraud arrangements) or criminal or regulatory investigation.
iii. The Corporate Operations Manager will report the outcome of their investigation and recommendation for next steps to the appropriate person. Dependent on the nature of the breach this could include:-
    - An employee's line manager;
    - The relevant Director;
    - The Accountable Officer;
    - The Chair of the Governing Body.
iv. If either the person to whom the Corporate Operations Manager has made a recommendation or the individual (or individuals) involved in the alleged breach have concerns about the investigation they can refer the matter to the Conflict of Interest Guardian for further investigation and recommendation.
v. When the investigation has concluded and any action has been taken, the Corporate Operations Manager will record the details of the breach, a summary of the investigation, the outcome and any comments from the Conflict of Interest Guardian (if relevant) in the register of breaches.
vi. Summaries of breaches (with any personal identifiable information removed) will be published on the CCG website.

10.4. The Corporate Operations Manager will report any breaches or ongoing investigations to the Audit and Governance Committee on a quarterly basis. Any breaches that place a significant risk to the achievement of the CCG's objectives will be reported to the Locality Director of NHS England.

11. Review of Policy

11.1. The Audit and Governance Committee will keep the effectiveness of this policy under review and the lay Member for Audit and Governance will ensure that the arrangements outlined remain fit for purpose in line with the requirements in paragraph 8.4.2 of the Group's Constitution.

11.2. The review process will include consideration of any lessons to be learned from any non-compliance with the policy during the year. This may include the committee undertaking an incident review in addition to any disciplinary or conduct procedures undertaken with the individual(s) concerned.

11.3. In addition, the CCG will conduct an annual audit of conflict of interest management in line with the terms of reference issued by NHS England. The results of this audit will be reported to the Audit and Governance Committee and will be reported in the Annual Governance Statement.

DECLARATION OF INTERESTS FORM

Name:	
Position within CCG:	

As Highlighted in Section 4 of the Declaring and Managing Interests policy, the CCG needs to be aware of relevant interests that may impact on the work of the CCG. The descriptions of interests in the boxes below are intended to be examples of the kind of interests that should be recorded and are not intended to be comprehensive. If you have any queries about whether an interest needs to be included on this form, please contact Peter McKenzie, Corporate Operations Manager for more information.

Type of Interest	Details	Whose interest? (Self or other[10])	Action to be taken to mitigate risk
Financial Interests • Roles and responsibilities held within member practices • Directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies) which may seek to do business with the CCG (or, where relevant, its providers) • Ownership or part ownership of companies, businesses or consultancies which may seek to do business with the CCG (or, where relevant, its providers) • Significant share holdings (more than £25,000 or 1% of the nominal share capital) in organisations which may seek to do business with the CCG (or,			

[10] See Paragraph 2.5

Type of Interest	Details	Whose interest? (Self or other[10])	Action to be taken to mitigate risk
where relevant, its providers) • Employment with (or provision of consultancy services to) an organisation which currently does or may seek to do business with the CCG (or, where relevant, its providers) • Receipt of research funding/ grants from the CCG (or, where relevant, its providers) • Interests in pooled funds that are under separate management (any relevant company included in this fund that has a potential relationship with the CCG must be declared) • Current contracts with the CCG in which the individual has a beneficial interest • Any payments (e.g. honoraria, one off payments, day allowances or travel or subsistence) from an organisation which currently does or may seek to do business with the CCG • The receipt of individual Gifts and Hospitality worth over £25 or several gifts worth over £100 in a 12 month period from a single source (see Section 6 for more details)			
Non-Financial Professional Interests • Roles acting as an advocate for a particular group of patients • Clinical areas of special interest for GPs • Membership of particular specialist professional body • Advisory roles with organisations such as the Care Quality Commission or National Institute for Health and Care Excellence			

Type of Interest	Details	Whose interest? (Self or other[10])	Action to be taken to mitigate risk
Non-Financial Personal Interests • Roles acting as a voluntary sector champion for a provider • Voluntary roles within organisations which currently or may seek to do business with the CCG • Membership of or a position of trust in a charity or voluntary organisation in the field of health and social care • Suffering from a particular condition that requires individually funded treatment • Formal interest with a position of influence in a political party or organisation • A member of a lobby or pressure group with an interest in health.			
Any other information you wish to declare			

In accordance with the requirements of the requirements of Paragraph 8.4 of the Constitution and Section 4 of the Managing Conflicts of Interest Policy I declare that I hold the above interest and confirm that:-

- **To the best of my knowledge and belief, the above information is complete and correct and that a failure to comply with the requirements of the Conflict of Interest Policy will be treated seriously and civil, criminal or internal disciplinary action may result.**
- **I will review and update this information as necessary in accordance with the requirements of Section 4 of the Managing Conflicts of Interest Policy at least annually and within 28 days of my becoming aware of a change of circumstances.**
- **I understand that the information may be held in both manual and electronic form in accordance with the Data Protection Act 1998.**
- **I understand that the information contained in this form will be published in the Register of Interests published on the Group's Website and may be disclosed to third parties in accordance with the Freedom of Information Act 2000.**

Signed_____ **Date:**_____

Appendix B

NHS Wolverhampton Clinical Commissioning Group
NHS England Challenge Template

To be used when commissioning services from GP practices, including provider consortia, or organisations in which GPs have a financial interest

Service:	
Question	**Comment/Evidence**
Questions for all three procurement routes	
How does the proposal deliver good or improved outcomes and value for money – what are the estimated costs and the estimated benefits? How does it reflect the CCG's proposed commissioning priorities?	
How have you involved the public in the decision to commission this service?	
What range of health professionals have been involved in designing the proposed service?	
What range of potential providers have been involved in considering the proposals?	
How have you involved your Health and Wellbeing Board(s)? How does the proposal support the priorities in the relevant joint health and wellbeing strategy (or strategies)?	
What are the proposals for monitoring the quality of the service?	
What systems will there be to monitor and publish data on referral patterns?	
Have all conflicts and potential conflicts of interests been appropriately declared and entered in registers which are publicly available?	

Why have you chosen this procurement route?[11]	
What additional external involvement will there be in scrutinising the proposed decisions?	
How will the CCG make its final commissioning decision in ways that preserve the integrity of the decision-making process?	

Additional question for AQP or single tender (for services where national tariffs do not apply)	
How have you determined a fair price for the service?	

Additional questions for AQP only (where GP practices are likely to be qualified providers)	
How will you ensure that patients are aware of the full range of qualified providers from whom they can choose?	

Additional questions for single tenders from GP providers	
What steps have been taken to demonstrate that there are no other providers that could deliver this service?	
In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	
What assurances will there be that a GP practice is providing high-quality services under the GP contract before it has the opportunity to provide any new services?	

[11] Taking into account S75 regulations and NHS Commissioning Board guidance that will be published in due course, Monitor guidance, and existing procurement rules.

APPENDIX C

CHECKLIST FOR CHAIRS

Timing	Checklist for Chairs	Responsibility
In advance of the meeting	1. **The agenda** to include a standing item on declaration of interests to enable individuals to raise any issues and/or make a declaration at the meeting.	Meeting Chair and Admin Officer
	2. A **definition of conflicts of interest** should also be accompanied with each agenda to provide clarity for all recipients.	Meeting Chair and Admin Officer
	3. **Agenda** to be circulated to enable attendees (including visitors) to identify any interests relating specifically to the agenda items being considered.	Meeting Chair and Admin Officer
	4. **Members should contact the Chair** as soon as an actual or potential conflict is identified.	Meeting members
	5. A **copy of the members' declared interests** is checked to establish any actual or potential conflicts of interest that may occur during the meeting.	Meeting Chair and Admin Officer
During the meeting	6. **Check and declare the meeting is quorate** and ensure that this is noted in the minutes of the meeting.	Meeting Chair
	7. Chair requests **members to declare any interests in agenda items**- which have not already been declared, including the nature of the conflict.	Meeting Chair
	8. **Chair makes a decision** as to how to manage each interest which has been declared, including whether / to what extent the individual member should continue to participate in the meeting, on a case by case basis, and this decision is recorded.	Meeting Chair and Admin Officer

Timing	Checklist for Chairs	Responsibility
	9. As minimum requirement, the following should be **recorded in the minutes of the meeting**: • Individual declaring the interest; • At what point the interest was declared; • The nature of the interest; • The Chair's decision and resulting action taken; • The point during the meeting at which any individuals retired from and returned to the meeting - even if an interest has not been declared;	Admin Officer
Following the meeting	**10.** All **new interests declared** at the meeting should be promptly updated onto the declaration of interest form; **11.** All new completed declarations of interest should be **transferred onto the register of interests.**	Individual(s) declaring interest(s) Corporate Operations Manager

Revised statutory guidance on managing conflicts of interest for CCGs: Summary Guide for GPs in Commissioning Roles

We have developed a series of summary guides to the revised *statutory guidance on managing conflicts of interest for CCGs*, which was published in June 2016. The guides are intended to be a helpful resource, which pull out the essentials you need to know. Conflicts of interest are inevitable in commissioning and it is how we manage them that matters. Conflicts of interest can affect anyone, although it is likely that some roles will have greater exposure to them than others. We have therefore developed a series of role specific guides - this guide is for GPs in commissioning roles. This guide is not intended to be a substitute for the full guidance, which can be accessed here.

I am a GP Involved in Commissioning…

What do I need to know?

- A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship. In some circumstances it could be reasonably considered that a conflict exists even when there is no actual conflict. In these cases it is important to still manage these perceived conflicts in order to maintain public trust.

- NHS England has published revised *statutory guidance on managing conflicts of interest* to support CCGs to manage conflicts of interest. Your CCG should also have a **conflicts of interest policy**.

- By law, conflicts of interest must be declared within **28 days** of them becoming apparent, but it is best to declare them as soon as possible. They should also be declared at the start of each meeting, where a conflict is likely to arise. CCG employees should be sent reminders to declare interests on a six-monthly basis (including collation of **"nil returns"**). Declarations should also be collated as part of recruitment processes and be a standing item on agendas.

- The **chair** of the meeting has ultimate responsibility for agreeing how to manage the conflict of interest in the meeting. Possible actions may include (but are not limited to):
    - Asking conflicted individuals to leave the meeting when the relevant matter(s) are being discussed
    - Allowing conflicted individuals to participate in some of the discussion, but asking them to leave the meeting at the point of decision-making
    - Restricting access to papers in advance of the meeting

- Clinical input is vital in commissioning and we strongly encourage clinicians and GPs to be members of CCGs' **primary care commissioning committees;** however, as an additional safeguard against the increased risk of conflicts of interest arising in primary care commissioning committees, it is recommended that GPs do not have voting rights on this particular committee.

- By law everyone must speak up if they have any concerns about how conflicts of interest are being managed. Details of how to report suspected or known **breaches** should be set out in your CCG's conflicts of interest policy.

- To raise awareness of the different types of conflicts of interest and to support individuals to manage them, NHS England is introducing **mandatory conflicts of interest online training** for all CCG employees and any practice member with involvement in CCG business. The training will be made available in the autumn of 2016.

What should be declared?

- The types of interests that should be declared include, but are not limited to:
    - **Financial interests,** where individuals may directly benefit financially from the consequences of a commissioning decision e.g., being a partner in a practice that is commissioned to provide primary care services;
    - **Non-financial professional interests**, where individuals may benefit professionally from the consequences of a commissioning decision e.g., having an unpaid advisory role in a provider organisation that has been commissioned to provide services by the CCG;
    - **Non-financial personal interests**, where individuals may benefit personally (but not professionally or financially) from a commissioning decision e.g., if they suffer from a particular condition that requires individually funded treatment;
    - **Indirect interests,** where there is a close association with an individual who has a financial interest, non-financial professional interest or a non-financial personal interest in a commissioning decision e.g., spouse, close relative (parent, grandparent, child, etc.) close friend or business partner.

- If in doubt, it is better for an interest to be declared, and managed appropriately, than to for it to be ignored.

What gifts and hospitality can be accepted?

- A 'gift' is any item of cash or goods, or any service, which is provided for personal benefit at less than its commercial value. Any personal gift of cash or cash equivalents or gifts offered by suppliers/contractors linked (currently or prospectively) to the CCG's business should be declined. Individuals must declare any offers of this nature (even if they are declined).

- Gifts from other sources should also be declined if accepting them might give rise to perceptions of bias or favouritism. However, items of little financial value (i.e., less than £10) could be accepted such as diaries and flowers and do not need to be declared.

- There is a presumption that offers of hospitality which go beyond modest or a type that the CCG itself might offer, should be politely refused. This includes (but is not limited to):
    - Hospitality of a value of above £25; and
    - In particular, offers of foreign travel and accommodation.

- There may be some limited and exceptional circumstances where accepting the types of hospitality described above may be contemplated. Express prior approval should be sought from a senior member of the CCG (e.g., the CCG governance lead or equivalent) before accepting such offers, and the reasons for acceptance should be recorded in the CCG's register of gifts and hospitality.

- In addition, particular caution should be exercised where hospitality is offered by suppliers or contractors linked (currently or prospectively) to the CCG's business. Offers of this nature can be accepted if they are modest and reasonable but advice should always be sought from a senior member of the CCG (e.g. the CCG governance lead or equivalent) as there may be particular sensitivities, for example if a contract re-tender is imminent. All offers of hospitality from actual or prospective suppliers or contractors (whether or not accepted) should be declared and recorded.

Revised statutory guidance on managing conflicts of interest for CCGs: Summary Guide for CCG Lay Members

We have developed a series of summary guides to the revised *statutory guidance on managing conflicts of interest for CCGs*, which was published in June 2016. The guides are intended to be a helpful resource, which pull out the essentials you need to know. Conflicts of interest are inevitable in commissioning and it is how we manage them that matters. Conflicts of interest can affect anyone, although it is likely that some roles will have greater exposure to them than others. We have therefore developed a series of role specific guides - this guide is for CCG lay members (there is also a separate guide for Conflicts of Interest Guardians). This guide is not intended to be a substitute for the full guidance, which can be accessed here.

