4.1

Appendix 1

Annual Reports and Accounts 2018-19

Annual Governance Statement

1.0 Introduction and context

1.1 NHS Dorset Clinical Commissioning Group is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

1.2 The Clinical Commissioning Group's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

1.3 As at 1 April 2018, the Clinical Commissioning Group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

2.0 Scope of responsibility

2.1 As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

2.2 I am responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group as set out in this governance statement.

3.0 Governance arrangements and effectiveness

3.1 The main function of the Governing Body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

3.2 The Membership has retained the power to make changes to its core constitution but has delegated the majority of the decision making functions to the CCG's Governing Body. The Governing Body has, in turn, delegated some decision making to the organisation's committees. Further information relating to the delegated responsibility to each of the committees is detailed in the Annual Report and Accounts 2018/19 and Terms of Reference (see pages 59 to 60).

4.0 UK Corporate Governance Code

4.1 NHS Bodies are not required to comply with the UK Code of Corporate Governance, however we have reported on our corporate governance arrangements throughout our Annual Report and Account.

4.2 From 1 April 2018 and up to the date of signing this statement, the CCG has complied with the provisions set out in the NHS Clinical Commissioning Group's Code of Governance and applied the principles of the Code.

5.0 Discharge of Statutory Function

5.1 I can confirm that the correct arrangements are in place for the discharge of statutory functions.

5.2 During establishment, the arrangements put in place by the CCG and explained within the UK Corporate Governance Code were developed with extensive expert external legal input to ensure compliance with all the relevant legislation. The legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

5.3 In light of recommendations of the 2013 Harris Review, the clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

5.4 Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

6.0 Risk Management arrangements and effectiveness

6.1 In May 2018, Internal Audit (BDO LLP became the CCG's internal auditors in April 2018) undertook a 'risk maturity assessment' of the CCG as an advisory piece of work. This assessment aimed to help ensure that an effectively risk management culture becomes embedded across the CCG by highlighting areas where processes could be improved.

6.2 The audit identified many aspects of good practice within the organisation, whilst recommending a number of opportunities for enhancement of the risk approach. The main themes of the recommendations included (amongst others) a need to clearly define the CCGs risk appetite and communicate it widely, and improved staff training.

6.3 The overall maturity assessment was rated as follows (against the risk maturity assessment matrix used within the audit):

	Risk Governance	Risk Identification And Assessment	Risk Mitigation and Treatment	Risk Reporting and Review	Continuous Improvement
Current	Defined	Managed	Defined	Managed	Defined
Target	Managed	Enabled	Managed	Enabled	Managed

6.4 Following the risk maturity audit recommendations, in March 2019 the Governing Body approved an updated 'risk appetite statement'. The statement details the appetite of the organisation in relation to risk in the following six domains: quality, safety and outcomes, reputation, innovation and transformation, workforce, compliance and regulation, and finance and operations.

6.5 The CCG recognises that to lead the health system within an Integrated Care System (ICS), the organisation needs to be bold and courageous, to ensure sustainability for the future. Acknowledgement and acceptance of a higher level of risk is sometimes necessary to facilitate innovation in the delivery of services. Therefore, following the formulation of the CCG risk appetite statement, work to develop and implement an ICS risk framework, ICS risk appetite and ISC risk register is underway.

6.6 Every activity that the CCG undertakes or commissions others to undertake on its behalf, brings with it an element of risk that has the potential to threaten or prevent the organisation achieving its strategic objectives. Unmanaged risk can affect people, assets, the organisation and reputation and ultimately be of detriment to the population the CCG serves.

6.7 The CCGs Risk Management Framework, which is regularly updated as the approach to risk within the organisation develops:

- standardises and clarifies the terminology of risk management;
- sets out the organisation's objective to identify, treat and mitigate risk;
- explains the roles and responsibilities within the CCG relating to risk;
- defines the role and objectives of the CCG's committees and groups;
- clearly explains the tools (Corporate Risk Register and Governing Body Assurance Framework) used by the CCG to document and manage risks to the organisation, detailing the clear, consistent and effective risk scoring systems used;

- details how the organisation has a clear view of the risks affecting each area of its activity, how the risks are being managed and their potential impact on the organisational objectives;
- assures the public, patients and their carers and representatives, staff and partner organisations that the CCG is committed to managing risk appropriately.

