Notice of Meeting and Agenda
Renfrewshire Health and Social Care Integration Joint Board Audit Committee

Date	Time	Venue
Friday, 24 November 2017	09:00	Council Chambers (Renfrewshire), Council Headquarters, Renfrewshire House, Cotton Street, Paisley, PA1 1AN

KENNETH GRAHAM
Clerk

Membership

Councillor Lisa-Marie Hughes: Councillor Scott Kerr: Morag Brown: Dorothy McErlean: Alan McNiven: David Wylie

Councillor Lisa-Marie Hughes (Chair) and (Vice Chair)

Further Information

This is a meeting which is open to members of the public.

A copy of the agenda and reports for this meeting will be available for inspection prior to the meeting at the Customer Service Centre, Renfrewshire House, Cotton Street, Paisley and online at www.renfrewshire.cmis.uk.com/renfrewshire/CouncilandBoards.aspx

For further information, please either email democratic-services@renfrewshire.gov.uk or telephone 0141 618 7112.

Members of the Press and Public

Members of the press and public wishing to attend the meeting should report to the customer service centre where they will be met and directed to the meeting.

Items of business

Apologies

Apologies from members.

Declarations of Interest

Members are asked to declare an interest in any item(s) on the agenda and to provide a brief explanation of the nature of the interest.

Minute of Meeting
Renfrewshire Health and Social Care Integration Joint Board Audit Committee

Date	Time	Venue
Friday, 15 September 2017	09:00	Abercorn Conference Centre, Renfrew Road, Paisley, PA3 4DR

PRESENT

Dr Donny Lyons and Dr Linda de Caesteker (both Greater Glasgow & Clyde Health Board); Councillor Lisa-Marie Hughes and Councillor Scott Kerr (both Renfrewshire Council); David Wylie (Health Board staff member involved in service provision) and Alan McNiven (third sector representative).

CHAIR

Dr Donny Lyons, Chair, presided.

IN ATTENDANCE

Ken Graham, Head of Corporate Governance (Clerk), Andrea McMahon, Chief Internal Auditor and Elaine Currie, Senior Committee Services Officer (all Renfrewshire Council); David Leese, Chief Officer, Sarah Lavers, Chief Finance Officer, Jean Still, Head of Administration and James Higgins, Project Officer (all Renfrewshire Health and Social Care Partnership); and David McConnell, Assistant Director and Adam Haar, Auditor (both Audit Scotland).

DECLARATIONS OF INTEREST

There were no declarations of interest intimated prior to the commencement of the meeting.

1 **MINUTE**

The Minute of the meeting of the Integration Joint Board (IJB) Audit Committee held on 3 February 2017 was submitted.

DECIDED: That the Minute be approved.

2 **MEMBERSHIP OF AUDIT COMMITTEE**

Under reference to item 2 of the Minute of the meeting of the IJB held on 23 June 2017 the Clerk submitted a report relative to membership of the IJB Audit Committee.

The report intimated that at the meeting of the IJB held on 23 June 2017 it was noted that the four council voting members had nominated Councillors Lisa-Marie Hughes and Scott Kerr to sit on the IJB Audit Committee and that the four health board voting members would consider their representation on the IJB Audit Committee.

The health board voting members had now advised that Dr Donny Lyons and Dr Linda de Caesteker would sit on the IJB Audit Committee until 18 September 2017 and thereafter the nominated health board voting members would be Morag Brown and Dorothy McErlean.

It was noted that Councillor Lisa-Marie Hughes would assume the Chair of the IJB Audit Committee when the current Chair, Dr Donny Lyons, vacated this role on 18 September 2017. It was further noted that the health board would assume the role of Vice Chair of the IJB Audit Committee as of 18 September 2017 and that this nomination be intimated at the next meeting of the IJB Audit Committee.

DECIDED:

(a) That it be noted that Councillor Lisa-Marie Hughes would assume the Chair of the IJB Audit Committee when the current Chair, Dr Donny Lyons, vacated this role on 18 September 2017;

(b) That it be noted that Dr Donny Lyons and Dr Linda de Caestecker would sit on the IJB Audit Committee until 18 September 2017 and thereafter, the nominated health board voting members would be Morag Brown and Dorothy McErlean; and

(c) That it be noted that the health board would assume the role of Vice Chair of the IJB Audit Committee as of 18 September 2017 and that this nomination be intimated at the next meeting of the IJB Audit Committee.

3 **RENFREWSHIRE IJB AUDITED ANNUAL ACCOUNTS 2016/17**

Under reference to item 5 of the Minute of the meeting of the IJB held on 23 June 2017 the Chief Finance Officer submitted a report relative to the audited annual accounts for the IJB for 2016/17.

The report intimated that the audit certificate issued by Audit Scotland provided an unqualified opinion that the abstract of accounts presented a true and fair view of the financial position of the IJB as at 31 March 2017, in accordance with the accounting policies detailed in the accounts. A report on the 2016/17 audit by Audit Scotland was attached to the report.

DECIDED: That the IJB Audit Committee recommend to the IJB that the audited accounts 2016/17 be approved for signature and the report by Audit Scotland be noted.

4 INTERNAL AUDIT ANNUAL AUDIT REPORT 2016/17

The Chief Internal Auditor, Renfrewshire Council, submitted a report relative to the Internal Audit annual report on the IJB.

The report intimated that the public sector internal audit standards required that the Chief Internal Auditor deliver an annual internal audit opinion on the overall adequacy and effectiveness of the internal control environment that could be used by the organisation to inform its governance statement. The report must also provide an audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

The annual report for the IJB was attached as an appendix to the report and outlined the internal audit work carried out for year ended 31 March 2017 and included the Chief Internal Auditor's independent and objective opinion as to the adequacy and effectiveness of the internal control environment.

DECIDED: That the Internal Audit annual report for 2016/17 be noted.

5 PROPOSED DATES OF MEETINGS OF THE AUDIT COMMITTEE 2017/18

Under reference to item 17 of the Minute of the meeting of the IJB held on 23 June 2017 the Clerk submitted a report relative to proposed dates of meetings of the IJB Audit Committee in 2017/18.

DECIDED:

(a) That meetings of the IJB Audit Committee be held at 9.00 am on 24 November 2017, 26 January and 29 June 2018; and

(b) That meetings of the IJB Audit Committee be held in the Abercorn Conference Centre, Renfrew Road, Paisley unless that venue is unavailable or unsuitable, in which case it be delegated to the Clerk and Chief Officer, in consultation with the Chair and Vice Chair, to determine an alternative venue.

To: **Renfrewshire Integration Joint Board**

On: **24 November 2017**

Report by: **Chief Internal Auditor**

Heading: **Internal Audit Progress and Performance 1 April 2017 to 30 September 2017**

1. Summary

1.1 A risk based Internal Audit Plan for 2017/18 was approved by the IJB Audit Committee on 3 February 2017. This report provides the Renfrewshire Integration Joint Board's Audit Committee with an update on the progress of that Audit Plan.

1.2 The Renfrewshire Health and Social Care Integration Joint Board directs both Renfrewshire Council and NHS Greater Glasgow and Clyde to deliver services that enable the Renfrewshire Integration Joint Board to deliver on its strategic plan.

1.3 Both Renfrewshire Council and NHS Greater Glasgow and Clyde have Internal Audit functions that conduct audits across each organisation and report the findings of these to the respective audit committees.

1.4 Members of the Integration Joint Board have an interest in the outcomes of audits at both Renfrewshire Council and NHS Greater Glasgow and Clyde that have an impact upon the Integration Joint Board's ability to deliver the strategic plan.

1.5 This report also provides a summary to the Renfrewshire Integration Joint Board's Audit Committee of the Internal Audit activity at these organisations from 1 April 2016 to 30 September 2017.

1.6 Internal Audit measures the progress and performance of the team on a regular basis using a range of performance indicators. This report monitors progress from 1 April 2017 to 30 September 2017, in terms of the delivery of the overall Audit Plan for the year and compares actual performance against targets set by Renfrewshire Council's Director of Finance and Resources.

2. Recommendations

2.1 That the Integration Joint Board Audit Committee are asked to note the content of the report.

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3. Progress on the IJB Audit Plan 2017/18

3.1 The Internal Audit Plan for 2017/18 provided for 35 days of internal audit resource, including assurance work, follow up of previous recommendations, planning and reporting and time for ad-hoc advice. The planned review of compliance with the integration scheme is due to commence shortly.

4. Renfrewshire Council Internal Audit Activity

4.1 In the period to 30 September 2017, the following Internal Audit reports have been issued to the Renfrewshire Council, Audit, Risk and Scrutiny Board which are relevant to the Integration Joint Board.

Audit Engagement	Assurance Level (note 1)	Number and Priority of Recommendations (note 2)			
		A	B	C	I
Pensions Auto-enrolment	Reasonable	-	7	3	-
Contract Monitoring Arrangements	Substantial	-	2	1	-
Civil Contingencies Service	Substantial	-	1	3	-
Complaints Procedures	Reasonable	-	3	3	-

Note 1 – For each audit engagement one of four assurance ratings is expressed:
Substantial Assurance – The control environment is satisfactory
Reasonable Assurance – Weaknesses have been identified, which are not critical to the overall operation of the area reviewed
Limited Assurance – Weaknesses have been identified, which impact on the overall operation of the area reviewed
No Assurance – Significant weaknesses have been identified, which critically impact on the operation of the area reviewed

Note 2 – Each audit recommendation is assigned a priority rating:
A = Critical Recommendation - Addresses a significant risk, impacting on the area under review
B = Important Recommendation – Implementation will raise the level of assurance provided by the control system to acceptable levels
C = Good Practice Recommendation – Implementation will contribute to the general effectiveness of control
I = Service Improvement – Implementation will improve the efficiency / housekeeping of the area under review

4.1.1 Appendix 1 to 4 provide a summary of the assurances, risks and overall opinion of each of the audit engagements in the table above.

5. NHS Greater Glasgow and Clyde Internal Audit Activity

5.1 In the period to 30 September 2017, the following Internal Audit reports have been issued to the NHS Greater Glasgow and Clyde Audit Committee, which are relevant to the Integration Joint Board.

Audit Review	Opinion (Note 3)	Number and Priority of Recommendations		
		High	Medium	Low
Estates – Backlog & Operational Maintenance	Medium	-	3	-
Repairs & Maintenance Spend Data	Medium	-	3	1
Health & Social Care Integration – Assurance Map	No rating	-	-	-
Health and Social Care Integration – Financial & Performance Reporting and Controls	Low	-	-	2
IT Project Governance	Medium	-	2	2

Data Security & Management: Information Commissioners Office – follow up	Medium	This was a detailed progress report on the 2016 ICO review; findings totals are not comparable with internal audit reports		
Cyber Maturity 'Technology' review	No rating	-	-	-
Reporting and monitoring arrangements for efficiency savings	High	1	4	-
Embedding Risk Management arrangements	Medium	-	3	1
Capacity Planning - Cancer Services	Medium	-	3	-
Property Transaction Monitoring	Low	-	-	-

Note 3
High risk indicates findings that could have a significant:
impact on operational performance; or
monetary or financial statement impact or
breach in laws and regulations resulting in significant fines and consequences; or
impact on the reputation or brand of the organisation.