I am a CCG lay member…

What do I need to know?

- A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship. In some circumstances it could be reasonably considered that a conflict exists even when there is no actual conflict. In these cases it is important to still manage these perceived conflicts in order to maintain public trust.

- NHS England has published revised *statutory guidance on managing conflicts of interest* to support CCGs to manage conflicts of interest. Your CCG should also have a **conflicts of interest policy**.

- Everyone is responsible for managing conflicts of interest, but your Accountable Officer has overall accountability in the CCG. Lay members can support the management of conflicts of interest by providing scrutiny, challenge and an independent voice in decision-making processes. Each CCG should also appoint a **Conflicts of Interest Guardian** (recommended to be the CCG's Audit Chair) to support with any queries or concerns relating to conflicts of interest.

- By law, conflicts of interest must be declared within **28 days** of them becoming apparent, but it is best to declare them as soon as possible. They should also be declared at the start of each meeting, where a conflict is likely to arise. If you have a genuine concern that an interest has not been declared or appropriately managed, you should raise this in accordance with your CCG's policy and be supported by your CCG in doing so.

- The **chair** of the meeting has ultimate responsibility for agreeing how to manage the conflict of interest in the meeting. Possible actions may include (but are not limited to):
    - Asking conflicted individuals to leave the meeting when the relevant matter(s) are being discussed
    - Allowing conflicted individuals to participate in some of the discussion, but asking them to leave the meeting at the point of decision-making
    - Restricting access to papers in advance of the meeting

- CCGs with delegated or joint commissioning arrangements should establish a **primary care commissioning committee** (PCCC). The PCCC should have a lay and executive majority (i.e., non-clinical) and a lay chair and vice-chair. To ensure appropriate oversight and assurance, and that the CCG audit chair's position as Conflicts of Interest Guardian is not compromised, the audit chair should not hold the position of chair of the PCCC.

- In light of lay members' expanding role in primary care co-commissioning, we strongly recommend that all CCGs consider increasing the number of CCG lay members on their Governing Body to a minimum of three. Where there are difficulties in recruiting additional lay members, CCGs could consider 'sharing' lay members between, for instance, CCGs in the same Sustainability and Transformation area.

- By law everyone must speak up if they have any concerns about how conflicts of interest are being managed. Details of how to report suspected or known **breaches** will be set out in the CCG's conflicts of interest policy.

- To raise awareness of the different types of conflicts of interest and to support individuals to manage them, we are introducing **mandatory conflicts of interest online training** for all CCG employees. The training will be made available in the autumn of 2016. NHS England will also deliver face-to-face training for lay members on conflicts of interest management. The dates will be advertised through the CCG and lay member network bulletins.

What should be declared?

- The types of interests that should be declared include, but are not limited to:

    - **Financial interests,** where individuals may directly benefit financially from the consequences of a commissioning decision e.g., being a partner in a practice that is commissioned to provide primary care services;
    - **Non-financial professional interests**, where individuals may benefit professionally from the consequences of a commissioning decision e.g., having an unpaid advisory role in a provider organisation that has been commissioned to provide services by the CCG;
    - **Non-financial personal interests**, where individuals may benefit personally (but not professionally or financially) from a commissioning decision e.g., if they suffer from a particular condition that requires individually funded treatment;
    - **Indirect interests,** where there is a close association with an individual who has a financial interest, non-financial professional interest or a non-financial personal interest in a commissioning decision e.g., spouse, close relative (parent, grandparent, child etc.) close friend or business partner.

- If in doubt, it is better for an interest to be declared, and managed appropriately, than to for it to be ignored.

What gifts and hospitality can be accepted?

- A 'gift' is any item of cash or goods, or any service, which is provided for personal benefit at less than its commercial value. Any personal gift of cash or cash equivalents or gifts offered by suppliers/contractors linked (currently or prospectively) to the CCG's business should be declined. Individuals must declare any offers of this nature (even if they are declined).

- Gifts from other sources should also be declined if accepting them might give rise to perceptions of bias or favouritism. However, items of little financial value (i.e., less than £10) could be accepted such as diaries and flowers and do not need to be declared.

- There is a presumption that offers of hospitality which go beyond modest or a type that the CCG itself might offer, should be politely refused. This includes (but is not limited to):
    - Hospitality of a value of above £25; and
    - In particular, offers of foreign travel and accommodation.

- There may be some limited and exceptional circumstances where accepting the types of hospitality described above may be contemplated. Express prior approval should be sought from a senior member of the CCG (e.g., the CCG governance lead or equivalent) before accepting such offers, and the reasons for acceptance should be recorded in the CCG's register of gifts and hospitality.

- In addition, particular caution should be exercised where hospitality is offered by suppliers or contractors linked (currently or prospectively) to the CCG's business. Offers of this nature can be accepted if they are modest and reasonable but advice should always be sought from a senior member of the CCG (e.g. the CCG governance lead or equivalent) as there may be particular sensitivities, for example if a contract re-tender is imminent. All offers of hospitality from actual or prospective suppliers or contractors (whether or not accepted) should be declared and recorded.

Post Title: Lay Member for Finance and Performance

Responsible to: Governing body and its Chair

Accountable to: Governing body and its Chair

Location: CCG Offices, Wolverhampton Science Park

Remuneration: £7,960 p.a

Term of office: five years, for up to two such terms only

1 Role Summary

As part of its on-going development, the CCG has decided to recruit an additional independent lay member to support the Governing Body in ensuring that the CCG continues to act effectively, efficiently and economically. The primary purpose of this new role will be to provide an independent strategic and impartial viewpoint on the Finance and Performance committee's work to scrutinise the financial and performance management of the CCG, providing an external view that is removed from the day to day running of the organisation. This will involve ensuring that there is transparent and clear reporting and appropriate scrutiny of financial and business control in all aspects of the CCGs business. This will support the overall focus on ensuring that the CCG is meeting its objectives in these areas within the overall planning and decision-making processes. To fulfil the requirements of national guidance on managing conflicts of interest, the post holder will also act as deputy chair of the Primary Care Joint Commissioning Committee.

2 Key Working Relationships

The post holder will be required to review management actions and consider reports from both internal and external providers of assurance to the governing body via the Finance and Performance Committee. They will need to engage with management and these third parties on sensitive, complex, contentious and confidential issues.

The Post Holder will be required to build an effective working relationship with the Governing Body Lead for Finance and Performance in order to ensure the committee discharges its duty in an effective manner.

3 Key Duties and Responsibilities

The post holder will be a Member of the Governing Body and act as Chair of the Finance and Performance Committee of the Governing Body. They will also act as Deputy Chair of the Primary Care Joint Commissioning Committee and may be asked to deputise for the Chair in their absence.

The post holder will work with the other members of the Finance and Performance Committee to ensure that there is effective governance, accountability and

stewardship of public money by providing support and appropriate challenge to the Chief Finance Officer and wider CCG Executive team in delivering the general financial duties of the CCG.

This will involve supporting the Committee in fulfilling its duties set out in its terms of reference, including:-

- Deciding when to report to the governing body on areas of concern regarding financial and performance issues;
- Effectively monitoring the group's delivery of the duty to act effectively, efficiently and economically;
- Effectively monitoring the group's delivery of the duty to have regard to the need to reduce inequalities;
- Reviewing the Chief Finance Officer's proposals for changes to the Prime Financial Policies;
- Reviewing and approving changes to the detailed financial policies;
- Considering budget variances and approving any changes to budgets not significant enough to require approval by the governing body;
- Considering and reviewing details of non-financial performance issues and any actions agreed to manage them
- Maintain an overview of and agree the Chief Finance Officer's timetable for producing the annual accounts and report;

The postholder will also be required to comply with the group's Constitution and Code of Conduct in particular:

- Demonstrate commitment to continuously improving outcomes, tackling health inequalities and delivering the best value for money for the taxpayer;
- Demonstrate commitment to clinical commissioning, the CCG and to the wider interests of the health services;
- Demonstrate a sound understanding of the NHS principles and values as set out in the NHS Constitution;
- Demonstrate a commitment to upholding The Nolan Principles of Public Life and reflect them in his/her leadership role and the culture of the CCG.
- No individual who could not be a member of the group's governing body by virtue of Schedule 5 of the 2012 Regulations (SI 2012/1631) (or any subsequent Regulations) will be eligible for this post.

NHS
Wolverhampton
Clinical Commissioning Group

Lay Member of Finance and Performance Committee
Person Specification

Supporting Evidence

The following criteria are all essential for this post and will be assessed using your application form then at any subsequent interview

In the supporting evidence of your application form, you must demonstrate your experiences by giving specific examples for the criteria within the person specification.

Factors	Description
Experience	• Recent and relevant financial and audit experience sufficient to enable them to competently engage with financial management and reporting in the organisation and associated assurances • A strong background in finance at a senior level in either the public or private sector would be desirable
Skills/Knowledge	• A sound understanding of financial and performance management. • A general understanding of health and an appreciation of the broad social, political and economic trends influencing it; • An understanding of the resource allocations devolved to NHS bodies and a general knowledge of the financial framework within which a CCG operates; • Capability to understand and analyse complex issues, drawing on the breadth of data that needs to inform CCG deliberations and decision-making, and the wisdom to ensure that it is used ethically to balance competing priorities and make difficult decisions; • The ability to chair meetings effectively;
Personal Attributes	• The confidence to question information and explanations supplied by others, who may be experts in their field; • The ability to recognise key influencers and engage and involve with them; • The ability to influence and persuade others at all levels articulating a balanced, not personal, view • Willingness to engage in constructive debate without being adversarial or losing respect and goodwill; • The ability to take an objective view, seeing issues from all perspectives, especially external and user perspectives; • the ability to communicate effectively, listening to others and actively sharing information;

WOLVERHAMPTON CCG
Governing Body – July 2016

Title of Report:	**Board Assurance Framework and Risk Register Quarter 1, 2016/17**
Report of:	Manjeet Garcha Director of Nursing & Quality
Contact:	Dawn Bowden, Quality Assurance Co-ordinator
Q&SC **Action Required:**	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To provide an update to the Governing Body on progress made during the reporting period i.e. April, May, June 2016 with particular attention being drawn to key risks that are recorded on the CCG Risk Register that may impact upon the Board Assurance Framework.
Relevance to Board Assurance Framework (BAF):	All domains detailed in the 16/17 framework.

1. KEY POINTS/BACKGROUND

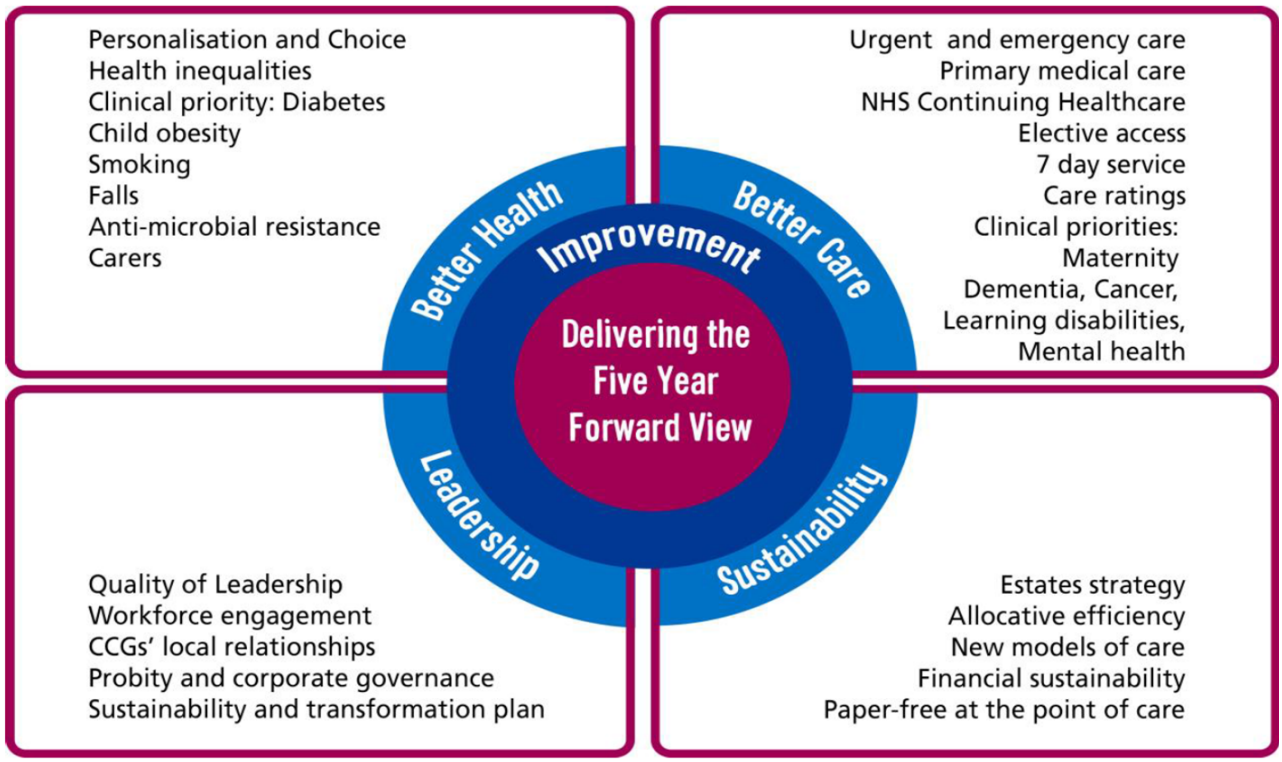
1.1 NHS England has introduced a new Improvement and Assessment Framework for CCGs (CCG IAF) from 2016/17 onwards to replace both the existing CCG Assurance Framework and separate CCG performance dashboard. The new framework takes an enhanced and more central place in the overall arrangements for public accountability of the NHS. The CCG IAF brings clarity, simplicity and balance to the conversation between NHS England and CCGs about what matters to both sides. It draws together in one place NHS Constitution and other core performance and finance indicators, outcome goals and transformational changes. In combination, these provide a more accurate account of the real job description of CCGs.

