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

Date	Time	Venue
Friday, 29 June 2018	09:00	Abercorn Conference Centre, Renfrew Road, Paisley, PA3 4DR

KENNETH GRAHAM
Clerk

Membership

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

Councillor Lisa-Marie Hughes (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 http://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 reception 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, 26 January 2018	09:00	Abercorn Conference Centre, Renfrew Road, Paisley, PA3 4DR

PRESENT

Councillor Lisa-Marie Hughes and Councillor Jane Strang (substitute for Councillor Scott Kerr) (both Renfrewshire Council); Morag Brown and Dorothy McErlean (both Greater Glasgow & Clyde Health Board); and David Wylie (Health Board staff member involved in service provision) and Alan McNiven (third sector representative).

CHAIR

Councillor Lisa-Marie Hughes, 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 and Jean Still, Head of Administration (all Renfrewshire Health and Social Care Partnership) and M Ferris, Senior Audit Manager and A Haahr, Senior Auditor (both Audit Scotland).

APOLOGY

Councillor Scott Kerr (Renfrewshire Council).

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 24 November 2017 was submitted.

DECIDED: That the Minute be approved.

2 **INTERNAL AUDIT PROGRESS AND PERFORMANCE - QUARTER 3**

The Chief Internal Auditor submitted a report relative to the internal audit plan for 2017/18 approved at the meeting of the IJB Audit Committee held on 13 February 2017.

The report intimated that the IJB directed both Renfrewshire Council and NHS Greater Glasgow and Clyde (NHSGG&C) to deliver services that enabled the IJB to deliver on its strategic plan. Both the Council and NHSGG&C had internal audit functions and conducted audits across each organisation, the findings of which were reported to the respective audit committees. Members of the IJB had an interest in the outcomes of the audits at both the Council and NHSGG&C that impacted upon the IJB's ability to deliver the strategic plan.

The report provided a summary of the internal audit activity of both organisations to 31 December 2017 in terms of the delivery of the overall audit plan for the year and compared actual performance against targets set by Renfrewshire Council's Director of Finance and Resources from 1 April to 31 December 2017.

A discussion took place relative to processes and policies in place within NHSGG&C in relation to suicide risk assessment and whether the tools were fit for purpose. It was proposed that the Chief Officer establish what processes and policies were in place and what training was given to staff in relation to these processes and policies. This was agreed. It was further proposed that the Chief Officer submit a report on these matters to a future meeting of the IJB which would then be shared with the NHSGG&C Board. This was also agreed.

DECIDED:

(a) That the report be noted;

(b) That the Chief Officer establish what processes and policies were in place and what training was given to staff in relation to these processes and policies; and

(c) That the Chief Officer submit a report on these matters to a future meeting of the IJB which would then be shared with the NHSGG&C Board.

3 **ANNUAL INTERNAL AUDIT PLAN 2018/19**

The Chief Internal Auditor submitted a report relative to the annual internal audit plan for 2018/19, a copy of which formed the appendix to the report.

The report intimated that, in line with the requirements of the Public Sector Internal Audit Standards, a risk-based internal audit plan for 2018/19 had been developed which set out a resource requirement of 35 days, including assurance work, time for follow-up of previous recommendations, ad-hoc advice and planning and reporting.

The allocation of internal audit resources was sufficient to allow emerging priorities and provided adequate coverage of governance, risk management and internal control to inform the annual assurance statement.

The audit plan might be subject to amendment during the course of the year due to the emergence of issues of greater priority or other unforeseen circumstances and any change would be reported to the IJB Audit Committee.

It was proposed that the Audit Committee consider requesting an independent report into the entire process following Capability Scotland's decision to cease provision of the day care services it operated, on behalf of the Renfrewshire Health and Social Care Partnership, at Whitehaugh and West Lane Gardens, Paisley and that this report be shared with the IJB.

The Chief Internal Auditor advised that this would be a matter for her consideration and not the remit of Audit Scotland, the IJB external auditors. It was proposed that the Chief Internal Auditor meet with members of the Audit Committee to establish the scope of an independent audit and thereafter the Chief Internal Auditor would advise the Audit Committee of the audit process.

DECIDED:

(a) That the internal audit plan for 2018/19 be approved;

(b) That it be noted that the internal audit plan for 2018/19 would be shared with Renfrewshire Council and NHSGG&C; and

(c) That the Chief Internal Auditor meet with members of the Audit Committee to establish the scope of an independent audit and thereafter the Chief Internal Auditor advise the Audit Committee of the audit process.

4 AUDIT SCOTLAND ANNUAL AUDIT PLAN 2017/18

The Chief Finance Officer submitted a report relative to the annual audit plan 2017/18 for the IJB which outlined Audit Scotland's planned activities in their audit for the 2017/18 financial year.

