**NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP**

**RISK MANAGEMENT FRAMEWORK 2012/2013**

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| Version 1.9 | 1 |
| Document status | Draft |
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| First Issued on: | August 2012 |
| Review Date: | April 2013 |
| Approved by: | TBC |
| Ratified by: | TBC |
| Dissemination: | All CCG Senior Officers via NELCCG intranet |

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| **CHANGE RECORD** | | | |
| **Version** | **Author** | **Nature of change** | **Date placed on the intranet** |
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1. Statement of intent

Risk management is an increasingly important business driver and stakeholders have become much more concerned about risk. Risk may be a driver of strategic decisions, it may be a cause of uncertainty in the organisation or it may simply be embedded in the activities of the organisation. An integrated approach to risk management enables NEL CCG to consider the potential impact of all types of risks on all processes, activities, stakeholders and commissioned services.

This framework aims to provide strategic direction, guidance and good management practice regarding embedding an integrated risk management approach, ensuring it is central to all CCG business, detailing clear lines of accountability and organisational responsibilities and arrangements.

Through implementation of this framework NEL CCG will establish the development of mechanisms that focus on overall risk reduction as an integral part of corporate governance and service delivery.

NEL CCG recognises its status as a learning organisation by actively promoting and encouraging learning across all business activities. Learning from all opportunities arising from adverse events, national reports, enquiries, complaints and comments is a key component of the NEL CCG approach to risk management.

The Health and Social Care Act 2012 will see Primary Care Trusts abolished in April 2013 and their commissioning responsibilities will be transferred to CCGs and the NHS Commissioning Board. A key aspect of this risk management framework in the lead-up to April 2013 is not only to manage the risks associated with the transition but also set in place robust arrangements to manage all risks facing the CCG. This framework will supplement and support the work of the Humber Cluster 1 through the transition year (2012-13).

The purpose of this framework is to define and document NEL CCG’s commitment to, and process for, handling risks that are inherent in the commissioning of an optimised high quality system for the care and treatment of patients. This framework will establish a programme of risk management that embraces innovation, reduces inefficiencies, increases effectiveness and informs a programme of continuous improvement. This framework describes our aims and objectives, our risk appetite, and culture in relation to Risk Management. It also provides an overview of the processes involved in proactively managing risk.

1. Scope

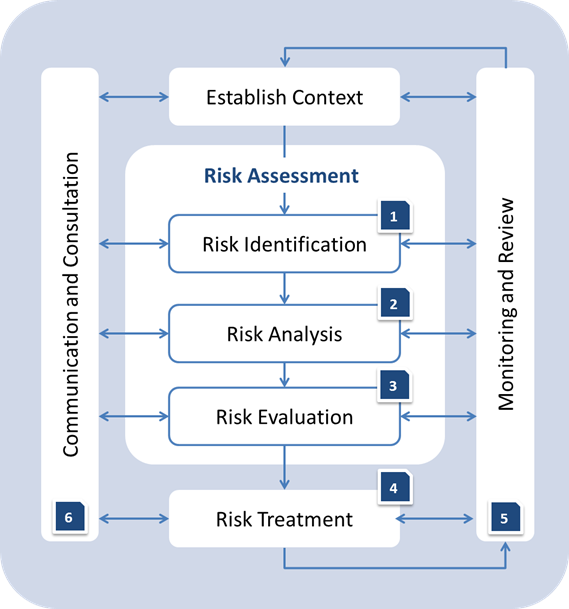
It is intended that the use of this framework extends to all staff engaged in any aspect of NEL CCG work. The scope of this framework is also intended to cover any risks associated with providers, independent contractors, contractual arrangements in respect of collaborations and multi-agency partnership delivery arrangements under which services are commissioned.

1. Definition

**Risk:** Is defined as the chance that something will happen that will have an impact on the achievement of NELCCG’s aims and objectives. It is measured in terms of likelihood (frequency or probability of the risk occurring) and severity (impact or magnitude of the effect of the risk occurring).

**Risk Management:** Is defined as “the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects”.

***Risk Management Process:*** NEL CCG has adopted principles of ISO 31000 risk management process within the risk management context of our organisation. The table below provides a high-level diagram of the risk management process from ISO 31000.



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Each stage of the risk management process should be documented in order to:

* Demonstrate the process is conducted properly
* Provide evidence of systematic approach
* Provide a record of risk and to develop our knowledge of risk
* Provide relevant decision makers with a risk management plan for approval etc
* Provide an accountability mechanism and tool
* Facilitate review and monitoring Provide an audit trail Share and communicate information.

**Significant Risks:** Are defined as those which, when measured according to the risk

grading tool are assessed to be ’High’, scoring 15 or above. The Board will take an

active interest in the management of significant risks.

***Acceptable risk:*** can be defined as ‘the residual risk remaining after controls have

been applied to associated hazards that have been identified, quantified, analysed,

communicated to the appropriate level of management and accepted after proper

evaluation.

1. CCG approach

NEL CCG will manage risk by:

* Clarifying strategic, management and delivery of objectives
* Identifying strategic and operational risks and challenges to those objectives
* Assessing risks and challenges
* Managing risks and challenges
* Reviewing and reporting on risks and challenges

1. Accountability and reporting structure

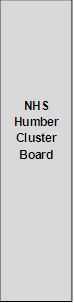
The Humber Cluster Chief Executive remains ultimately accountable for ensuring that sound systems for risk management are in place and implemented by NEL CCG. There is Senior Officer and management commitment to, and leadership of, the Risk Management Framework and accompanying guidance at CCG level. NEL CCG is responsible for approval of the Risk Management Framework and endorsement of corporate objectives relating to risk management. The CCG is also responsible for reviewing the effectiveness of its systems of internal control and for managing its affairs efficiently and effectively, reporting major risk issues to the Humber Cluster Board as appropriate.

The NEL CCG fully recognises that the effective assessment and management of risk is a core business function and that that the principles of governance must be supported by an effective risk management system that is designed to deliver improvements in patient safety and care as well as the safety of its staff, patients and visitors.

A management structure has been developed to ensure that risk management and corporate assurance arrangements are appropriately embedded within NEL CCG. Through this structure, the organisation is able to gain assurance of the successful delivery of its vision, its strategic plan, achieve financial balance, and ensure organisational delivery of safe services.

The Humber Cluster Audit Committee and Humber Cluster Board are kept informed of all major risks and assured that corresponding robust and adequately progressed risk treatment plans exist via reports from the North east Lincolnshire Integrated Governance and Audit Committee and the Delivery Assurance Committee.

All staff are required to utilise the risk management processes as a mechanism to highlight areas they believe need to be improved. Management of risks is a fundamental duty of all staff whatever their grade, role or status. All staff must follow NEL CCG policies and procedures which explain how this duty is to be undertaken. In particular, all staff must ensure that identified risks and incidents are dealt with swiftly and effectively and reported to their immediate line manager, in order that further action may be taken where necessary.