The new framework covers indicators located in four domains:

1) **Better Health** – this section looks at how the CCG is contributing towards improving the health and wellbeing of its population and bending the demand curve;
2) **Better Care** - this principally focuses on care redesign, performance of constitutional standards and outcomes, including in important clinical areas;

3) **Sustainability** – this section looks at how the CCG is remaining in financial balance and is securing good value for patients and the public from the money it spends;
4) **Leadership** – this domain assesses the quality of the CCG's leadership, the quality of its plans, how the CCG works with its partners and the governance arrangements that the CCG has in place to ensure it acts with probity, for example in managing conflicts of interest.

The diagram below summarises the framework:



The committee is requested to refer to ***Appendix 1*** and note that Quarter 4 domain ratings (2015/16) have been carried forward into Quarter 1 (2016/17) due to the new framework being published.

Significant work is being undertaken to better align WCCG's Board Assurance Framework with new national guidance. Further training and discussions will take place in September at the Governing Body Development sessions being held in conjunction with PWC and Ernst & Young.

Updates will be reflected in Quarter 2's Board Assurance Framework paper to Q&SC and Audit & Governance Committee in October 2016.

1.2 The Quality and Safety Committee receives monthly updates within the quality report detailing red risks and their associated movement into or out of the red zone of the risk register. In addition, a quarterly report is shared with the Quality & Safety Committee as well as the Audit & Governance Committee pertaining to the risk register and Board Assurance Framework. The CCG Governing Body receives an assurance report based on discussions that have taken place at both of these committees in order to assure the Board of the suitability and robustness of the risk register and Board Assurance Framework.

1.3 Reporting in this way enables each committee to consider the full risk register, the breadth of risk recording and raise queries in regard to departmental profiles and items that may be deemed to be gaps in the register. It also provides the committee with the opportunity to add and/or remove red rated risks as they deem appropriate.

2. CURRENT SITUATION

2.1 Assurance Framework – ***Appendix 1*** demonstrates the scores assigned to each domain by responsible directors for Quarter 1. Mitigating controls within each Domain, and associated red risks, performance reds, are reviewed by respective directors on a regular basis.

2.2 Risk Register – provides an update on risk entries and movement within the amber/red region of the risk register.

There were 11 red risks live on the risk register at the end of Quarter 1.

There have been 5 new red risks added to the risk register during Quarter 1.

One risk has been downgraded from red to green since the previous quarter.

One red risk has been closed during Quarter 1.

2.3 A summary of all risk entries are presented at QSC on a quarterly basis, the risks are listed in accordance with how they link to the respective Board Assurance Framework Domain. This work is currently being undertaken and a full alignment will be completed by October Governing Body Meeting.

2.4 The following tables confirm the numbers of risk entries and their status:-

Risk Register Entries 2015/16	**Q4 15/16**	**Q1 16/17**
Number of Open Risks	110	112
Number of Reds	8	11
Number of Ambers	62	57
Number of Green Risks	40	44

Risk owners are expected to manage their own risks and ensure that risks are reviewed before their review date. The Quality Assurance Co-ordinator continues to issue routine follow up emails to remind owners when their risk(s) are nearing/past their review date. Where risks remain overdue they are escalated to the responsible director. A deep dive review is being undertaken regularly on specific risks to challenge scoring and management of the risk. This is undertaken at six week intervals at SMT and commenced on 5th April 2016. The next deep dive will take place during July. SMT are required to update and add all new risks before Quality and Safety Committee.

2.5 Programme Delivery Boards – It is anticipated that Heads of Service will review their risks based on approved work programmes. Quality and Risk Team representatives are attending meetings, actively influencing inclusion of programme risks and monitoring each Board's risk register.

2.6 Better Care Fund – The Better Care Fund Risk Register is being operationally managed by the CCG's BCF Delivery Lead and monitored via BCF Programme Delivery Board.

2.7 The Quality & Risk Team actively monitors risk entries (new/existing) to ensure they are recorded correctly and progressed in a timely manner. Any queries are raised with risk owners and/or Directors.

2.8 Financial/Resource Implications - If a risk has a financial/resource implication, risk handlers must now provide further assurance details in the appropriate section within the Risk Register for Finance colleagues to note.

2.9 Relevant committees/groups are reminded of the need to record risks and receive reports on risks associated with their respective responsibilities.

2.10 Monthly risk activity is reported to the Quality & Safety Committee, quarterly reports on the Board Assurance Framework are provided for Quality & Safety Committee, Audit & Governance Committee and the Governing Body.

2.11 Risk Management Strategy has been reviewed during Quarter 1 2016/17, currently in draft form and out for consultation. Feedback has been encouraged from QSC with a view to ratification in August.

3. CLINICAL VIEW

3.1 The CCG strives to ensure the services it commissions are achieving minimum standards of clinical quality as defined by regulatory requirements, contractual requirements and best practice. The Quality Team engages with Secondary Care Consultant, Nursing professionals and GP colleagues.

4. PATIENT AND PUBLIC VIEW

4.1 Patient Representatives will be given the opportunity to comment on the content of the report prior to discussion

5. RISKS AND IMPLICATIONS

Key Risks

5.1 There is potential that not all services are pro-actively recording risks associated with their area(s) of responsibility on the risk register & therefore the committee is not fully informed on the organisation's risks. On-going monitoring and management of existing risk entries and publicity of the need to pro-actively record risks continues to take place. Programme Delivery

Boards have been continually urged to ensure that programme risks are reflected in each PDB's risk register.

5.2 Risks recorded against assurance domains within the Assurance Framework continue to be recorded as part of the on-going assurance that the Q&SC should consider and approve ***(Appendix 1).***

Financial and Resource Implications

5.3 There are no financial implications associated with this report. The treatment of individual risks may have financial implications, which are addressed through financial approval processes.

Quality and Safety Implications

5.4 See full report detailing the impact on patient safety, experience and effectiveness.

Equality Implications

5.5 The content of this report has been prepared in consideration of the Protected Characteristics within the CCG's Equality Strategy.

Medicines Management Implications

5.6 The Quality Team engages with the Head of Medicines Optimisation regarding any risks that may have an impact on the prescribing budget.

Legal and Policy Implications

5.7 Statutory responsibilities associated with organisation governance including risk management e.g. management of Health and Safety at Work Regulations (amended 1999).

Refer to report - Risk Management Strategy.

6. **RECOMMENDATIONS**

- RECEIVE and NOTE the report.
- CONFIRM the current red rated risks, or AGREE to add and/or remove red rated risks as appropriate.
- NOTE that the Quality and Safety Committee & Audit & Governance Committee will receive this report prior to an assurance report being shared with the Governing Body for the period covered.
- CONFIRM if the BAF Scores are supported given the supplementary evidence available in Appendix 1 (revised and supplementary info).

Name: Manjeet Garcha

Job Title: **Director of Nursing and Quality**
Date: **July 2016**

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	**Date**
Clinical View	Helen Hibbs	05/07/16
Public/ Patient View	NA	
Finance Implications discussed with Finance Team	NA	
Quality Implications discussed with Quality and Risk Team	Nicola Ensor/Manjeet Garcha	05/07/16
Medicines Management Implications discussed with Medicines Management team	NA	
Equality Implications discussed with CSU Equality and Inclusion Service	NA	
Information Governance implications discussed with IG Support Officer	NA	
Legal/ Policy implications discussed with Corporate Operations Manager	Peter McKenzie	05/07/16
Signed off by Report Owner (Must be completed)	Manjeet Garcha	05/07/16

CCG BOARD ASSURANCE FRAMEWORK: Quarter 1 Update 2016/17
Principle Objectives & Risks (BAF)

Appendix 1

Domain Number	Description	Rationale	Board Lead	Risk Review Status 2016/17			
				Q1	Q2	Q3	Q4
Domain 1	**Better Health** How the CCG is contributing towards improving the health and wellbeing of its population and bending the demand curve.	Quarter 1 score remains at amber, due to Level 2 for our Acute/Community as well as care homes/private sector providers. Issues include cdiff, pressure ulcers, cancer targets, safer staffing and prevalence of serious incidents.	Manjeet Garcha	4 x 3 = 12			
	Mitigating Controls Documents : Quality Strategy, Commissioning Strategy, Finance Strategy, Patient & Public Engagement Strategy, CCG Constitution Forums : CCG Board Membership, Programme Delivery Boards, Locality Meetings, Finance and Performance Committee, Quality and Safety Committee, Data Quality Forum, Joint Francis Task & Finish Group (multi agency), Health and Well Being and Integrated Commissioning Board. Plans : Local Priorities, Integrated Commissioning Plan, Two Year Operating Plan, Five Year Strategic Plan, Organisational Development Plan, CCG Audit Programme & Output Reports NHS standard contract: levers deployed to encourage providers to improve performance where delivery of the target position slips.						

Domain Number	Description	Rationale	Board Lead	Risk Review Status 2016/17			
				Q1	Q2	Q3	Q4
Domain 2	**Better Care** Care redesign, performance of constitutional standards and outcomes, including in important clinical areas.	Robust governance is in place to oversee the Better Care Fund programme and delivery of its work stream. There is a risk that the pooled budget may incur some over-spend and there is a Risk Share Agreement/Section 75 underpinning this. However, overspend and the inability to address the demographic growth pressure poses a financial risk to the CCG.	Steven Marshall	2 x 4 = 8			
	Mitigating Controls Documents : Quality Strategy, Commissioning Strategy, Finance Strategy, Patient & Public Engagement Strategy, CCG Constitution Forums : CCG Board Membership, Programme Delivery Boards, Locality Meetings, Finance and Performance Committee, Quality and Safety Committee, Data Quality Forum, Joint Francis Task & Finish Group (multi agency), Health and Well Being and Integrated Commissioning Board. Plans : Local Priorities, Integrated Commissioning Plan, Two Year Operating Plan, Five Year Strategic Plan, Organisational Development Plan, CCG Audit Programme & Output Reports NHS standard contract: levers deployed to encourage providers to improve performance where delivery of the target position slips.						

Domain Number	Description	Rationale	Board Lead	Risk Review Status 2016/17			
				Q1	Q2	Q3	Q4
Domain 3	**Sustainability** How the CCG is remaining in financial balance and is securing good value for patients and the public from the money it spends;	All headlines are significant to the CCG and individually as well as collectively could pose significant risk to the CCG if they fail to achieve their objectives. That said, the organisation has many mitigating factors in place to ensure that the risks do not crystallise or are reduced as far as possible and therefore the score allocated in the status box reflects a view of the current mitigated position.	Claire Skidmore	3 x 4 = 12			
	Mitigating Controls Documents: Plan on a Page, Finance Strategy, Monthly Returns to NHSE, budget manager statements, reporting for QIPP Programme Board, Finance and Performance Committee and Governing Body. Forums: Joint Working with LA i.e. BCF, Collaborative Working with Associate Commissioners, Health & Wellbeing Board, Locality meetings, QIPP Programme Board, Finance and Performance Committee, Governing Body, Joint Efficiency Review Group with BCPFT, Capital Review Group, work with emerging Vertical Integration and Primary Care Home models. Plans: Plan on a Page, Commissioning Intentions, Operational Plan, Strategic Plan.						

Domain Number	Description	Rationale	Board Lead	Risk Review Status 2016/17			
				Q1	Q2	Q3	Q4
Domain 4	**Leadership** The quality of the CCG's leadership, the quality of its plans, how the CCG works with its partners and the governance arrangements that the CCG has in place to ensure it acts with probity, for example in managing conflicts of interest.	Leadership team in place. CSU contract moved to Arden & Gem and review of OD. Plan to be undertaken to provide leadership development working in Black Country STP. Governing Body development sessions on-going.	Dr Helen Hibbs	2 x 4 = 8			
	Mitigating Controls Documents : Organisational Development Strategy, Professor S Fairlea Review/Report/Action Plan (complete Jan 14), MOU with Public Health/LA, Forums : Interim Director Appointments & Board Development, Mentoring for Executive Directors, Board Development Sessions, Integrated Transformation Board (BCF), Collaborative Working Among Accountable Officers, Collaborative Commissioner Network, Working as a Governing Body (leadership/assurance/ chairmanship) Plans : Team Level Appraisal Plans/Records & Individual Objectives, Appraisal Records, Organisational Development Plan, CCG Audit Programme, HR Review						

LIKELIHOOD		CONSEQUENCE		Please Note: Scores are determined in line with the CCG's Risk Quantification Tool (likelihood x consequence)
1	RARE	1	MINOR	
2	UNLIKELY	2	MODERATE/LOW	
3	POSSIBLE	3	SERIOUS	
4	LIKELY	4	MAJOR	
5	ALMOST CERTAIN	5	FATAL/CATASTROPHIC	

*Note Scoring is based upon likelihood of not satisfying the rationale within this financial year.

NHS
Wolverhampton
Clinical Commissioning Group

Risk Management Strategy

DOCUMENT STATUS:	**To be Approved /Approved**
DATE ISSUED:	**Draft Consultation February 2016**
DATE TO BE REVIEWED:	**June 2018**

AMENDMENT HISTORY

VERSION	DATE	AMENDMENT HISTORY
1.0	**June 2012**	
2.0	**December 2013**	
3.0	**February 2016**	
3.1	**June 2016**	**In response to new guidance**

REVIEWERS

This document has been reviewed by:

NAME	TITLE/RESPONSIBILITY	DATE	VERSION
Sarah Southall	Head of Quality and Risk/Author	February 2016	3 FD
Dawn Bowden	Quality Assurance Co-ordinator	June 2016	3.1

APPROVALS

This document has been approved by:

GROUP/COMMITTEE	DATE	VERSION
Quality & Safety Committee	July	3.1 final

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These documents will provide additional information:

REF NUMBER	DOCUMENT REFERENCE NUMBER	TITLE	VERSION

RISK MANAGEMENT POLICY

STATEMENT OF INTENT

The overall aim of Wolverhampton Clinical Commissioning Group (CCG) is to be a first class commissioner of healthcare services putting customers and patient/service users at the centre of what they do. As part of this aim, it is vital that the services we commission are safe, effective and deliver positive experiences for patients

Integral to achieving this aim is the development and implementation of a robust and integrated system of managing all risks that could potentially impact on the CCG when it commissions services.