The report highlighted that the annual audit plan 2017/18 included a section on Audit Issues and Risks and that within this section Audit Scotland had identified a risk of 'management override of controls'. This risk had been included in the audit plans of all bodies which Audit Scotland worked with, in light of updated international standards on auditing. The inclusion of this risk was not a reflection of increased risk within the Joint Board and Audit Scotland had confirmed that they had not found any issues on this in previous years.

DECIDED: That Audit Scotland's annual audit plan 2017/18 be noted.

5 LOCAL CODE AND SOURCES OF ASSURANCE FOR GOVERNANCE ARRANGEMENTS

Under reference to item 4 of the Minute of the meeting of the IJB Audit Committee held on 24 November 2017 the Head of Administration submitted a report relative to the Local Code of Corporate Governance based on the seven principles of the Chartered Institute of Public Finance and Accountancy (CIPFA) framework and the Society of Local Authority Chief Executive's (SOLACE) framework approved at the meeting of the IJB held on 23 June 2017.

The report intimated that the Local Code included identified sources of assurance which enabled the IJB Audit Committee to review and asses its governance arrangements against the Annual Governance Statements from 2017/18 onwards.

At the meeting of the IJB Audit Committee held on 24 November 2017 it had been decided that further work be undertaken to populate the Sources of Assurance template to rate compliance against each principle and provide updates, as appropriate, against the status of each source.

It was noted that the Chief Internal Auditor would also provide independent assurance to the IJB on compliance with the Code of Corporate Governance.

DECIDED:

(a) That the Sources of Assurance statement, as detailed in the appendix to the report, be approved;

(b) That it be noted that as previously agreed the annual review of IJB governance arrangements would be scrutinised by the IJB Audit Committee in advance of IJB approval; and

(c) That it be noted that the Chief Internal Auditor would also provide independent assurance to the IJB on compliance with the Code of Corporate Governance.

6 TRAINING FOR AUDIT COMMITTEE MEMBERS

Under reference to item 3 of the Minute of the meeting of the IJB Audit Committee held on 24 November 2017 the Chief Internal Auditor submitted a report relative to a proposed programme of training briefings which would be delivered at meetings of the IJB Audit Committee.

The proposed programme of training briefings was appended to the report.

DECIDED: That the programme of training briefings, as detailed in the appendix to the report, be approved.

7 DATE OF NEXT MEETING

DECIDED: That it be noted that the next meeting of the IJB Audit Committee would be held at 9.00 am on 29 June 2018 in the Abercorn Conference Centre, Renfrew Road, Paisley.

To: **Renfrewshire Health and Social Care Integration Joint Board Audit Committee**

On: **29 June 2018**

Report by: **Chief Internal Auditor**

Heading: **Summary of Internal Audit Reports**

1. Summary

1.1 A risk based Internal Audit Plan for 2017/18 was approved by the IJB Audit Committee on 29 January 2018. In line with the Public Sector Internal Audit Standards, Internal Audit must communicate the results of each engagement to the Board. All planned reviews have been completed.

1.2 Appendix 1 provides details those audit engagements completed during the period 1 January to 18 May 2018 with the overall assurance rating and the number of recommendations in each risk category. The committee summary for each report is also attached. For each audit assignment where recommendations have been made, the relevant managers have put action plans in place to address the issues raised.

2. Recommendations

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

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.

11. **Privacy Impact** - none.

List of Background Papers – none.

Author: Andrea McMahon, Chief Internal Auditor

Appendix 1

Integration Joint Board Audit Committee

Internal Audit Service

Summary of Final Audit Reports issued

Engagement	Assurance Rating (note 1	Recommendation Ratings			
		Critical	Important	Good Practice	Service Improvement
Compliance with the Integration Scheme	Substantial			1	
Local Code of Corporate Governance	Reasonable		1		

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Assurance Level	
Substantial Assurance	• There is a sound system of internal control designed to achieve the objectives of the area being reviewed. • The control processes tested are being consistently applied.
Reasonable Assurance	• The internal control processes are generally satisfactory with some areas of weakness being identified that could put some objectives of the area being reviewed at risk • There is evidence that the level of non-compliance with some of the control processes may put some of the objectives of the area being reviewed at risk.
Limited Assurance	• Weaknesses in the system of internal controls are such as to put the objectives of the area being reviewed at risk. • The level of non-compliance puts the objectives of the area being reviewed at risk.
No Assurance	• Control processes are generally weak with significant risk to the achievement of the objectives of the area being reviewed. • Significant non-compliance with control processes leaves the processes/systems open to error or abuse.

Recommendation Rating	
Service Improvement	Implementation will improve the efficiency / housekeeping of the area under review.
Good Practice	Implementation will contribute to the general effectiveness of control.
Important	Implementation will raise the level of assurance provided by the control system to acceptable levels.
Critical	Addresses a significant risk, impacting on the objectives of the area under review.

Internal Audit Report

IJB

Integration Scheme Compliance (B0017/2018/002)

B0017/2018/002 **Date: May 2018**

COMMITTEE SUMMARY

Audit Objectives
The objective of the audit was to ensure that adequate evidence is available to confirm that significant elements of the Integration Scheme are being complied with.