Medium risk indicates findings that could have a moderate:
impact on operational performance; or
monetary or financial statement impact; or
breach in laws and regulations resulting in fines and consequences; or
impact on the reputation or brand of the organisation.

Low risk indicates findings that could have a minor:
impact on the organisation's operational performance; or
monetary or financial statement impact; or
breach in laws and regulations with limited consequences; or
impact on the reputation of the organisation.

5.1.1 **Estates – Backlog and Operational Maintenance**

This audit evaluated the design and control operation of the key controls in operation around Backlog Maintenance over the period 1 April 2016 to 30 November 2016.

PwC identified findings covering resolving unplanned maintenance issues, service level agreements and statutory compliance resource requirements.

Management responded that there had been a significant improvement in the delivery of backlog maintenance projects. This ensured that the highest risk items are being addressed in order to reduce both risk and backlog maintenance costs to NHSGGC. The introduction and roll out of a new system (FMFirst) throughout the estate will enable all future operational statutory compliance tasks and SHTM maintenance tasks to be delivered efficiently.

5.1.2 **Repairs & Maintenance Spend Data**

This audit analysed the profile of spend on repairs and maintenance within NHSGGC, and used Accounts Payable data from Estates cost centres and created a series of summaries to explore the trends in spend over the period 1 September 2015 to 31 August 2016. In addition, existing reporting created by management around spend was assessed.

PwC's findings covered documentation of contractors and suppliers on local contracts and agreements and payment category data quality. Since the audit work was carried out, an increased level of compliance with framework contracts was reported. The report referred to "15% of Estates repairs and maintenance spend was with contractors covered by the agreements" the committee requested that a reconciliation be prepared to compare that figure with the current usage.

5.1.3 **Health & Social Care Integration, Assurance Map**

The overall objective of this review was to evaluate the design and operation of the key controls in place to ensure there is effective financial and performance monitoring and reporting with Glasgow City HSCP.

While the operational practicalities of providing integrated health and social care to the public are still being developed, from discussion with both NHSGGC and a sample of the IJB officers from the six HSCPs, there is clear commitment from all organisations. There is a good degree of positivity and optimism around what it can deliver. The review identified the following areas for improvement in the processes which are needed to allow further progress:

- Timeliness of performance monitoring data does not meet the requirements of the IJBs (low risk); and
- Roles and responsibilities of the dual role of the Principal Finance Managers and Management Accountants are not formally documented (low risk).

Management considered that this report provided a useful indication of the key risks associated with the services delegated to Glasgow City HSCP and the assurances in place to monitor and manage those risks.

5.1.4 **Health and Social Care Integration, Financial and Performance Reporting and Controls**

The overall objective of this review was to evaluate the design and operation of the key controls in place to ensure there is effective financial and performance monitoring and reporting with the HSCP.

PwC considered that there is clear commitment from all organisations to provide integrated health and social care to the public. The review did identify areas for improvement in the processes to allow further progress - timeliness of performance monitoring data does not meet the requirements of the IJBs and the roles and responsibilities of the dual role of the Finance Managers and Management Accountants are not formally documented.

Management responded that a recent management accounts restructure would improve financial reporting and allowed HSCPs to develop integrated finance teams as integration progresses over the next few years. A service level agreement has also been drafted to clarify reporting responsibilities. In addition, the Board's performance team will continue to work closely with each partnership to develop appropriate reporting arrangements.

5.1.5 **Cyber Maturity 'Technology'**

This review sought to understand the cyber maturity of the technology domain that is part of PwC's cyber maturity assessment tool. This domain was prioritised for this audit to understand progress made in enhancing technology controls highlighted as requiring improvement by the recent 'eHealth Leads – Cyber Security Survey' self-assessment. The work focused on processes and controls in place and covered a number of important control areas concerning how the organisation protects its critical information assets via the technical controls it has put in place to minimise the risks of accidental loss or deliberate theft of data.

Management considered that the report recognises the existing controls as a result of the multi-layered security defences, and also outlines opportunity for improvement.

5.1.6 **IT Project Governance**

This audit focused specifically on the key elements of the project governance framework in place to enable effective decisions to be made, in terms of planning, approving, prioritising and delivering a portfolio of technology-driven work.

PwC found that formal project management governance framework and supporting documentation is well defined and that the framework's key processes and controls are being followed consistently. However, they did find that there is a lack of detail within project business case documentation to clearly articulate the benefits the project will deliver, and how such benefits will be measured. In addition, there was limited evidence provided to demonstrate that NHSGGC defines project budgets within business cases or subsequently monitors actual cost versus budget.

Management commented that significant progress has been made within eHealth in the last 12 months to ensure that a governance structure and standard processes are in place. eHealth will ensure that the actions identified will be implemented in a timely manner.

5.1.7 **Data Security & Management: Information Commissioners Office, follow up**

This report did not follow PwC's normal format, but was designed to show progress towards meeting the ICO's findings. The review examined what work management had undertaken to address issues raised by the Information Commissioners Office (ICO) report. This report provides a summary of progress made by management to address the issues raised by the ICO report. As the Board will continue to be exposed to risk until all actions have been satisfactorily completed, an overall report grading of 'medium' was allocated to reflect the level of open actions.

This review found that NHSGGC has made good progress since July 2016 as 22 out of the 40 findings previously raised have been evidenced as closed. The remaining 18 actions passed their due dates and have been rescheduled to be closed by August 2017. The outstanding topics are in the areas of Training, Information Governance (IG) Champions and the development of an Information Asset Register.

Management commented that following the conclusion of the fieldwork the Board had a number of actions in hand to further progress improvements. A follow up assessment was undertaken by management in April 2017 and provided the ICO with assurance that the agreed audit recommendations had been, or were in the process of being, appropriately implemented to mitigate the identified risks and thereby support compliance with data protection legislation and implement good practice. The ICO do not require the Board to submit any further audit updates.

5.1.8 **Reporting and monitoring arrangements for efficiency savings**

The review assessed the measures in place to enable NHSGGC to report and monitor on the delivery of the identified Cash-Releasing Efficiency Savings (CRES) in place to achieve a balanced budget. The audit confirmed that effective monitoring systems are in place with accurate information available on a regular basis to enable key stakeholders to monitor current performance. However, the review identified risks arising around:

- Unallocated savings plans; and

- Savings Plans are financial year-end loaded increasing reliance on 'Board Relief': by 31 December 2016, plans had not yet been commenced or delivered for 17% of the sampled savings plans.

Management commented that this report, on an extremely challenging area of the organisation, was broadly welcomed, and that the recommendations will be taken on board. It was also noted that it was difficult to have a medium term financial plan in the absence of an agreed strategy from the centre. It was acknowledged that the Board did need to get to a break-even position on a recurring basis.

5.1.9 **Embedding Risk Management arrangements**

The main focus of this review was to assess how effectively the risk management process had been embedded within the management decision making processes, and to assess the progress made against the agreed actions from the 2015/16 Internal Audit review.

The audit identified three medium risk findings relating to the corporate level approach to Datix implementation, the postponement (at the request of Chief Officers) in HSCPs of the roll out of Datix risk registers requires clarity as to the agreed approach for risk management in Partnerships and limited evidence that the impact that the RMSG's review has on the Corporate Risk Register.

Management advised that it is currently considering options around the management of the risk agenda, with a view to a revised process by the end of July 2017.

5.1.10 **Capacity Planning, Cancer Services**

The review considered the effectiveness of the capacity planning processes and controls in place within Cancer Service. The review identified, three medium risk findings:

- whilst the cancer performance report provides a great deal of information, it is general in nature and does not demonstrate clear links between additional investment, actions taken and the impact on performance;
- the increased risk in respect of cancer services' performance for 2017/18 has not been appropriately assessed. There is no longer term assessment of expected performance or escalation of the impact to the Acute Services Committee or the Board;
- capacity planning arrangements do not support the ability to facilitate the most integrated use of resources that will have the greatest impact on the Board's overall performance.

The cancer pathway was difficult to plan for, but Glasgow had a structured approach. PwC would also provide examples of best practice used elsewhere.

5.1.11 **Property Transaction Monitoring**

In accordance with the NHS Scotland Property Transactions Handbook guidance and the requirements of the NHS circular CEL 08 (2011), property transaction monitoring must be performed each year by the Internal Audit function with the findings reported to the Audit Committee.

Internal Audit is required to categorise individual transactions entered into in the year and which have been subject to review as follows:

A - "the transaction appears to have been properly conducted";

B - “there are reservations on how the transaction was conducted’; or

C - “a serious error of judgement has occurred in the handling of the transaction”.

PwC reviewed a sample of NHSGGC property transactions concluded during the period 1st April 2016 to 31st March 2017, to ensure that property transactions concluded in the period complied with the mandatory requirements as set out within the NHS Scotland Property Transactions Handbook.

PwC found that the transactions sampled had been handled in line with the mandatory requirements and that the necessary Post Transaction Monitoring Pro-forma had been completed for each property. They concluded, therefore, that all transactions sampled were classified as

“A – the transaction appears to have been properly conducted” in line with the requirements of CEL 08 (2011).

The review found that there was a high standard of documentation stored as back-up for these transactions, with all stages of the property transactions evidenced sufficiently.

5.1.12 **Internal Audit Annual Report 2016/17**

PwC also presented their draft Annual Internal Audit Report to the NHSGGC Audit Committee. The report outlined the internal audit work PwC carried out for the year ended 31 March 2017. The internal audit input was delivered in 642 days.

It was explained that the Head of Internal Audit was required to provide a written report to the Accountable Officer to inform the NHS Board’s Governance Statement. The internal audit work carried out during the year was based on the internal audit annual plan for the year which had been approved by the Audit Committee. The Head of Internal Audit’s opinion was as follows:

“Generally satisfactory with some improvements required. Governance, risk management and control in relation to business critical areas is generally satisfactory. However, there are some areas of weakness and non-compliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk. Some improvements are required in those areas to enhance the adequacy and effectiveness of the framework of governance risk management and control.”

The key factors which contributed to that opinion were highlighted, and, in particular, that three of the audit reviews undertaken during 2016/17 were rated as high risk. These were Waiting Times Management and Reporting, Business Continuity Management and Reporting and Monitoring Arrangements for Efficiency Savings.

PwC acknowledged that management had accepted the findings in these reviews and that action plans were in place to address issues identified. Management advised that disclosure in respect of these key points would be made in the Governance Statement, and also in the Audit and Risk Committee’s assurance statement.

6. Internal Audit Performance

(a) Percentage of audit plan completed as at 30 September 2017

This measures the degree to which the Audit plan has been completed

Actual 2016/17	Annual Target 2017/18	Audit Plan Completion Target to 30 Sept 2017	Audit Plan Completion Actual to 30 Sept 2017
91.8%	95.0%	42.8%	41.4%

Actual performance is slightly below target. This is due to a higher than average proportion of annual leave being taken by staff over the summer months and also a vacancy within the internal audit team. Management will monitor this indicator closely over the next quarter and take any action required.

(b) **Percentage of assignments completed by target date**

This measures the degree with which target dates for audit work have been met.

Target 2017/18	Actual to 30 Sept 2017
95.0%	100%

Actual performance is ahead of the target set for the year.

(c) **Percentage of audit assignments completed within time budget**

This measures how well the time budget for individual assignments has been adhered to.