**NELCCG Delivery Assurance Committee**

**NELCCG Integrated Governance & Audit Committee**

**NELCCG Council of Members**

**NELCCG Governing Body**

**NHS Humber Cluster Governance Committee**

The table below describes the key roles and responsibilities of individuals involved in the process of risk management during 2012/13.

|  |  |
| --- | --- |
| **Role** | **Responsibilities** |
| Humber Cluster  Chief Executive | * Accountable Officer CTP/CCG * Overall responsibility for the Risk Management structure is in place within the CTP/CCG and its sub-committees * Adheres to statutory requirements and guidance issued by Department of Health |
| Humber Cluster Accountable Officer (Director of Quality and Governance) | * Accountable Officer across the Cluster * Overall responsibility for the Risk Management Strategy and Policy within the CCG * Ensures robust systems and processes exist for the identification and management of all risks within the CCG * Adheres to guidance issued by Department of Health |
| NEL CCG Chief Operating Officer | * Provides strategic advice and ensures progress against the annual plan to reduce risks and monitor developments in practice * Ensures new developments in risk management are implemented, the risk registers are continually reviewed and developed |
| NEL CCG Chief Financial Officer | * Responsible for the integrity of the system of internal financial controls, financial risk and for specific responsibilities as set out in the Standing Financial Instructions. * Ensures that NHS financial objectives are met and fraudulent use of resources is appropriately reported and investigated. |
| NEL CCG Senior Management | * Ensures robust systems and processes exist for the identification and management of all risks within their designated area and scope of responsibility * Ensures that policies and procedures are followed * Ensures staff receive appropriate training and that the local risk register is developed and monitored on a regular basis, and any risk or concerns that cannot be addressed locally are reported to the next tier of management |
| NEL CCG Employees | * Reporting incidents/accidents and near misses * Maintaining safe working practices * Being aware of their duty under legislation to take reasonable care of their own safety and the safety of others * Complying with all CCG policies, procedures and guidance for the protection of the health, safety and welfare of themselves and others * Familiarising themselves and complying with the CCG’s Risk Management Strategy * Identifying risks within their area of work and taking appropriate action to assess and manage such risks and/or report them to their line manager * Attending training and development events to ensure a full understanding of their risk management responsibilities |

1. Risk Management process

A formal risk management process enables us to identify risks posed to the organisation and plan accordingly. The starting point for the risk management process is to establish responsibilities across the organisation.

NEL CCG has adopted a process where logical steps are taken to manage risks effectively. Following on from setting priorities, potential risks or opportunities are then identified and evaluated before a course of action is determined to address the identified risks. As few risks remain static and new issues are likely to emerge, it is essential that all risks captured are routinely monitored. Finally, reporting of risk issues and in particular reporting and reflecting on any adverse events that do occur is essential to ensure that NEL CCG continuously improves its risk management activities.

The aim of the risk management process is not to remove all risk but to recognise that some level of risk will always exist. It is recognised that taking risks in a controlled manner is fundamental to innovation and development.

These processes broadly fall into two categories: proactive and reactive risk processes, as described below:

Proactive Risk Processes

Strategies, Policies and Procedures

In addition to this Risk Management Strategy there are a range of other policies, adopted that support the management of risk in the CCG.

Emergency Planning and Business Continuity

The CCG has in place a comprehensive Major Incident Plan, as well as a range of plans and other associated documents that are designed to ensure the resilience of the CCG in a range of scenarios that would limit the operating capacity of the CCG. These plans are tested on a regular basis, and learning from these tests is communicated back into relevant groups to ensure that the processes are refined.

Standards and Accreditation

The CCG ensures that it meets a range of standards and accreditations. Many of these are covered by the Policy for the Management of External Agency Visits, Inspections and Accreditations.

Audit Activity (Clinical, Internal and External)

There is extensive audit activity within the CCG covering a range of issues. Findings from these reviews are fed back to appropriate members of staff, and reports are made to the Integrated Governance

Exception Reports to the Delivery Assurance Committee and Integrated Governance Committee on Key CCG Priorities

Regular reports are made identifying potential risks to the CCG’s strategic priorities, and what actions are being taken to minimise these risks.

Organisational Learning

The CCG seeks to learn from the experiences of other organisations. For example, published reports from key regulators are always reviewed, with findings compared to existing CCG practice.

Training (incorporating Statutory and Mandatory Training)

Extensive training activity takes place in the CCG on a range of subjects. Much of this is regulated by professional bodies such as the GMC, RCN etc, while some is linked to individual personal development plans, or the implementation of CCG policies. As a minimum all staff receives appropriate statutory/mandatory training as described in the Mandatory Training Policy.

Risk Register

The CCG has a robust process for the management of the Corporate Risk Register. The CCG wide risk register is supported by comprehensive risk assessment systems in all areas, and is stored on the Covalent risk management system.

Reactive Risk Processes

The CTP also identifies potential risks from events that have already occurred.

The main drivers of this come from:

Complaints

The CCG has well-established complaints process that is responsible for handling all CCG complaints and ensures that all concerns are responded to within the approved timescales. Complaints will be graded using the Risk and Incident Grading Matrix; all serious complaints are the subject of a full root cause analysis. Information and action plans arising from complaints are used to develop or change the service delivery. All information relating to complaints is held within Datix. Any identified risks that score 12 and above and are not able to be managed via the normal process will be reported in line with the Protocol for Maintaining & Developing the Directorate and Corporate Risk Registers for inclusion within the corporate risk register. The CCG’s Complaints handling process is described in detail in the *Complaints Policy*.

Incidents

The CCG has a system for reporting all Incidents, or Serious Untoward Incidents which is described in the CCG’s *Incident Reporting Policy* *and the Serious Incident Reporting Policy*. All notified incidents are graded using the CCG’s standard risk assessment matrix and are recorded within Datix. Any identified risks that score 12 and above and are not able to be managed via the normal process will be reported in line with the Protocol for Maintaining & Developing the Directorate and Corporate Risk Registers for inclusion within the corporate risk register.

Root Cause Analysis

Where something happens within the CCG that impacts on services, potential risks are identified and appropriate management action put in place to reduce or eliminate the possibility of a similar occurrence. This can be separate or complementary to the processes described in the CCG’s *Incident & Accident Reporting Policy and the Serious Incident* *Policy.*

Central Alert System (CAS)

The CCG has robust processes in place to respond to alerts issued through the national frameworks, through its own internal alert system. These are set out in the *Procedure for the Management of the Central* *Alerting System Procedure*.

1. Risk Assessment Process

Identification of risk

The identification of risk requires an intimate knowledge of the organisation, the market in which it operates, the legal, social, political and cultural context in which it exists, as well as a good understanding of its strategic and operational objectives (IRM, 2002).