Audit Scope
Obtained and reviewed for adequacy, documentation and information in relation to: • Clinical and Care Governance • Chief Officer updates regarding acute hospital services and the set aside budget for these services • Participation and Engagement • Information Sharing and Data Handling • Complaints

Key Audit Assurances
Clinical and Care Governance arrangements are in place that cover the areas specified in the Integration Scheme. Regular updates are provided to the IJB regarding acute hospital services and the set aside budget for these services. Participation and Engagement Strategy was in place within 6 months of formation of the IJB.

Key Risks
There are no key risks arising from this audit.

Overall Audit Opinion
In general, arrangements are in place to confirm that the IJB are complying with the elements of the Integration Scheme covered in this audit. The audit has identified that the Information Sharing Protocol in relation to Health and Social Care Integration amongst Renfrewshire Council, Greater Glasgow Health Board and The Integration Joint Board has not been annually reviewed as agreed.

Management Commentary
Management agreed to action the one good practice recommendation made in relation to reviewing the Information Sharing Protocol.

Internal Audit Report

INTEGRATION JOINT BOARD

Local Code of Corporate Governance (C0371/2018/038)

C0371/2018/038 **Date: May 2018**

COMMITTEE SUMMARY

Audit Objectives
The objective of the audit was to ensure that: • There is sufficient evidence held by the Integration Joint Board (IJB) to demonstrate compliance with the Local Code of Corporate Governance.

Audit Scope
1.1 Obtained a copy of the IJB's 'Sources of Assurance' template approved by the IJB Audit Committee in January 2018 which lists the evidence available to support compliance with each principle of the Local Code of Corporate Governance. 1.2 Obtained a copy of the CIPFA/SOLACE document entitled, 'Delivering Good Governance' and carried out testing to ascertain the level of compliance by comparing the evidence available per the IJB, 'Sources of Assurance' template against the requirements of the Code.

Key Audit Assurances
Evidence was available to support the IJB's compliance with some of the behaviours and actions linked to the sub-principles within the Local Code of Corporate Governance.

Key Risks
There are no key risks to report in relation to the IJBs demonstration of compliance with the Local Code of Corporate Governance.

Overall Audit Opinion
Due to evidence being omitted from the Sources of Assurance and the format of the Local Code of Corporate Governance, members are unable to identify easily that all the elements of the code are being fully complied with.

Internal Audit Report

INTEGRATION JOINT BOARD

Local Code of Corporate Governance (C0371/2018/038)

C0371/2018/038 **Date: May 2018**

Management Commentary
The working version of the Local Code of Corporate Governance and Sources of Assurance will be reviewed and updated. Further discussion will also take place with the IJB Chair and Vice Chair in relation to behaviours and actions detailed for each sub-principle with a view to streamlining this and avoiding duplication/repetition.

To: **Renfrewshire Health and Social Care Integration Joint Board Audit Committee**

On: **29 June 2018**

Report by: **Chief Internal Auditor**

Heading: **Summary of Internal Audit Activity in Partner Organisations**

1. Summary

1.1 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.

1.2 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.

1.3 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 or support corporate functions.

1.4 This report provides a summary to the Renfrewshire Integration Joint Board's Audit committee of the Internal Audit activity undertaken within these partner organisations.

2. Recommendations

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

3. Renfrewshire Council Internal Audit Activity

3.1 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
Adults with Incapacity	Limited	-	5	-	-
Charging and Payments for Adult Services	Limited	1	4	1	1
Corporate Health & Safety	No Assurance	4	6	1	-
Records Management	Limited	0	6	4	-
Corporate Purchase Cards	Reasonable	-	1	5	-

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

3.1.1 **Adults with Incapacity**

The objectives of this audit were to ensure that there is documentary evidence that the process flow chart has been followed for the use of Adults with Incapacity (Scotland) Act 2000 and that the process is undertaken timeously. A sample of 20 case files were selected for review.

The audit identified that although there is a process in place for the use of Adults with Incapacity (Scotland) Act 2000, the guidance available to officers is outdated and on some occasions the relevant paperwork in relation to referring and applying for Adults with Incapacity intervention was unable to be located and those that were found were not always signed. A revised policy, process flow chart, referral forms and supporting guidance have been developed to ensure the accuracy and timely completion of the relevant paperwork and required authorisation process.

3.1.2 **Charging and Payments for Adult Services**

The objectives of this review were to ensure that there are adequate documented procedures in place for preparing financial assessments and arranging for invoices to be raised; controls exist to ensure that financial assessments are accurate; all invoices are raised timeously and are accurate and posted onto the accounts receivable ledger; and that there are appropriate procedures in place to regularly review financial assessments and deal with changes in circumstances timeously.