Wolverhampton CCG seeks to maintain a comprehensive system of internal controls that enables proactive identification and management of risks of a commissioning, operational, corporate and financial nature including fraud, whilst avoiding any loss of flexibility and innovation in service provision.

The management of risk is therefore a key organisational responsibility which all management and staff must accept as one of their fundamental duties, and every member of staff must have a real sense of ownership and commitment to identifying and minimising risks.

The Board endorses the **Risk Management Strategy**, which is a proactive approach to:

- **Identifying** the risks that exist
- **Analysing** those risks for potential frequency and severity
- **Eliminating** the risks that reasonably and practicably can be eliminated
- **Reducing** the effect of those risks that cannot be eliminated
- **Putting in place** mechanisms to absorb the financial consequences of those residual risks that remain.

The responsible committee – Quality & Safety Committee – will maintain close liaison with the Audit & Governance Committee to ensure risk management is actively reported and continuous improvement and learning associated with risk management is being actively managed & reviewed.

Signed

_____

Chief Officer
Date: June 2016

1.0 INTRODUCTION

Risk is inherent in everything that we do, from determining service priorities, taking decisions about future strategies, or even deciding not to take any action at all. Good risk management awareness and practice at all levels is a critical success factor for Wolverhampton CCG.

Commissioning a healthcare service is in itself a fundamentally risky activity, so it can be said that we already manage some risks on a continual basis, e.g. making assessments of health economy need, ensuring that we work in relatively risk free environment etc. We will approach management of risk in a structured, systematic and consistent manner.

Wolverhampton CCG, recognizes that some risk is unavoidable and therefore control measures may need careful consideration and implementation to mitigate the risk(s) identified. It will have a risk management policy approved by the Quality and Safety Committee that describes its risk management philosophy and assigns the relevant responsibilities.

This Risk Management Strategy aims to provide Wolverhampton CCG with a framework for the development of a robust risk management strategy and related processes throughout the organization.

The strategic direction is focused on improvements in the local health system through the Quality Innovation, Productivity Prevention (QIPP) Programme with enhanced relationships with local authorities, patients and public groups, and the Health and Wellbeing Board. This strategic direction will:-

- foster an environment that promotes health and wellbeing and tackles inequalities
- ensure that everyone in Wolverhampton can access integrated services which are flexible and responsive to their needs
- commission services which deliver high quality, efficient and cost effective care but above all are safe.

QIPP will be heavily embedded within the CCGs undertaking and will be used as the vehicle to save money yet drive up standards to achieve higher quality services.

Furthermore, the CCG's operating plan is underpinned by care quality as a golden thread and through applying a risk based approach the CCG will strive for continuous improvement in care quality and efficiency.

2.0 Purpose & Scope

This strategy describes the procedures Wolverhampton CCG will use to minimise risk through a comprehensive system of internal control to commission the delivery of high standards of care and covers all patients, service users, staff, stakeholders and those working on or visiting CCG premises, but also covers clinical, organisational and financial risk at strategic and operational levels.

The key objectives of the approach are:-

- To identify, control and eliminate or reduce to an acceptable level all risks which may adversely affect;

- the quality of services commissioned by Wolverhampton CCG the health, safety and welfare of patients, service users, staff and visitors
- the ability of Wolverhampton CCG to provide services
- the ability of Wolverhampton CCG to meet its commitments to partner agencies and the public
- to actively manage it's organisational responsibilities including those afforded to their workforce and nominated representatives.

3.0 Roles & Responsibilities

The Governing Body

The Governing Body has a duty to assure itself that Wolverhampton CCG has properly identified the risks it faces, and that it has processes in place to mitigate those risk(s) and the impact they have on the organisation and its stakeholders.

Therefore, the Governing Body will seek to ensure that the following are achieved:

- Know the most significant risks facing the organisation
- Ensure appropriate levels of risk awareness throughout the organisation
- Know how the organisation will manage a crisis
- Understand the importance of external confidence in the organisation and how this affects risk
- Be assured that the risk management process is working in the organisation
- Have a clear risk management strategy that describes the risk management philosophy and responsibilities of the wider CCG

Senior Responsible Officer

The Senior Responsible Officer has overall accountability for the management of risk and the duties regarding quality of service. They will establish and maintain an effective strategy for risk management by:-

- Continually promoting risk management and demonstrating personal involvement and support
- Ensuring an appropriate committee structure is in place, with regular reports to the Board
- Ensuring that Executive Directors are appointed with managerial responsibility for progressing risk management

Directors

Directors are responsible for directing the implementation of the Risk Management Strategy and associated governance arrangements with staff & stakeholders pertinent to their area of responsibility by:-

- Identifying and carrying out risk profiling and assessment of risk across the functions for which they are accountable
- Treatment of risk(s) including identification, recording & reporting to demonstrate that all reasonable mitigating actions have been identified & put in place to effectively manage the risk
- Continually demonstrating personal involvement and support for the promotion of risk management & reporting on risks associated with their area of control via the central risk management system (Datix)
- Ensuring that managers and heads of department accountable to them understand and pursue risk management in their areas of responsibility

- Setting objectives for risk management and monitoring achievement
- Ensuring that staff employed are of an appropriate professional standing and adequately trained for the tasks they are required to undertake
- Ensuring the development and implementation of effective integrated governance which will promote safety, address risk and create an environment which pursues excellence

These reflect key operational, and day-to-day, responsibilities delegated to them.
Directors must ensure that the implementation of the policy is fully addressed within their respective areas, and that all their staff members are made aware of its overall content and implications

Chief Financial Officer is accountable for progressing financial risk management and for ensuring that effective risk management is in place.

Associate Director of Operations
At strategic level the Associate Director of Operations will be a firm advocate of the strategy and risk management processes, ensuring effective corporate governance practices duly reflect the principles therein. Operations will be a key enabler for full implementation of the strategy's governance arrangements and documentation.

When determining the effectiveness of corporate governance practices, risk management will be recognised as integral to the CCG so that risks are identified on a pro-active and re-active basis. In addition, the strategy will be fully implemented within all Operations portfolio's and is integral to the scrutiny of stakeholder activity that is encountered where risks may have an impact on the CCG.

Executive Lead Nurse (Quality) is responsible for all aspects of clinical quality for commissioned providers and is accountable for the risk management process across the CCG, regularly reviewing the effectiveness of strategy.

Head of Quality & Risk reporting to the Executive Lead Nurse, is the lead for risk management within the CCG ensuring that the day to day co-ordination of risk management is undertaken & duly reported to all responsible forums. They will take all reasonable steps to ensure recommendations for improving & responding to risk management information is effectively communicated.

Heads of Service are expected to be continually aware of risk management issues and will ensure the risk management system is used as an intrinsic component of their day to day work.

All Staff requires the full support of all staff in the assurance and risk management processes. It is the responsibility of all Wolverhampton CCG employees to:-

- Take account of and be actively aware of the potential for things to go wrong
- Report areas of concern including clinical, non-clinical and financial issues (including fraud) to line managers
- Recognise and report incidents, accidents & near misses in accordance with the incident reporting and investigation policy
- Participate in risk assessment processes as necessary

- Provide safe standards of clinical practice through compliance with the regulations of the appropriate professional bodies
- Be aware of emergency procedures e.g. resuscitation, evacuation and fire precaution procedures etc. relating to their particular location
- Be aware that they have a statutory duty to take reasonable care for their own safety and the safety of all others that may be affected by their actions or inaction
- Be familiar and comply with all Wolverhampton CCG policies, procedures and instructions to protect the health, safety and welfare of anyone affected by services
- Be aware of Wolverhampton CCG Risk Management Strategy and Policy and their responsibilities
- Attend risk management training as required by the CCG
- Be aware of the Information Governance Policy

Program Delivery Boards will ensure that there are risks recorded for each project within their respective portfolio. The responsible Program Delivery Board will routinely consider the register of risks to ensure their portfolio has been duty assessed and a true representation of the risks and corresponding controls they have recognised.

Further guidance can be found in the Risk & Safety Management System.

4.0 Definitions & Terms Used

The Senior Responsible Officer has overall responsibility for ensuring robust systems in place to reduce risk to a minimal level. The risk management policy outlines processes and protocols staff are expected to follow to achieve effective risk management.

The following terms are used in this document:

Hazard	Hazards are the actual 'physical' situations that can cause the harm.
Risk	Risk is the chance that an event will occur and will impact upon the Trust's objectives. It is measured in terms of likelihood (frequencies probability of the risk occurring) and severity (consequence of effect of the risk occurring).
Risk Assessment	Risk Assessment is the process used to determine risk management priorities by evaluating and comparing the level of risk against predetermined acceptable levels of risk.
Risk Management	Risk Management is the systematic application of management policies, procedures and practices to the tasks of identifying, analysing, assessing, treating and monitoring risk
Control	The resources, systems, processes, culture, structure and tasks that support staff in the achievement of organisational objectives. Effective control provides a reasonable assurance that the organisation will achieve its objectives reliably, and enables it to respond to significant operational, financial and compliance risks
Clinical Risk	Clinical risk can be defined as direct risks relating to the care of the patient and the standards of care received on the patients' journey through the organisation. Issues that can have an impact on the standard of clinical care received include patient discharge arrangements, patient research studies, infection prevention & control, medicines management, clinical audit, ensuring that there are sufficient staffing levels and that these staff are appropriately trained
Organisational Risk	Organisational risk can be defined as risks relating to communication, provision of goods and services, data protection, information systems, human resources, and risks that threaten the achievement of the organisations objectives
Financial Risk	Financial risk can be defined as risks that will threaten the effective financial controls, including the systems to maintain proper accounting records and success of QIPP projects. It is important that the organisation is not exposed to avoidable financial risk and that financial information used within Wolverhampton CCG and for external publication is reliable
Information Risk	Information risks can be defined as risks that affect personal identifiable information. Information risk management seeks to identify and control information risks in relation to business processes and functions and is led by the Senior Information Risk Owner (SIRO).
Strategic Risk	Defined as risks which affect the achievement of the organisation's strategic objectives
Operational Risk	Is defined as risks which affect the achievement of local objectives
Environmental Risk	Is defined as risks associated with organisational actions which may have an impact upon the environment
Reputational Risk	Is defined as risks which affect public and stakeholder perception of the organisation

5.0 Delivery of the Risk Management Strategy

5.1 Through adopting a sensible approach to risk management practices steps can be taken to protect people from harm and suffering. The principles of risk management are:

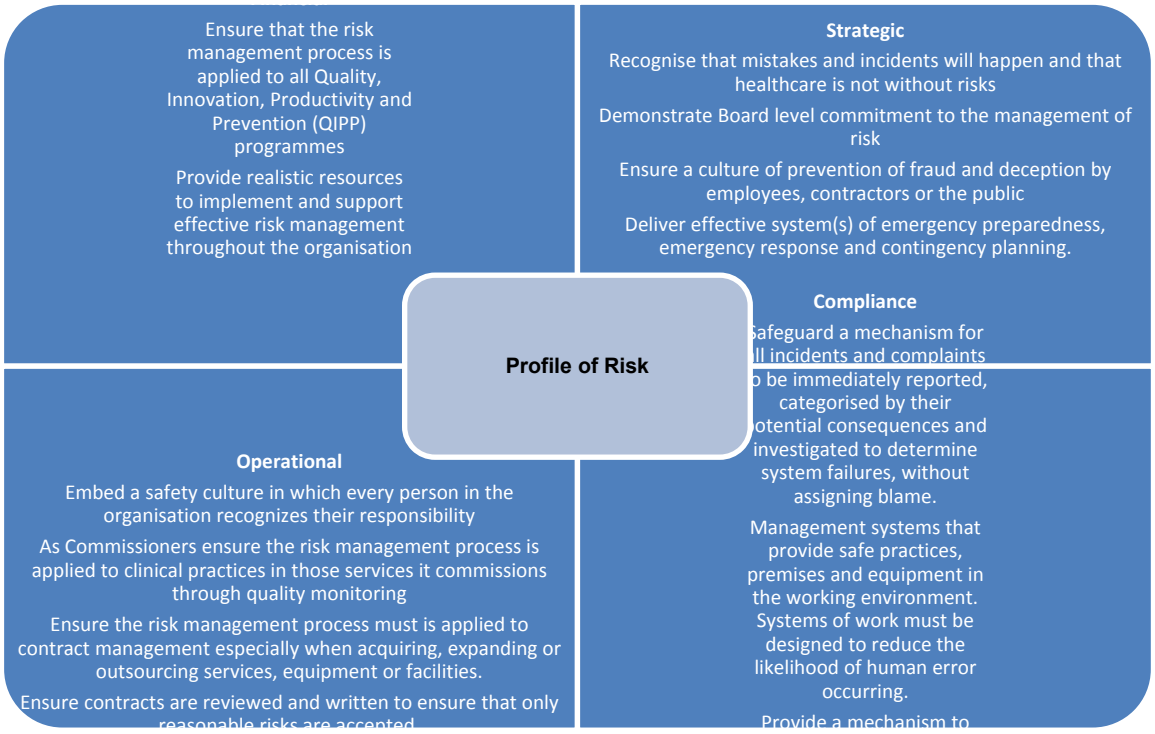
- ensure workers and the public are properly protected
- enable innovation and learning
- ensure that those who detect risks manage them responsibly
- provide overall benefit by balancing benefits and risks, with a focus on reducing significant risks
- enable individuals to understand that as well as the right protection, they also have to exercise responsibility

In healthcare clinical risk management enables us to recognise the events that may result in unfortunate or damaging consequences in the future, their severity and how they can be controlled. The definition of risk management has been defined as, the identification, analysis and economic control of those risks. Which can threaten the assets or earning capacity of an enterprise 9Dickson, G 1195).

