Good Governance Institute

Herts Valleys Clinical Commissioning Group

Governance review and board development plan

May 2013

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Background

In January 2013 Herts Valleys Clinical Commissioning Group (HVCCG) appointed the Good Governance Institute (GGI) to provide support around the actions identified in their rectification plan. The CCG had received notification that it was to be authorised from 1st April, but with many conditions. A largely new leadership team on the executive side was just coming on board, and other consultancies were working with the CCG on other elements of organisational development. Specifically, GGI was asked to:

- Carry out a governance review, and start to put in place relevant governance and board development actions in order to bring the CCG's governance up a standard that would meet good governance practice
- Undertake a significant clinical engagement programme, with interviews and a survey aimed at reaching GPs, practice managers, practice nurses and the localities
- Develop and initiate a board development programme
- Support, through systems development and training, the CCG's quality and risk functions

This report describes the governance review itself, and includes details of the board development programme. Though the governance review was actually completed in and tested with the board in early March, because of GGI's work on the other elements of the plan we are able to provide more detail of the continuing development activities since the formal review itself was completed.

The aims of the governance review were to:

- Review and strengthen governance arrangements
- Strengthen assurance
- Development and start to implement a board development plan
- Contribute to board leadership development

The key themes from the rectification plan that we were mindful of in undertaking this task were:

- Ensuring that clinical views were foremost in decision-making and planning
- Issues around the capacity to properly manage complaints, ensuring that trends are analysed, actions taken and proper communication is in place
- Ensuring that the CCG meets the requirements as specified in the legislation and guidance
- Putting in place clear governance structures
- Ensuring that the board had the requisite skills to carry out it's functions and duties
- Putting in place and initiating a board development plan
- Developing systems to support two-way accountability within the CCG

HVCCG had a bruising experience around the authorisation process. The then accountable officer left and the very significant number of conditions to authorisation could have been a bitter pill for the GPs on the board to swallow. From the start of our engagement with HVCCG, however, we were struck by the open attitude and willingness to listen and change. The team at HVCCG has worked enormously hard and have made the authorisation process and subsequent preparation for the rectification visits a

constructive period of rapid development. We have found the board and staff receptive to our suggestions and support, and would thank all concerned for their contribution to this governance review and board development plan.

Review method

It was very clear early on that the board team developing the application for authorisation had been in management mode, and that little had been done to move on to a more formal governance-type system of board working. For this reason, we were asked to place most of our effort on lifting the organisation to good governance practice, rather than just measuring where the organisation then stood. The governance review itself was carried out over a month and included:

- Board observation on two occasions by two different people, to understand board working and behaviours
- Document review of board papers and reports, policies, etc
- Individual interviews with board members and board supports
- Locality board observations
- Final feedback and agreement with the whole board at a development session

We did not carry out a full board effectiveness review, which would have then included external and internal stakeholder reviews, testing specific governance systems by following example issues through the governance system, 360 appraisal of board members, committee observation and review, etc. The level of the review was the right one given this was a new organisation with a largely new executive team and that the task, agreed by all, was essentially developmental. Our review has proved quite sufficient to establish and get the board to agree a baseline of where they were in March and the developmental needs they have over the coming months.

Key findings

The CCG board is committed to doing the right things and has made significant progress in a short space of time. We found that little time had been spent by the board on understanding what their role was as a corporate board within an accountable organisation, and there had been little attempt to tease out management tasks from governance responsibilities. We felt this was entirely understandable, and had been a consequence of the GP team on the board working as a task group to build the CCG and apply for authorisation. Because of this, very little (and in some areas no) progress had been made on the normal governance trajectories which we would expect to see and which are captured as issues on our CCG maturity matrix (appendix I). We would usually get a board team to agree where they now were on the matrix, and where they aspired to be. Because the board had not set itself the task of starting the governance journey in a concerted way until we arrived we feel it better to use the matrix to identify initial board and governance development (to July 2013), and then fifteen months into authorisation (July 2014). As stated above, the board were very keen to move forward and start to introduce appropriate governance rigour around their working.