Risk identification must be approached in a methodological way to ensure that all significant activities of the CTP have been identified and all the risks stemming from these have been defined**.**

Business activities can be categorised in a number of ways (IRM, 2002):

* *Strategic*: Concerns the long term strategic objectives of the organisation that can be effected by factors such as regulatory changes, capital availability, and reputation and well as political risks.
* *Operational:* Concern the day to day issues that the organisation faces whilst working towards its strategic objectives
* *Financial:* Concerns the effective management and control of finances

Priorities identified by any risk register will be distorted if risk identification is not carried out at all levels of the organisation including the Board *(Source: Making It* *Happen. NHS Risk Register Working Group, 2002)*

Given the definition of risk, the key question to be answered when identifying a risk is:

*“What could significantly impact on the likelihood of the CTP achieving its strategic or corporate objectives and targets?”*

In determining what may “impact on the likelihood” of achieving the strategic or corporate objectives it is also important to articulate the risk clearly and avoid the identification of what are merely issues, gripes or actions being taken.

Risk description

The objective of good risk description is to display the identified risk in clear and structured format. Covalent provides a structured framework to ensure comprehensive risk identification, description and assessment process. By considering the consequence and probability of each risk it should be possible for the organisation to prioritise the key risks that it faces. Table 1.0 below provides an overview of all information held within Covalent in relation to the description of each individual risk.

Table 0.1

|  |  |
| --- | --- |
| **Field** | **Contents** |
| Code | This individual identification number for the risk. The code is assigned by the Risk Coordinator. |
| Title | A short description of the risk which specifically identifies the event. This should be a very short summary of the risk which is no longer than one sentence. The sentence needs to articulate clearly, exactly what the risk is. To do this it is useful to consider 3 elements to a risk, namely:   * The event * The consequence * The impact   A typical phrasing would be:   * Loss to… * Failure of… * Lack of…   Or more simply….   * There is a risk that……   The field is limited to 255 characters. |
| Description | Provides a description of the scope of the risk and details of possible events, including a short description of the events, their size, type and number. This section can be used to provide further detail of the risk. There is no limit to the number of characters that can be used but again the actual risk should be clearly articulated. |
| Active | This field indicates whether the risk is currently active or not. Risks are deactivated once mitigation has taken place and the target risk score has been reached. |
| Management | Identify the current management status of the internal controls put in place to manage the risk. Options: Over controlled, Controlled, Control pending, Uncontrolled. |
| Priority | Indicates the level of priority.  1= High/Significant Risks  2 = Moderate Risks  3= Low risks |
| Approach | Following identification and analysis of the risk, a decision will need to be made as to whether the CCG can terminate (eliminate/avoid), treat (manage), tolerate (accept) or transfer (Shift the burden of responsibility or burden of loss to another party through for example insurance.   * ***Treat:*** In many cases, action can be taken to change the way activities are carried out in order to reduce the risk identified as far as possible. * ***Terminate***: In some cases, definitive action can be taken in order to eliminate the exposure to risk or in some cases the activity can be undertaken in a different way in order that the risk does not occur. * ***Tolerate:*** Very low and low risks can be accepted as requiring no further action. On reviewing this type of risk it may, be decided that some cost effective action would reduce the risk still further. Action on this risk is a lower priority. If the risk is small or cannot be reduced, avoided or transferred (it may be that the cost of insurance cover is prohibitive), the CCG will need to accept it and prepare an action plan in order to minimise the effects of the risk exposure, in order that the risk becomes acceptable (re: definitions). * ***Transfer*:** The most common form of risk transfer is insurance. |
| Source of risk | Identifies the source of the risk for example: strategic plan, corporate business plan, directorate business plans, *complaints incidents, claims, internal audit,* *internal inspection, regulators, CAS alerts, risk assessments, consultations, bench-marking, performance targets, national enquiries, other* |
| Current risk rating | The identified risk needs to have a regular assessment undertaken using the agreed risk assessment process. Ideally, each risk should be risk assessed on a monthly basis particularly for risks that represent a high or significant risk to the organisation (current rating of 15+). However, the absolute maximum amount of time between risk assessments is 3 months. This approach has been adopted across the CCG in order to promote and embed a culture of active risk management. The current or residual risk is the assessment of the likelihood and impact of the event occurring at the particular moment in time e.g.. Mitigating actions may only be partially implemented, and although the risk has reduced from the original risk assessment the target risk assessment has not yet been reached. |
| Original risk assessment rating | Risk evaluation = Likelihood and magnitude of event and possible impact or consequences should the risk materialise. This is undertaken by using the CCG’s Risk Matrix. The identified risk needs to have a risk assessment undertaken using the CCG’s agreed risk assessment process. The original risk or raw risk assessment must reflect the likelihood and impact of the event occurring if there were no controls or mitigating actions in place. On this basis an impact and likelihood score should be selected and the date when this assessment was carried out completed. This section is only completed once. |
| Target risk assessment | Each risk needs to be assigned a target assessment. This represents an assessment of the likelihood and impact of the event occurring once all internal controls or mitigating actions have been implemented. It is frequently the case that whilst the impact of the risk may remain the same as the original raw assessment, successful mitigating actions/internal controls will reduce the likelihood of the risk occurring. The date by which the target should be reached (the deadline) should then be completed. |
| Year identified | The year the risk was first identified |
| Potential effects | Description of the impact of the risk on the CCG. This section should clearly describe the effect to the organisation if the risk is realised i.e. what would happen if no action is taken to mitigate the risks. |
| Internal controls | Describe the internal controls in place and whether they are effective This section should clearly set out what internal controls are in place. It is useful to identify specific actions that need to take place rather than describing a general approach. |
| Notes & history | This section is used to provide updates on the progress of managing the risk. |
| Documents | All associated documents, papers relating to the risk should be uploaded in this area. |
| Managed by | Name of Director accountable for managing the risk. |
| Assigned to | Name of person reasonable for managing the risk. |
| Administered by | Name of administer. |
| Related links | This section allows the risk to be linked to other modules in Covalent. |

Risk estimation (risk matrix)

NEL CTP has adopted the qualitative 5x5 matrix developed by the National Patient Safety Agency (2008). Using the 5x5 matrix provides a tool for prioritising risk treatment. All risks should be graded according to impact and likelihood. The risk rating is calculated by multiplying the likelihood and impact scores to obtain the risk rating by consulting the risk domains. See Appendix 1 for more details.

Risk evaluation & treatment

Once the above process has been completed, it is then necessary to compare the risk against criteria such as associated costs, benefits, legal requirements etc. This stage is then used to inform decisions about the significance of risks and whether risks should be accepted or treated. It is essential that risks are evaluated in a consistent manner in order to separate those risks that are unacceptable from those that are tolerable. The 5x5 matrix is used to evaluate the risk. The degree to which risks are considered acceptable maybe specific, relating to a particular issue, or generic, focusing on the total number risks which the organisation is prepared to tolerate at any one time. All risks scoring below 12 on the 5x5 risk matrix are considered to be acceptable but should be mitigated when possible and recorded within the relevant directorates risk register.