Target 2017/18	Actual to 30 Sept 2017
95.0%	97.1%

Actual performance is ahead of the target set for the year, although this is likely to reduce over the remainder of the year.

(d) **Percentage of audit reports issued within 6 weeks of completion of audit field work**

This measures how quickly draft audit reports are issued after the audit fieldwork has been completed.

Target 2017/18	Actual to 30 Sept 2017
95.0%	97.1%

Actual performance is ahead of the target set for the year.

Implications of the Report

1. **Financial** - none.

2. **HR & Organisational Development** - none.

3. **Community Planning** - none.

4. **Legal** - none.

5. **Property/Assets** - none.

6. **Information Technology** - none.

7. **Equality & Human Rights** - none

8. **Health & Safety** - none.

9. **Procurement** - none.

10. **Risk** - The subject matter of this report is the progress of the risk based Audit Plan's for the IJB, and those reports relating to Renfrewshire Council and NHSGGC in which the IJB would have an interest.

11. **Privacy Impact** - none.

List of Background Papers – none.

Author: Andrea McMahon, Chief Internal Auditor

Internal Audit Report

Finance & Resources

Pension Auto Enrolment (A0084/2016/001)

A0084/2016/001 **Date: October 2017**

COMMITTEE SUMMARY

Audit Objectives
To ensure that: • Arrangements are in place to enrol all new employees into the pension scheme; • There is a timetable established for re-enrolment of employees opting out of the scheme; • Communications with employees are effective and advise employees of their rights; • Where employees opt-out of the pension scheme, this is actioned timeously.

Audit Scope
Interviewed the appropriate staff to ascertain the arrangements in place for enrolling all new employees into the pension scheme, for actioning employee requests to opt-out of the pension scheme, for timetabling the re-enrolment of employees that have opted out and for communicating employee rights. Prepared and undertook a series of tests to assess the adequacy of the above arrangements.

Key Audit Assurances
Processes are in place to auto-enrol all new eligible employees in the pension scheme. Arrangements regarding regular automatic re-enrolment in the pension scheme are sufficient.

Key Risks
There is risk that information held by pension providers may not be up to date if information regarding enrolment and employee opt-outs is not sent to the pension provider timeously. Employees may not be given the correct information regarding postponed enrolment.

Overall Audit Opinion
The audit has identified that although there are arrangments in place to cover the requirements of the Pensions Act 2011, recommendations have been made within the report to improve the processes to record and pass this information to the pension provider timeously. Recommendations have also been made to improve the communication issued to employees regarding postponed enrolment.

Management Commentary
Management within Finance and Resources Service developed an action plan to address

the recommendations made, including:

1. Documenting processes for pension auto-enrolment to formalise the expected controls.

2. Changes arising from checking exception reports will be checked by a second officer for accuracy.

3. A verification exercise is being undertaken to ensure that all required documentation has been provided to the Strathclyde Pension Fund.

4. Investigate potential improvements that can be made to document storage.

5. Amending the communications that are provided to employees where auto-enrolment has been postponed.

Internal Audit Report

Finance and Resources

Contract Monitoring Arrangements – Property Services (A0014/2016/001)

A0014/2016/001 **Date: August 2017**

COMMITTEE SUMMARY

Audit Objectives
The objectives of the audit were to ensure that: • Arrangements are in place to monitor the progress of physical completion of the contract; • Arrangements are in place to monitor the cost of the contract against the predetermined contract value; • Roles and responsibilities for contract management are clear and understood; • Contract monitoring is undertaken by officers with appropriate skills; • Reporting against the contract is regular and timely.

Audit Scope
1. Interviewed the appropriate staff, evaluated the contract monitoring arrangements and identified any possible improvements. 2. Prepared and undertook a series of tests to confirm the adequacy and effectiveness of the contract monitoring arrangements identified. The projects selected for testing were two primary school projects.

Key Audit Assurances
1. Physical completion of the contracts tested was monitored though weekly Clerk of Work reports. 2. Costs were monitored against predetermined contract values in Quantity Surveyor monthly financial reports. 3. Appropriate roles were undertaken by officers with relevant skills e.g. Clerks of Works, Architects, Contractors. 4. Regular and timely reports were provided to appropriate officers.

Key Risks
1. If risk registers are nor completed, key risks may not be clearly stated, assessed and appropriately managed.

Internal Audit Report

Finance and Resources

Contract Monitoring Arrangements – Property Services (A0014/2016/001)

A0014/2016/001 **Date: August 2017**

Overall Audit Opinion
The audit has identified that satisfactory arrangements are in place for monitoring completion of the school projects and reporting progress to the appropriate officers. Some recommendations have been made, including the completion of risk registers when risks are identified in Property Services projects, which will further enhance the control environment.

Management Commentary
Management within Finance and Resources Service developed an action plan to address the recommendations made, including: 1. Developing risk registers for future large scale or complex projects. 2. Implementing arrangements for notifying the insurance section of expected handover dates.

Internal Audit Report

Community Resources

Civil Contingencies Service (A0017/2016/001)

A0017/2016/001 **Date: July 2017**

COMMITTEE SUMMARY

Audit Objectives
The objectives of the audit were to ensure that: • Appropriate governance documents and structures are in place with each of the partner authorities; • Roles and responsibilities and accountabilities have been appropriately recorded and communicated and training provided; • Civil contingency plans are prepared and approved by the appropriate managing body; • Plans are regularly reviewed, updated and tested; • Regular feedback is provided to the Joint Board including performance management information.

Audit Scope
1. Interviewed the appropriate officers to ascertain the arrangements in place for the governance and effectiveness of the Joint Civil Contingencies Service and identified any areas for improvement. 2. Tested to ensure that governance procedures were followed and records were appropriately maintained.

Key Audit Assurances
1. There are adequate governance arrangements operating between the civil contingencies service and partnering authorities and the appropriate governance documents are in place. 2. Roles and responsibilities and accountabilities have been appropriately established and communicated to all partners. Civil Contingencies Service (CCS) regularly facilitate appropriate training to partnering authorities staff. 3. Regular feedback is provided to the Joint Board including performance management information.

Key Risks
Where Civil Contingencies Service do not retain formal evidence that services within partnering authorities have undertaken test exercises, they may not be able to satisfy themselves that the plans in place are adequate.

Overall Audit Opinion
The audit has provided a substantial level of assurance in relation to the governance arrangements and organisation of the Civil Contingencies Service (CCS). There are appropriate governance arrangements in place with all partnering authorities and there is regular feedback to the Joint Board. The auditor has made some recommendations, which if

implemented, will further enhance the oversight arrangements which the Civil Contingencies Service has over the contingency planning arrangements the partnering authorities have in place.

Management Commentary
Management within Environment & Communities developed an action plan to address the recommendations made, including: 1. The Council Resilience Management Team will include service plans and testing arrangements as a standing item on the agenda.

Internal Audit Report

Corporate

Complaints Procedures (B0047/2018/004)

B0047/2018/004 **Date: September 2017**

COMMITTEE SUMMARY

Audit Objectives
The objectives of this review were to ensure that: • relevant staff are aware of the Complaints procedures; • there is sufficient evidence held by Services to demonstrate compliance with the Complaints procedures.

Audit Scope
1. Checked that there are sufficient procedures in place to ensure that relevant staff are aware of the Council's Complaints Procedures. 2. Checked that these procedures are being adhered to i.e. Complaints Registers are being properly maintained by services. The services selected for testing were Development and Housing and Finance and Resources.

Key Audit Assurances
1. The Council's Complaints Handling Procedures and Employee Guide provide adequate instructions to staff dealing with complaints.

Key Risks
1. The Council may not be able to demonstrate that all complaints have been adequately recorded.

Overall Audit Opinion
The audit has provided reasonable assurance over the awareness and compliance with Complaints Handling Procedures. Some recommendations have been made to timeously complete actions identified from a review of complaints correspondence and to review existing training programmes to consider ways to ensure that staff are following the Complaints Handling Process effectively.

Management Commentary
Management within Chief Executive's Service developed an action plan to address the recommendations made, including: 1. Undertaking an internal review of the corporate complaints process, lead by the Policy and Commissioning Service within Chief Executive's Service. The purpose of the review is to consider potential opportunities to enhance existing processes and

	cross service working. Recommendations through the internal audit review will be fully incorporated as part of the review.

To: **Renfrewshire Integration Joint Board**

On: **24 November 2017**

Report by: **Chief Internal Auditor**

Heading: **Training for Audit Committee Members**

1. Summary

1.1 In line with national guidance produced by the Chartered Institute of Public Finance and Accountancy (CIPFA) on the implementation of Audit Committee Principles in Scottish Local Authorities, it is good practice to provide training on audit and risk related matters to members of the Audit Committee.

1.2 A proposed programme of training briefings is outlined at Appendix 1 which will be delivered at board meetings, and at Appendix 2 the outline for the briefing at the current meeting on "The Role of the Audit Committee".

1.3 A further programme of training briefings will be prepared following consultation with the members of the Audit Committee.

2. Recommendations

2.1 That the IJB Audit Committee approve the current programme of training briefings.

2.2 That the IJB Audit Committee are asked to note the content of the training briefing on the Role of the Audit Committee.

2.3 That the members of the IJB Audit Committee consider what topics should be included on a future programme of training briefings.

Implications of the Report

1. **Financial** - none.

2. **HR & Organisational Development** - none.

3. **Community Planning** - none.

4. **Legal** - none.

5. **Property/Assets** - none.

6. **Information Technology** - none.

7. **Equality & Human Rights** - none

8. **Health & Safety** - none.

9. **Procurement** - none.

10. **Risk** – Training for members on audit and risk related matters is good practice.

11. **Privacy Impact** - none.

List of Background Papers – none.

Author: Andrea McMahon, Chief Internal Auditor

Role of the Audit Committee

Integration Joint Board

24 November 2017

Andrea McMahon

Chief Internal Auditor

Overview

- Governance and Audit Committee Principles
- Members' Roles
- Chief Internal Auditor's Role
- External Auditor's Role

Governance Arrangements

- No statutory obligation for an IJB to establish an audit committee
- IJB should determine the arrangements which best suit its circumstance
- Proportionate arrangements which are compliant with good practice governance standards in the public sector

Governance Arrangements

- Key component of the Boards governance framework
- Purpose - To provide those charged with governance independent assurance on the adequacy of the risk management framework, the internal control environment and the integrity of financial reporting and annual governance process

Audit Committee Principles

Principal 1	• **The Control Environment** • Independent assurance of the adequacy of the risk management framework and the associated control environment within the authority
Principal 2	• **Risk Related Performance** • Independent scrutiny of the authority's financial and non-financial performance to the extent that it affects the authority's exposure to risk and weakens the control environment
Principal 3	• **Annual Accounts and the External Auditor** • Assurance that any issues arising from the process of drawing up, auditing and certifying the authority's annual accounts are properly dealt with.