Our high-level findings in this review are:

Governance and management. The board is just feeling its way towards their governance rather than management responsibilities. This manifested itself in a board that was potentially divided between the GPs and the rest. This was not because of any issues of conflict, but simply because the board had not reflected on executive and non-executive roles – and what the appropriate board member role was in managing the organisation and its development. Since March the board has now appointed the lay non-executives and has started to explore the possibility of clinical members of the board with no programme lead responsibilities, making these individuals effectively clinical non-executives. This opens up significant possibilities around sound assurance and having an audit committee with clinical involvement. Also, during this period the interim accountable officer has been appointed on a substantive basis, and other senior and second-line reports have been recruited and have started to contribute to the better running of key governance systems. While there is a way to go to develop the board to good governance practice there has been a very promising start and much useful debate. The next few months will be crucial to establishing the unique added value that a corporate board brings to an organisation through good governance practice.

Roles and responsibilities. As part of this journey from the 'board' being the team that put the CCG together, and which had weekly meetings of which one in four were full 'board meetings' and towards a recognisable system of board governance, roles and responsibilities have needed to become more explicit and understood. The executive accountability for quality, risk and clinical governance is an example of this. The Board Nurse has been formally identified as the executive lead and is now able to take forward these key programmes which will support board work and effectiveness. The process of making roles clear has been uncomfortable at times. The board has patient representatives attending board meetings and the future role of these individuals was clearly different in their minds to that of others on the board. We understand this is being resolved. The board handbook now being developed will helpful clarify roles and accountabilities, as well as describe how the key governance systems of the organisation are designed to work.

Structures and systems. Alongside the process of general clarification, the CCG badly needed to sort out its governance and managerial systems and structures. The governance structures were explained in the Constitution in broad terms. Over the last two months there has been considerable effort to developing these structures and systems. For example, specific terms of reference for the board committees are now developed for board agreement, and a risk system has been put in place and training around this is starting. Another important issue the board is getting to grips with is agenda planning, and commissioning the committees around what assurance they need to be providing back to the board. Within the year these systems need testing and review as part of their own quality improvement process.

The CCG and the localities. We felt that this CCG is a little tender over the localities. We understand the localities are based on forms of GP association that stretch back a number of years and which provide a natural locus within four localities for the GP members of the CCG. We use the word 'tender' because on the one hand the localities were presented to us as the real power-house of the CCG and the potential delivery mechanism of much of the CCG work, but on the other as groupings who had not fully grasped the sovereignty of the CCG. We err towards the latter view, without in any way criticising the contributions of the localities. We feel this is simply a facet of this being early days, and the CCG board prior to February as being the task group to secure CCG authorisation. Now the role of the CCG board has switched into being an accountable body and the localities have the tasks of selecting some of the members of the board, two-way communication of ideas and agreements and the delivery of CCG policies and actions. We feel more work needs to be done with the localities to better understand and become confident with this their new role. One key role for the localities, which we commend them to whole-heartedly embrace, is to support the CCG with growing future clinical engagement and succession planning for the CCG by encouraging the next general of clinical leaders to become involved with the CCG's programme of work. This has been identified in the interim clinical engagement report.

Assurance and dashboards. The ordinary reporting to the CCG was frankly inadequate. Some key reports such as the Board Assurance Framework (BAF) and the risk register had been inherited from the PCT and the content was not relevant to the CCG, nor was the board using them. The quality report was a jumble of detail prepared raw by the commissioning support function, with little by way of interpretation. The finance reports were better, but not owned by the board. The new executive team were very aware of the significant task they had in terms of improving the standard of reporting, and working with the board to be discerning and directive around what was needed to govern and be accountable for the CCG. Early progress has been made, and with the new risk system and new BAF the board can now begin to work with governance instruments that are the CCG's own and fit for purpose. Board development sessions are in hand to help the board become confident and agile with these instruments. The reporting of finance and quality has become much more sound, and again sessions are planned with the board to build understanding and ownership.

Grip on commissioning. We suspect that, like many CCGs, the main task of the board team prior to February had been securing authorisation, and we commend the board for flipping from this focus to genuinely starting to make their raison d'être the commissioning function. With the rectification programme's needs being addressed in parallel, it would have been an easy distraction to focus on knocking the deliverables on the rectification programme off one by one, but the board has been settling in to focussing on the many and manifest problems in the local health and social care economy and their role as commissioner in starting to tackle these issues. The CCG has volunteered itself to take part in the pilot of the GGI commissioning simulator in the summer that will again help to move development activities from being a competent board to being a commissioning board. The development of the programme office will be a significant means of focussing effort on commissioning activity.