**APPENDICES**

**Appendix 1 – NELCCG Risk Matrix**

Impact scores (I)

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Impact score (severity levels) and examples of descriptors** | | | | |
|  | **1** | **2** | **3** | **4** | **5** |
| **Domains** | **Insignificant** | **Minor** | **Moderate** | **Major** | **Catastrophic** |
| **Safety**  Impact on the  safety of patients,  staff or public  (physical/  psychological  harm) | Minimal injury  requiring  no/minimal  intervention or  treatment.  No time off work | Minor injury or illness,  requiring minor intervention  Requiring time off work for >3  days (for physical or  psychological reasons)  Increase in length of hospital  stay by 1-3 days | Moderate injury requiring  professional intervention  Requiring time off work for 4-14  days (for physical or  psychological reasons)  Increase in length of hospital  stay by 4-15 days  RIDDOR/agency reportable  incident  An event which impacts on a  small number of patients | Major injury leading to  long-term  incapacity/disability  Requiring time off work  for >14 days (for physical  or psychological reasons)  Increase in length of  hospital stay by >15 days  Mismanagement of  patient care with longterm  effects | Incident leading to  death  Multiple permanent  injuries or irreversible  health effects (for  physical or  psychological  reasons)  An event which  impacts on a large  number of patients |
| **Quality/**  **complaints/**  **audit** | Peripheral  element of  treatment or  service  suboptimal  Informal  complaint/inquiry | Overall treatment or service  suboptimal  Formal complaint (stage 1)  Local resolution  Single failure to meet internal  standards  Minor implications for patient  safety if unresolved  Reduced performance rating if  unresolved | Treatment or service has  significantly reduced  effectiveness  Formal complaint (stage 2)  complaint  Local resolution (with potential to  go to independent review)  Repeated failure to meet internal  standards  Major patient safety implications  if findings are not acted on | Non-compliance with  national standards with  significant risk to patients  if unresolved  Multiple complaints/  independent review  Low performance rating  Critical report | Totally unacceptable  level or quality of  treatment/service  Gross failure of patient  safety if findings not  acted on  Inquest/ombudsman  inquiry  Gross failure to meet  national standards |
| **Human**  **resources/**  **organisational**  **development/**  **staffing/**  **competence** | Short-term low  staffing level that  temporarily  reduces service  quality (< 1 day) | Low staffing level that reduces  the service quality | Late delivery of key objective/  service due to lack of staff  Unsafe staffing level or  competence (>1 day)  Low staff morale  Poor staff attendance for  mandatory/key training | Uncertain delivery of key  objective/service due to  lack of staff  Unsafe staffing level or  competence (>5 days)  Loss of key staff  Very low staff morale  No staff attending  mandatory/ key training | Non-delivery of key  objective/service due  to lack of staff  Ongoing unsafe  staffing levels or  competence  Loss of several key  staff  No staff attending  mandatory training  /key training on an  ongoing basis |
| **Statutory duty/**  **inspections** | No or minimal  impact or breech  of guidance/  statutory duty | Breech of statutory legislation  Reduced performance rating if  unresolved | Single breech in statutory duty  Challenging external  recommendations/ improvement  notice | Enforcement action  Multiple breeches in  statutory duty  Improvement notices  Low performance rating  Critical report | Multiple breeches in  statutory duty  Prosecution  Complete systems  change required  Zero performance  rating  Severely critical report |
| **Adverse**  **publicity/**  **reputation** | Rumours  Potential for  public concern | Local media coverage –  short-term reduction in public  confidence  Elements of public expectation  not being met | Local media coverage –  long-term reduction in public  confidence | National media coverage  with <3 days service well  below reasonable public  expectation | National media  coverage with >3 days  service well below  reasonable public  expectation. MP  concerned (questions  in the House)  Total loss of public  confidence |
| **Business**  **objectives/**  **projects** | Insignificant cost  increase/  schedule  slippage | <5 per cent over project  budget  Schedule slippage | 5–10 per cent over project  budget  Schedule slippage | Non-compliance with  national 10–25 per cent  over project budget  Schedule slippage  Key objectives not met | Incident leading >25  per cent over project  budget  Schedule slippage  Key objectives not met |
| **Finance**  **including claims** | Small loss Risk of  claim remote | Loss of 0.1–0.25 per cent of  budget  Claim less than £10,000 | Loss of 0.25–0.5 per cent of  budget  Claim(s) between £10,000 and  £100,000 | Uncertain delivery of key  objective/Loss of 0.5–1.0  per cent of budget  Claim(s) between  £100,000 and £1 million  Purchasers failing to pay  on time | Non-delivery of key  objective/ Loss of >1  per cent of budget  Failure to meet  specification/ slippage  Loss of contract /  payment by results  Claim(s) >£1 million |
| **Service/**  **business**  **interruption**  **Environmental**  **impact** | Loss/interruption  of >1 hour  Minimal or no  impact on the  environment | Loss/interruption of 8 hours >4  hours  Minor impact on environment | Loss/interruption of > 1 day 8  hours  **Minor** - **Moderate** impact on  environment | Loss/interruption of > 1  week 1 day  Moderate Major impact  on environment | Loss/interruption of >1  week  Major impact on  environment  Permanent loss of  service or facility  Catastrophic impact  on environment |
| **Additional**  **Examples** | Incorrect  medication  dispensed but not  taken  Incident resulting  in bruise or graze  Delay in routine  transport for  patient | Wrong drug or dosage with no  adverse effects  Physical attack such as  pushing, shoving or pinching  causing minor injury  Self-harm resulting in minor  injuries  Grade 1 pressure ulcer  Laceration, sprain, anxiety  requiring occupational health,  counselling (no time off work) | Wrong drug or dosage  administered with potential  adverse effects  Physical attack causing  moderate injury  Self-harm requiring medical  attention  Grade 2/3 pressure ulcer  HCAI  Incorrect or inadequate  information/communication on  transfer of care  Vehicle carrying patient involved  in RTA  Slip/fall resulting in injury such as  a sprain | Wrong drug or dosage  administered with  adverse effects  Physical attck resulting in  serious injury  Grade 4 pressure ulcer  Long term HCAI  Slip/fall resulting in injury  such as dislocation,  fracture blow to head  Post-traumatic stress  disorder  Failure to follow-up and  administer vaccine to  baby born to mother with  hep b | Unexpected death  Suicide of patient  known to the service  in the pst 12 months  Hommicide commited  by a mental health  patient  Large scale cervical  screening errors  Incident leading to  paralysis  Incident leading to  long term mental  health problem  Rape/serious sexual  assault |

***Likelihood Score (L)***

What is the likelihood of the impact (re)occurring?