6.8 This documented approach to managing identified risk helps the CCG achieve agreed standards, reduce overall costs and maintain and enhance the standard of service provided.

6.9 The CCG ensures that risk management is embedded in all aspects of the work of the organisation. Examples include:

6.10 **Equality Impact Assessments:** CCG is committed to ensuring a reduction in health inequalities and places the needs of Dorset communities at the heart of all commissioning functions. 'Equality analysis' is undertaken when commissioning services, making changes to services, using information within services and within the policies that are used. Additionally, the CCG publishes an annual 'Equality and Diversity report' which acknowledges the organisation's successes in relation to equality and diversity, as well as making recommendations for improvement.

6.11 **Incident Reporting:** Incident and serious incident reporting is openly encouraged from all staff, GP practices and the provider organisations (both NHS and non-NHS) that are commissioned by the CCG. This information is analysed and used to identify any risks which may impact the business of the CCG.

6.12 **Stakeholder engagement:** In line with our duty, the CCG actively involves local people ('public stakeholders') in the planning and development of locally commissioned services.

6.13 **Counter fraud methodology:** The CCG also actively deters risks through the adoption of robust counter-fraud methodology. All clinical and non-clinical staff receives training on the identification of fraud within the CCG. The CCG has a contract with Tiaa to provide counter fraud and security management services that have an annual work programme.

6.14 The CCG's Executive Lead for fraud and corruption is the Chief Finance Officer, who is responsible for authorising investigations, including the arrest, interviewing and prosecution of subjects and the recovery or write-off of any sums lost to fraud.

Capacity to handle risk

6.15 The CCG's Governing Body Assurance Framework provides assurance to the Governing Body of the controls that are in place to mitigate the key risks that could impact on the CCG's delivery of its programmes and priorities.

6.16 Key controls where assurance cannot be fully demonstrated are highlighted in blue on the framework, with an explanation of the work in progress to achieve assurance. Quarterly updates are provided to the Directors of the progress against achieving full assurance, with formal reports submitted to every Governing Body and Audit and Quality Committee meeting. This pro-active method of managing risk is a preventative approach to limit the risk exposure to the organisation.

6.17 The Corporate Risk Register is a risk management tool which acts as a central repository for all current risks identified by the organisation. All risks are recorded and managed via the Ulysses software 'Safeguard Risk Management System' and are mapped (where applicable) to the strategic objectives of the CCG.

6.18 In relation to risk management the Governing Body membership and executive team are responsible for:

- articulating the organisation's strategic objectives;
- identifying risks to the achievement of its strategic objectives;
- protecting the reputation of the CCG; providing leadership, active involvement and support for risk management;
- determining the risk appetite for the CCG;
- ensuring the approach to risk management is consistently applied;
- ensuring that there is a structure in place for the effective management of risk throughout the CCG and that this structure is consistently applied;
- monitoring these processes on an on-going basis via the Governing Body Assurance Framework and Corporate Risk Register;
- reviewing and approving the Risk Management Framework on an annual basis.

6.19 The CCG is able to assure itself of the validity of the Annual Governance Statement in a number of ways. These are:

- adherence to the Risk Management Framework;
- adherence to the CCG committee structure, Committee Terms of Reference and reporting framework;
- biannual confirmations from the Chairs of the key groups and committees that the assurances for which their programmes have delegated responsibility have been scrutinised and that there are no significant lapses in assurance or (in the case of lapses/gaps in assurance) details of the work being taken, including action plans, to resolve the lapses/gaps;
- scrutiny of the draft Annual Governance Statement (this document) by members of the Audit and Quality Committee prior to submission and sign off at the special meeting for closure of finances in May 2018.

6.20 Leadership for the risk management process within the CCG is provided via the Governing Body, with responsibility delegated to the Audit and Quality Committee. The organisational structure has been established in order to assist with this process and is described in the following paragraphs.

6.21 All Directors are responsible for compliance with the Risk Management Framework to ensure that remedial actions are identified and taken wherever key risks are identified within their area of responsibility.

6.22 The Director of Quality and Nursing is the designated lead for risk and patient safety within the CCG, and is responsible for ensuring that the Risk Management Framework is implemented and evaluated effectively.