The audit identified that there are procedures in place for preparing financial assessments. However, delays between the date a client starts receiving care and the date they are first charged for care result in the council not receiving full payments for the services provided and some clients may not be charged the correct rate if full financial assessments and reassessments are not carried out for new and existing clients.

It is acknowledged that Charging and Payments management have implemented new procedures and are continuing to work to improve controls in this area. Management within Finance and Resources, agreed to action the recommendations made, including; working with Adult Services to put measures in place to minimise any delays in processing financial assessments / reassessments for non-residential care, preparing adequate documentation detailing clearly the processes to be followed by staff and improving the document filing system.

3.1.3 **Corporate Health and Safety**

The purpose of the audit is to carry out a review of the arrangements in place for corporate Health and Safety. The review covered the arrangements in place during 2016/2017. Key controls were reviewed and evaluated in relation to, clearly defined and

understood roles and responsibilities, including risk identification; adequate and up-to-date policies and procedures in place which were readily available to those that need them; regular engagement with other service areas to ensure compliance with legislative requirements; a programme of health and safety audits was in place and results were followed up adequately; adequate arrangements in place for reporting, accidents, incidents and near misses and these were adequately followed up; and performance monitoring and reporting arrangements were appropriate.

Four key risk areas were identified from the audit review:

Although there is a Health and Safety Policy in place, which details the high level governance arrangements including the roles and responsibilities of key officers, current practice does not follow the arrangements as set out in the policy at both a corporate and service level. There is a risk that health and safety activity may be uncoordinated, reactive and not subject to an appropriate level of scrutiny.

The policy is also not being followed at an operational level with pro-active health and safety audit inspections not being undertaken as expected at a corporate level and there is inconsistency at a service level. This increased the risk that action is not taken in a timely manner to rectify any issues that would have been identified through the checking regime.

There is a corporate process for logging incidents, however there is a lack of effective monitoring and follow up of the mitigating actions required. This increases the risk that remedial action is not taken in a timely manner.

Performance information in relation to health and safety is not being prepared, monitored and reported consistently. Without adequate monitoring and reporting of both Corporate and Service health and safety performance, there is an increased risk that trends are not identified and remedial action taken where necessary and the arrangements are not subject to an appropriate level of scrutiny.

Based on the audit work carried out the control environment was assessed as unsatisfactory. The Auditor was concerned that the governance arrangements may not be fit for purpose. Operational arrangements were not adequate and there is a lack of appropriate processes and scrutiny. The audit recommended that management review the governance and operational practice as a matter of priority.

In relation to the key risks management has addressed these by implementing an independent strategic review of the corporate health and safety governance and operational arrangements. A formal Corporate Health & Safety Team duty officer process has been developed, which includes a daily check of the systems to ensure any actions required as a result of an incidents are being effectively dealt with. All previous actions have now been reviewed. KPIs will be developed for the Corporate Health & Safety Team and these will be agreed with the senior management.

3.1.4 **Records Management**

The objectives of this audit were to ensure that the records management improvement action plan is progressing as expected and is regularly monitored by management; there is an adequate process developed to facilitate scheduled reviews and update of the plan; services are complying with a sample of elements in the plan; and there is sufficient evidence held by Services to demonstrate compliance with the Records Management Plan.

The audit identified that scheduled reviews of the Records Management Plan are in place and progress is monitored by management. However, not all actions within the improvement action plan are progressing as expected and the deadlines for these actions have not been revised. Following the audit review, management have also identified that the recent resignation of the Records Manager may further impact on the progress of the plan should there be difficulties in recruiting to the post. There was also evidence that all services are not complying with some of the elements in the Records Management Plan e.g. completion of Destruction Certificates.

A new Records Manager has recently been recruited and management agreed to review the timescales and revise these to be more realistic in light of the first year of implementation having passed and taking into account lessons learned. The Records Management Service Working Group meetings have been re-introduced, this group will be the forum for raising awareness of the requirements for records management and embed processes within services.

3.1.5 **Corporate Purchase Cards**

The purpose of the audit was to ensure that the corporate purchase cards are being utilised in accordance with the documented policy and guidance. The review also sought to ascertain the main suppliers of goods and services purchased using the Pcard identifying areas of off contract spend and to consider if best value would be achieved by establishing contracts with these suppliers.
The review identified that frequent transactions are in the main below £499.99, in line with the intended use of Pcards. There may also be security/compatibility implications if Pcards are used to purchase IT goods or services that do not have prior approval from ICT Services and value for money may not be achieved if non-contract purchases are made with Pcards.

The supplier Amazon was found to have the largest non contracted spend via Pcard in the financial year 2016/2017. Due to the time taken to ascertain the details of items purchased in each transaction and the large variation of items identified as being purchased during testing, the auditor was unable to identify any large areas of spend where there is already a preferred method of purchase. No specific recommendation was made in this regard.

The PCard Procedures have been updated to reflect the audit recommendations made and PCard holders have been reminded of their roles and responsibilities regarding the issues raised in the audit report.