The philosophy of risk management in the CCG is to actively identify risk(s), analyse them and ensure that all reasonable control measures have been considered, identified an applied to mitigate the risk.

5.2 Risk Assessment

In order to control the risks the CCG encounters, all teams are required to ensure they have undertaken risk profiling to determine the profile of risks within their portfolio.



These principles apply to all areas of Wolverhampton CCG.

A risk profiling template can be found within the appendices of this policy. When completed the responsible person should ensure a suitable and sufficient assessment of risk has been undertaken in line with Health and Safety Executive Guidance (5 Steps to Risk Assessment) http://www.hse.gov.uk/pubns/indg163.pdf

A risk assessment comprises of 5 steps:

- Identify the hazards
- Who might be harmed
- Evaluate the risks
- Record your significant findings
- Regularly review your risk assessment

Organisations with fewer than 5 employees do not have to write anything down but it is useful to do this so that you can review it at a later date.

The CCG Datix System is used to capture all 5 Steps to risk assessment and is reliant upon regular reviews being undertaken usually the following circumstances will apply:

- Have there been any significant changes?
- Are there improvements you still need to make?
- Have you learnt something new or has the situation changed?

In any event risk amendments should be reviewed in line with the following frequencies:

- Red Risk < 3 months
- Amber Risks 3-6 months
- Green Risks 6-12 months

5.3 Organisational Risk Management Structure & Governance Arrangements

Wolverhampton CCG has put in place a comprehensive structure of controls to co-ordinate and manage risk within the organisation. This consists of rigid lines of accountability through which issues of risk can be debated and the effectiveness of Wolverhampton CCG risk management arrangements assured.

Figure 1 below shows how the various elements of this structure and how they interrelate to ensure that the Board is kept fully informed and assured of the risk management processes.

The main committees and a summary of their remit are as follows:-

Quality & Safety Committee responsible for leading the risk management process, taking a strategic view of governance, to give directions to the other CCG committees and groups regarding management of risk and to receive assurance from these Groups where NHS Standards are being achieved/not achieved. Its remit includes Business Continuity, Financial Governance (including governance of the QIPP program, Quality and Clinical governance, Risk management (including health & safety), Security management and information governance.

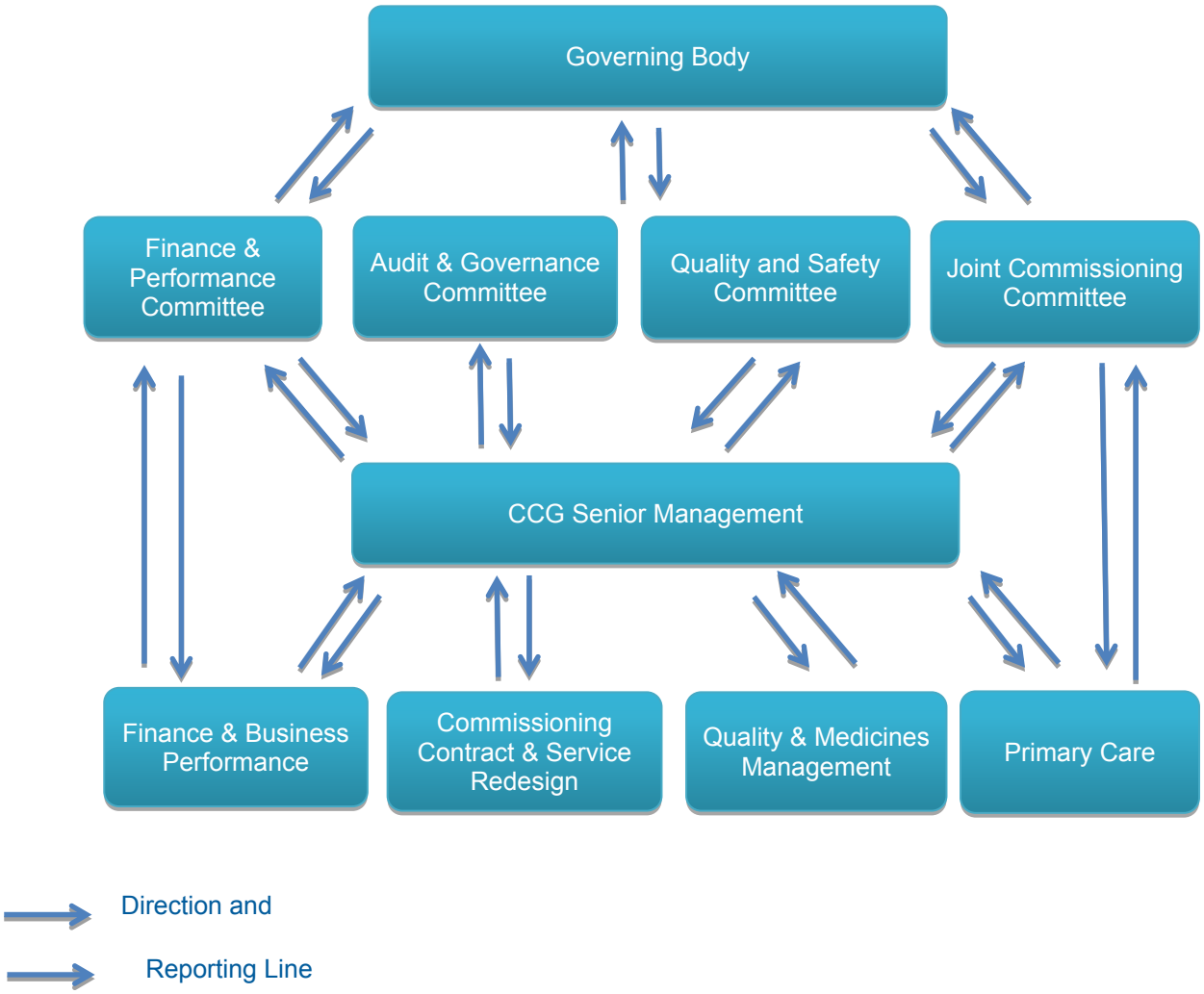
It keeps under active review the content of the corporate risk register, addressing corporate issues, and provides assurances to the Board that directorates and departments within the CCG are managing their risks effectively.

This Quality & Safety Committee is accountable to the CCG Governing Body and will give monthly integrated assurance reports to this forum.

Audit and Governance Committee fulfills the role of scrutiny and verification of the entire process of governance in accordance with the requirements of standing financial guidance and the requirements of the annual Statement on Internal Control.

Figure 1

Organisational Monitoring and Reporting Structure

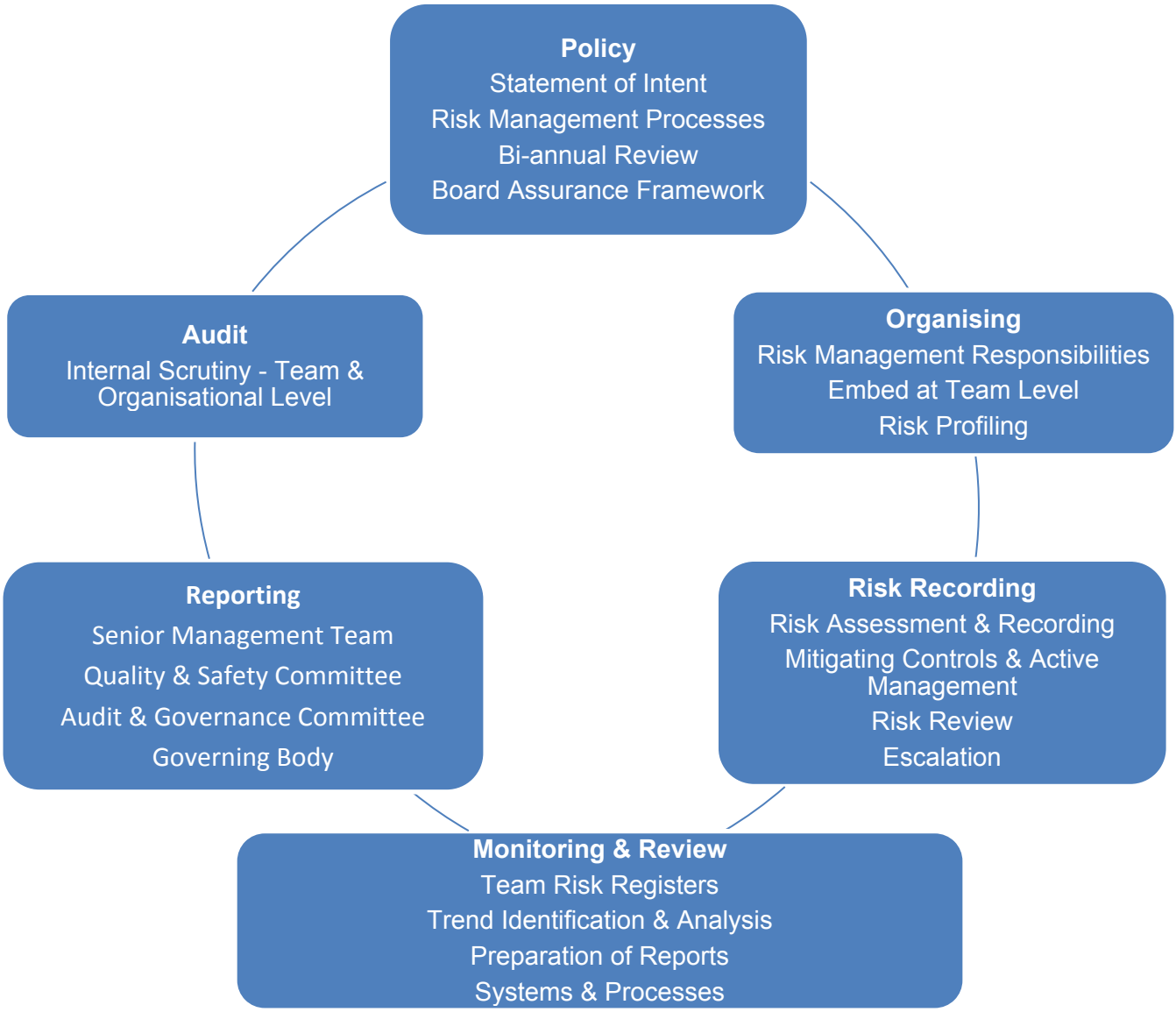


Integrated Governance - Integrated governance provides the umbrella for all NHS governance approaches, it is a co-coordinating principle. It does not seek to replace or supersede clinical, financial or any other governance domain. It highlights their vital importance and their inter-dependence and interconnectivity hence the relationship between both the Quality & Safety Committee & Audit & Governance Committee, in addition to onward reporting to the CCG Governing Body.

Wolverhampton CCG uses an integrated governance approach to examine the risks to its strategic and operational objectives, using the same methodology no matter the nature and context of the risk. This approach enables Wolverhampton CCG to manage risk in an identical way across services and provides a uniform method of assurance for the Board via the Audit & Governance Committee.

Figure 2

Risk Management Framework



Policy – The policy is owned by the Quality & Risk Team and is overseen by the Head of Quality & Risk. The systems & processes contained within it are actively managed on a day to day basis via the Quality & Risk Team.

Organising - The CCG cannot manage its risks effectively unless it knows what the risks are. All directors & heads of service are responsible for ensuring their teams are briefed on the policy and that the processes contained within it are actively implemented and embedded. Therefore, all teams will hold a risk profile and ensure this is accurately recorded on the risk register to encompass ALL risks the service faces. Key personnel from within teams may be tasked with maintaining such records in support of their team.

Risk Recording – All risks whether controlled or not should be recorded on the Datix Risk Management System. Using the five steps to risk assessment found in appendix 2 all risk handlers will adopt these principles to record risks and arrange for approval by the responsible manager. Risk assessment is a continuous process and will therefore require all assessments to be regularly reviewed. The CCG recognises that it is impossible to eliminate all risks, but that a robust risk assessment process is essential. Where risks are increasing or not progressing satisfactorily they should be escalated initially to the responsible Head of Service, Director followed by discussion at Senior Management Team.

Managers and heads of service are responsible for profiling risks within their areas of responsibility. The risk profiling will cover a breadth of types of risks including employer risks i.e. health and safety and statutory risks and Commissioning risks i.e. achievement of QIPP projects.

Risks will be identified, assessed and analysed and added to the risk register. Managers are responsible for ensuring that risk assessments are carried out within their respective areas and that a rolling program of risk assessments is determined.

The risk identification and assessment will be undertaken by multidisciplinary teams comprised of suitably competent persons who have detailed working knowledge of the working processes, procedures and systems. In the process of carrying out risk assessments, staff will identify hazards and areas of risk in their workplace or in aspects of their work duties. The results of risk assessments should be reported and communicated to the managers responsible.

Monitoring & Review – All teams will have access to the Datix System, depending upon the level of access will determine the types of report team members have access to. Risk registers can be generated at manager & team level. The Quality & Risk Team introduce such reports to teams for their ongoing monitoring and review at team level.
The Quality & Risk Team will routinely review all entries on the system to ensure timely review, scoring, assurance & identify trends for consideration by teams and where necessary shared routinely at Senior Management Team. The Risk Management Process is defined in figure 3 below.

In situations where significant risks have been identified and where local control measures are considered to be potentially inadequate, will need to be brought to the attention of the Quality and Safety Committee, if local resolution has not been satisfactorily achieved.

Managers should treat risks locally if the risk has scores in low (green) or medium (amber) categories. This will include reviewing and analysing formal assessment reports, establishing risk treatment plans and ensuring the appropriate information is entered onto the Risk Register. Risks identified as extreme (red) will be brought to the immediate attention of the Responsible Officer(s) for their approval/authorisation.

Reporting – A range of groups will receive reports within the CCG, at strategic level the responsible committees and Senior Management Team will receive regular reports for consideration and approval. Following approval assurance reports are prepared at quarterly intervals for the Governing Body.