Core Functions

- Assurance statements, including the Annual Governance Statement
- Oversee internal audit function
- Effectiveness of risk management framework
- Effectiveness of the control environment
- External Audit and Inspection agencies

Members' Roles

- Good understanding of the organisation as a whole
- Good understanding of internal control
- Objective and independent of mind
- Independence
- Mix of skills (including financial expertise)
- Participate in training
- Challenging and seek assurance

Assurance Statements

- Financial Statements
- Governance Statement
- Recommend to the Integration Joint Board

Internal Audit

- Statutory requirement
- Guidance on the appointment of the Chief Internal Auditor
- Internal Audit of Partner Bodies
- Co-operation and co-ordination of audit work
- Sharing of information
- Public Sector Internal Audit Standards

External Audit

- Accounts Commission
- Wider remit than private sector audit
- Audit certificate and consideration of matters arising
- Annual report to members
- External audit reports, main issues and implementation of recommendations

Benefits of an Effective Audit Committee

- Raising awareness of internal control
- Public confidence in financial and other reporting
- Reinforce the importance and independence of internal and external audit
- Provide additional assurance through objective and independent review
- Reduce the risk of illegal or improper acts

To:	**Renfrewshire Integration Joint Board Audit Committee**
On:	**24 November 2017**
Report by:	**Chief Finance Officer**
Heading:	**Local Code and Sources of Assurance for Governance Arrangements**

1. Summary

1.1. At its meeting on 23 June 2017, the Integration Joint Board (IJB) approved a Local Code of Corporate Governance based on the seven principles of CIPFA's and SOLACE's Framework. The Local Code includes identified sources of assurance which enable the IJB Audit Committee to review and assess its governance arrangements, against which it will measure itself in Annual Governance Statements from 2017/18 onwards.

1.2. Due to the complexity of this document, members felt it would be helpful to further understand individual principles and our compliance with each of these. In response to this feedback an overview of each source of assurance per each of the principles will be developed.

1.3. A draft example of the overview is included at Appendix 1 for members to agree whether this is suitable for the purpose outlined above. Subject to Audit Committee approval of this, further work will be undertaken to populate the remaining principles and also rate our compliance against each source of assurance. An updated version of this will then be taken to the IJB in January 2018 so members are kept routinely sighted on this as per the agreed reporting arrangements.

2. Recommendations

2.1. It is recommended that the IJB Audit Committee:

- Note the contents of this report;
- Approve the overview template to be populated for each of the principles, noting that this will thereafter be brought back to the IJB in January 2018;
- Agree the annual review of IJB governance arrangements and reporting of the outcome of that review in an Annual Governance Statement will scrutinised by the IJB Audit Committee in advance of IJB approval.

3. Background

3.1. The IJB's approved Annual Governance Statement for 2015/16 confirmed that it had adopted governance arrangements that were consistent with the principles of CIPFA's and the Society of Local Authority Chief Executives' (SOLACE) framework 'Delivering Good Governance in Local Government: Framework' and the Statement explained how the IJB complied with the

Framework and also met the Code of Practice on Local Authority Accounting in the UK.

3.2. While the Framework is written in a Local Authority context, most of the principles are applicable to the IJB, particularly as legislation recognises IJBs as a local government body under Part VII of the Local Government (Scotland) Act 1973, and therefore subject to the Local Authority Accounting Code of Practice.

3.3. At its meeting on 23 June 2017, the IJB approved a Local Code of Corporate Governance based on the seven principles of CIPFA's and SOLACE's Framework.

4. Sources of Assurance

4.1. The Local Code includes identified sources of assurance which enable the IJB to review and assess its governance arrangements, against which it will measure itself in Annual Governance Statements from 2017/18 onwards.

4.2. Appendix 1 provides an update on the current status of each source of assurance, highlighting where any sources have still to be developed or updated, and confirms review arrangements for all sources which are in place.

5. **Compliance with Local Code**

5.1. The Local Code of Governance Arrangements is a statement of the policies and procedures through which we direct and control our functions and how we interact with service users, the local community and other stakeholders. It enables the IJB to demonstrate that its governance structures comply with the core and sub principles contained in the Framework, and test their governance structures and partnerships against the Framework's principles.

5.2. The Local Code of Corporate Governance is subject to ongoing review by the Chief Finance Officer to ensure that internal controls, risk management and other governance arrangements are improved through the implementation of the framework. The update on the Local Code will be brought to the January 2018 Audit Committee.

6. Future Governance Arrangements

6.1. It is recommended that the review of the Local Code of governance arrangements, and scrutiny of the outcome of that review in the 2017/18 Annual Governance Statement, is carried out by the IJB Audit Committee in advance of being presented for IJB approval.

Implications of the Report

1. **Financial – Nil**
2. **HR & Organisational Development – Nil**
3. **Community Planning – Nil**
4. **Legal – T**he Local Code and sources of assurance ensure that the Integration Joint Board is compliant with the Integrated Resource Advisory Group guidance in relation to audit provision and the Local Authority Accounts (Scotland) Regulations 2014.
5. **Property/Assets – Nil**

6. **Information Technology –** managing information and making information available may require ICT input.
7. **Equality & Human Rights –** The recommendations contained within this report have been assessed in relation to their impact on equalities and human rights. No negative impacts on equality groups or potential for infringement have been identified arising from the recommendations contained in the report. If required following implementation, the actual impact of the recommendations and the mitigating actions will be reviewed and monitored, and the results of the assessment will be published on the Council's website.
8. **Health & Safety – Nil**
9. **Procurement – Nil**
10. **Risk –** Without a Local Code and sources of assurance, there is a risk that the Integration Joint Board does not have an effective framework for the assessment of its governance arrangements.
11. **Privacy Impact** – None. The information to be made available via the Publication Scheme is information which would be disclosed in response to a request under the Freedom of Information (Scotland) Act 2002. This therefore would not include Personal Data as defined by the Data Protection Act 1998.

List of Background Papers – Local Code and Sources of Assurance for Governance, 23 June 2017, Renfrewshire IJB

Author: Frances Burns, Change and Improvement Manager

Note Principle B onwards will be updated in line with the layout/detail at Principle A, following approval of this by the Audit Committee.

Appendix 1: Sources for Assurance Overview (EXAMPLE)

Governance Principles				
Principle A Behaving with integrity, demonstrating strong commitment to ethical values and representing the rule of the law.				
SOURCE	**STATUS**			**ADDITONAL INFORMATION**
	IN PLACE AND UP-TO-DATE	**CURRENT DRAFT BEING UPDATED**	**OUTSTANDING**	
Integration Scheme	X			
Governance Arrangements and Structure (IJB and Committees)	X			
Standing Orders	X			
Code of Conduct	X			
Declaration of Interests	X			
IJB Induction	X			
IJB Development Programme	X			
Financial Regulations	X			
Annual Accounts (including Governance Statement, Statement of Income and Expenditure and Balance Sheet)	X			
Annual Audit Report	X			
Audit Plans (Internal and Third Party)	X			
Information Governance (Freedom of Information, Records Management and Information Sharing)	X			
Clinical and Care Governance Arrangements and Reporting	X			

Note Principle B onwards will be updated in line with the layout/detail at Principle A, following approval of this by the Audit Committee.

Principle B Ensuring openness and comprehensive stakeholder engagement.			
Sources of Assurance			
STATUS	**IJB**	**RENFREWSHIRE COUNCIL**	**NHSGGC**
In place and up to date	• Governance Arrangements and Structure (IJB and Committees) • IJB Membership (incl. Stakeholder Members for patients/service users, carers, third and independent sectors and Trade Unions) • Publication of IJB and Committee papers • Strategic Plan • On-going Development of Other Strategies/Plans (e.g., Children and Young People Services Plan, Dementia Strategy, Commissioning and Procurement Strategy and Communications Strategy) • Locality Plans • Participation and Engagement Strategy • Equalities Mainstreaming and Outcome Plan • Communications Strategy including Joint Media Protocol • Locality Engagement Forums • Public Petitions • Information Governance (Freedom of Information, Records Management and Information Sharing)	• Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Webcast of Council Meetings • Complaints Procedure • Petitions Board • Community Planning Partnership • Implementation of the Community Empowerment (Scotland) Act 2015 • Strategic Plan • Performance Management Framework and Reporting • Information Governance (Freedom of Information, Records Management and Information Sharing) • Publication of Committee papers and minutes • Workforce Plan (including Organisational Development Strategy) • Supervision Framework • Staff Survey • Communications Strategy including Joint Media Protocol • Staff Engagement Opportunities • Equalities Arrangements (including EQIAs, working groups and staff groups)	• NHSGGC Feedback Service • NHSGGC Local Delivery Plan • Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Register of Interests • Performance Management Framework and Reporting • Information Governance (Freedom of Information, Records Management, Information Sharing and Information Security) • Publication of Board papers • Workforce Plan (including Organisational Development Strategy) • Supervision Framework • Staff Survey • Communications Strategy including Joint Media Protocol • Staff Engagement Opportunities • Equalities Arrangements (including EQIAs, working groups and staff groups) • Trade Union liaison and engagement

Note Principle B onwards will be updated in line with the layout/detail at Principle A, following approval of this by the Audit Committee.

		• Trade Union liaison and engagement	

Principle C Defining outcomes in terms of sustainable economic, social and environmental benefits.			
	Sources of Assurance		
STATUS	**IJB**	**RENFREWSHIRE COUNCIL**	**NHSGGC**
In place and up to date	• Strategic Plan • Locality Plans • On-going Development of Other Strategies/Plans (e.g., Children and Young People Services Plan, Dementia Strategy, Commissioning and Procurement Strategy and Communications Strategy) • Performance Management Framework and Reporting • Annual Performance Report	• Strategic Plan and Other Plans (e.g., Children's Services Plan, Annual Service Plan and Improvement Report (ASPIR)) • Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Performance Management Framework and Reporting • Annual Performance Report	• NHSGGC Local Delivery Plan • Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Performance Management Framework and Reporting • Annual Performance Report

Note Principle B onwards will be updated in line with the layout/detail at Principle A, following approval of this by the Audit Committee.

Principle D Determining the interventions necessary to optimise the achievement of intended outcomes.			
Sources of Assurance			
STATUS	**IJB**	**RENFREWSHIRE COUNCIL**	**NHSGGC**
In place and up to date	• Risk Management Strategy and Procedure and Reporting • Budget Monitoring and Reporting • Performance Management Framework and Reporting • Audit Plans and Assurance (Internal and Third Party) • Clinical and Care Governance Arrangements and Reporting • Information Governance Assurance (Freedom of Information, Records Management and Information Sharing)	• Risk Management Strategy and Procedure and Reporting • Resilience Plans and Arrangements (Business Continuity and Emergency Plans) • Budget Monitoring, Reporting and Financial Planning • Performance Management Framework and Reporting • Audit Plans and Assurance (Internal and Third Party) • Social Work Professional Governance and Integrated Clinical and Professional Governance arrangements and reporting • Information Governance Assurance (Freedom of Information, Records Management, Information Sharing and Information and Physical Security) • Health and Safety Arrangements (including policies and procedures and audits)	• Risk Management Strategy and Procedure and Reporting • Resilience Plans and Arrangements (Business Continuity and Emergency Plans) • Budget Monitoring and Reporting • Performance Management Framework and Reporting • Audit Plans and Assurance (Internal and Third Party) • Clinical Governance and Integrated Clinical and Professional Governance Arrangements and Reporting • Information Governance Assurance (Freedom of Information, Records Management, Information Sharing and Information Security) • Health and Safety Arrangements (including policies and procedures and audits)

Note Principle B onwards will be updated in line with the layout/detail at Principle A, following approval of this by the Audit Committee.