4. NHS Greater Glasgow and Clyde Internal Audit Activity

4.1 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. A summary has been provided for those reports with individual findings graded as medium or high.

Review	Report classification (Note 2)	Number of individual findings		
		High	Medium	Low
Key financial controls: payroll	Low	-	-	-
Clinical and care governance	Low	-	-	2
Public Health: screening programmes	Low	-	-	2
Information Governance	Low	-	1	2

Gifts and hospitality compliance	Medium	-	3	1
Programme management	Low	-	-	1
Health and safety compliance	Medium	-	3	-
Corporate risk management	Low	-	1	2
Achieving Financial Balance	Medium	1	-	-
Financial Planning 2018/19	Medium	-	2	1
Total findings		**1**	**10**	**11**

Note 2
***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.

4.1.1 Information Governance – low risk, 1 medium finding

The primary objective of this audit review was to examine the progress made to design and implement a Board-wide Information Asset Register, populate the Register with the right data for it to be an effective information source against which other data protection requirements can be fulfilled, and to establish the operational processes to ensure the Information Asset Register remains effective.

The medium risk finding was in relation to populating the IAR; over 350 information assets have been registered at the time of writing. The Information Governance Team continues to work with the wider Directors to ensure the work progresses, but as asset questionnaires are submitted there will be an ongoing need to review submissions and ensure the controls in place to protect personal and sensitive personal data assets are appropriate under GDPR requirements. It is important to be able demonstrate to the regulator that risk assessment of the controls around each asset has been undertaken, and remedial action has been taken. This 'paper shield' will be important in the event of a regulator audit or data breach. Management should ensure an assessment of the controls for each asset is documented against the health Board's information security standards and requirements for the protection of personal and sensitive personal data.

4.1.2 Gifts and hospitality compliance – medium risk, 3 medium findings

The Directorate for Health Finance of the Scottish Government instructed all Scottish Health Boards to consider a number of actions to provide assurance as to the extent and adequacy of controls that are in place for the notification and recording of gifts and hospitality. These were to commission an internal audit review of the processes for notification and recording of gifts and hospitality; to confirm that hospitality registers are up to date and conform to Standing Financial Instructions; to provide a reminder to staff that they must comply with these SFIs and ensure they are read and understood; and to invite Counter Fraud Services to present to key staff on provisions of the Bribery Act.

PwC's review covered the following areas: the guidance available in the Code of Conduct, additional guidance available to some staff groups (eHealth, Pharmacy, the Area Drugs and Therapeutic Committee and Procurement were considered), reporting and approval, maintenance of the register and governance arrangements.

They noted that there are areas where the current policies and procedures in relation to gifts and hospitality could be improved. The medium risk findings were:

There were aspects of both the staff and Board Members' Codes of Conduct which could be strengthened - no timescale is specified in either Code of Conduct for how quickly declarations should be made following receipt of gifts/hospitality and for Board Members, nor is there a requirement to declare declined gifts/hospitality, which is inconsistent with the staff code of conduct.

Some board members who had joined the Board had not yet completed a declaration of interests; Board Members' interests should be disclosed per the code of conduct.

There was no procedure in place to ensure that items of gifts or hospitality are given approval timeously.

4.1.3 **Health and safety compliance – medium risk, 3 medium findings**

This review considered the steps taken by management to progress a sample of actions to address points raised by the Health & Safety Executive (HSE) and also considered the processes across Acute, Partnerships and Property Procurement and Facilities Management (PPFM) for identifying and undertaking investigations into any incidents which must be reported to the HSE under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

The three medium risk findings were:

Only the Partnerships H&S team had a formally documented process for the identification, reporting and investigation of RIDDOR incidents and there is an inconsistent approach taken across the Board's three H&S teams for conducting investigations into RIDDOR incidents. As a result of the inconsistencies noted, the processes in place within Acute and PPFM are considered less robust than the process in place within Partnerships.

From a sample of twenty-five incidents reported to RIDDOR, it was found that seven of these were not reported to HSE within the required timescales.

There is no consistent process in place to monitor progress against identified recommendations resulting from RIDDOR investigations, to provide oversight that required lessons learned are being taken and on a timely basis.

4.1.4 **Corporate risk management – low risk, 1 medium finding**

The purpose of this review was to consider the effectiveness of the Board's corporate risk management arrangements, including the work that was undertaken to revise the Corporate Risk Register.

The review identified one medium risk finding: PwC found that Datix could be used more effectively in the organisation. Inconsistencies were noted between updates that are being made 'offline' on a hard copy of the CRR and the information held on Datix, as updates are not being made to Datix on a timely basis. At a Directorate level, they also noted that risks were not being reviewed on Datix on a regular basis.