Confidential Risks – There will be occasions when information is deemed confidential and when risks should not be evident in public facing reports all risk owners will have the opportunity to confirm if a risk entry is confidential.

Audit – There are two core methods that will be used to scrutinise the risk management system, these are:-

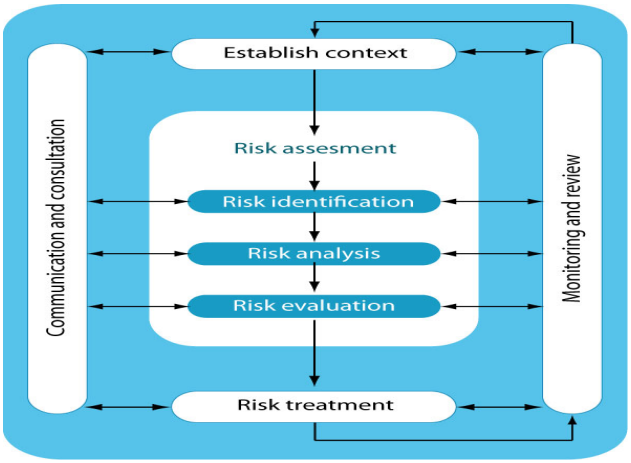
Scorecard/Self-Assessment: Internal scrutiny will be completed by adopting the scorecard system that will determine levels of compliance across the organization. The scorecard will be at six month intervals and used to demonstrate compliance across the organization with risk management processes and standards.

Internal Audit: Internal audit will assess the CCG's assurance framework to ensure that

- It covers all of its key business areas and provides a proper balance of all principal objectives and the risks that threaten their achievement
- It identifies the controls used to manage those risks and the potential sources of assurance about their effectiveness
- The Board will be informed, via the Audit Committee, how well the PCT's internal control arrangements (including governance and risk management) help it to achieve its objectives.

Where weaknesses are identified in the control environment or any systems and procedures, a timetable for remedial action with the relevant managers will be agreed.

Risk management process based on ISO 3100 should be actively applied by all teams and staff within the CCG as follows:-



Statutory Responsibilities
The Health & Safety at Work Act 1974 sets out the legal framework for the management of risks, requiring all risks to be reduced until they are as low as is 'reasonably practicable'.
In practice, this means that Wolverhampton CCG will balance possible risk reduction activities with the cost and difficulty of implementation to determine what level of risk is 'acceptable'. Wolverhampton CCG will regard those risks that have been reduced until they are as low as is reasonably practicable as being 'acceptable risks'. In effect this means that steps have been taken to reduce the severity of the risk and likelihood of it occurring, and that the resources required for further reduction significantly exceed the potential financial, operational and reputational impact.

As a general principle Wolverhampton CCG will seek to eliminate and control all risks which have the potential to:
• harm its staff, service users, visitors and other stakeholders;
• have a high potential for incidents to occur;
• result in loss of public confidence in Wolverhampton CCG and/or its partner agencies;
• have severe financial consequences which would prevent Wolverhampton CCG from carrying out its functions on behalf of its residents.

Wolverhampton CCG recognises that it is impossible, and not always desirable, to eliminate all risks and that systems of controls should not be so rigid that they stifle innovation and imaginative use of limited resources.

All risks that are identified as red that cannot be reduced to an acceptable level will have a supporting contingency plan in place that has been agreed with the responsible director and shared with the Quality and Safety Committee.

As a general principle Wolverhampton CCG has determined the following levels of risk:

Acceptable Risks
Risks in the low (green) category will be considered to be an "Acceptable risk".
Existing controls should be monitored and adjusted. No further action or additional controls are required. Consideration may be given to a more cost-effective solution or improvement that imposes no additional cost burden.
Review 6-12 months intervals.

Unacceptable Risks
Risks in the medium (amber) categories will be considered to be "Unacceptable risks." Efforts should be made to reduce the risk, but the costs of prevention should be carefully measured and weighed against the impact of an event. There is also a need to establish more precisely the likelihood of harm as a basis for determining the need for improved control measures. Such risks may be temporarily "acceptable" if new controls are in the process of being implemented.
Review 3-6 months intervals.

Significant Unacceptable Risks
Risks in the extreme (red) category will be considered to be "Significant risks".
Immediate action must be taken be taken to manage the risk. Control measures should be put into place, which will have the effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required. Significant resources

may have to be allocated to reduce the risk. Where the risk involves work in progress urgent action should be taken.
Review at no longer than 3 month intervals.

5.4 Risk Registers

Managers are responsible for adding risks identified through risk profiling exercises and continual assessment of risk to the organisations risk register. Risks will be recorded and quantified in the CCG's Risk Register, for which the Senior Management Team and Quality and Safety Committee will routinely monitor. The Register will be populated by reference to incidents, complaints and contract non-compliances as well as management assessments of inherent risk. Action plans to address such risks will be clearly defined, as required by the risk management policy, will be endorsed by responsible Director for the risk(s) contained so that the necessary actions can be approved in line with the CCG's Risk Management System.

Datix will be used to record all risks and comprises of all risks identified from the following sources:

- Department Risk Registers / Risk Assessments
- Information Governance Risks/Assessments
- Internal Inspections/Audits
- Complaints
- Queries
- Serious untoward incidents/incident trends
- Staff, stakeholders and patient consultation exercises
- Benchmarking
- Mandatory targets
- National reports/inquiries
- Care Homes (high risk)
- Notices from NHSE i.e. high alert investigations
- Care Quality Commission, Health and Safety Executive, NHSLA, PHSO, WMQRS and risk management assessment reports.

5.5 The risk register template will comprise of the following context:

Board Assurance Framework

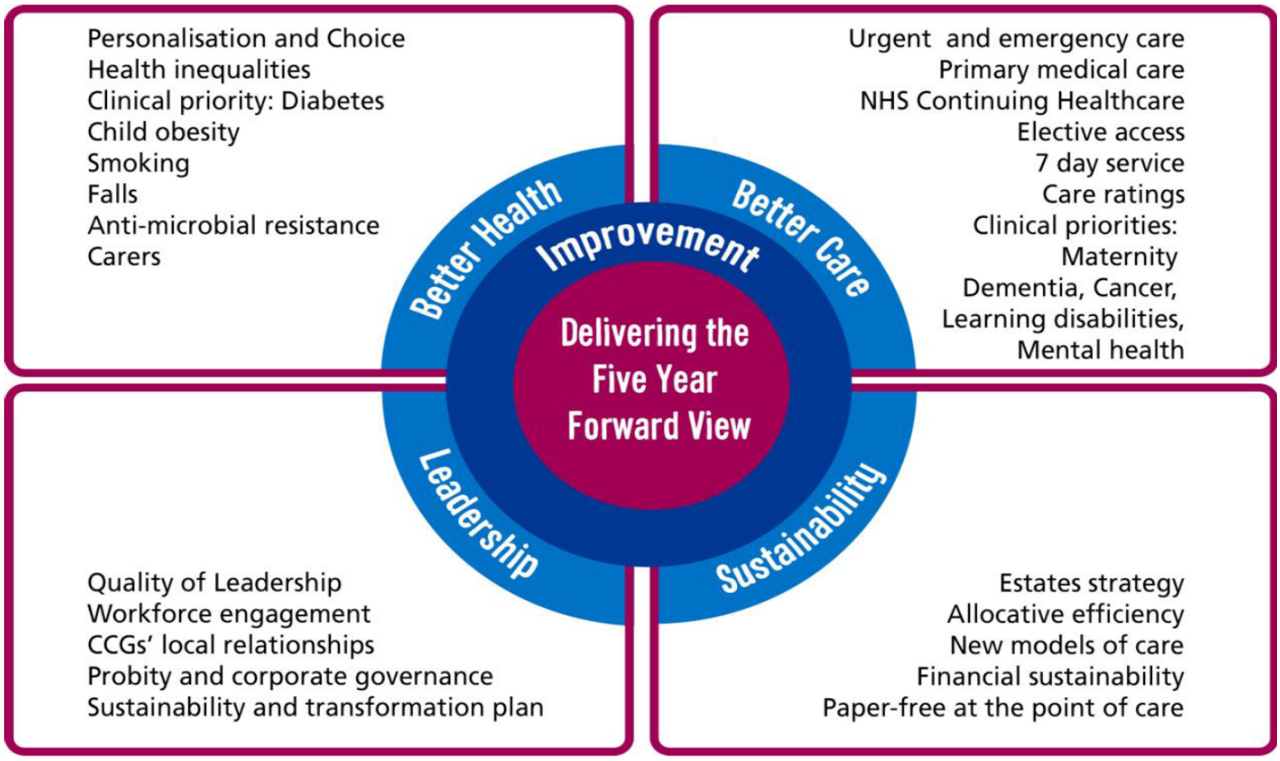
NHS England has introduced a new Improvement and Assessment Framework for CCGs (CCG IAF) from 2016/17 onwards to replace both the existing CCG Assurance Framework and separate CCG performance dashboard. The new framework takes an enhanced and more central place in the overall arrangements for public accountability of the NHS. The CCG IAF brings clarity, simplicity and balance to the conversation between NHS England and CCGs about what matters to both sides. It draws together in one place NHS Constitution and other core performance and finance indicators, outcome goals and transformational changes. In combination, these provide a more accurate account of the real job description of CCGs.

The new framework covers indicators located in four domains:

1) Better Health – this section looks at how the CCG is contributing towards improving the health and wellbeing of its population and bending the demand curve;

2) Better Care - this principally focuses on care redesign, performance of constitutional standards and outcomes, including in important clinical areas;
3) Sustainability – this section looks at how the CCG is remaining in financial balance and is securing good value for patients and the public from the money it spends;
4) Leadership – this domain assesses the quality of the CCG's leadership, the quality of its plans, how the CCG works with its partners and the governance arrangements that the CCG has in place to ensure it acts with probity, for example in managing conflicts of interest.

The diagram below summarises the framework:



The Board Assurance Framework sets out:

- Strategic objectives of the CCG
- Rationale for satisfying the objectives
- Board Lead Director
- Initial Risk Score (based upon likelihood of achievement within the financial year)
- Quarterly Risk Score (reviewed at quarterly intervals)

The individual domains are updated at quarterly intervals and are considered at Quality and Safety for approval

Domain Number	Description	Rationale	Board Lead	Q4 2014/15	Risk Review Status 2015/16			
					Q1	Q2	Q3	Q4
Domain								
	Mitigating Controls Documents : Forums :							
Red Risks Associated with Domain								

Wolverhampton CCG will review their strategic objectives and principal risks on an annual basis in line with national guidance and where deemed appropriate the CCG will identify at local level any further domains they will work towards.

The CCG Governing Body will approve the Board Assurance Framework at the commencement of each financial year and at quarterly intervals thereafter.

6.0 Communication, Monitoring and Review

Communication

Communication and transparency for risk management arrangements is crucial to the effectiveness of the processes defined within the strategy. The strategy will be consulted on among responsible heads of service & directors (Senior Management Team) and shared with stakeholders via distribution at responsible committees, newsletter and by posting on both the Internet and Intranet.

Monitoring & Review

The effectiveness of the implementation of Wolverhampton CCG Risk Management Strategy will be measured using the following indicators as the basis for the regular assurance to the Quality and Safety Committee and Audit and Governance Committee:-

Indicator Description	***What this will tell us***
Meet suggested NHSLA Risk Management and ISO 31000 standards as defined within the strategy.	The CCG does/does not have a suitably embedded risk management framework in line with ISO 3100.
Implement Wolverhampton CCG strategy (ie Risk Management Structure, Framework & Process) as per ISO 3100	The CCG has a robust procedure in place for identification and management of risk that is included in the implementation plan.
Completed risk assessments/datix risk entries are fully completed including the provision of assurance information.	Risks are being recorded correctly & the information in reports is timely & accurate for the audience(s).
Risk Registers utilising Datix software are fully in place including a range of types of risk in each department and at corporate level.	There is evidence of effective management of risk within the CCG.
Applicable staff attend a Team Briefing using the strategy training presentation as a form of information and instruction on Risk Management training.	That heads of department and their staff have been well-informed of their role and responsibility for risk management. Specifically each are/function that are being maintained to the expected standard.
A Board Assurance Framework exists in line with the requirements of the strategy and is approved by the Governing Body at the beginning of each financial year and they received regular updates on performance & advocate action required to address gaps in assurance.	The Board Assurance Framework is in place and endorsed by the Governing Body who are clear on where the gaps in assurance are for the organization & the actions being taken to address them.
Risk register reporting to responsible forums and persons	Risk register is challenged at SMT by a deep dive into specific risks to ensure risk entries are scored and accurately reflect the latest position.

This scorecard will be used as the basis for assurance reporting to the responsible committees who will receive assurance at no longer than quarterly intervals.

7.0 Training

The Strategy comprises if a breadth of responsibilities for all staff and will therefore be reliant on a series of supportive measures lead by the Quality and Risk Team. Staff will need to be fully aware of the requirements of this strategy if it is to be effectively implemented. It is the responsibility of all managers to ensure their staff groups receive appropriate information instructions for training and supervision in risk management.

Implementation training to support this strategy for each aspect of Risk Management will comprise of the following:

Area	Staff Group	Method	Contact	Frequency
Strategy Implementation Training Presentation	GPs All CCG staff and Board Members	Strategy Implementation Presentation slides, Team meetings, staff briefings, presentation on internet.	Head of Service, Quality and Risk Team	Annual
Risk Profiling	Heads of Service Directors and PDB Chairs	1:1 or Group Exercise	Quality Assurance Officer (DB)	Annual
Use of Datix System	Nominated Team Members Heads of Service Directors	Group Demonstration	Quality Assurance Officer (DB)	Annual Refresher (as required)
Risk Assessment		Documented Guidance (via intranet)		
Risk Registers		1:1/Group Demonstration for Heads of Service/Directors		
Board Assurance Framework	Senior Management Team Quality & Safety Committee Audit & Governance Committee Board Members	Report or Presentation	Head of Quality & Risk	Annual

The above program of training will be overseen by the Quality & Risk Team commencing March 2016 onwards and will feature in reports on risk management to the Quality and Safety Committee and Governing Body.