Risk. The management of risk was especially poorly understood by the CCG, and the board development programme started with a session on risk appetite. As identified above, the risk systems of the CCG seemed to have been copied and pasted from the former PCT, and many of the board members were not aware of what they should expect from a risk system. Developing the risk system has accordingly been a priority, and a system is now in place that is fit for purpose. The CCG have populated the BAF and high-level risk register, and are gaining growing awareness of issues such as risk escalation, relating the risk system to other reports (eg quality, commissioning activity).

Stakeholder relationships. Much of this was assumed, and based on individual knowledge of board members rather than organised into systems. The board has set up a basic account management system, and the new accountable officer has done much at the managerial level to start to formalise engagement processes. However there is significant work to be done in respect of wider stakeholder engagement. This will be particularly challenging due to instability in some of the local providers

Individual development needs. This had been addressed at only the most basic level. As part of the whole board coaching and the setting up of proper governance and board management systems this will be picked up. During the coming few months we understand the board will be undertaking an individual director 360 review process, and through the Chair initiating individual appraisal and personal development planning systems as described on the GGI CCG governance maturity matrix. This will include issues ranging from Chairing and committee skills through to detailed understanding around post-Francis issues for CCGs.

Improvement outcomes for better governance and board working

To enable a CCG board to understand the sufficiency of their working, GGI have developed and tested a holistic framework for good governance in CCGs. This was initially adapted from the GGI standard governance framework for good governance in healthcare organisations. It has been amended for CCGs, and tested with a range of CCG boards. The framework is in the form of a maturity matrix (appendix I), which takes the main elements of good governance and describes how they can be applied in a CCG setting. As described previously, at HVCCG the board agreed to approach the matrix as if starting from first base, and have agreed a development trajectory to achieve level 4 across all areas by July 2014. The immediate aim is to achieve at least consistent level 2s by July 2013.

Purpose and values. A great deal of work has gone into agreeing the CCG's strategic objectives, and sharpening these up for the BAF. The board has debated purpose, vision and values, but in an ad hoc way and firming these up together with the recent work on strategic objectives will form an essential platform for using these as the basis for decision-taking on commissioning issues.

Strategy. The recent agreement of strategic objectives has been somewhat isolated from partner organisations and the local health and social care market. The objectives are being better linked to the business plan and hold the potential for forming a more controlled basis for the commissioning intentions for the next commissioning cycle. They can, however, certainly inform the current commissioning cycle. The GGI clinical engagement work is explicitly addressing how strategy links from CCG members through to decisions taken.

Leadership. The executive leadership is now largely in place, and the recent election including from localities to the board was well supported. The board will need to continue to address leadership development at both locality and CCG levels, and put in place talent development and succession plans. The board needs to more overtly think through the CCG's leadership role in the local health economy, and have insight into reputation and authority.

Service user, staff, stakeholder and public engagement. This has been very much managed on an intuitive basis, and the CCG will need to move forward in a more formal and structured way. The account management system can be made to work, but needs formalisation around process and reporting. These are very early days and the board development plan has an emphasis on ensuring a stepped development of the board's role with stakeholders.

Finance. With the accountable officer and finance director now in place it has been possible to really start to get to grips with the board being informed around finance and putting in place a sound financial regime. As the systems are developed the board development programme has an identified session on finance issues, and will also through the whole board coaching process help the board reflect on how the regular finance reports are supporting the board.

Risk and agility. The board has had a session on risk appetite, and an integrated risk framework has been put in place. The board will need to build confidence in using these systems, and continue to develop and use the BAF and risk register. Training sessions have been put in place to help the board become confident around using risk management as a key way of working. The risk framework has been linked to the committee system. The developing quality system will also support the effective management of risk.

Integrated reporting. Very rapid progress has been made around building the systems for reporting now that senior executive positions have been filled. The next phase of board development needs to be characterised by an iterative process of continual refinement and improvement to reporting, and including in some of the elements of developmental activity such as the post-Francis quality sessions planned around specific care groups.

Assurance and stewardship. There is now an assurance framework in place, and terms of reference for the key committee structures. These link to the quality and risk systems as they are being developed.

Board performance. The development of the board handbook will be a developmental process to clarify roles, responsibilities and the working systems of the CCG. The planned 360 and PDP developments should allow the board to make significant progress by July to achieving the whole year development aspiration.

Probity and reputation. The building blocks for this are in place, but have not been linked to issues around competition law. A session has been identified to ensure this happens, and the board handbook will include details of the mechanisms for ensuring that reputation is explicitly managed. A session of reputation management has been included in the board development programme.