Principle E Developing the entity's capacity, including the capability of its leadership and individuals within it.			
Sources of Assurance			
STATUS	**IJB**	**RENFREWSHIRE COUNCIL**	**NHSGGC**
In place and up to date	• Workforce Plan (including Organisational Development Strategy) • IJB Induction • IJB Development Programme	• Workforce Plan (including Organisational Development Strategy) • Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Clinical and Care Governance Arrangements and Reporting • Elected Member Induction, Training and Development • Staff Induction • Leadership, First Line Management and Staff Development and Training Opportunities • Supervision and Personal Development Plan Framework • Staff Groups for Equalities and Diversity • Trade Union liaison and engagement	• Workforce Plan (including Organisational Development Strategy) • Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Clinical and Care Governance Arrangements and Reporting • Board Members Induction • Staff Induction • Leadership, First Line Management and Staff Development and Training Opportunities • Supervision and Personal Development Plan Framework • Staff Groups for Equalities and Diversity • Trade Union liaison and engagement (Staffside)

Note Principle B onwards will be updated in line with the layout/detail at Principle A, following approval of this by the Audit Committee.

Principle F Managing risk and performance through robust internal control and strong public financial management.			
Sources of Assurance			
STATUS	**IJB**	**RENFREWSHIRE COUNCIL**	**NHSGGC**
In place and up to date	• Integration Scheme • Financial Regulations • Budget Monitoring and Reporting • Annual Accounts (including Governance Statement, Statement of Income and Expenditure and Balance Sheet) • Annual Audit Report • Risk Management Strategy and Procedure and Reporting • Audit Plans and Assurance (Internal and Third Party) • Clinical and Care Governance Arrangements and Reporting • Information Governance (Freedom of Information, Records Management and Information Sharing)	• Financial Regulations/Procedures • Annual Accounts (including Governance Statement, Statement of Income and Expenditure and Balance Sheet) • Risk Management Strategy and Procedures and Reporting • Anti-Bribery/Fraud Policy • Audit Plans and Assurance (Internal and Third Party) • Social Work Professional Governance and Integrated Clinical and Professional Governance arrangements and reporting • Information Governance Assurance (Freedom of Information, Records Management, Information Sharing and Information and Physical Security) • Procurement regulations, training and development • Contract Management Framework • Project Management Framework	• Schedule of Reserved Decisions • Scheme of Delegation and Standing Financial Instructions • Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Financial Procedures • Financial Reporting and Scrutiny across Management Structures • Risk Management Strategy and Procedures and Reporting • Fraud Policy • Audit Plans and Assurance (Internal and Third Party) • Clinical and Care Governance Arrangements and Reporting • Information Governance (Freedom of Information, Records Management, Information Sharing and Information Security)

Note Principle B onwards will be updated in line with the layout/detail at Principle A, following approval of this by the Audit Committee.

Principle G Implementing good practices in transparency, reporting and audit to deliver effective accountability.			
	Sources of Assurance		
STATUS	**IJB**	**RENFREWSHIRE COUNCIL**	**NHSGGC**
In place and up to date	• IJB and Committee Reporting Framework and Schedule • Publication of IJB and Committee papers • Financial Regulations • Financial Reporting (e.g., Budget Monitoring, Financial Allocations and Budgets and Capital Programme) • Annual Accounts (including Governance Statement, Statement of Income and Expenditure and Balance Sheet) • Annual Audit Report • Risk Management Strategy and Procedure and Reporting • Performance Management Framework and Reporting • Annual Performance Report • Audit Plans and Assurance (Internal and Third Party) • Clinical and Care Governance Arrangements and Reporting	• Committee Reporting Framework and Schedule • Publication of Committee papers and minutes • Financial Regulations/Procedures • Financial Reporting and Scrutiny across Management Structures (e.g., Budget Monitoring) • Annual Accounts (including Governance Statement, Statement of Income and Expenditure and Balance Sheet) • Risk Management Strategy and Procedure and Reporting • Performance Management Framework and Reporting • Annual Performance Report • Audit Plans and Assurance (Internal and Third Party) • Social Work Professional Governance and Integrated Clinical and Professional Governance arrangements and reporting • Revised remit for Audit, Risk and Scrutiny Board	• Committee Reporting Framework and Schedule • Publication of Board papers • Financial Regulations/Procedures • Financial Reporting and Scrutiny across Management Structures (e.g., Budget Monitoring) • Annual Accounts (including Governance Statement, Statement of Income and Expenditure and Balance Sheet) • Risk Management Strategy and Procedure and Reporting • Performance Management Framework and Reporting • Audit Plans and Assurance (Internal and Third Party) • Clinical and Care Governance Arrangements and Reporting

To:	**Integration Joint Board Audit Committee**
On:	**24 November 2017**
Report by:	**Chief Officer**
Heading:	**Risk Management Policy & Strategy**

1. Summary

1.1. The purpose of this report is to provide an update to the IJB Audit Committee on the status of the Risk Register(s) currently being maintained by Renfrewshire Health & Social Care Partnership (HSCP).

1.2. The changes and updates in this report were reviewed by the Senior Management Team on 31 October 2017. In terms of accountability, it was agreed that two separate risk registers should be maintained – one specifically for the strategic responsibilities of the IJB and another for the operational responsibilities of the HSCP.

2. Recommendation

The IJB Audit Committee is asked to:

- Review the content of this report;
- Approve the IJB risk register; and
- Note the Health & Social Care risk register.

3. Background

3.1. It was agreed at the IJB meeting on 23 June 2017, that risk management arrangements would be reviewed by the IJB Audit Committee.

4. Current Position

4.1 The Health & Social Care Partnership previously combined risks for the IJB, Social Work and Health into one risk register. The status of this Risk Register is regularly reported to the Senior Management Team.

4.2 Future scrutiny of the Integration Joint Board risk register will be undertaken by the Audit Committee, and information relating to key partnership risks will be provided to the Audit Committee for awareness.

Outcomes of this scrutiny will be available via the minutes for this Committee.

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5. IJB Risk Register

5.1 The IJB Risk Register is maintained, updated and reported in line with the Risk Management Policy developed for integration bodies.

5.2 Going forward, as previously stated in 1.2, it was proposed that the current Risk Register is divided into 2. This would be an IJB Risk Register and a combined Health and Social Care Partnership Risk Register.

5.3 The IJB Risk Register would note risks specifically relating to the Board in respect of financial sustainability and accountability for delivery of the Strategic Plan.

5.4 The previously approved Risk Management Policy and Strategy has been updated to reflect this change and is attached as Appendix 1.

5.5 There are **5** 'live' risks on the IJB Risk Register with **3** items having a risk level of 'High' and **2** with a risk level of 'Moderate'.

5.6 The most recent version of the IJB Risk Register is attached as Appendix 2.

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6. HSCP Risk Register

6.1 The Renfrewshire HSCP Risk Register is currently maintained, updated and reported in line with the expectations of both NHSGGC and Renfrewshire Council.

6.2 There are **13** 'live' risks on the HSCP Risk Register, with **9** items having a current risk level of 'high' and **4** items with a risk level of 'moderate'.

6.3 The most recent version of the HSCP Risk Register is attached as Appendix 3.

Implications of the Report

1. **Financial -** There are no financial implications arising from the submission of this paper. It is anticipated that costs associated with the management of individual risks will be met through service budgets. Where additional funding is required in the management of specific risks this should be considered by the Chief Financial Officer on a case by case basis.

2. **HR & Organisational Development -** There are no HR & OD implications arising from the submission of this paper

3. **Community Planning -** There are no Community Planning implications arising from the submission of this paper

4. **Legal -** There approval of the Risk Management Policy and Strategy and initial list of risks is in line with the requirements of the Integration Scheme.

5. **Property/Assets -** There are no property/ asset implications arising from the submission of this paper.

6. **Information Technology -** There are no ICT implications arising from the submission of this paper.

7. **Equality and Human Rights -**The recommendations contained within this report have been assessed in relation to their impact on equalities and human rights. No negative impacts on equality groups or potential for infringement have been identified arising from the recommendations contained in the report

8. **Procurement Implications -** There are no procurement implications arising from the submission of this paper.

9. **Privacy Impact -** There are no privacy implications arising from the submission of this paper.

10. **Risk** – none.

11. **Risk Implications –** As per the subject content of this paper

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List of Background Papers – None.

Author: Jean Still, Head of Administration

Appendix 1

Renfrewshire Integration Joint Board

Renfrewshire
Health and Social Care Partnership

Risk Management Policy and Strategy

CONTENTS

Policy – the risk management approach

1.1 Renfrewshire Integration Joint Board (IJB) is committed to a culture where its workforce is encouraged to develop new initiatives, improve performance and achieve goals safely, effectively and efficiently by appropriate application of good risk management practice.

1.2 In doing so the IJB aims to provide safe and effective care and treatment for patients and clients and a safe environment for everyone working within the Health & Social Care Partnership and others who interact with the services delivered under the direction of the IJB.

1.3 The IJB believes that appropriate application of good risk management will prevent or mitigate the effects of loss or harm and will increase success in the delivery of better clinical and financial outcomes, objectives, achievement of targets and fewer unexpected problems.

Key benefits of effective risk management:

- appropriate, defensible, timeous and best value decisions are made;
- risk 'aware' not risk 'averse' decisions are based on a balanced appraisal of risk and enable acceptance of certain risks in order to achieve a particular goal or reward;
- high achievement of objectives and targets;
- high levels of morale and productivity;
- better use and prioritisation of resources;
- high levels of user experience/ satisfaction with a consequent reduction in adverse incidents, claims and/ or litigation; and
- a positive reputation established for the IJB.

1.4 The IJB purposefully seeks to promote an environment that is risk 'aware' and strives to place risk management information at the heart of key decisions. This means that the IJB can take an effective approach to managing risk in a way that both addresses significant challenges and enable positive outcomes.

1.5 In normal circumstances the IJB's tolerance for risk is as follows:

- any low risk is acceptable without any further action to prevent or mitigate the risk;
- any moderate risk is tolerable - control measures implemented or introduced must be cost effective;
- any high risk may be tolerable - providing the IJB is assured regarding the adequacy and effectiveness of the control measures in place. Any further control measures implemented or introduced must be cost effective in relation to the high risk;
- any very high risk is deemed to be unacceptable and measures should be taken to terminate, transfer or treat a very high risk to a more tolerable position.

This can be seen clearly in the matrix to the right:

Likeli-hood	Consequent Impact 1	2	3	4	5
5	5	10	15	20	25
4	4	8	12	16	20
3	3	6	9	12	15
2	2	4	6	8	10
1	1	2	3	4	5

In exceptional circumstances a combination of factors may converge to produce a very high risk, for which the IJB may have limited control (such as demographic change and financial pressures). Recognising this scenario, and taking on board the inherent level of risk experienced in some service areas, the IJB would expect that, while it may have the capacity to deal with some very high risk, it would not wish to tolerate any more than two very high risks at any given time.

1.6 The IJB promotes the pursuit of opportunities that will benefit the delivery of the Strategic Plan. Opportunity-related risk must be carefully evaluated in the context of the anticipated benefits for patients, clients and the IJB.

1.7 As agreed at its meeting on 23 June 2017, the responsibility for monitoring the risk management arrangements for the IJB would be within the remit of the IJB Audit Committee.