6.23 All Directors, Deputy Directors and Managers have delegated responsibility and authority with regard to the management of risk within their specific areas of work, including compliance with the Risk Management Framework and for ensuring that remedial action is taken wherever key risks are identified within their area of responsibility, including:

- the reporting of adverse incidents, together with actions to prevent or minimise a reoccurrence;
- identifying and adding risks to the Corporate Risk Register in a timely manner;
- coordinating the application of resources to minimise, manage and control the likelihood and/or impact of the risk;
- undertaking risk assessments and actions implemented;
- ensuring staff undertake mandatory and statutory training.

6.24 The CCG has clear governance structures with delegation of responsibility clearly articulated in the terms of reference for committees and groups (as described on pages 65 to 66). All committees review their effectiveness annually and there are clear lines of reporting from all committees and groups to the Governing Body. The Governing Body through reports and updates reviews the quality, performance and financial stewardship of the organisation. Any risks identified relating to these areas have been recorded in the Corporate Risk Register and/or the Governing Body Assurance Framework.

6.25 The CCG operates a ‘Declaration of Interest’ register and this is checked regularly; potential conflicts of interest are taken into account in all aspects of the CCGs business. Declarations of interest are recorded at every formal committee and group meeting.

6.26 The Head of Patient Safety and Risk, supported by the Patient Safety and Risk Manager has delegated responsibility for:

- co-ordinating and managing activities relating to clinical, corporate and financial risks for the CCG;
- monitoring risk management and patient safety within commissioned and corporate services for the CCG;
- maintaining the Corporate Risk Register and Governing Body Assurance Framework through engagement with the Directors and Directorate Risk Leads;
- the management of all Never Events, Serious Incidents Requiring Investigation and Adverse Incidents.

6.27 The Patient Safety and Risk team within the CCG supports the consistent identification, assessment and management of risk across the organisation

and, as a team, are central to the dissemination and application of best practice. Additionally, the team administers the key administration and system processes and acts as a central resource and advisory function in relation to risk and risk management.

6.28 Face-to-face training for existing CCG employees was implemented during 2018/19 covering the key components of risk management. Plans are in place to roll out training to all new staff during 2019 through the induction process.

6.29 The cumulative contribution of the above mechanisms assists in the assurance of commissioning services that ensure patient safety is high profile.

Improving our Security Posture

6.30 Cyber-attacks are a continually growing threat and all businesses including the CCG need to operate in a culture of "when" rather than "if" the organisation is breached to ensure that the CCG is as prepared as possible and respond as effectively as possible.

6.31 During 2018-19 the CCG IT team implemented a new Security, Information and Event Management (SIEM) solution which analyses logs throughout the CCG looking for suspicious behaviour and patterns of attack. The Information Security Team currently receives between five and 30 'alarms' each day (which require investigation) and sees continuous connection attempts (approximately every 15 seconds) from hostile nations. The CCG also experiences 'healthcare-specific' attacks on its infrastructure as 'threat actors' (the "attacker") probe whether healthcare-specific applications such as SystmOne (an electronic clinical record) is exposed to the internet.

6.32 The Information Security Team needs to spend time during 2019-20 understanding 'what normal looks like' on CCG systems adding custom rules to tune out 'noise' and focus upon looking for suspicious activity relating specifically to the CCG.

6.33 The SIEM solution now highlights suspicious and attack activity which is to be expected on any computer network. As these activities are now visible due to the SIEM, the CCG will need to remain committed to identifying, classifying and remediating them.

Cyber Attack (March 2019)

6.34 In March 2019, the CCG was impacted by a cyber-attack.

6.35 There was no data lost due to this incident and the attacker did not manage to compromise any further CCG systems.

6.36 The CCG is deploying enhanced phishing reporting and blocking as a result of this attack and this will be implemented through May 2019.

6.37 A challenge for the year ahead is to educate and train staff to spot and take action on phishing emails.

Risk Assessment

6.38 The CCG continues to develop and embed its approaches to risk management both internally in the organisation and as a partner within developing ICS. The CCG views integrated risk management as a key element in the successful delivery of both CCG and ICS business and remains committed to ensuring staff are equipped to assess, manage, escalate and report risks.

6.39 To deliver the CCGs vision to "provide services to meet the needs of local people and delivery better outcomes", a number of programmes and priorities have been developed, supported by two enabling programmes.