Decision-making and decision-taking. There are now formal structures in place around how decisions are taken, but these are rudimentary and need honing with the passage of time. More work needs to be done to find the right level for how the CCG board works in terms of decision making and decision taking with the localities.

Board committee structures. These are now codified with terms of reference developed from the Constitution sections about committee role. The CCG is starting to get into the usual rhythm of working between the board and committees. The audit committee is at an early stage of working and will need particular focus during these first months of work.

Quality

The rectification programme makes explicit reference to the need to show that governance arrangements are in place to ensure that decision-making and planning processes allow clinical views and quality to be foremost. The plan notes that the majority of the board are clinicians, but requires further evidence that there are processes to ensure that quality is a priority in governance, decision-making and planning arrangements.

Executive leadership for quality has now been joined up with risk and governance within the remit of the Board Nurse. The quality and audit committees have been formalised with explicit terms of reference available to them, and considerable work has taken place to improve the quality reports to the board. The board development plan has a strong emphasis on developing a CCG-owned concept of quality that will be made operational through the commissioning process. The interim clinical engagement report identifies confidence with the clinical leadership by the board, and has picked up a genuine bias towards quality from the clinical membership. The local healthcare economy is challenged in many ways, and the CCG is clearly aware that it needs to stay ahead of the game in the post-Francis world and has plans to do so.

All this provides a very promising basis for CCG development along the lines described in the rectification plan, as well as some tangible early wins having been achieved. There is now a more formal architecture in place for decision-making and taking, and this has a clear and leading place for clinical views. The quality system as it has been developed mirrors and is congruent to the integrated risk framework. Developmental interventions are in place to support the board fully implement the use of these systems.

Board development approach

We have been able to develop an evidence-based board development programme. This has been based on:

- The governance review
- Requirements in the rectification plan
- Known best practice for ongoing CCG development
- Issues that have arisen from the Capita organisational development work, and the GGI work on quality and risk, and the GGI clinical engagement work (interim report now available)

The board agreed to appoint a whole board coach for the coming period, this being a senior GGI associate who has been on the boards of two PCTs and Chaired one of these, was the Chair of a PCT cluster and is now the Chair of an NHS Trust. The coach is able to work with the whole board team and to help facilitate their initial board development programme, work more closely with the Chair around the ordinary board meetings and board business and with individual board members to help them become confident with their board role.

Within the governance review the board agreed development aspirations for the coming year using the GGI governance maturity matrix for CCGs. This describes the overall direction of travel for the board into 2014. The initial board development programme has been agreed and specified until July, at which stage there will be a session with the board to review the work to date and to agree the next six months of board and governance development.

The main themes of the board development plan are:

- Strategy – vision, leadership, engagement
- Grip – quality, finance, assurance, stewardship, risk
- Planning – decision-making, agenda setting, personal and corporate development

The board development plan to July 2013 is detailed in Appendix II.

Conclusion

This governance review and board development programme have been carried out during a time of rapid progress for the CCG, and in tandem with a number of other significant improvement efforts. It has been helpful that GGI have been able to share work with our colleagues at Capita, who have been carrying out the organisational development work and setting up the programme office.

By agreeing a development-by-doing approach, resources devoted to the review have been minimal and the majority of effort has gone towards improvements. A great deal has been managed in a short time, and this now needs to bed in and be used and gradually refined by the board. July will be an important milestone to test that these changes are being successfully implanted.

Appendix I

Maturity Matrix developed by the Good Governance Institute with input from colleagues working on and with CCG Governing Bodies

See following pages

Clinical Commissioning Group Good Governance Framework

Maturity Matrix developed by the Good Governance Institute with input from colleagues working on and with CCG Governing Bodies

Hertfordshire Valleys CCG aims to achieve progress level 2 across all key elements by July 2013, and progress level 4 by July 2014

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To use the matrix: identify with a circle the level you believe your organisation has reached and then draw an arrow to the right to the level you intend to reach in the next 12 months. 0 ⇢ ?