4.1.5 **Achieving financial balance – medium risk, 1 high finding**

Whilst the overall rating of this report was medium, there was a high risk finding. In successfully achieving financial balance in the year, the Board relied heavily on the use of non-recurring support. The percentage of total savings achieved which were on a non-recurring basis was approximately 70% in 2017-18, compared with around 40% in 2015-16. While non-recurring savings will always form part of a Board's savings, the lack of enduring savings increases future financial challenges and poses a risk to the NHS Board's financial sustainability. PwC noted that it was critical that the NHS Board puts in place a transformation plan that will deliver recurring savings and provide financially sustainability for the future. Measures recently put in place, such as the Financial Improvement Programme, should clearly and regularly communicate to the Finance and Planning Committee and the Board on the progress made to reduce the Board's recurring deficit.

4.1.6 **Financial planning – medium risk, 2 medium findings**

The scope of this review focussed on the planning process and key assumptions that underpin the Board's 2018/19 financial position. The process was to establish the Board's net cash efficiency challenge for 2018/19, and no service redesign or transformation assumptions were applied efficiency challenge.

The review concluded that overall, the planning process has been undertaken with an objective of transparency and there is clarity over the key assumptions underpinning the 2018/19 cash efficiency challenge. Addressing the two medium risk findings identified would also further strengthen the transparency of the financial planning process. The findings were:

In the Board's key financial plan assumptions, the level of certainty that can exist for each assumption varies. This is a normal feature of the planning process, however given the extent of the financial challenge it is important that these areas of risk in the plan are clearly understood by the Board and are subject to regular monitoring.

The Board's planning arrangements are intended to set out the total saving challenge to be addressed. In most cases the presentation of information is shown on a gross basis before any saving plans are applied. However, PwC noted that for primary care prescribing cost pressure is presented net of planned saving schemes.

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 matters arising from the risk based Audit Plan's 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

To: **Renfrewshire Health and Social Care Audit Committee**

On: **29 June 2018**

Report by: **Chief Internal Auditor**

Heading: **Internal Audit Annual Report 2017/2018**

1. Summary

1.1 The Public Sector Internal Audit Standards (PSIAS) requires that the Chief Internal Auditor must deliver an annual internal audit opinion, on the overall adequacy and effectiveness of the internal control environment; that can be used by the organisation to inform its governance statement. The purpose of this report it to advise the Audit Committee of the Chief Internal Auditor's Internal Audit Annual Report and the annual internal audit opinion.

1.2 The Internal Audit Annual Report outlines the internal audit work we have carried out for the year ended 31 March 2018. The annual internal audit opinion must conclude on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

1.3 The report attached, at Appendix 1, includes the Chief Internal Auditor's independent and objective opinion as to the adequacy and effectiveness of the internal control environment. In forming the opinion, the Chief Internal Auditor has conducted a review of the Internal Audit reports issued to the IJB in the year and the internal audit annual reports from the partner organisations.

2. Recommendations

2.1 That the Audit Committee notes the content of the Internal Audit Annual Report for 2017/2018.

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 report provides an opinion on the overall internal control environment including governance and risk management of the Integration Joint Board.

11. **Privacy Impact** - none.

List of Background Papers – none.

Author: Andrea McMahon, Chief Internal Auditor

Renfrewshire Health and Social Care Integration Joint Board

Internal Audit Annual Report 2017-2018

June 2018

Renfrewshire Health and Social Care Integration Joint Board

Internal Audit Annual Report 2017/2018

Contents

Renfrewshire Health and Social Care Integration Joint Board

Internal Audit Annual Report

1 April 2017 – 31 March 2018

1. Introduction

1.1 Renfrewshire Council provides an internal audit service to the Renfrewshire Health and Social Care Integration Joint Board (IJB). This includes:

- The compilation of an annual audit plan following consideration and evaluation of those areas of greatest risk in the organisation's operation, and consultation with the Chief Officer;
- Delivery of the planned audit assignments;
- Follow up of previous audit recommendations;
- Provision of any ongoing advice support and training on audit and risk related matters;
- Provision of an Annual Report and Assurance Statement to the IJB Audit Committee.

1.2 The Service operates in accordance with the Public Sector Internal Audit Standards which defines Internal Audit's role as:

".....an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes."

1.3 In line with the Standards, the purpose of this Annual Report is to report on:

- The outcome of the planned Internal Audit reviews 2017/18 relating to the IJB;
- The outcome of Internal Audit reviews of supporting Renfrewshire Council corporate systems;
- Internal audit performance;
- Planned audit work for 2018/19;
- The annual assurance statement which provides an opinion on the overall adequacy and effectiveness of the IJB's internal control environment.

1.4 The operational delivery of services within the Health Board and Local Authority on behalf of the Integration Joint Board will be covered by their respective internal audit arrangements. In concluding on the overall opinion, the Chief Internal Auditor has conducted a review of the Internal Audit reports issued to the IJB in the year and the internal audit annual reports from Renfrewshire Council and NHS Greater Glasgow and Clyde.