6.40 Achievement of these programmes and priorities is at risk if the strategic risks (documented below) are realised. From Q3 2018/19, these strategic risks have been scored for each risk using the NPSA risk matrix and the score is documented on the publically available Governing Body Assurance Framework. At the end of March 2019, the risk assessment scores are as follows:

- inadequate funding is available to deliver the required services and the transformation programme (HIGH 16 – Likely x Major);
- unprecedented rise in demand on services occurs (HIGH 16 – Likely x Major);
- the Integrated Care Partnership breaks down (MODERATE 12 – Possible x Major);
- there is significant, sustained failure of a major provider (MODERATE 12 – Possible x Major);
- there are insufficient skilled and qualified staff within the system (HIGH 20 – Almost certain x Major)

6.41 This assessment will be undertaken by the Directors quarterly, with a visual demonstration on the Assurance Framework of any scoring changes (i.e.: increased or decreased risk).

6.42 All assurance lines on the Assurance Framework are aligned to the strategic risks and priorities/programmes and all corporate risks are aligned to a priority or programme.

6.43 The Governing Body receives regular assurance on the management of internal risks and assurance both directly via regular reports including the full Governing Body Assurance Framework and Corporate Risk Register and via assurance from the Audit and Quality Committee.

6.44 Reports are also received on a monthly basis by Directors summarising the top risks to the organisation (those scoring over 15), new risks, closed risks and any other key risk issues. Directors also review the full Corporate Risk Register at every meeting.

6.45 All risks identified in the Corporate Risk Register require the formulation of an action plan. A member of the Patient Safety and Risk team communicates with risk leads on a monthly or quarterly basis (dependant on risk level) to record progress against action plans and documents the effect these are having on the residual risk score. All action plans are formally reported via the Corporate Risk Register. The document includes all risks that may impact on the achievement of the CCG's objectives.

6.46 Risks are scored on a likelihood x consequence matrix to score the potential severity of a risk being realised. Risks scored above 15 are categorised as high risk.

6.47 During 2018/19 the existing process to record operational risks associated with development project continued, with a clear route to escalate any of the risks identified to the Corporate Risk Register.

6.48 Between 1 April 2018 and 31 March 2019, 23 risks were added to the Corporate Risk Register. Of these 23 risks, eight have been closed within the year. 31 risks remain open.

6.49 Of the remaining 31 open risks, eight are assessed as high risk. The risks relate to:

- deprivation of liberty without authorisation;
- financial overspend within personal health commissioning;
- timely and adequate support to GP practices;
- potential closure of one GP practice;
- delayed transfers of care;
- ambulance response times (two risks);
- demand for elective services.

6.50 The outstanding risks in place on 31 March 2019 are carried over into the new financial year and will continue to be managed within the Risk Management Framework described within this statement. The risk profile of the CCG is subject to on-going in-year revision.

6.51 As Accountable Officer I can confirm that there have been no significant lapses of protective security.

7.0 Other sources of assurance

Internal Control Framework

7.1 A system of internal control is the set of processes and procedures in place in the clinical commissioning group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

7.2 The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

7.3 The Corporate Risk Register has controls described for every risk entry. The controls are reviewed on a monthly or quarterly basis (depending on their risk level) along with progress for reducing the risk to ensure they are still effective.

7.4 The framework provides assurance to the Governing Body of the controls that are in place to mitigate the key risks that could impact on the CCG's delivery of its strategic objectives.

Annual Audit of conflicts of interest management

7.5 The updated/revised statutory guidance on managing conflicts of interest for CCGs (published June 2017) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

7.6 In November 2018, the annual internal audit of conflict of interest was undertaken with the final report published in January 2019.

7.7 The scope of this audit covered the areas set out by NHS England in their published audit template for this nationally mandated review. To meet their requirements, the audit gave assurance over the following five key areas: governance arrangements; declarations of interests and gifts and hospitality; registers of interests, gifts and hospitality and procurement decisions; decision making processes and contract monitoring; and identifying and managing non-compliance.

7.8 An overall assurance of 'substantial assurance' was achieved for 'design' with the audit finding a sound system of internal control designed to achieve system objectives.

7.9 An overall assurance of 'moderate assurance' was achieved for 'effectiveness', with evidence found of non-compliance with some controls, that may put some of the system objectives at risk. Three 'low level' recommendations were made in relation to this finding. A low level recommendation is defined as "*areas that individually have no significant impact, but where management would benefit from improved controls and/or have the opportunity to achieve greater effectiveness and/or efficiency."* For further information, refer to Section 10.