Version 1.0 March 2013

Progress Levels / Key elements	0 No	1 Basic Level – Principle Accepted	2 Basic level – agreement of commitment and direction	3 Early progress – in development	4 Firm progress – in development	5 Results – being achieved	6 Maturity – and comprehensive assurance	7 Exemplar
Purpose and vision	No	Purpose debated and agreed; values, priorities and drivers established.	Purpose and vision is affirmed in public and internal /partnership documents. Board has agreed values.	Local priorities and target areas to tackle inequalities agreed with stakeholders.	Board has a robust mechanism for commissioning and decommissioning services.	Evidence that national targets and local priorities are being met. Review process for strategy in place.	Annual debate on purpose and impact scheduled by Board in light of achievement of purpose in year.	Success has allowed CCG Board to extend its role and influence.
Strategy	No	Strategy developed and agreed by board, after taking into account JSNA and utilising the skills of the wider clinical community.	Integrated Plan and targets in place to support strategy. Commissioning intentions developed, and supported by HWBs.	Board has protected long-term priorities from short-term pressures.	Annual cycle of Board activity in place, defining strategic progress during year.	Board continually testing how changing environment effects delivery of strategy.	Evidence that strategic aims are being consistently stuck to and met.	Trust/Board is able to demonstrate consistent achievement of strategic goals over life of strategy.
Leadership	No	Good understanding of strengths and weaknesses of local providers, and within CCG membership. CCG leadership in place.	CCG Board can evidence engagement with and support of local clinical community for plans. CCG leadership insightful of reputation with internal and external stakeholders.	CCG can demonstrate use of creative disruption and market shaping.. Board sucession plan in place.	CCG Board has full appreciation of commissioning plans across the sub-region. CCG leadership considered authoritative and trusted by stakeholders.	CCG is recognised as system leader in local health and social care economy.	Board is confident it is leading rather than following local development agenda.	Board considered a national leader, providing support to other organisations.
Service user, staff, stakeholder & public engagement	No	Engagement policy and strategy in place that recognises and makes use of patients and public.	Service user, staff and public recognised as resource to focus, design and deliver service improvement.	Regular analysis is undertaken of trends from complaints and other forms of patient feedback and press coverage of NHS locally is monitored.	Stakeholders confirm organisation effectively engages with them.	Governance Between Organisations issues regularly tested with partners.	Organisation is trusted by service users and the local public. Employer of choice.	Organisation recognised as a national leader in effective engagements with stakeholders.
Finance	No	Board has developed a financial strategy with a clear link to service quality and take into account trends and potential high impact changes.	Board understands financial regime and resources are planned and used in a sustainable manner that invests in the future.	Board is receiving concise and complete financial information on main variations in provider activity and management costs.	Board effectively monitors financial performance, activity and sustainability of providers in accordance with contracts.	Board has developed clear processes for dealing with any areas which begin to show significant variance. Is acting to test market as necessary.	Has developed risk based approach to long-term financial plans and budgets and is budgeting proactively.	Successful leverage of wider community resources to improve quality and outcomes.
Risk & agility	No	Board understands risk as a strategic instrument to drive change.	Known risks identified, mediated and mitigated. Board Assurance Framework (BAF) in place.	Risk appetite for key issues known and built into strategy and BAF.	Continuity plans and 'what if?' scenarios are regularly tested.	Board confident it can respond to a crisis/ opportunity in timely fashion.	Board is able to measure and demonstrate risk appreciation.	Board has successful, demonstrable risk reduction track record.

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Clinical Commissioning Group Good Governance Framework