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

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

***Risk scoring = Impact x likelihood (I x L)***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Likelihood** | | | | |
| **Impact** | **1** | **2** | **3** | **4** | **5** |
| **5 Catastrophic** | 5 | 10 | 15 | 20 | 25 |
| **4 Major** | 4 | 8 | 12 | 16 | 20 |
| **3 Moderate** | 3 | 6 | 9 | 12 | 15 |
| **2 Minor** | 2 | 4 | 6 | 8 | 10 |
| **1 Insignificant** | 1 | 2 | 3 | 4 | 5 |

|  |  |
| --- | --- |
| 1 – 6 | Low to Moderate Risk |
| 8 – 10 | Moderate Risk |
| 12 | High Risk |
| 15 – 25 | Significant Risk |

**Appendix 2 –**

**NORTH EAST LINCOLNSHIRE COUNCIL OF MEMBERS**

**TERMS OF REFERENCE**

Version date: July 2011

Objectives

* To provide a forum that considers & advisers on the service commissioning agenda for Health & social Care
* To ensure that the continued development of the Commissioning Consortia is aligned to the principles & aspirations of the constituent practices
* To provide a forum for engagement & debate with key stakeholders & partners
* To provide a point of reference for the development of approaches to engaging clinicians in the development & delivery of key changes that are required to enable sustainable services
* A forum for two way communication between practices & the GPCC
* To provide advice to the GPCC Board through the Steering Group Chair

Operating principles:

People have said that for the future GP commissioning arrangements to be successful that we can’t just “move the deck chairs”.

We need to work differently:

* We need to provide constructive challenge & act as a critical friend to ensure that the CC continues to encourage innovation & operates in a way that empowers individuals to lead on areas of work that they feel passionate about.
* We need to become a learning community that adopts the best. Bottom quartile performance is not acceptable, top quartile performance should be celebrated and rapidly adopted.
* We need systems that challenge “top-down” priorities and legitimise local decisions

Membership:

Core Membership - Each practice will be responsible for determining who will be its core member on the steering group meeting & therefore would be able to vote on the practices behalf. Core members would therefore constitute the individual named on the practice mandate. Each Core member will have a vote proportionate to the number of patients registered with the practices they represent on the 1st of April of the previous year.

Associate members - In addition to the Core members the Steering Group will have a number of associate members. Each Associate member will be agreed by the Steering Group, & will subsequently be invited to attend all future meetings. Associate members could be drawn from other sectors of the Health and Social Care Community and could be from different Professional backgrounds. Associate members will be actively encouraged to be involved in & contribute to the work of the Steering Group.

Associate members will be non-voting members of the Group.

Conflicts of Interest:

Where a member of the Steering Group (core or associate) believes that he /she has a conflict of interest in terms of an agenda item, they must declare this at the beginning of the meeting. It will be up to the remaining members of the Steering Group to determine whether the conflict is so material that the member with the conflict should leave the meeting for the duration of the item, or whether they are able to stay & contribute to the discussion but would be excluded from any vote on that item.

Quoracy:

The meeting will be quorate when the Core members in attendance control a majority of the votes from the constituent (mandated) practice members.

Meeting arrangements:

The Steering Group will elect a Chair and Vice Chair from the Core Membership. In order to be appointed each nominee will require a single proposer from a Core member which could include nomination by him/herself.

The Chair will be proposed and appointed first then the Vice Chair.

The proposed individuals who secure a minimum of 50.1% of the votes of the mandated membership will be deemed to have been appointed.

The initial tenure for the for the appointments will be for the period to 31st March 2011, Subsequent to the initial tenure the appointment will be for a period of one year when expressions of interest for fresh nominations will be sought. If no fresh nominations are forthcoming then the current incumbents will remain in office.

The Steering group will meet no less than monthly during the period to 31st March 2011 & subsequently no less than Quarterly. The duration between meetings will be agreed by the members of the Steering Group quarterly in advance of the meetings.

Administration support will be provided by the Commissioning Intelligence Office.

**Appendix 3 - NELCCG GOVERNING BODY *(Please not; these terms of reference are currently being revised and may be subject to change in the near future)***

**NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP COMMITTEE (CCGC)**

**TERMS OF REFERENCE**

**1.0 PREAMBLE**

1.1 The Statutory Board of NHS East Riding of Yorkshire Primary Care Trust, Hull Teaching Primary Care Trust, North Lincolnshire Primary Care Trust and North East Lincolnshire Care Trust Plus (the “Cluster Board”) has resolved to establish a committee to be known as the North East Lincolnshire Clinical Commissioning Group Committee (CCGC) as required to support the PCTs in the discharge of their functions.

1.2 These terms of reference set out how North East Lincolnshire Clinical Commissioning Group Committee (CCGC) shall support the Cluster Board in delivering the statutory requirements of North East Lincolnshire CTP.

**2.0 PRINCIPAL FUNCTION**

2.1 The North East Lincolnshire CCGC is a Committee of the Cluster Board. It aligns and consolidates the governance arrangements between the Board and the emerging North East Lincolnshire Clinical Commissioning Group.

2.2 The North East Lincolnshire CCGC will operate within the strategy set by and the legal framework for the PCTs in the NHS Humber Cluster and North East Lincolnshire Partnership Arrangements. The powers and responsibilities of North East Lincolnshire CCGC are set out in these Terms of Reference and the Partnership Legal Agreement.

2.3 These Terms of Reference should be read in conjunction with the NHS Humber Cluster Standing Orders, Scheme of Delegation, Standing Financial Instructions and other financial procedures and form part thereof.

**3.0 AUTHORITY**

3.1 The Cluster Board is responsible for ensuring that it discharges the PCTs’ statutory duties for the commissioning of health and health care services.

3.2 The Chief Executive for each of the PCTs in the NHS Humber Cluster is the Accountable Officer for those PCTs in accordance with the Accountable Officer Memorandum for Chief Executives [2002].

3.3 The Director of Finance for each of the PCTs in the NHS Humber Cluster is responsible for ensuring that each of those PCTs meets it statutory duties for financial management.

3.4 The NHS duties, functions and responsibilities delegated by the Cluster Board to the North East Lincolnshire CCGC are set out in Annex 1. These duties, functions and responsibilities are to be exercised by the CCGC in relation to the geographic area of North East Lincolnshire CTP.

3.5 The Adult Social Care duties, functions and responsibilities delegated to the North East Lincolnshire CCGC are set out in the Partnership Legal Agreement, 3 year Strategic Agreement and Memorandum of Understanding.

**4.0 PRINCIPAL RESPONSIBILITIES**

4.1 The North East Lincolnshire CCGC has been established to drive forward clinical commissioning and to facilitate the delivery of the policy ambition set out in Liberating the NHS: Legislative Framework and Next Steps, and to deliver integrated health and social care commissioning for the citizens of North East Lincolnshire.

* 1. It is charged with supporting the safe and secure transfer of health and adult social care commissioning responsibilities from the North East Lincolnshire CTP to the North East Lincolnshire Clinical Commissioning Group within the extant statutory framework. This will require:
* Securing leadership, capacity and capability.
* Supporting the development of North East Lincolnshire Clinical Commissioning Group.
* Managing resources delegated to it.
* Ensuring that the responsibilities delegated to it are delivered.

4.3 The North East Lincolnshire CCGC will set out its arrangements for the effective, efficient and economic discharge of its responsibilities for health and adult social care. These arrangements will need to be described in the CCGC Assurance Plan (September 2011) and Delivery Agreement (March 2012).