8.0 Linked Policies & Procedures

Information Governance Policy
Finance Strategy
Serious Incident Reporting Policy
NICE Assurance Policy
Health and Safety Management Plan
Operating Plan 2015-2017
Commissioning Strategy

Appendix 1

Quick Guide to Risk Management

Step by Step Guide to Risk Management	The following section provides a step-by-step approach to be used to manage risk across any organisation and is used when carrying out tasks such as risk assessment and the setting up of corporate and department/program risk registers. The process can also be used for projects, independent contractors and where relevant for specific projects or service developments. Risk management does not occur in a vacuum but within the context of the organisation itself taking into account its financial resources, corporate objectives and strategic aims, legal requirements, nature of its business and the needs of the population that it serves.	
Step 1: Defining the Context	Risk management should be a continuous process that supports the development and implementation of the strategy of an organisation. Defining the context is on-going rather than one off process at both organisational and operational levels. It should methodically address all the risks associated with all of the activities of the organisation. Examples of key documents that can help define context within the CCG as a whole include: • Business Plan • Heath improvement and modernisation plan • Organisational Strategy documents There must be good communication and consultation with staff, service users, the public and other stakeholders in order to ensure that the context within which you are assessing the risk is up to date, relevant and accurate. Establishing the context also means defining the goals, objectives, strategies, scope and parameters of the activity or part of the organisation to which the risk management process is being applied. This can include: • Defining the project or activity and establishing its goals and objectives. • Defining timescales and responsibilities. • Identifying any further information needed. Establishing and defining the context is a vital stage in the risk management process whether you are looking at strategic or operational risk. By narrowing the parameters of the context you can divide the management of the risk into more easily manageable pieces which can enable more focus on relevant risks.	*Examples of establishing a context for risk management might be looking at risk in a specific project such as QIPP projects, refurbishment of a building, along a care pathway, during a specific intervention or within a specific area, site or environment*
Step 2: Hazard Identification	Hazard identification establishes the exposure of the organisation to risk and uncertainty. Comprehensive identification using a well-structured systematic approach is critical, because a potential risk not identified at this stage is excluded from further analysis. All risks relevant to the context, whether under control of the organisation or not, should be included at this stage. The aim is to generate a comprehensive list of events that might happen during/within the process/activity/project/ environment etc under review should be captured during risk profiling. This needs to be an inclusive process. Sources might include brainstorming, checklists, incidents and complaints, claims, audit data, external inquiry reports, morbidity mortality data, trend analysis, care pathway analysis, experience – here or elsewhere. The key questions are: • What could happen and at what point? • How could it happen and why? Risks identified need to be captured during risk profiling then documented on the Risk Register.	*An example of identifying risks might be considering the sort of harm that could happen to a frail patient during rehabilitation to mobilise. This would include the patient breaking a bone due to an inadequate assessment of their mobility or inappropriate handling by health professional. The health professional might sustain a back injury due to poor manual handling. Equipment used might be faulty or worn causing injury to either. Risks to a corporate project such as the delivery of a new service might include, financial loss, loss of service etc*

Step 3: Risk Analysis	Identify the controls (currently in place) that deal with the identified hazards and assess their effectiveness. Based on this assessment, analyse the risks in terms of likelihood and consequence. Refer to the Risk Matrix to assist you in determining the level of likelihood and consequence, and the current risk level (a combination of likelihood and consequence). The objectives of risk analysis are to separate the minor more acceptable risks from the major risks and to provide data to assist in the evaluation and treatment of risks. The first stage is to determine existing controls for each of the hazards identified – existing management, safe systems of work, procedures etc to control the risk. The next step is to look at the severity of the risk materialising and the likelihood of it happening given controls that may already be in place. There are a variety of ways of analysing consequences and likelihood. Wolverhampton CCG has adopted a quantitative analysis. **Likelihood** The likelihood level should be assessed using the quantification matrix and be documented on the risk assessment and risk register. See matrix **Consequence** The severity level should be assessed using the quantification matrix and be documented on the risk assessment and risk register. See matrix **Controllability** The ability of the CCG to control the risks identified should be ascertained using the controllability matrix on the quantification matrix, this should also be documented on the risk assessment and register. Once the likelihood and consequence have been ascertained, the combined risk rating can be found by multiplying the corresponding numbers to achieve a risk score/rating. Once the risk rating has been ascertained, action can then be taken to eliminate the risk, or reduce it to an acceptable level. The above colour ratings signify the level of risk and therefore the level of attention that is required to manage them, which are as follows: • Green – Low Risk: These are risks that can be managed by routine procedures usually by line managers, review the risk at 6-12 month intervals. • Amber – Medium Risk: These are risks that require the attention of line management at a bare minimum and/or senior management as deemed appropriate in order to be eliminated or reduced to an acceptable level as soon as is reasonably practicable, review at 3-6 month intervals. • Significant Amber – High Risk: These risks require the attention of line management and the appropriate Senior Manager as soon as is reasonably practicable. • Red – Extreme Risk: These are risks that require **immediate** attention and responsibility from senior management up to Director Level in order to quickly and effectively eliminate, reduce or manage them. Any risk graded at this level **must** be flagged immediately for the attention of the appropriate Director (who will inform the Senior Responsible Officer) and approved by them. Reviewers of red risks must be at no more than 3 month intervals and approved by the relevant Director.	*Risks can be analysed and quantified in this way from both a pro-active and reactive perspective. Pro-Actively, this process can be carried out as part of the Risk Assessments process. Reactively, any incident that occurs must be rated in this way and the risks managed. In both cases this process would take into consideration both the severity and likelihood of risks that have been identified. For example, a member of staff performs a risk assessment exercise on their work environment and identifies one hazard as sharps injuries. Analysing the risk of this occurring would involve considering many factors; what is the number of task involving needles, competence of staff, equipment, time constraints etc. Looking at the severity/likelihood charts, they would make judgment call possibly along the lines of:* *• Severity of a frail patient falling during mobilizing on a hard floor is:* ***Moderate (3)*** *• The likelihood of this occurring, using correct mobility aids, under supervision of competent staff:* ***Possible (2)*** *• The overall risk rating would therefore be* ***6 (likelihood x severity),*** *falling into the green low risk level. This risk would require the attention of the line manager in order to monitor practice and ensure that any additional controls are implemented.*

Step 4: Risk Prioritisation	Risk prioritisation involves agreeing the order in which risks need to be addressed. The starting point for this will be the rating itself and in the main the priorities will reflect high and moderate risks. However, some minor risks may be easy to address and tackled for that reason sooner rather than later. Some high risks may be part of the nature of care given itself and therefore difficult, impractical and even inappropriate to reduce. Reducing a risk may have an adverse impact on another aspect of PCT business or prevent the taking up of an important opportunity. The risk prioritisation must take the broader context of the service and PCT into account. Local and corporate objectives as well as the extent of the opportunity, which could result from taking the risk, should be considered here. Where the priority is agreed is different to the numerical rating given, the rationale for the prioritisation must be documented. As this is in part a subjective process the need for good communication, consultation and transparency is crucial. The end result is a prioritised list of risks for further action.	*An example of risk evaluation would be where a service completed its identification and analysis of risks and found that patient falls and the risk of hospital acquired infection were the two highest rated risks they faced – both being amber risks. As such the service agreed to deal with these two issues as their highest priorities*
Step 5: Risk Treatment	Risk treatment involves identifying the range of options for dealing with the risk. The options include: **Prevention** Terminate the risk by doing things differently and thus removing the risk, where it is feasible to do so. Often this is not an option in the provision of health care. In any event avoiding activity likely to generate risk is often the result of an inappropriate understanding and attitude to risk management. Risk aversion can lead to missed opportunities and increase in other risk areas by failure to engage with appropriate decision making around risk management. **Reduction -** Treat the risk, take action to control it in some way where the actions either reduce the likelihood of the risk developing or limit the impact/consequence of the risk. **Transference -** This involves another party bearing or sharing the risk – for example service level agreements, jointly managed services etc. Where risks are transferred in whole or in part the organisation acquires a new risk in that the organisation to which the risk has been transferred may not manage the risk or their share in it appropriately. **Acceptance -** After risks have been reduced or transferred there may be residual risks, which are retained. Risks may be tolerated because nothing can be done at a reasonable cost to mitigate it or the likelihood and consequence of the risk are at an acceptable level. **Contingency -** Plans should be put in place to manage the consequence of these risks if they should occur, including identifying means of financing the risk. The various options for treating the risk need to be assessed on the basis of a costs and benefit derived. Options can be taken in combination or separately. In general the cost of managing risks needs to be commensurate with the benefits obtained. However, decisions should take account of the need to carefully consider rare but severe risks, which may warrant risk reduction measures that are not justifiable on strictly economic grounds. Once the options have been considered and the most appropriate way forward identified, a risk action plan needs to be drawn up and implemented.	*For example, the service decided that the most appropriate way of dealing with the risk of harm during mobilising of patients required following action:* *• Mandatory manual handling training and refresher courses for all staff engaged in manual handling.* *• Clinical supervision sessions for staff to look at best practice around assessing patient frailty, mobility assessment and issues around documentation.* *The ward manager took responsibility for organising the training and the lead nurse took responsibility for facilitating the supervision session. It was agreed that a small clinical audit group would undertake a review of records and report back after 6 months to the team meeting.*

Step 6: Monitoring & Review	It is necessary to monitor risks, the effectiveness of risk action plans, strategies and the management system set up to control the implementation. Risk and the effectiveness of control measures need to be monitored to ensure that changing circumstances do not alter risk priorities. Few risks remain static. It is necessary to regularly repeat the risk management cycle.	*After 6 months, the number of falls in the ward had decreased; this led to further review of the risk assessment.*
Step 7: Communication & Consultation	These are important considerations in each step of the risk management process – to both internal and external stakeholders. This ensures that those who are responsible for implementing risk management and those with a vested interest understand the basis upon which decisions are made and why particular actions are required.	*For example a number of issues has been raised regarding suitability of manual handling/mobility equipment. This information was fed into the next team meeting where the risk register was considered. As all staff had had an opportunity to take part in identifying risks and had been able to comment on the risk register at team meetings, there was considerable support for continuing to use the risk register as structured way of looking at risks*

CCG BOARD ASSURANCE FRAMEWORK
Principle Objectives & Risks (BAF)

Appendix 2

Domain Number	Description	Rationale	Board Lead	Risk Review Status 2016/17			
				Q1	Q2	Q3	Q4
Domain 1	**Better Health** Personalisation and choice Health Inequalities Clinical priority – Diabetes Child obesity Smoking Falls Anti-microbial resistance Carers		Manjeet Garcha				
	Mitigating Controls e.g. documents/plans						

Red Risks Associated with Domain 1	

Domain Number	Description	Rationale	Board Lead	Risk Review Status 2016/17			
				Q1	Q2	Q3	Q4
Domain 2	**Better Care** Urgent and Emergency Care Primary Medical Care NHS Continuing Healthcare Elective Access 7 day service Care ratings Clinical priorities Maternity Dementia Cancer Learning Disabilities Mental Health		Steven Marshall				

	Mitigating Controls e.g. documents/plans
Red Risks Assocated with Domain 2	

Domain Number	Description	Rationale	Board Lead	Risk Review Status 2016/17			
				Q1	Q2	Q3	Q4
Domain 3	**Sustainability** Estates Strategy Allocative Efficiency New models of care Financial sustainability Paper free at the point of care		Claire Skidmore				
	Mitigating Controls e.g. documents/plans						

Red Risks Associated with Domain 3	

Domain Number	Description	Rationale	Board Lead	Risk Review Status 2016/17			
				Q1	Q2	Q3	Q4
Domain 4	**Leadership** Quality of Leadership Workforce engagement CCG's local relationships Probity and corporate governance Sustainability and transformational plan		Dr Helen Hibbs				
	Mitigating Controls e.g. documents and plans						

Red Risks Associated with Domain 4	

Appendix B

Policy & Protocol Pro-forma

This Pro-forma should be completed by any CCG staff member to:

- Request the production of a new CCG Approved Document
- Request an update to a CCG Approved Document. ✓

The completed pro-forma must be sent to the COM for review. See Appendix A – Policy Development Process

Name of Person Making the Application	Sarah Southall	Date: 8.2.16
Job Title/Contact Email	Head of Quality & Risk sarah.southall@nhs.net	
Signature of Line Manager Supporting the Application		
For Policy: Name of Proposed Document	Risk Management Strategy	
Area(s) Impacted by the Document E.g.: (HR/Finance/ Governance/ Health & Safety/ IM&T/ etc.)	Risk, governance	
Is this a New Document or an Amendment to an Existing Document?	Revision to existing	
Reason for the Request: (please provide brief details – if the change relates to a change in legislation please indicate if a wholesale review if required)	Periodic review of content as expected by Quality & Safety Comm	
Ex: DoH Guidelines/directives	✓	
NHSCB Guidelines		
Legislative Change		
Local Management issue	✓	
Risk Management	✓	
Audit Recommendation		
Other		
For Protocol: Which Policy does the Protocol Support?		
Is this a CCG wide or local protocol?		
Is this a New Protocol or an Amendment to an Existing Protocol?		
Reason for the Request: (please provide brief details)		

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NHS
Wolverhampton
Clinical Commissioning Group

Risk Management Strategy – Implementation Slides

Head of Quality & Risk

June 2016

What's Changed?