Data Quality 2018-19

7.10 The data used by the Governing Body and delegated Committees/groups is obtained from various sources the majority of which are national systems and official NHS data sets. The Provider data is quality assured through contract and performance monitoring and against the Secondary Uses Service (SUS).

7.11 The specific governance of data quality and consistency across the STP providers, via the collaborative agreement, is owned by the Operational Finance Reference Group and managed via the Business Intelligence Reference Group (BIRG) and Data Quality Working Group (DQWG) which have relevant membership and representation from all partner organisations.

Information Governance

7.12 The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by a Data Security and Protection toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively

7.13 The CCG places high importance on ensuring there are robust Information Governance (IG) systems and processes in place to manage data security risks and the protection of patient and corporate information.

7.14 Responsibility for IG rests with me, as Accountable Officer; I have delegated authority to the Senior Information Risk Owner (SIRO), the Caldicott Guardian and the Data Security and Protection Group (DSPG). A range of measures are used to manage and mitigate information risks, including annual mandatory staff training, physical security, data encryption, access controls and departmental spot checks.

7.15 The CCG's IG status is regularly reviewed by the DSPG which is a standing group that reports to the Governing Body via the Audit and Quality Committee. Its purpose is to support and drive the broader IG agenda and provide assurance to the Governing Body that effective IG best practice mechanisms are in place. Risks to information, including data protection, data security, confidentiality, integrity and availability, are managed and controlled via this group which meets bi-monthly.

7.16 The SIRO has responsibility for leading and implementing the information asset risk assessment and management processes within the CCG in addition to advising the Governing Body on the effectiveness of information risk management throughout the CCG.

7.17 As part of the annual DSP Toolkit submission, a comprehensive assessment of information security is undertaken. The effectiveness of this assessment is reported to, and monitored by, the DSPG. This includes details of any personal data related serious incidents, the CCG's annual DSP toolkit score and reports of other IG incidents and audit reviews. Regular reports are received in relation to policies, the Caldicott risk register, information assets and records management.

7.18 There is a staff handbook in place to ensure that staff are aware of their roles and responsibilities under IG and the Data Protection Act 2018.

7.19 The CCG has self-assessed against the DSP Toolkit mandatory requirements and achieved the target of 'standards met'.

7.20 There are processes in place for incident reporting and investigation of serious incidents.

7.21 Information risk assessment and management procedures have been established via the DSPG, the SIRO and the Risk Management Team. Work continually takes place to ensure that these are embedded throughout the organisation. All incidents which have a data protection element are investigated with lessons learnt shared via the DSP Group.

7.22 There have been no serious breaches of the Data Protection Act (Level 2 reportable) in 2018/19 which required reporting to the Information Commissioners Office.

7.23 For further information on responding to Freedom of Information requests please see page 42 of the Annual Report and Accounts.

Business Critical Models

7.24 As Accountable Officer I can confirm that there is an appropriate financial and business framework and environment in place to provide assurance of business critical models, in line with the recommendation from the MacPherson report. These are overseen by the Governing Body and Audit and Quality Committee. External assurance is received via external audit and quarterly assurance meetings with NHS England.

Third party assurances

7.25 NHS Dorset CCG seeks third party assurances when a provider enters a sub-contracting arrangement. The lead provider is then required to report on outcomes of the commissioned service including all aspects of the sub-contracted element of the service. The NHS Standard Contract, General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) Contracts affords the CCG adequate levers and mechanisms to address any concerns that may arise from any third party arrangements. For Personal Health Commissioning, when the NHS Standard Contract is not used, joint contracts with Local Authority partners similarly offer the required level of assurance for such third party arrangements.

8.0 Control issues

8.1 There were no significant control issues identified in 2018/19.

9.0 Review of economy, efficiency & effectiveness of the use of resources

9.1 There are procurement processes to which the CCG adheres. There is a scheme of delegation which ensures that financial controls are in place across the organisation.

9.2 The roles of the accountable and delegated committees and groups are clearly articulated in pages 59 to 60 of this statement and the scheme of delegation has been reviewed, and approved, in year.

9.3 In order to ensure that the CCG delivers on its financial duties and meets its control total, and equally to ensure we tackle the sustainable elements of the Sustainability and Transformation Plan (STP), a collaborative agreement was agreed by the four Foundation Trusts within Dorset and the NHS Dorset CCG in December 2016.