2. Responsibilities of Management and Internal Audit

2.1 It is the responsibility of management to ensure that the areas under their control are adequate and effective and that there is a sound system of internal control which facilitates the effective exercise of the organisation's functions and which includes arrangements for the management of risk.

2.2 Internal Audit is not a substitute for effective control exercised by management as part of their responsibilities. Internal Audit's role is to independently assess the adequacy of the risk management, internal controls and governance arrangements put in place by management and to undertake sufficient work to evaluate and conclude on the adequacy of those controls for the period under review.

3. Internal Audit Activity during 2017/2018

3.1 The Internal Audit Plan for the IJB for 2017/2018 provided for a review of the compliance with the Integration Scheme. Following approval of the IJB Local Code of Corporate Governance it was agreed that a review of the adequacy and compliance with the Local Code of Corporate Governance would also be undertaken on an annual basis.

3.2 Appendix 1 details the assurances arising from the internal audit work carried out in line with the 2017/18 audit plan and relevant engagements undertaken by the partner internal audit functions. These completed engagements have been reported to the Audit Committee throughout the year and supports the annual assurance statement.

3.3 The Annual Report for 2016/2017 was submitted to the IJB Audit Committee Authority on 29 June 2017.

3.4 The implementation rate of audit recommendations is a measure of operational culture and effectiveness. During 2017/18, 1 recommendation was followed up and was confirmed as implemented.

4. Review of Internal Audit Performance

4.1 Internal Audit produces regular reports on its performance during the year to the IJB Audit Committee and to Renfrewshire Council's Audit, Risk and Scrutiny Board, against a range of measures set annually by Renfrewshire Council's Director of Finance and Resources. These targets are set for all internal audit engagements and include Renfrewshire Council and other associated bodies, for which the team provides internal audit services. Table 1 shows the actual performance against targeted performance for the year.

Table 1

Internal Audit Performance 2017/18

Performance measure	Target 2017/18	Actual 2017/18
% of audit assignments completed by target date	95%	96%
% of audit assignments completed within time budget	95%	95%
% completion of audit plan for the year*	95%	93%

* this measures the completion percentage as at 31 March. 100% of the plan is ultimately delivered through the finalisation of the outstanding elements in the new financial year.

4.2 Actual performance for the year, in relation to percentage completion of the audit plan, is 2% below the target performance level. This was due to the actual level of resources available being lower than had been planned for, due to vacancies and two Council engagements being deferred into early 2018/19 due to other operational commitments within the services. All IJB specific audit engagements were completed by 30 April 2018.

4.3 The Chief Auditor is required to develop and maintain a quality assurance and improvement programme that covers all aspects of internal audit including conformance with the PSIAS. There is an opportunity to improve and formalise the internal audit reporting arrangements to Board and this has been addressed early in 2018/19.

4.4 External Audit

External Audit's review of the internal audit service concluded that overall the service operates in accordance with the PSIAS, although some recommendations for improvement were made which have been addressed.

5. Planned Work for 2018/19

5.1 Following a risk based assessment of the activities of the IJB and consultation with the Chief Officer and Chief Financial Officer the Internal Audit Plan for 2018/2019 provides for 35 days of Internal Audit resource to undertake:

- A governance review focused on financial governance arrangements; and
- The annual review of the adequacy and effectiveness of the Local Code of Corporate Governance.

The plan also provides time for planning and reporting, follow up on previous recommendations, ad-hoc advice and consultancy. The Internal Audit Plan for 2017/2018 was approved by the IJB on 26 January 2018.

6. Audit Assurance Statement

6.1 The audit work performed in relation to the 2017/18 internal audit plan has been reported to the Chief Officer. Relevant audit work undertaken by partner organisations has been reported to the Audit Committee. Where areas for improvement in internal control have been identified appropriate recommendations have been made, and accepted for action by management.

6.2 A number of significant matters have been identified in relation to the internal control, risk management and governance arrangements within the partner organisations and these have been recommended by the respective Chief Internal Auditors for inclusion in the partner governance statements. There are no significant matters arising in relation to those audit engagements specific to the IJB.

6.3 It is not feasible for the system of internal control to be without any weakness. It is important to balance the risks involved in accepting systems limitations with the consequences if a problem emerges. Internal Audit recognises this and assesses this in its reporting mechanism.

6.4 In this context, it is considered that a reasonable level of assurance can be placed upon the adequacy and effectiveness of the IJB's internal control, risk management and governance arrangements, as evidenced by:-

- The results of the audit work in 2017/18 and the opinion's contained in the Internal Audit Annual Reports of the Health Board and the Local Authority.
- Management self assessment of internal control, risk management and governance arrangements.
- Management action to respond to audit recommendations.