1.8 The IJB Audit Committee will receive assurance reports not only on the adequacy but also the effectiveness of its risk management arrangements and will consequently value the contribution that risk management makes to the wider governance arrangements of the IJB.

1.9 The IJB, through the following risk management strategy, has established a Risk Management Framework, (which covers risk policy, procedure, process, systems, risk management roles and responsibilities).

Strategy - Implementing the policy

1. Introduction

1.1 The primary objectives of this strategy will be to:

- promote awareness of risk and define responsibility for managing risk within the IJB;
- establish communication and sharing of risk information through all areas of the IJB;
- initiate measures to reduce the IJB's exposure to risk and potential loss; and,
- establish standards and principles for the efficient management of risk, including regular monitoring, reporting and review.

1.2 This strategy takes a positive and holistic approach to risk management. The scope applies to all risks, whether relating to the clinical and care environment, employee safety and wellbeing, business risk, opportunities or threats.

1.3 **IJB/ Strategic risks** represent the potential for the IJB to achieve (opportunity) or fail to meet (threat) its desired outcomes and objectives as set out within the Strategic Plan, and typically these risks require strategic leadership in the development of activities and application of controls to manage the risk.

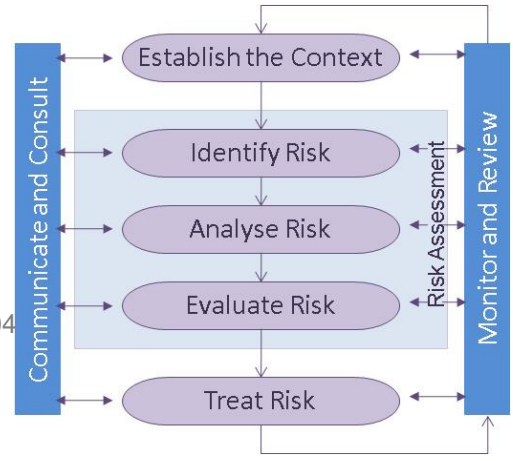
1.4 **Operational/ Partnership risks** represent the potential for impact (opportunity or threat) within or arising from the activities of an individual service area or team operating within the scope of the IJB's activities. Parent bodies will retain responsibility for managing operational risks as operational risks will be more 'front-line' in nature and the development of activities and controls to respond to these risks can be led by local managers and team leaders. Where a number of operational risks impact across multiple service areas or, because of interdependencies, require more strategic leadership, then these can be proposed for escalation to the IJB risk register.

1.5 All risks will be analysed consistently with an evaluation of risk as being low, moderate, high or very high.

1.6 This document represents the risk management framework to be implemented across the IJB and will contribute to the IJB's wider governance arrangements.

2. Risk management process

2.1 Risk Management is about the culture, processes and structures that are directed towards realising potential opportunities whilst also proactively identifying and managing adverse effects[1] . It is pro-active in understanding risk and uncertainty, it learns and builds upon existing good practice and is a continually evolving process that has an important



[1] Australia/ New Zealand Risk Management Standard, AS/NZS 4360: 2004

role in ensuring that defensible and beneficial decisions are made.

2.2 The IJB embeds risk management practice by consistent application of the risk management process shown in the diagram on the right, across all areas of service delivery and business activities.

3. Application of good risk management across the IJB activities

3.1 Standard procedures (3.1.1 – 3.1.10) will be implemented across all areas of activity that are under the direction of the IJB in order to achieve consistent and effective implementation of good risk management.

3.1.1 Full implementation of the risk management process. This means that risk management information should (wherever possible) be used to guide major decisions in the same way that cost and benefit analysis is used.

3.1.2 Identification of risk using standard methodologies and involving subject experts who have knowledge and experience of the activity or process under consideration.

3.1.3 Categorisation of risk under the headings below:

- IJB/ Strategic Risks: such as risks that may arise from Political, Economical, Social, Technological, Legislative and Environmental factors that impact on the delivery of the Strategic Plan outcomes and financial sustainability.
- Operational/ Partnership Risks: such as risks that may arise from or impact on Clinical Care and Treatment, Social Care and Treatment, Customer Service, Employee Health, Safety & Well-being, Business Continuity/ Supply Chain, Information Security and Asset Management.

3.1.4 Appropriate ownership of risk. Specific risks will be owned by/ assigned to whoever is best placed to manage the risk and oversee the development of any new risk controls required.

3.1.5 Consistent application of a standard risk matrix to analyse risk in terms of likelihood of occurrence and potential impact, taking into account the effectiveness of risk control measures in place.

3.1.6 Consistent response to risk that is proportionate to the level of risk. This means that risk may be terminated; transferred elsewhere (ie to another partner or third party); tolerated as it is; or, treated with cost effective measures to bring it to a level where it is acceptable or tolerable for the IJB in keeping with its appetite/ tolerance for risk. In the case of opportunities, the IJB may 'take' an informed risk in terms of tolerating it if the opportunity is judged to be (1) worthwhile pursuing and (2) the IJB is confident in its ability to achieve the benefits and manage/ contain the associated risk.

3.1.7 Implementation and maintenance of risk registers as a means of collating risk information in a consistent format allowing comparison of risk evaluations, informed decision-making in relation to prioritising resources and ease of access to information for risk reporting.

3.1.8 Reporting of IJB/ strategic risks and key operational risks to the IJB on a six monthly basis (beginning of financial year and a mid year update).

3.1.9 Operation of a procedure for movement of risks between IJB/ strategic and operational/ partnership risk registers that will be facilitated by the Senior Management Team.

3.1.10 Routine reporting of risk information within and across teams and a commitment to a 'lessons learned' culture that seeks to learn from both good and poor experience in order to replicate good practice and reduce adverse events and associated complaints and claims.

Realising the risk management vision

4. Risk management vision and measures of success

Appropriate and effective risk management practice will be embraced throughout the Integration Joint Board as an enabler of success, whether delivering better outcomes for the people of Renfrewshire, protecting the health, safety and well-being of everyone who engages with the IJB or for maximising opportunity, delivering innovation and best value, and increasing performance.

4.1 In working towards this risk management vision the IJB aims to demonstrate a level of maturity where risk management is embedded and integrated in the decision making and operations of the IJB.

4.2 The measures of success for this vision will be:

- *good financial outcomes for the IJB*
- *successful delivery of the strategic plan, objectives and targets*
- *successful outcomes from external scrutiny*
- *fewer unexpected/ unanticipated problems*
- *fewer incidents/ accidents/ complaints*
- *fewer claims/ less litigation*

Risk leadership and accountability

5. Governance, roles and responsibilities

5.1 Integration Joint Board Audit Committee

On behalf of the Integration Joint Board, the Audit Committee is responsible for:

- oversight of the IJB's risk management arrangements;
- receipt and review of reports on IJB/ strategic risks and any key operational/ partnership risks that require to be brought to their attention; and,
- ensuring they are aware of any risks linked to recommendations from the Chief Officer concerning new priorities/ policies and the like *(The 'risk implications' section on relevant board papers can facilitate this)*.

5.2 Chief Officer

The Chief Officer has overall accountability for the IJB's risk management framework, ensuring that suitable and effective arrangements are in place to manage the risks relating to the functions within the scope of the IJB. The Chief Officer will keep the Chief Executives of the IJB's partner bodies informed of any significant existing or emerging risks that could seriously impact the IJB's ability to deliver the outcomes of the Strategic Plan or the reputation of the IJB.

5.3 Chief Finance Officer

The Chief Finance Officer will be responsible for promoting arrangements to identify and manage key business risks, risk mitigation and insurance.

5.4 Senior Management Team

The Head of Administration is responsible for:

- supporting the Chief Officer and Chief Finance Officer in fulfilling their risk management responsibilities;
- arranging professional risk management support, guidance and training from partner bodies;
- receipt and review of regular risk reports on strategic, shared and key operational risks and escalating any matters of concern to the Audit Committee; and,
- ensuring that the standard procedures set out in section three of this strategy are actively promoted across their teams and within their areas of responsibility.

5.5 Individual Risk Owners

It is the responsibility of each risk owner to ensure that:

- risks assigned to them are analysed in keeping with the agreed risk matrix;
- data on which risk evaluations are based are robust and reliable so far as possible;
- risks are defined clearly to make explicit the scope of the challenge, opportunity or hazard and the consequences that may arise;
- risk is reviewed not only in terms of likelihood and impact of occurrence, but takes account of any changes in context that may affect the risk;
- controls that are in place to manage the risk are proportionate to the context and level of risk.

5.6 All persons working under the direction of the IJB

Risk management should be integrated into daily activities with everyone involved in identifying current and potential risks where they work. Individuals have a responsibility to make every effort to be aware of situations which place them or others at risk, report identified hazards and implement safe working practices developed within their service areas. This approach requires everyone to:

- understand the risks that relate to their roles and activities;
- understand how their actions relate to their own, their patient's, their services user's/ client's and public safety;
- understand their accountability for particular risks and how they can manage them;
- understand the importance of flagging up incidents and/ or near misses to allow lessons to be learned and contribute to ongoing improvement of risk management arrangements; and,
- understand that good risk management is a key part of the IJB's culture.

5.7 Partner Bodies

It is the responsibility of relevant specialists from the partner bodies, (such as internal audit, external audit, clinical and non clinical risk managers and health and safety advisers) to attend meetings as necessary to consider the implications of risks and provide relevant advice. It is the responsibility of the partner bodies to ensure they routinely seek to identify any residual risks and liabilities they retain in relation to the activities under the direction of the IJB.

5.8 Senior Information Risk Owner

Responsibility for this specific role will remain with the individual partner bodies.

Resourcing risk management

6. Resourcing the risk management framework

6.1 Much of the work on developing and leading the ongoing implementation of the risk management framework for the IJB will be resourced through the Senior Management Team's arrangements (referred to in 5.4).

6.2 Wherever possible the IJB will ensure that any related risk management training and education costs will be kept to a minimum, with the majority of risk-related courses/ training being delivered through resources already available to the IJB (the partner body risk managers/ risk management specialists).

7. Resourcing those responsible for managing specific risks

7.1 Where risks impact on a specific partner body and new risk control measures require to be developed and funded, it is expected that the costs will be borne by that partner organisation.

7.2 Financial decisions in respect of the IJB's risk management arrangements will rest with the Chief Finance Officer.

Training, learning and development

8. Risk management training and development opportunities

8.1 To implement effectively this policy and strategy, it is essential for people to have the competence and capacity for managing risk and handling risk judgements with confidence, to focus on learning from events and past experience in relation to what has worked well or could have been managed better, and to focus on identifying malfunctioning 'systems' rather than people.

8.2 Training is important and is essential in embedding a positive risk management culture across all activities under the direction of the IJB and in developing risk management maturity. The Senior Management Team will regularly review risk management training and development needs and source the relevant training and development opportunities required (referred to in 5.4).

Monitoring activity and performance

9. Monitoring risk management activity

9.1 The IJB operates in a dynamic and challenging environment. A suitable system is required to ensure risks are monitored for change in context and scoring so that appropriate response is made.

9.2 Monitoring will include review of the IJB's risk profile at Senior Management Team level.

9.3 Monitoring of the risk profile will be undertaken on a quarterly basis.

9.4 It is expected that partner bodies will use IJB risk reports to keep their own organisations updated on the management of the risks, highlighting any IJB risks that might impact on the partner organisation.