4.4 The Cluster Board will hold the North East Lincolnshire CCGC to account against this plan.

4.5 The Cluster Board remains accountable for the delivery of each of the PCT’s statutory duties and where the Cluster Board is not assured that the North East Lincolnshire CCGC is discharging the duties, functions and responsibilities that it has been delegated by the Cluster Board efficiently, effectively and economically, the Cluster Board reserves the revoke the delegation of any or all of such duties, functions and/or responsibilities subject to the requirements of the legal Partnership Agreement and the Memorandum of Understanding.

**5.0 MEMBERSHIP**

5.1 The North East Lincolnshire CCGC membership shall be:

Chairman: Associate Non Executive \*

Vice Chairman: Steering Group Chair (GP)\*

2 Elected GP’s\*

Shadow Accountable Officer (GP)\*

Assurance and Safety lead (GP)\*

1 Associate Non Executive (Local Authority member)\*

1 Lay member (Accord)\*

1 Local Authority Executive Director\*

Shadow GPCC (CCG) Chief Operating Officer/Chief Financial Officer\*

In Attendance shall be:

Strategic Adult Social Care Advisor

Associate Non Executive (integrated governance and audit)

Shadow GPCC (CCG) Director of Strategic Change

Shadow GPCC (CCG) Director of Commissioning Intelligence

Shadow GPCC (CCG) Assistant COO (registered nurse)

Senior Public Health representative

NB: Those members \* above are voting members of the Committee. (NB it is recommended that clinical members have the majority vote).

The membership will be reviewed in line with the North East Lincolnshire Clinical Commissioning Group’s Constitution.

5.2 The North East Lincolnshire CCGC can also invite other individuals, including professional advisers, to attend as may be required from time for professional advice. Such individuals will not have voting rights.

5.3 Decisions required as part of a meeting of the North East Lincolnshire CCGC will be determined by simple majority vote. Where the votes are tied and there is therefore not a majority then the Vice Chair (as a clinician) will have a second and casting vote to maintain a clinical majority.

5.4 Other staff, Directors and officers of the NHS Humber Cluster may be invited to attend to advise or support particular discussion from time to time as required. For the avoidance of doubt individuals that attend meetings of the Committee but are not members shall not have any voting rights.

**6.0 QUORUM**

6.1 A meeting of the North East Lincolnshire CCGC will be quorate only when a minimum of four members are present. These four members must include the Chair or Vice Chair, at least two General Practitioners and either the CCGC Senior Officer or the Senior Financial Officer.

6.2 In exceptional circumstances and where agreed with the Chair, members of North East Lincolnshire CCGC may participate in meetings by telephone, by the use of video conferencing facilities and/or webcam where such facilities are available. Participation in a meeting in any of these manners shall be deemed to constitute presence in person at the meeting.

**7.0 FREQUENCY**

7.1 The North East Lincolnshire CCGC will normally meet monthly and at least 10 meetings will be held each year.

7.2 The agenda for meetings of North East Lincolnshire CCGC will be set by the Chair.

7.3 The agenda and papers for a meeting of the North East Lincolnshire CCGC will be distributed five working days in advance of the meeting. Items for the agenda should be notified to the Chair of the North East Lincolnshire CCGC ten days in advance of each meeting. The setting of agendas for and minutes of meetings should identify where discussion should be rightly recorded as being of a confidential or commercially sensitive nature.

7.4 An annual programme and timetable of meetings will be developed with the Chair.

**8.0 REPORTING ARRANGEMENTS**

8.1 The North East Lincolnshire CCGC reports to the Cluster Board.

8.2 The Chair of the North East Lincolnshire CCGC or their agreed deputy will be invited to attend each meeting of the Cluster Board.

8.3 North East Lincolnshire CCGC will provide a report to each meeting of the Cluster Board. The report should be written and circulated with the agendas and papers and shall set out the work of the North East Lincolnshire CCGC including any key decisions made under delegated responsibilities. It should provide assurance to the Cluster Board on the range of delegated responsibilities of the North East Lincolnshire CCGC. This will include such matters as financial performance, local and national performance and quality standards, key risks and remedial action. Assurance reports will be routinely provided to the Audit Committee in relation to delivery of an integrated governance model within the North East Lincolnshire CCGC.

8.4 Minutes from the North East Lincolnshire CCGC will be formally received at the next meeting of the Cluster Board held in public.

8.5 Minutes of the North East Lincolnshire CCGC shall also be circulated to all constituent practices and formally published.

**9.0 SUB GROUPS**

9.1 The North East Lincolnshire CCGC shall establish such sub groups to assist with the delivery of its delegated responsibilities and progress its work as it sees fit. These sub groups will have clear terms of reference, be supported by an agreed scheme of delegation and be required to provide assurance on key areas of responsibility i.e. finance, performance, partnerships and corporate/governance. Such sub groups have no executive powers. For the avoidance of doubt the North East Lincolnshire CCGC shall not delegate its responsibilities further with the exception of those responsibilities included in the Legal Agreement and Partnership Arrangement with North East Lincolnshire Council.

**10.0 ADMINISTRATION ARRANGEMENTS**

10.1 The North East Lincolnshire CCGC will be supported by the Business Support Team within the Chief Operating Officer Directorate.

**11.0 INTERESTS**

11.1 North East Lincolnshire CCGC shall hold a Register of Interests, business pecuniary or other of its members. This Register shall record all relevant and material personal or business interests within the meaning of the Policy for the Management of Conflicts of Interest [Annex 2]. Any change to these interests should be notified to the CCGC Chair prior to each meeting.

11.2 Failure to disclose an interest by a member of the North East Lincolnshire CCGC may result in suspension from the Committee, in line with the Code of Conduct.

11.3 Any interest relating to a Committee agenda should be brought to the attention of the Chair in advance of the meeting and recorded in the minutes or as soon as the interest becomes apparent .

11.4 All members of North East Lincolnshire CCGC and participants in meetings of North East Lincolnshire CCG shall comply with the Standards of Business Conduct for NHS staff and NHS Code of Conduct.

**12.0 DISPUTES**

12.1 In the event of a dispute between the North East Lincolnshire CCGC members it shall be managed in accordance with the arrangements for dispute management [in Annex 3] which sets out arrangements for the identification, escalation and resolution of any disagreements, subject to the requirements of the Memorandum of Understanding.

12.2 Where a dispute remains unresolved it should be notified to the Chair of the PCTs in the NHS Humber Cluster who will determine resolution in line with the Disputes Procedure [Annex 3]. Unless agreed to the contrary the dispute will be considered by the Cluster Board at its next or specially convened meeting, subject to the requirements of the Memorandum of Understanding.

***12.3 The decision of the Cluster Board in any matter, subject to the Memorandum of Understanding, will be final.***

**13.0 LIABILITY OF MEMBERS**

13.1 North East Lincolnshire CTP shall provide an indemnity to any member of the North East Lincolnshire CCGC that if any such person acts honestly and in good faith such person will not have to meet out of personal resources any personal civil liability which is incurred in the execution or purported execution of the functions of the North East Lincolnshire CCGC, save where they have acted recklessly.

**14.0 DOCUMENT CONTROL**

14.1 The above Terms of Reference will be considered by the Cluster Board and will be regularly reviewed at least annually.