9.4 Monthly monitoring of actions, performance and financial metrics have been agreed and are monitored through by Operations and Finance Reference Group (OFRG) and the Senior Leadership Team (SLT). In addition, Dorset has been supported as a first wave 'Integrated Care System' (ICS), one of eight recognised STPs in the country, which recognises the progress Dorset has made and continues to make. Following the move in Dorset towards an Integrated Care System, a Finance Investment Group has now been set up, with an independent lay Chair to ensure strong system wide governance is in place to management investment funding for, and on behalf of, the Dorset system.

9.5 In order to continue to deliver efficiency within the CCG, a sustainability taskforce is in place led by the Accountable Officer to ensure that Quality**,** Innovation**,** Productivity and Prevention (QIPP) continues to be a priority.

9.6 Monthly reporting is in place to Directors, with bi-monthly reporting to the Governing Body on financial performance and delivery against the agreed plan; this will include the actions for QIPP and proposed mitigations for any variance to plan that could lead to non-delivery.

Delegation of functions

9.7 It is implicit through the work of the Governing Body and delegated Committees that members have clear responsibility for ensuring appropriate use of resources. Where there are concerns in relation to budgetary management, these are clearly documented in the Corporate Risk Register including those key financial risks relating to the CCG's commissioned Providers. During the course of 2017/18 there were three risks identified and recorded on the Corporate Risk Register relating to aspects of financial risk.

9.8 Through the committee structure within NHS Dorset CCG, regular reports are received on the performance of contracted Providers. Areas of under and over performance are addressed through contract meetings and reported though performance and quality papers to CCG groups and committees.

9.9 The Audit and Quality Committee, under the scheme of delegation, monitor the financial stewardship of the organisation via detailed reporting to every meeting and is responsible for scrutinising and signing off the end of year financial accounts. At year end the CCG achieved the control total that had been agreed with NHS England.

9.10 The Governing Body, Audit and Quality Committee, Quality Surveillance Group and Directors Performance meetings retain oversight of all risks including those deemed to be systematic and are responsible for ensuring that relevant mitigating actions are undertaken. There have been no significant internal control failures identified throughout the financial year 2017/18.

9.11 Internal Audit has found no significant lapses in key controls tested in any of the audits that have been undertaken in this financial year.

9.12 With the exception of the South West 999 service and contract support for some out of area contracts including London, Southampton, Bristol and Portsmouth, Dorset CCG does not contract any commissioning support services from an external Provider.

9.13 The CCG commissions support services from other NHS organisations under the NHS Contract for Goods and Services for the provision of back office functions such as payroll, occupational health and procurement. The contract form provides the framework under which assurance on performance can be monitored and managed.

Counter Fraud Arrangements

9.14 The CCG's Accountable Officer for fraud, bribery and corruption is the Chief Finance Officer, who is responsible for authorising investigations, including the arrest, interviewing and prosecution of subjects and the recovery or write-off of any sums lost to fraud.

9.15 The CCG has a nominated Local Counter Fraud Specialist (LCFS) who is responsible for the investigation of any allegations of fraud, bribery and corruption and for the delivery of a programme of proactive counter fraud work, as detailed in the annual work-plan approved by the Audit and Quality Committee. Where fraud is established or improvements to systems or processes identified, the LCFS will recommend appropriate action to the CCG.

9.16 The LCFS works closely with the Workforce Department when investigating cases involving members of staff and provides evidence to the CCG's investigating officer for disciplinary matters.

9.17 Monitoring of the Group's counter fraud arrangements is undertaken by the Audit and Quality Committee. The LCFS, who is responsible for the investigation of any allegations of fraud, bribery and corruption and for the delivery of a programme of proactive counter fraud work, attends each committee meeting to report progress against the agreed counter fraud work-

plan and advise the outcome of any completed investigations or proactive exercises.

9.18 The CCG is required to submit an annual Self Review against NHS Counter Fraud Authority's 'Standards for Commissioners' which provides assurance of compliance to those 'Standards'.

9.19 A Fraud Response Plan is in place which sets out these roles and responsibilities and the steps to be taken by the CCG if fraud is suspected. All staff are required to report any suspicions of fraud, bribery or corruption that they may have either to the LCFS, NHS Counter Fraud Authority or the Chief Finance Officer.