Continuation of Maturity Matrix …

Progress Levels / Key elements	0 No	1 Basic Level – Principle Accepted	2 Basic level – agreement of commitment and direction	3 Early progress – in development	4 Firm progress – in development	5 Results – being achieved	6 Maturity – and comprehensive assurance	7 Exemplar
Integrated reporting	No	Board has identified what it means by quality and the data it needs for assurance.	Board reports cover activity, cost and quality and are aligned to targets, standards and strategic objectives.	Board is receiving standardised information from providers and can compare performance.	CCG has strong processes for monitoring referrals.	Consistency across local system for monitoring of quality and finance leading to better assurance for CCG and public.	Consistent levels of innovation and quality improvement year on year.	CCG is quoted as source of public confidence in quality of services.
Assurance and stewardship	No	Board is confident that Assurance Framework is balanced & reflects priorities.	Control mechanisms in place for entire BAF. Board has identified and agreed assurances. Annual review of Audit Committee planned.	Assurance systematically sought and data from internal, external and clinical audit and patients is systematically triangulated.	Providers are assuring CCG of performance and quality in a timely way allowing for benchmarking across system.	CCG able to re-invest significant resources derived from own referral management savings/ service change and promotion of provider innovation.	Board confident through evidence that it has intelligent analysis & assurance of all systems across the health economy.	Organisation benchmarks are a national leader in terms of outcomes against resources, and in costs associated with assurance system.
Board Performance	No	Roles and responsibilities of all board members and relationship to localities clarified and understood.	Board has agreed the value it wishes to add. Development programme agreed and implemented.	Induction and PDPs in place for Board and aspirant board members.	360 ° appraisal of Board undertaken and informs Board Development Plan.	Systematic feedback sought on added value of the Board.	Board is recognised as adding value by stakeholders.	Board recognised as 'public appointment of choice' nationally.
Probity & reputation	No	Standards of Conduct for Board explicit and accepted. Plans in place to manage conflicts of interest.	Conflicts of Interest system includes Board and senior staff, is up-to-date and records actions.	Board has third party evidence of its reputation and standing.	Probity expected of all partners and providers and this written into contracts.	Reputational risk considered in scenario and 'what if?' exercises. Reputational risk appetite agreed.	Organisation seeks and acquires good governance recognition.	Organisation able to show how high-standing benefits achievement of strategy.
Decision making and decision taking	No	Decision-making includes appropriate consultation and option / impact appraisal.	Decisions capitalise upon the expertise of clinicians, staff and patients across the health and social care economy.	Integrated information and risk-assessments used by Board, and available for other stakeholders.	Board consistently takes decisions based on evidence. Audit committee has reviewed key decisions.	Clinicians are engaged in pathway redesign and provider appetite for innovation is harnessed.	BAF issues and Board agendas similar over last year.	Board successfully able to influence national decisions.
Board Committee structures	No	Relationship between CCG Board and Locality Groups clear and implemented. Audit committee role developed to take on independent scrutiny function.	Board Secretary holds compliance and tracking role for all assurance issues of the board. SID appointed. Audit Committee in place.	Workload and agendas for committees planned and task groups have time-limited existence.	Audit Committee workload and agendas under control. Internal & external auditors & advisors aligned to agenda & role.	Annual cycle of Board business reviewed at year-end and planned activities completed.	Overall time investment in board working and committees reduced through organisational effectiveness.	Board's systems adopted by others as examples of good governance practice.

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Appendix II

Hertfordshire Valleys CCG board development plan

This initial board development plan focuses on priorities identified by the Good Governance Institute (GGI) in their February 2013 high-level review of governance. Towards the end of this initial programme the board will need to take stock and agree their development programme for the following year.
This plan forms part of an overall programme of work to implement better board working and good governance practice in line with the GGI good governance framework for CCGs.

The key issues this programme addresses are:

- Addressing issues raised in the authorisation process and described in the rectification plan
- Developing director skills and competence, in line with proper clarification around roles and accountabilities
- Supporting better commissioning through constructive stakeholder relationships and proper board grip on performance
- Continued commitment to comprehensive clinical and membership engagement
- Building a strategic focus for board, 'lifting' attention towards strategic aims while at the same time developing proper systems for holding management to account for month on month performance
- Addressing both post-Frances quality responsibilities for CCGs and proper control of finances within the local healthcare economy

Board development plan March – July 2013

(with review to fix development programme August 2013 – January 2014)

Date	Task	Outcome
March / April 2013	Initiate the production of Board Handbook to: • confirm roles and responsibilities of all board members • integrate HVCCG wishes and legal and regulatory requirements • agree standards of conduct Firm up systems of appointment. Produce Induction manual and programme. Ensure implemented for all board members. Task to run to July (AC-N). Board agrees strategic objectives for the CCG. Identifies key risks and drivers in local healthcare economy to delivery of strategic objectives. Develop Corporate Risk Register and Board Assurance Framework (BAF) and relate to annual cycle of business. Development of risk mechanisms and revision of BAF and Corporate Risk Register. Discussion of how, post Francis, the Board will recognise and respond to issues relating to risk. (HM / PM).	• The Board has in place an integrated risk framework, supported by a BAF and a risk register • All Board members understand their responsibilities and accountabilities as Board members – including executive and non-executive roles. • The Board has identified what kind of Board it wishes to be and what value it wishes to add. • There are clear objectives set for the CCG and the risks to implementation have been identified, the CCG and localities are clear about their respective responsibilities and accountabilities and there is good clinical engagement across the CCG area. • A basis has been established for good clinical engagement across the CCG.