10. Monitoring risk management performance

10.1 Measuring, managing and monitoring risk management performance is key to the effective delivery of key objectives.

10.2 Key risk indicators (KRIs) will be linked where appropriate to specific risks to provide assurance on the performance of certain control measures. For example, specific clinical incident data can provide assurance that risks associated with the delivery of clinical care are controlled, or, budget monitoring PIs (Performance Indicators) can provide assurance that key financial risks are under control.

10.3 The performance data linked to the Strategic Plan will also inform the identification of new risks or highlight where existing risks require more attention.

10.4 Reviewing the IJB's risk management arrangements on a regular basis will also constitute a 'Plan/ Do/ Study/ Act review cycle that will shape future risk management priorities and activities of the IJB, inform subsequent revisions of this policy and strategy and drive continuous improvement in risk management across the IJB.

Communicating risk management

11. Communicating, consulting on and reviewing the risk management framework

11.1 Effective communication of risk management information is essential to developing a consistent and effective approach to risk management.

11.2 Copies of this policy and strategy will be widely circulated via the Senior Management Team and will form the basis of any risk management training arranged by the IJB.

11.3 The Policy and Strategy (version 2.0) will be submitted to the Integration Joint Board Audit Committee for approval at its meeting of 24 November 2017.

11.4 This policy and strategy will be reviewed regularly to ensure that it reflects current standards and best practice in risk management and fully reflects the IJB's business environment.

Appendix 2: Renfrewshire IJB Risk Register

Report Type: Risks Report
Generated on: October 2017
HSCP Senior Management Team

Financial Sustainability

Context	Risk Statement	Owned by	Current Risk Control Measures	Likelihood	Impact	Evaluation
IJBRR.17.01.01 Development of IJB 2018/19 budget. Content: The IJB's 2018/19 budget is still being developed. The savings required for 2018/19 are more challenging than those required in 2017/18. There is high projected growth in demand and increase costs.	There is a risk that delays in agreeing the 2018/19 budget will impact negatively on the financial management of the IJB and service delivery.	HSCP Chief Finance Officer	*The timing of NHS financial planning and associated partnership budget contributions is a national issue. We continue to raise this through a number of forums both locally and nationally. *See also the risk control measures given for the risk above.	03	04	12 High

Action Codes	Linked Actions	Latest Note	Assigned To	Due Date	Status

Context	Risk Statement	Owned by	Current Risk Control Measures	Likelihood	Impact	Evaluation
IJBRR.17.01.02 Demographic pressures Context: (1) Medium and longer term financial planning (2) Corporate and service review activities (3) Strategic commissioning approach (4) Development of cost care models	There is a risk that if financial and demographic pressures of services were not effectively planned for and managed over the medium to longer term, there would be an impact on the ability of the service to deliver services to the most vulnerable people in Renfrewshire.	HSCP Senior Management Team	* Demand management review undertaken * Long term financial planning processes, including strategic commissioning plans * Budget monitoring processes in place and subject to ongoing review * Client group budget management meetings held * Programme of financial management training in place for budget holders * Eligibility criteria established as appropriate * Programme of service reviews in place * Investment in service redesign opportunities to improve efficiency and effectiveness.	02	05	10 High

Action Codes	Linked Actions	Latest Note	Assigned To	Due Date	Status

Context	Risk Statement	Owned by	Current Risk Control Measures	Likelihood	Impact	Evaluation
IJBRR.17.01.03 Key financial risks Context: 1.Service Areas individually, or in combination, experience expenditure levels which exceed funding allocations and threaten achievement of HSCPs key financial objectives due to: (a) Pay growth (b) Prescribing (c) Sickness & Absence cover (d) Community equipment expenditure (e) Impact arising from Resource Allocation Model (f) Financial impact of any clinical failures 2. The requirement for savings to be delivered in 2018/19 could result in the removal of budget which could have an impact on front line services and likelihood of this is increasing.	There are a number of financial challenges facing the IJB and if not adequately addressed, could lead to financial instability within the partnership and potential impact to service delivery.	HSCP Chief Finance Officer	*Financial management framework implemented. *Regular monitoring by Chief Finance Officer. *Budget meetings across all service areas. *Finance issues to be discussed at SMT and IJB meetings. *Main pressure area remains requirement to increase staffing levels. *Daily reviews of patients on special observations, together with detailed monitoring on a weekly basis remains in place and regular meetings between management and clinical staff are held. *Regular financial performance meetings in place with HSCP Chief Officer, Chief Finance Officer, NHS Director of Finance and Council Director of Finance and Resources *Regular meetings of Medicines Management Group with a focus on prescribing year end out-turn. *Discussion at GP forum on importance of prescribing financial break even. *Financial situation to be discussed at GP forum and each practice visited thereafter to highlight and agree further prescribing cost reduction measures. *Continued vigilance particularly around effect of generic drug price fluctuations. *Risk assessments undertaken to ensure unacceptable clinical risks are avoided.	02	05	10 high

Action Codes	Linked Actions	Latest Note	Assigned To	Due Date	Status

Strategic Plan

Context	Risk Statement	Owned by	Current Risk Control Measures	Likelihood	Impact	Evaluation
IJBRR.17.02.04 Health Inequalities Context: (1) Health Improvement (2) Partnership working	There is a risk that health inequalities increase. This may result from long-term conditions, deprivation or individual risk-taking behaviours resulting in a population with higher levels of need, lower levels of resilience and fewer opportunities to participate fully in their communities.	Head of Strategic Planning & Health Improvement	*EQIA support service policies and redesign on an ongoing basis *Increase focus on equalities issues across range of HSCP initiatives. *Health Improvement Team in place *Community Links Team in place *Support for community led health activities *Targeted events to raise awareness *Focus of strategic plan	03	03	9 Moderate

Action Codes	Linked Actions	Latest Note	Assigned To	Due Date	Status

Context	Risk Statement	Owned by	Current Risk Control Measures	Likelihood	Impact	Evaluation
IJBRR.17.02.05 Meeting targets and maintaining standards Context: Lack of relevant disaggregated data hinders detailed analysis and planning.	There is a risk that failure to Local Delivery Plan/ Strategic Plan targets and standards, and other key performance indicators could result in a decreased level of service for patients and clients	HSCP Senior Management Team	*Proforma reports presented to all IJB meetings with full scorecard presented 6-monthly *Monitoring by planning groups and SMT *Needs Assessment carried out *Frameworks guidance/circulars *Legislation *National and Local Performance Indicators *Equality Scheme Action Plans *Flexible Budgets *Staffing resources are flexed to meet priorities/demand *Development of data capture systems to inform local planning. learning and education plans reflect need for anti-discriminatory practice *Quality care and professional governance arrangements	03	03	9 Moderate

Action Codes	Linked Actions	Latest Note	Assigned To	Due Date	Status

Appendix 3: Renfrewshire HSCP Risk Register

Report Type: Risks Report
Generated on: October 2017
HSCP Senior Management Team

1 - HSCP Organisational

Context	Risk Statement	Owned by	Current Risk Control Measures	Likelihood	Impact	Evaluation
HSCPRR.17.01.01 Information Governance Context: (1) Subject Access Requests (2) Data sharing agreements (3) GDPR	There is a risk that failure to develop and implement robust procedures around information governance could lead to inappropriate sharing of sensitive information and potential sanctions from the Information Commissioner and breach of copyright law. There is a risk of failure in the implementation of the General Data Protection Regulations (GDPR) which are effective from 25 May 2018.	HSCP Head of Administration	*Procedures are in place on all sites for use/release of data, including Multi-Agency Public Protection Arrangements (MAPPA) related information, monitoring of Information Governance Standards, Caldicott Guardian responsibilities, Information Sharing Protocols. *All portable devices encrypted *Copyright notices circulated to all bases and clearly displayed at all photocopiers/printers. *Staff made aware of copyright information available on StaffNet including summary of National Policy on Copying of Print Materials Protected by Copyright August 2011. *Process developed for responding to requests for personal data/ Subject Access Requests *Process developed for managing electronic and manual record containing personal data *Data protection training and awareness sessions in place *Operational policies *Professional standards of conduct *Information Governance Managers and Information Governance Team in place *Staff training and awareness sessions under development	03	04	12 High

Action Codes	Linked Actions	Latest Note	Assigned To	Due Date	Status

Context	Risk Statement	Owned by	Current Risk Control Measures	Likelihood	Impact	Evaluation
HSCPRR.17.01.02 Workforce Planning Context: A flexible and skilled workforce is essential to the future development of high quality services and reliance on locum and agency staffing increases financial pressures. (1) Specific pressures around medical staffing, district nursing and home care services (2) Sufficient numbers of staff (3) Right competencies (4) Professional Registration (5) Pressures resulting from additional complex planning structures which require managerial and clinical input. (example: moving forward together, Regional Planning)	There is a risk that failure to prioritise effective workforce planning could lead to longer term workforce difficulties, shortages in some skill sets and potential impact on service delivery.	HSCP Heads of Health & Social Care (West Renfrewshire and Paisley); HSCP Head of Mental Health, Addictions & Learning Disabilities; Head of Strategic Planning & Health Improvement; HSCP Snr Professional Nurse Advisor.	*Quality assurance process of working on shift to identify areas of good practise and additional care pressures. *Vacancies are recruited to follow risk assessment and review of staffing profile with minimum delay *There is a monthly forward planning of off-duty rosters as per rostering policy with weekly review of planned roster by service manager and daily review by lead nurses to identify and manage any shortfalls *The completion of an integrated workforce plan based on the six steps methodology currently under development will inform longer term planning and decision making in relation to current and future utilisation of workforce resources *Weekly review of areas of high clinical activity and deployment of resources to meet this. *Weekly request to nurse bank to meet additional staffing resource requirement. *Daily reconciliation of staffing levels for each area and review of available redeployment opportunities and risk management to ensure appropriate deployment of all available staffing according to risk. *Services working in accordance with rostering policy and monitoring/ escalation guidance *Robust application of attendance management policy to maximise available staffing resources. *Robust application of safe and supportive observation policy to ensure application of enhanced observations meets requirements of least restriction as described within Milan Principles. *PNA overview of workforce recommendations in line with local/ Board/ national review *Systems in place to support nursing registration/ revalidation in order to minimise risk of lapse and consequently on service delivery *Template letter now reviewed. Local process updated to enable reporting measures. *Professional assurance framework in place.	04	04	16 High

Action Codes	Linked Actions	Latest Note	Assigned To	Due Date	Status

Context	Risk Statement	Owned by	Current Risk Control Measures	Likelihood	Impact	Evaluation
HSCPRR.17.01.03 Resilience - Incident Management Context: (1) Disruptive events that impact on the community, the environment, our employees or the reputation of the service. (2) http://www.firescotland.gov.uk/media/864542/west_crr_version_1.2.pdf	There is a risk that ineffective preparation and planning for potential disruptive events such as those reflected within the West of Scotland Community Risk Register, that directly relate to the HSCP services, may result in the inability to effectively respond and manage the event in a way minimises harm to the community, our employees and the reputation of the HSCP.	HSCP Head of Administration	*Participation in Partner Organisations' emergency planning (ie for major incidents, pandemics etc) *Participation in joint exercises *Participation in various working groups to discuss and develop incident response arrangements. *Emergency contacts directory *Call cascade tests by Local Authority *Robust and tested Business Continuity Plan	02	03	6 Moderate