9.20 As part of the Governance arrangements that are in place, external audit undertakes 'a value for money' audit, which assesses the CCGs performance in respect of efficiency, effectiveness and economy. This is undertaken on an annual basis to provide external assurance. In addition, the CCG is required to report to NHS England how it is delivering in respect of use of resources as part of a regular assurance process.

10.0 Head of Internal Audit Opinion

10.1 The role of internal audit is to provide an opinion to the Governing Body, through the Audit and Quality Committee, on the adequacy and effectiveness of the internal control system to ensure the achievement of the organisation's objectives in the areas reviewed. The annual report from internal audit provides an overall opinion on the adequacy and effectiveness of the organisation's risk management, control and governance processes, within the scope of work undertaken by our firm as outsourced providers of the internal audit service. It also summarises the activities of internal audit for the period.

10.2 During the year, Internal Audit issued the following audit reports:

Report	Assurance Assessment	
	Design	Operational Effectiveness
Risk Maturity Assessment	n/a	n/a
Individual Patient Treatments	Moderate	Moderate
Continuing Healthcare – Assessment processes	Moderate	Limited
Primary Commissioning	Substantial	Moderate
Key Financial Systems	Substantial	Substantial
Conflicts of Interest	Substantial	Moderate
IT Architecture Maturity Assessment	n/a	n/a
Partnership Working – Dorset Cancer Partnership	Substantial	Moderate

10.3 The overall Head of Internal Audit opinion is set out as follows:

1. Overall opinion;
2. Basis for the opinion; and
3. Commentary.

Overall Opinion

10.4 Overall, we are able to provide moderate assurance that there is a sound system of internal control designed to meet the CCG's objectives and that controls are being applied consistently. Moderate assurance is the second highest assurance rating and, under the previous NHS internal audit standards, is equivalent to the following: significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.

Basis of opinion

10.5 The basis for forming my opinion is as follows:

- an assessment of the design and operation of the underpinning Governing Body and Assurance Framework and supporting processes
- an assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses;
- any reliance that is being placed upon third party assurances.

10.6 In forming this view, the following was also taken into account:

- the CCG is forecast to deliver its planned in year underspend of £1,734k. As a result, its cumulative surplus that it has built up will total £35,319k;
- the CCG has displayed strong controls in relation the key financial system, conflicts of interest and primary care commissioning processes. Good progress has been made during the year with the implementation of the actions arising from the audit work;
- one report resulted in a limited assurance for operational effectiveness, with three 'high' rated findings. This related to the Continuing Healthcare - assessment processes. A moderate assurance was provided on the design opinion. This area of risk was highlighted by management and the assurance level is consistent with their expectations. This demonstrates the CCG's awareness of their risk areas, and their proactivity in engaging with Internal Audit to ensure they are addressed. Work is in progress to address the actions, with additional resource and support allocated.

11.0 Review of the effectiveness of Governance, Risk Management and Internal Control

11.1 My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the Clinical Commissioning Group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

11.2 Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the Clinical Commissioning Group achieving its principles objectives have been reviewed. I have been advised on the implication of the result of this review by:

- the work of the internal auditors;
- Executive Directors, Senior Managers and Clinical Leads within the CCG who have responsibility for the development and maintenance of the internal control framework;
- available performance information;
- comments made by the external auditors in their annual audit letter and other reports.

11.3 The Governing Body Assurance Framework and Corporate Risk Register have been designed to provide me, as Accountable Officer, with sources of assurance which are evidence that the effectiveness of controls that manage risks to the CCG are achieving their principal objectives and are reviewed on an on-going basis as described on pages 64 to 69.

11.4 The Executive Directors within the CCG who have responsibility for the development and maintenance of the system of internal control provide me, as Accountable Officer, with assurance.

11.5 As Accountable Officer, I have received assurance of the effectiveness of the CCG's internal controls as discharged through the committees described in page 59 to 60. Plans are in place to address any areas of improvement identified; monitoring arrangements are in place to address these.

11.6 Pages 63 to 75 describe the process that has been applied in maintaining and reviewing the effectiveness of the system of internal control, including the role and outputs of the:

- Governing Body;
- Audit and Quality Committee;
- Clinical Commissioning Committee;
- Remuneration Committee;
- Primary Care Commissioning Committee.

12.0 Conclusion

I can confirm that no significant internal control issues have been identified.

Tim Goodson
Accountable Officer
[Date]