- Refresh undertaken February & June 2016
- Roles & responsibilities updated
- Risk Assessment Review Frequencies
- Risk Management Reporting Structure (Primary Care)
- Confidential Risks
- Acceptable/unacceptable/significant unacceptable risks
- Risk Register
- Board Assurance Framework
- Monitoring & Review
- Training & New Strategy
- Quick Guide to Risk Management

Roles & Responsibilities

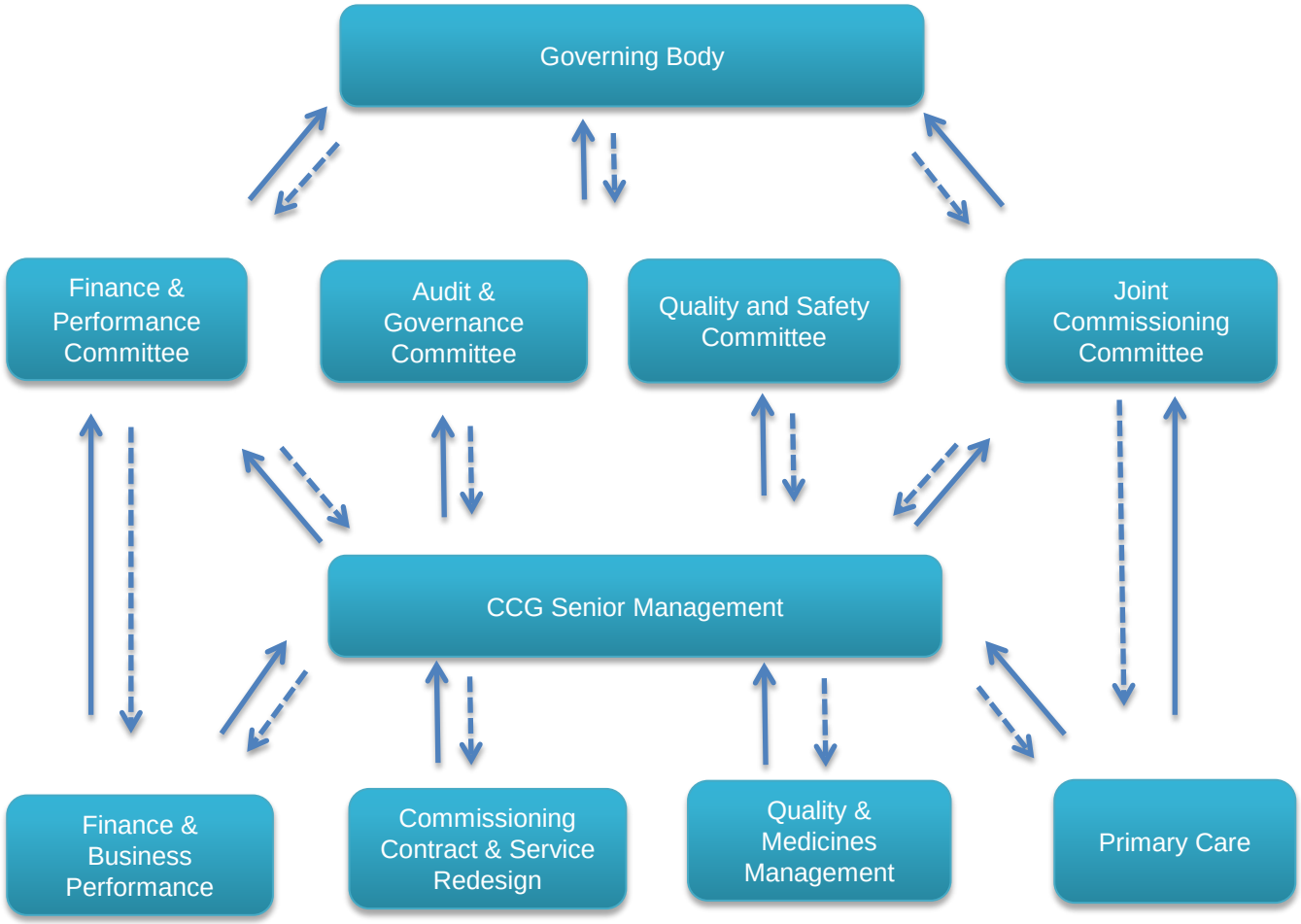
- Now includes reference to Associate Director of Operations
- All staff responsibilities should be noted
- Ownership at departmental level has been a weakness previously
- Use of Datix as a management system

Risk Assessment Review

Frequencies have changed to:-

- Red Risk (Score 15-25) <3 months
- Amber Risk 3-6 months (8-12)
- Green Risk 6-12 months (1-6)

Risk Management Reporting Structure



Confidential Risks

- New section following learning from incident in 2015
- Select in Datix if content is confidential & shouldn't be shared in reports or content is sensitive
- Detail will be excluded from reports to committee's and groups to maintain confidentiality/sensitivity of content

Risk Levels

- Acceptable Risks – Risks in the low (green) category are considered acceptable and require less frequent review.
- Unacceptable Risks – Risks in the medium (amber) category will be considered unacceptable if there are efforts required to reduce the risk further.
- Significant Unacceptable Risks – Risks in the extreme (red) category that require immediate action to manage the risk.

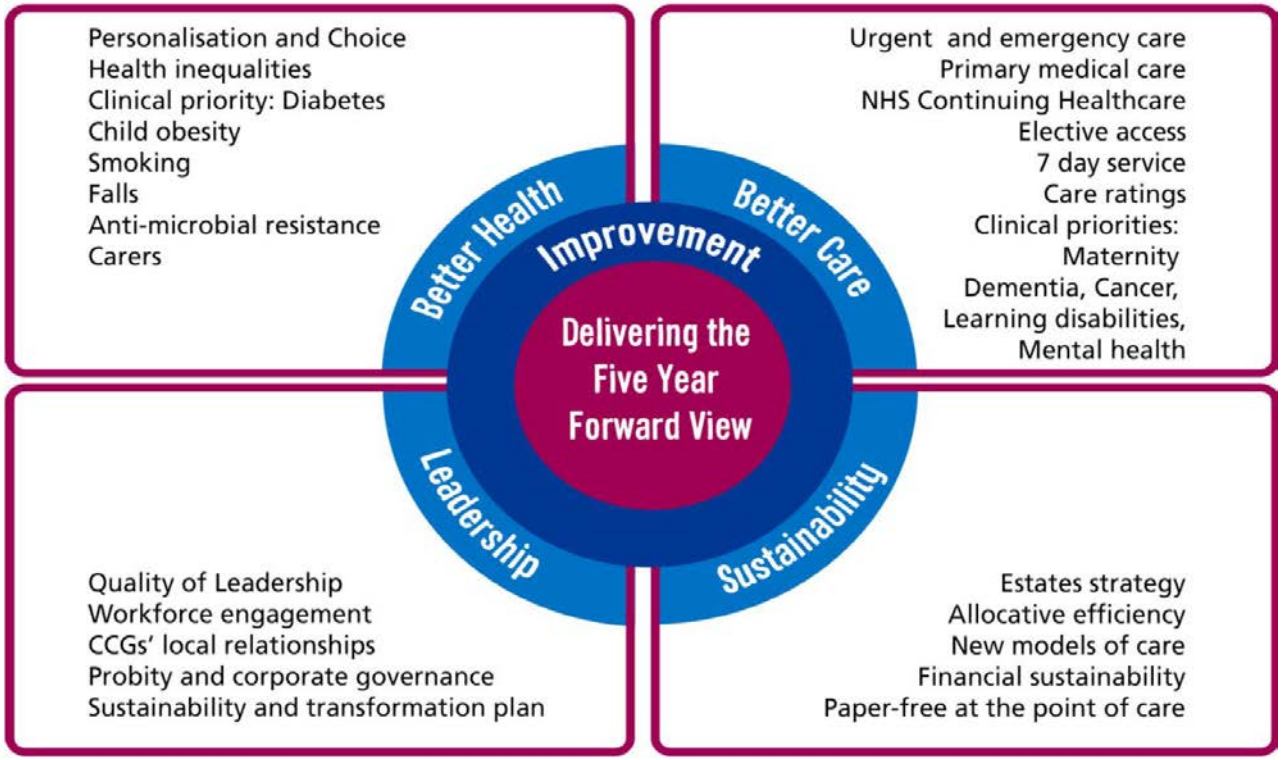
Risk Registers

- Risk Register Template is different
- Implemented April 2016

ID	Title	Opened	Description	Delivery Board	Harm	Risk level (initial)	Rating (initial)	Mitigating	Residual Risk Level	Rating (current)	Risk Review Summary	Acceptable Risk Level	Rating (Target)	Target Score - Achieved Date	B - Gaps	Handler	*Director	Closed date	Confidential Data
345	Children who display sexually harmful behaviour.	04/12/2014	The Commissioner (S Fellows) made aware by colleagues in local authority and RWT that a potential gap exists regarding referral and treatment of children who display sexual harmful behaviour.		Children who have displayed or who are at risk of displaying this behaviour to other children including siblings may not have access to the appropriate levels of specialist clinical intervention and risk management. SFellows looking into this as matter of urgency.	High	16	The Inspire service (bcpft) currently provides this service to children with a learning disability. Gap appears to be around children who have mental health difficulties. SF has asked for necessary details regarding this. These are children that to best of SF's knowledge are in looked after children patients or supported by youth offending team.	High	16	9.12.15 - reviewed by Mai Gibbons/Dawn Bowden on behalf of S. Fellows. Commissioning are in the process of procuring AIMS training for staff employed by BCPFT to enable them to accept referrals for SHB. The YOT have already completed this training and can provide a service for those young people known to the YOT. Until BCPFT have completed AIMs training, this remains a high risk. 27.01.16 Referrals managed on a spot purchase basis. Training being sourced by commissioner for BCPFT staff to be paid for from CAMHS TRANSFORMATION funds. 4.11.15 - Support provided by BCPFT as below. Training to be scoped and procured. Care pathway to be described. Commissioner to be made aware of any actual gaps so that services can be specifically procured. 3.09.15 BCPFT continue to provide support via INSPIRE, individual cases with additional needs addressed via	Moderate	12		Gap appears to be around children who have mental health difficulties.				

Click on Tools to convert PDF documents to Word or Excel.

Board Assurance Framework



BAF Reporting Template now changed

Monitoring & Review

- Quarterly Reporting to:-
  - Quality & Safety Committee
  - Audit & Governance Committee
  - Governing Body (Executive Nurse Report)
- Scorecard of indicators taken from key areas of the strategy to provide assurance that the strategy is being actively applied and it's effectiveness (see handout)

Part 1 : Strategy		
Indicator Description	What this will tell us	Assurance
Meet suggested NHSLA Risk Management and ISO 31000 standards as defined within the strategy.	The CCG does/does not have a suitably embedded risk management framework in line with ISO 3100.	
Implement Wolverhampton CCG strategy (ie Risk Management Structure, Framework & Process) as per ISO 3100	The CCG has a robust procedure in place for identification and management of risk that is included in the implementation plan.	
Completed risk assessments/datix risk entries are fully completed including the provision of assurance information.	Risks are being recorded correctly & the information in reports is timely & accurate for the audience(s).	
Risk Registers utilising Datix software are fully in place including a range of types of risk in each department and at corporate level.	There is evidence of effective management of risk within the CCG.	
Applicable staff attend a Team Briefing using the strategy training presentation as a form of information and instruction on Risk Management Training.	That heads of department and their staff have been well-informed of their role and responsibility for risk management. Specifically each are/function that are being maintained to the expected standard.	
A Board Assurance Framework exists in line with the requirements of the strategy and is approved by the Governing Body at the beginning of each financial year and they received regular updates on performance & advocate action required to address gaps in assurance.	The Board Assurance Framework is in place and endorsed by the Governing Body who are clear on where the gaps in assurance are for the organization & the actions being taken to address them.	
Risk register reporting to responsible forums and persons	Risk register is challenged at SMT by a deep dive into specific risks to ensure risk entries are scored and accurately reflect the latest position.	

Part 2 : Training & Monitoring

Requirement	Assurance	Action Required for Improvement
Strategy Implementation Training Presentation • GPs • All CCG Staff • Board Members	Groups/forums receiving this information include…….. Induction of new staff……	
Risk Profiling • Heads of Service, Directors & PDB Chairs	Risk profiles have been reviewed for …….this has attended by …….and identified……..	
Use of Datix System • Nominated Team Members • Heads of Service • Directors	Our monthly review of Datix has identified use by …… and the following issues…….	
Risk Assessment • New Risks • Suitability of Updates/Reviews	There have been ….. new risks captured on the register as follows:- • ….. • ….. Risk reviews are/are not taking place etc etc include numbers and issues	
Risk Registers • Produced & Utilised by which forums • Numbers of Red/Amber/Green Risks • Overdue Risks • Escalations to Heads of Service/Director(s)	The following forums routinely receive Risk Register Reports and are included on their meeting agendas (please list) There are … red etc etc on the register There are ….. overdue risks Teams have been reminded, escalations during this period have been to…… due to ……	
Board Assurance Framework • Senior Management Team • Quality & Safety Committee • Board Members	Reporting Challenge Guidance/Changes to Content Audit	

Training

Area	Staff Group	Method	Contact	Frequency
Strategy Implementation Training Presentation	GPs All CCG staff and Board Members	Strategy Implementation Presentation slides, Team meetings, staff briefings, presentation on internet.	Head of Service, Quality and Risk Team	Annual
Risk Profiling	Heads of Service Directors and PDB Chairs	1:1 or Group Exercise	Quality Assurance Officer (DB)	Annual
Use of Datix System	Nominated Team Members Heads of Service Directors	Group Demonstration	Quality Assurance Officer (DB)	Annual Refresher (as required)
Risk Assessment		Documented Guidance (via intranet)		
Risk Registers		1:1/Group Demonstration for Heads of Service/Directors		
Board Assurance Framework	Senior Management Team Quality & Safety Committee Audit & Governance Committee Board Members	Report or Presentation	Head of Quality & Risk	Annual

Risk Profile Review

- Review team/service/portfolio profile
- Existing Risk Register as a starting point
- Use risk profile template
- Arrange review with support from Quality Assurance Co-ordinator
- Update Datix
- Monitor & Review

Questions??

If you have any queries please contact the Quality & Risk Team who will be happy to help☺

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