Action Codes	Linked Actions	Latest Note	Assigned To	Due Date	Status

Context	Risk Statement	Owned by	Current Risk Control Measures	Likelihood	Impact	Evaluation
HSCPRR.17.01.04 Resilience - Business Continuity Context: (1) Non-availability of premises, employees or systems impacting on services/functions	There is a risk that non availability of (1) premises either through fire or flood etc; (2) key staff or significant numbers of front-line staff and/or (3) systems (telephony, Swift, power failure etc) may result in adverse impact on service provision.	HSCP Head of Administration	*Investment in and management of properties to ensure premises are fit for purpose. *Business continuity plans in place for all areas of the service *Policies and processes in place regarding system failures e.g. helpdesk *SWIFT/AIS guidance regularly updated and communicated to staff, with system subject to ongoing programme of upgrading. *Rigorous implementation of absence management and support policies.	02	03	6 Moderate

Action Codes	Linked Actions	Latest Note	Assigned To	Due Date	Status

Context	Risk Statement	Owned by	Current Risk Control Measures	Likelihood	Impact	Evaluation
HSCPRR.17.01.05 Staff Governance, Health, safety & Wellbeing Context: (1) Employee safety and wellbeing in the community	There is a risk if the Health and Safety of staff is not supported through a comprehensive range of policies and procedures. If full compliance is not achieved this may impact on the ability of the service to provide a safe working environment for staff (including violence to staff).	HSCP Senior Management Team	*Compliance with Staff Governance standards *Joint Health and Safety Committee in place *The HSCP's organisational development and service improvement strategy focuses on 3 key objectives that will support the workforce to be committed, capable and engaged in person-centred safe and effective service delivery *Completion of individual risk assessments for clients *Warning flag system in place on electronic care records *Interview rooms designed in line with health, safety and professional standards *Ongoing programme of staff training on health and safety issues. *Recording of accidents and violent incidents, with statistics reviewed on a regular basis by partnership Health and Safety Committee. *Guidance on driving and transport use *Guidance on effective use of equipment in place *Investigation and ongoing review process of significant incidents *Learning from RIDDOR led by Health & Safety advisors *Staff debriefing following incidents *Active lone working policies, procedures and personal alarms *Occupational Health services, stress management and counselling *Adverse weather policies in place (check similarity)	03	04	12 High

Action Codes	Linked Actions	Latest Note	Assigned To	Due Date	Status

Context	Risk Statement	Owned by	Current Risk Control Measures	Likelihood	Impact	Evaluation
HSCPRR.17.01.06 Equality & Human Rights Compliance Context: (1) Meeting main duties flowing from Act (2) Promoting access to care and support across minority groups	There is a risk if compliance of duties which came into force in April 2011 in relation to the Equality Act is not met. If relevant activities are not prioritised by the service, there may be a risk of future legal or financial challenge.	Head of Strategic Planning & Health Improvement	*The Equality Impact Assessment toolkit is implemented *Equality implications are recorded as part of IJB board papers *Equality and diversity training for all employees *The partnership has representation on the Diversity and Equality Alliance in Renfrewshire Group to promote and raise awareness of equalities *Fora with minority groups established *Signposting events held with West of Scotland Racial Equality Council *Participation in community planning and corporate equalities groups.	03	03	9 Moderate

Action Codes	Linked Actions	Latest Note	Assigned To	Due Date	Status

2 - HSCP Clinical & Care

Context	Risk Statement	Owned by	Current Risk Control Measures	Likelihood	Impact	Evaluation
HSCPRR.17.02.07 Public Protection Context: The partnership has a public protection role. (1) Adult and child protection (2) Effective risk management (3) Management of high-risk offenders (4) Multi-agency training and procedures	There is a risk that inconsistent assessment and application of Adult and Child Support and Protection procedures may result in poor identification of those at risk or those who have been harmed, and may also lead to a failure to comply with legislative requirements.	Heads of Health & Social Care (Paisley & West Ren); Head of Mental Health, Addictions & Learning Disability Services.	*Robust policies and procedures communicated throughout the HSCP. *Regular caseload management by team leaders in place, clinical supervision of staff established. *Governance arrangements at service, HSCP, Partnership and NHSGGC levels. *Multi-agency child and adult protection committees well established, with independent chair in place for both. *Chief Officers Group, comprising of leaders from all relevant partner agencies, meet on a regular basis to discuss key issues. Joint Communications sub-group now established. *Multi-agency child and adult protection training programme in place, facilitated by dedicated trainer. *Regular programme of case file auditing undertaken by the adult and child protection committee. Social Work implementing an internal case file audit programme. *The self evaluation and quality assurance processes conducted by all services. *Multi-agency action plan developed to progress recommendations of Significant Case review *Annual conferences held by both the adult and child protection committees *Self-evaluation activities undertaken on an annual basis by both the adult and child protection committees. *Management and supervision policies in place and levels of management review established. *Recording protocols and data quality checks undertaken * Lead officers for child and adult protection, and MAPPA identified with Social Work. *Development work undertaken with STRADA in relation to work with families where parental addiction exists. *Contract monitoring undertaken *Information management and security policies in place corporately.	03	05	15 High

Action Codes	Linked Actions	Latest Note	Assigned To	Due Date	Status

Context	Risk Statement	Owned by	Current Risk Control Measures	Likelihood	Impact	Evaluation
HSCPRR.17.02.08 Clinical and Care Governance Context: (1) Pressure re providing adequate staffing levels to meet demands of activity. (2) Examples of clinical and care incidents include Suicide or Self Harm; Violent patients; Absconding patients; Accidental and Deliberate Overdose; Moving and Handling Incidents	There is a risk that failure to comply with all clinical standards and protocols and appropriate clinical and environmental risk assessments could result in harm to staff, patients and service users, visitors and the public	HSCP Senior Management Team	*Proactive controls arising from clinical and general management systems and processes including provision and uptake of relevant training, robust policy and procedures, Health & Safety Forum, Quality Care & Professional Governance Group, Patient Safety Forum and incident monitoring. *Ongoing monitoring includes structured responsibility for detection and review of Critical Incidents with special emphasis on ensuring lessons learned from incidents are disseminated and applied across the HSCP, Renfrewshire Council and the NHS Board. *Consider forthcoming Duty of Candour *Professional structure in place	03	05	15 High

Action Codes	Linked Actions	Latest Note	Assigned To	Due Date	Status

Context	Risk Statement	Owned by	Current Risk Control Measures	Likelihood	Impact	Evaluation
HSCPRR.17.02.09 Failure of major providers Context: (1) Care providers (2) GP services	There is a risk that failure or loss of a major service provider may impact on our capacity to deliver services, protect vulnerable children and adults and may impact on additional costs to cover key services.	HSCP Senior Management Team	*Appraisal of providers conducted as part of procurement process. *Purchasing patterns monitored by Finance Team and senior managers. *Programme of reviews of all service providers. *Main providers registered and monitored by Care Inspectorate, with reports accessible for review. Participation in local and national contingency arrangements relating to providers facing financial uncertainty to ensure minimal impact on local service users. *Contract compliance and performance monitoring including the new arrangements for the two hospices *Clinical Director providing support and guidance to GP services reporting challenges in recruitment and capacity *Practice Support Pharmacists are being deployed to GP surgeries based on level of workforce shortages and risk of failure	03	04	12 High

Action Codes	Linked Actions	Latest Note	Assigned To	Due Date	Status

Context	Risk Statement	Owned by	Current Risk Control Measures	Likelihood	Impact	Evaluation
HSCPRR.17.02.10 Lost Bed Days Context: (1) Change in criteria - the number of days where a patient has to be ready for discharge has been reduced to 3 days (2) Change in arrangements re beds at Darnley	There is a risk that failure to meet agreed reduction in lost bed days, resulting in adverse impact on patients and acute services bed capacity/cost pressures, in particular those arising from Adults with Incapacity cases.	Heads of Health & Social Care (Paisley and West Ren)	*Monthly Performance Monitoring in place. *Regular monitoring of position and mechanism for dialogue with Local Authority and Acute Division in place. *Regular reporting to IJB, SMT, OPR and NHSGGC Ageing Population Group.	04	04	16 High

Action Codes	Linked Actions	Latest Note	Assigned To	Due Date	Status

Context	Risk Statement	Owned by	Current Risk Control Measures	Likelihood	Impact	Evaluation
HSCPRR.17.02.11 Developing self-evaluation arrangements Context: (1) Public Service Improvement Framework (2) Consolidation of CSE accreditation (3) Supported self-evaluation with the Care Inspectorate (4) Case file auditing programme	There is a risk that self-evaluation of performance and practice is key to the continuous improvement of the service. There is a risk that insufficient development of this agenda will impact on service development activity and increase the burden of external scrutiny.	Heads of Health & Social Care (Paisley and West Ren); Head of Mental Health, Addictions & Learning Disability Services; Head of Strategic Planning & Health Improvement.	* Inspection overview submitted to Board on 6 monthly basis * Programme of self assessment rolled out across service using PSIF. * Complaints monitoring allows for key areas of development to be identified - update	03	03	9 Moderate

Action Codes	Linked Actions	Latest Note	Assigned To	Due Date	Status

Context	Risk Statement	Owned by	Current Risk Control Measures	Likelihood	Impact	Evaluation
HSCPRR.17.02.12 Self-directed support Context: (1) Social Care (Self-Directed Support) (Scotland) Act 2013 (2) Personalised approach to social care services (3) Individual budgets (4) Prioritising and meeting assessed needs (5) Managing expectations	There is a risk that challenges around implementation of the 4 options could impact on service users and the reputation of the HSCP	Heads of Health & Social Care (Paisley & West Ren); Head of Mental Health, Addictions & Learning Disability Service; Chief Finance Officer.	*Streamlined controlled business process introduced to promote equity and quickly deliver supported plans that are agreed using agreed resource allocation system *Ongoing training and development programme in place ensuring staff remain up to date with current business process *Development of resource directory being progressed *Procurement process developed and established and embedded within current processes *Financial allocation systems refreshed in line with FY16/17 and living wage commitment *Assessment and care management documentation developed and refreshed for frontline staff to ensure consistency with self-directed support process *CIPFA SDS Guidance implemented and embedded within current processes	03	04	12 High

Action Codes	Linked Actions	Latest Note	Assigned To	Due Date	Status

3 - HSCP Hosted Services

Context	Risk Statement	Owned by	Current Risk Control Measures	Likelihood	Impact	Evaluation
HSCPRR.17.03.13 Workforce Planning (H06 - Performers and Ophthalmic Lists)	There is a risk that failure to undertake all relevant checks with regard to Applicants seeking inclusion in GG&C Performers & Ophthalmic Lists, resulting in failure to comply with regulatory requirements and could result in a GP and/or Ophthalmic practitioner being incorrectly admitted to the list.	Head of Primary Care Support	*Application checklists to be adhered to ensure all appropriate checks are undertaken. *Process in place to liaise with Clinical Director/Optometric Advisor if any issues raised in relation to Clinical references provided, prior to admitting applicant to relevant list.	03	04	12 High

Action Codes	Linked Actions	Latest Note	Assigned To	Due Date	Status