14.2 Any changes to these Terms of Reference shall not be effective unless agreed by the Cluster Board.

**Appendix 4 –**

**NORTH EAST LINCOLNSHIRE CARE TRUST PLUS**

**INTEGRATED GOVERNANCE COMMITTEE**

**TERMS OF REFERENCE**

**1. PURPOSE**

The Integrated Governance Committee (IGC) is a committee of the board that exists to provide assurance to the CTP board that there are robust structures, processes and accountabilities for risk management and clinical quality within the organisation and its commissioned services.

**2. TERMS OF REFERENCE**

In line with the CTP Scheme of Delegation, the IGC has certain duties that form its Terms of Reference, which are detailed below. Terms in italics are those delegated duties from the CTP Scheme of Delegation

**2.1 Risk Management**

*2.1.1 Advise the board on all aspects of risk management and integrated governance;*

*2.1.2 Provide an assurance to the board that there are robust structures, processes*

*and accountabilities in place for identifying and managing significant risks facing the organisation (i.e. strategic, operational, clinical and organisational);*

* + 1. The IGC will carry out these delegated duties through the following actions and

processes:

1. Monitor the implementation and progress of embedding the CTP Risk Management Strategy and policy and advise the CTP Board of any issues that arise;
2. Regularly review the CTP risk register to ensure risks are appropriately identified, mitigated and controlled. The committee will have a particular focus on high-level risks;
3. Recommend to the CTP Board any risks that require escalation to be considered for inclusion in the Board Assurance Framework;
4. Provide a regular report to the Audit Committee on risk management and governance issues and make recommendations as appropriate;
5. To receive regular reports on complaints, incidents, claims, PALS issues and patient experience data, share good practice across the CTP and recommend appropriate action in the organisation to manage risks and trends in these data.

(vi) Provide the functions outlined in 2.1.3 (i) – (v) to the Provider Services Associate Board in respect of provider services.

**2.2 Integrated Governance**

*2.2.1 Ensure continuous quality improvement through specific work programmes*

*developed in line with national drivers;*

*2.2.2 Ensure accountability arrangements for certain statutory responsibilities*

*including child protection, infection control and health and safety;*

*2.2.3 Monitor the trust’s progress in fulfilling its equality and diversity policy*

2.2.4 The IGC will carry out these delegated duties through the following actions and

processes:

1. Approve the CTP’s Clinical Effectiveness Strategy and receive regular reports on progress on its implementation.
2. Receive reports on progress with training programmes in relation to point 2.2.2 of these terms of reference. Identify risks to the achievement of these objectives and make recommendations for action to address these.
3. Provide regular updates and an annual report to the board.
4. Monitor issues in relation to registration with the Care Quality Commission.

**2.3 Operational Responsibilities**

*2.3.1 Be responsible for the coordination of external regulation activity*

2.3.2 The IGC will carry out this delegated duty by ensuring there are appropriate action plans, policies and a sub-committee infrastructure to support the IGC and the organisation to respond to external requirements. This includes receipt of relevant audit reports (internal and external) and monitoring that plans are being delivered effectively.

**3. MEMBERSHIP**

Director of Quality (Chair)

Two Non-Executive Directors

Associate Director of Finance

Associate Director of Human Resources and Workforce Development

Associate Director of Informatics

Commissioning Group Director Representative

Corporate Risk Manager

Assistant Director of Assurance and Adult Safeguarding

Director of Mental Health

Associate Director of Quality/Strategic Nurse

Assistant Director of Corporate Performance

Deputy Chair: Associate Director of Quality

The IGC may request the attendance of any member of CTP staff or partner organisation staff as required by the work of the IGC.

**4. QUORUM**

4.1 No business of the IGC will be enacted unless one Non-Executive Director and at least three other members are present.

4.2 Membership of the IGC will consist of named representatives and substitutes will have to be agreed with the chairman prior to the meeting. Named representatives are listed at Appendix A.

**5. Frequency of Meetings**

5.1 The IGC will meet bi-monthly.

**6. REPORTING ARRANGEMENTS**

The IGC reports to: CTP Board – minutes (in draft format if necessary) received after each meeting; formal reports received on a regular and annual basis

Receives reports from: Sub-committees, as detailed at Appendix B,

after each meeting

Minutes circulated to: Audit Committee, Provider Services Associate Board, Care Contracting Committee

The IGC will provide a report to the Audit Committee after each meeting.

**7. ADMINISTRATIVE Arrangements**

7.1 The Chairman of the IGC will draw up the agenda for each meeting.

7.2 The agenda and papers will be distributed five days in advance of the meeting.

7.3 The minute secretary to IGC will record meetings and detail the recommendations of the Committee. The minutes and recommendations of the Committee will be reported to the board after each meeting

7.4 The Directorate of Quality will provide administrative support to the IGC.

**8. TENURE**

The IGC is a permanent committee of the CTP Board

**9. DATE OF AGREEMENT FOR TERMS OF REFERENCE AND DATE OF NEXT**

**REVIEW**

These Terms of Reference were agreed at the IGC Meeting held 19 November 2010 . and will be reviewed by the end January 2011.

**10. DATE OF TERMS OF REFERENCE RATIFICATION BY REPORTING COMMITTEE**

Terms of reference ratified by CTP Board [date to be inserted when received and ratified by the CTP Board]

**11. DATE OF EFFICACY REVIEW AND FREQUENCY**

The committee will undertake a review annually of its efficacy as a committee and how well it meets its Terms of Reference, following the Trust’s agreed process.

The next review will be carried out by the end of December 2010 to inform the review of the Terms of Reference, or earlier if required.

**Appendix 5 -**

**NORTH EAST LINCOLNSHIRE CARE TRUST PLUS**

**TERMS OF REFERENCE**

**DELIVERY ASSURANCE COMMITTEE**

**1. PURPOSE**

* 1. The Delivery Assurance Committee is a committee of the Clinical Commissioning Group (CCG) Committee that exists to:
     1. Provide delivery assurance to the Shadow Board and cluster that there are robust structures, processes and accountabilities in place for managing performance and delivery throughout the organisation

* + 1. Oversee the continuous development of the organisations internal performance and delivery assurance framework, encompassing balanced scorecard and exception reporting, tailoring the approach to meet the emerging style and requirements of the CCG
    2. Ensure arrangements for delivery assurance are established and operating effectively for the CCG, meeting current and future requirements
    3. Ensure that all leads for individual performance/assurance measures are held to account in meeting agreed targets / indicators.