Date	Task	Outcome
May 2013	Session on how QIPP agenda will be managed, what dashboards / trend analyses will be required and an early warning system for problems with quality and finance. Discussion with key providers on expectations of them in terms of reporting on quality/ finance challenge and QIPP agenda. Assignment of 'account management' responsibilities to executive team members (HM / PM). Produce annual cycle of business. Agree Board agenda format. To include performance dash-board. Discussion of how the Board commissions audit committee to provide assurance (PM). Session on financial regime and successful scrutiny of finance for board members (AW). Chair holds 1:1s with Board members. Personal Development Plans agreed. 1:1 coaching sessions offered to individual Board members (PM). Session to socialise the agreed risk system with board members, staff and localities (HM)	• BAF has been used to inform the Board's annual cycle of business; • A performance dashboard has been developed and all Board members have a good understanding of what it is telling them and how to use it; • There is a robust quality management system, quality improvement process and quality assurance in place from across the health and social care economy to the Board and then from the Board to external stakeholders; • Consistency of reporting from providers allows for better benchmarking of information and performance; • All Board members have a good understanding of the finances of the CCG, what the financial reports are telling them and what successful scrutiny and challenge would look like; • The board and locality board members are confident around the integrated risk system • The BAF and risk register are increasingly populated and used by the CCG • CCG Board understands how it will manage quality / finance agenda and has an early warning system in place.

Date	Task	Outcome
June 2013	Work with sub-committees on work-load, agendas and annual work programme (PM). Review of partnership arrangements, in particular with public health, Health and Well-Being Boards and NHS England. Work through features of good and bad partnerships. Review of current account management system for relationships with main local providers Post-Francis quality events held jointly with providers around key care areas, e.g. dementia, diabetes (MG/PM). Coaching for individual directors. Session on quality and safety system and successful scrutiny of quality and safety by Board Members (JN). Large scale listening event with membership to build on GGI facilitated engagement exercise to inform development of objectives, priorities for the CCG and the formalisation of inter-relationship between CCG Board and Localities (DG / PM).	• Ensure that sub-committee members understand their responsibilities, what the Board requires of them and the inter-relationships between the committees; • Board works proactively to manage demand through effective working with public health and joint commissioning. Had developed good understanding of what it means by partnership and how to achieve effective partnership working; • Board has signalled its intention to be an effective leader of the health economy by promoting a better understanding of how the health, housing and social care providers can work together to deliver better outcomes for patients living with long terms conditions; • Board is receiving the assurance it needs around quality and safety of services and is in a position, collectively and individually, to assure external stakeholders;

Date	Task	Outcome
July 2013	Consideration of how CCG will test its reputation within the local health and social care economy (PM). Board-to-Board sessions planned with key providers (HM / PM). Scenario session around effectiveness of decision-making, the extent to which they have been consistent with stated values and impact on quality. Relate to risk appetite and values. Potentially this could be integrated with the commissioning simulator session (HM / PM). Appraisal process agreed for individual Board members and process for 360° appraisal of Board agreed (A C-N). Session on conflicts of interest and competition law (A C-N). Listening event with patient and community groups. Feeds into board discussion on how views of patients and the public will be taken into account. Stock-take on progress of board development plan. Agreement of next phase for board development plan. Review of the GGI CCG good governance matrix to affirm progress towards developmental goals	• Board knows how it will review its own performance and manage its reputation within the local health and social care economy and the wider system; • Board has increased understanding of the CCGs commissioning intentions with its providers, understood the aspirations of providers and built stronger relationships; • Board has clear process in place for managing competition and dealing with conflicts of interest; • Board understands how it will ensure that it is listening to the widest possible range of voices and how these will inform its decision-making; • Board will have taken stock of its performance and taken the opportunity to review a number of key decisions that it has taken and checked whether it used the right information, the decisions remain safe, whether the impacts on quality were sufficiently understood or whether they were consistent with the CCGs stated values; • Board will continue with the evidence-based and outcome orientated approach to board development

PM = Peter Molyneux
HM = Hilary Merrett
AC-N = Andrew Corbett-Nolan
Jan = Jan Norman
Alan = Alan Warren
MG = Professor Martin Green
DG = David Goldberg

A whole Board coach (Peter Molyneux) is supporting the facilitation of the programme. Some Part B Sessions of the CCG Board can be used to hold sessions in the programme that lend themselves more to briefing.

Herts Valleys Clinical Commissioning Group

Governance review and board development plan

May 2013

www.good-governance.org.uk