**2. TERMS OF REFERENCE**

2.1 The Terms of Reference of the Delivery Assurance Committee are as follows:

* + 1. To challenge and support Senior Officers and senior leads to ensure delivery of performance and quality outcomes and targets for the parts of the annual plan for which they are responsible
    2. To ensure continuous development and improvement through the setting of challenging but achievable targets and outcomes, ensuring work programmes are developed and managed to support delivery and attendant risks are identified and managed.
    3. To oversee the CCG’s performance and outcomes against the prevailing NHS and Adult Social Care performance management regimes. This will include discussing and agreeing recommendations to the CCG Committee and/or CCG Shadow Board for corrective action. Overview the CTP benchmark position against peers group(s) and national comparators.
    4. To provide the Shadow Board with assurance in relation to provider performance and quality delivery including community, mental health, children’s services, health promotion, acute services, Commissioning Support Services and adult social care.
    5. To provide the Shadow Board with assurance in relation to the performance and quality delivery of children’s services as per the partnership agreement.
    6. To oversee the CCG compliance with equality and diversity requirements in line with national requirements.
    7. To consider the future delivery and performance implications of new legislation, assessments, targets and guidance that will impact the CCG and ensure that pre-emptive action is taken to meet all such requirements.
    8. To oversee, manage and develop the CCGs performance management and delivery assurance framework and supporting systems/processes/policies to ensure it is fit for purpose (for current and future requirements) and it is adhered to by all areas within the organisation.
    9. To ensure that performance reports to the cluster and within the internal reporting (including the Scorecard) are correct, appropriate and valid.
    10. To challenge and provide final sign-off to performance targets, indicators and trajectories developed as part of any national / local / cluster or partnership processes
  1. The Delivery Assurance Committee has an operational performance management role in relation to the CCGs risk register in so far as holding leads accountable for the active management and of risks in their areas as per Term of Reference 2.1.2. The Committee will escalate risks by exception to the Integrated Governance & Audit Committee thus there is no overlap of duties with the Integrated Governance Committee.

**3. MEMBERSHIP**

* 1. Membership of the Delivery Assurance Committee is as follows:
* Assistant Chief Executive (Chair)
* Deputy Chief Executive x2
* CTP Locality Chair (through transition to April 2013)
* GP member
* Director of Strategic Change
* Community Lay Member
* ASC Strategic Advisor
* Strategic Lead for Planning
* Practice Manager

3.2 Attendees of the Delivery Assurance Committee are as follows:

* Performance Manager

3.3 Membership of the Delivery Assurance Committee will consist of named representatives and named deputies. Attendance by deputies will need to be approved by the Chair before any meeting.

3.4The Delivery Assurance Committee may request the attendance of any member of staff or senior/clinical lead from the CCG or outside organisations as and when appropriate.

**4. QUORUM**

4.1 The Delivery Assurance Committee will be quorate if any three members are present.

**5. FREQUENCY OF MEETINGS**

5.1 The Delivery Assurance Committee will meet a minimum of 4 times a year.

5.2 Meetings of the Delivery Assurance Committee will be planned for the calendar year ahead.

5.3 Decisions may be taken between formal physical meetings through email, teleconference or other ‘virtual’ means. Any such decisions will be recorded and taken to the following formal meeting for information.

**6. REPORTING ARRANGEMENTS**

6.1 The Delivery Assurance Committee reports to the CCG Shadow Board bi-monthly by exception.

6.2 The Delivery Assurance Committee will ensure as part of the reporting arrangements that highlights and exceptions in relation to delivery and performance are communicated internally and externally as appropriate.

**7. ADMINITRATIVE ARRANGEMENTS**

7.1 Administrative support will be provided to the Delivery Assurance Committee by the corporate support team.

7.2 The Assistant Chief Executive will draw up the agenda for each meeting.

7.3 The agenda and papers will be distributed five working days in advance of the meeting.

**8. TENURE**

8.1 The Delivery Assurance Committee is a permanent committee of the CCG Shadow Board.

**9. DATE OF AGREEMENT FOR TERMS OF REFERENCE AND DATE OF NEXT**

**REVIEW**

9.1 These Terms of Reference were agreed at the Delivery Assurance Committee meeting held on …… and will be reviewed by the end May 2013.

**10. DATE OF TERMS OF REFERENCE RATIFICATION BY REPORTING COMMITTEE**

10.1 These Terms of Reference were ratified on behalf of the CCG Shadow Board by the Integrated Governance and Audit Committee held on \*\*\* **[date to be inserted when received]**

**11. DATE OF EFFICACY REVIEW AND FREQUENCY**

11.1 The committee will undertake a review annually of its efficacy as a committee and how well it meets its Terms of Reference

**Appendix 6 - Guidance on Risk Management in Partnership Working**

A partnership can be defined as having:

* An agreed framework for jointly delivering common goals, with
* Shared risk and resources, which provide
* Identified added value and measurable impact, based on
* Shared accountability for outcomes, which cannot be obtained in other ways

Developing a risk management approach to partnership working can ensure:

* All partners understand the risks associated with the partnership and how they are to be managed
* The partnership is able to anticipate and respond to change
* Surprises, loss and associated costs are minimised
* Raised risk awareness and enhanced accountability of those involved in the partnership
* Enhanced communication
* An improved basis for allocation of resources and delivery of improved services.

Problems arise in partnerships when governance and accountability are weak, i.e. when leadership, decision-making, scrutiny and systems and processes such as risk management are under-developed.

In order to meet best practice NEL CCG must meet two key responsibilities for each partnership they have. They must:

* Provide assurance that the risks associated with working in partnership with another organisation have been identified and prioritised and are being appropriately managed
* Ensure that the partnership has effective risk management procedures in place

There are two aspects to risk management in partnership working:

**Outside looking in - from the CCG perspective**

The CCG needs to consider:

What are the risks it faces in being involved in the partnership? This risk identification exercise must be undertaken before partnership working commences and should be incorporated into the business case.

Risks that should be considered and may apply include:

* Reputation risk
* Legal risk
* Financial risk
* Resources conflicts
* Reliance on a partner to deliver the CCG objectives
* The partners track record in managing risk
* Risks specific to the partnership and the objectives e.g. clinical

A viable exit strategy needs to be identified should the partnership fail.

The risks identified should be risk assessed and transferred to the Corporate Risk Register for on-going management and monitoring. Any risks that are identified as major will be added to the Corporate Risk Register for consideration by the Board.

**On the inside - from the partnerships perspective**

The lead organisation should seek the following assurances from perspective partners:

* How well is risk management embedded in their business?
* Does their risk management methodology conform to good practice?
* Who are the key players involved?

As a minimum the CCG lead for the partnership must undertake a pre-partnership risk assessment (see above –outside looking in). Other partners may have done the same. If there is a willingness to share these risks this could form the basis of a partnership risk identification exercise and a joint risk register being established for the duration of the partnership.

Other considerations are:

* How will shared key risks be reported to the CCG?
* What will be the arrangements for joint risk registers?
* How will action plans be prioritised?

Risk within the partnership will include some of the risks already identified through the pre-partnership risk assessment, but others to consider may be:

* Lack of ‘buy-in’ from all partners
* Confused governance arrangements e.g. financial control, reporting arrangements
* Organisational culture differences
* Partnership is seen a CCG lead
* Risks inherent in professional judgement/activity e.g. clinical competency requirements
* Reliance on IT system/equipment
* Change in national policy
* Workforce issues e.g. recruitment/training
* Data Protection & Confidentiality – information sharing