Signed

Chief Internal Auditor

Date 29 June 2018

Appendix 1

Summary of Internal Audit Assurances for the IJB and partner organisations Renfrewshire Council and NHS Greater Glasgow and Clyde

Integration Joint Board		
Audit Engagement	**Assurance Level**	**Significant Matters**
Compliance with the Integration Scheme	**Substantial**	• None
Local Code of Corporate Governance	**Reasonable**	• None
Renfrewshire Council		
Audit Engagement	**Assurance Level**	**Significant Matters**
Corporate – Health & Safety	**No Assurance**	• In the context of the objectives of the audit review, the control environment has been assessed as unsatisfactory. The Auditor is concerned that the current governance arrangements may not be fit for purpose. Operational arrangements are not currently adequate and there is a lack of appropriate processes and scrutiny. Management need to review the governance and operational practice as a matter of priority.
Adults with Incapacity	**Limited**	• The audit identified that although there is a process in place for the use of Adults with Incapacity (Scotland) Act 2000, the guidance available to officers is outdated. Furthermore, on some occasions the relevant paperwork in relation to referring and applying for Adults with Incapacity intervention was unable to be located and those that were found were not always signed.
Adult Services Charging & Payments	**Limited**	• The audit has provided limited assurance over the arrangements in place for administering financial assessments for non-residential care and raising invoices by the Charging and Payments team. It is acknowledged that Charging and Payments management have implemented new procedures and are continuing to work to improve controls in this area.
Corporate Records	**Limited**	• Although there is a Records

Management		Management Plan in place that has been approved by the Keeper of Records Scotland, there is evidence to support that services are not fully complying with laid down practices. Furthermore, the estimated completion dates contained in the improvement action plan against a number of elements have not been achieved and therefore require to be revised.
Payroll - Pensions Auto Enrolment	**Reasonable**	• None
Corporate Purchase Cards	**Reasonable**	• None
Corporate Complaints Procedures	**Reasonable**	• None
Contract Monitoring Arrangements (Property Services)	**Substantial**	• None
Civil Contingencies Service	**Substantial**	• None
NHS Greater Glasgow and Clyde		
Audit Engagement	**Risk Level**	**Significant Matters**
Achieving Financial Balance	**High**	• The Board successfully achieved financial balance in the year, however, this relied heavily on the use of non-recurring support. The percentage of total savings achieved which were on a non-recurring basis was circa 70% in 2017/18, an increase from 40% in 2015/16. While non-recurring savings will always form part of a Board's savings, the lack of enduring savings increases future financial challenges and risks its financial sustainability. It is critical that the Board puts in place a transformation plan that will delivers recurring savings and provides financially sustainability for the future.
Waiting times management	**High**	• In order to address the deteriorating performance against the Treatment Time Guarantee, management implemented a programme of demand and capacity gap assessment and improvement. The demand and capacity gap assessment exercise is of significant strategic and clinical importance to NHSGGC and its delivery is both complex

		and multi-faceted. However, we found that the exercise, despite its complexity and scale, has been initiated and partly executed without any formal project management discipline.
Mental Health: Crisis Management	**High**	• Internal Audit performed sample testing over the execution of the three risk assessment tools operating across NHSGGC and found that in a significant number of instances, across all three tools, risk assessments were not completed in accordance with the governing policies in place.
Delayed discharge	**Medium**	• None
Premium rate agency use	**Medium**	• None
Cyber security maturity: Phase 2	**N/A**	• None
Key financial controls: Accounts payable	**Low**	• None
Key financial controls: Fixed assets	**Low**	• None
Key financial controls: Payroll	**Low**	• None
Clinical and Care Governance	**Low**	• None
Information Governance – Information Asset Register	**Low**	• None
Public health screening programmes	**Low**	• None
Gifts and hospitality compliance	**Medium**	• None
Programme management – Moving Forward Together	**Low**	• None
Health and safety compliance	**Medium**	• None
Corporate risk management	**Low**	• None
Financial Planning 2018/19	**Medium**	• None
Property Transactions Monitoring	**N/A**	• None

To: **Renfrewshire Health and Social Care Integration Joint Board Audit Committee**

On: **29 June 2018**

Report by: **Chief Internal Auditor**

Heading: **Internal Audit Reporting Arrangements**

1. Summary

1.1 The Chief Internal Auditor is required to develop and maintain a quality assurance and improvement programme that covers all aspects of internal audit including conformance with the Public Sector Internal Audit Standards (PSIAS). It has been identified that there is an opportunity to improve and formalise the internal audit reporting arrangements to Joint Committee.

1.2 This report outlines the details and outcome of the Chief Internal Auditor's considerations in relation to the Joint Committee reporting arrangements for completed audit engagements and follow up work.

1.3 The report also highlights changes to the reporting of internal audit performance to the IJB.

2. Recommendations

2.1 Members are requested note the reporting arrangements put in place to communicate the results of Internal Audit work to the IJB Audit Committee.

2.2 Members are requested to note that updates on progress with the IJB audit plan will be provided to each meeting of the Audit Committee and that overall performance of the Internal Audit function will be reported and monitored quarterly by Renfrewshire Council's Audit, Risk and Scrutiny Board.

3. Background

3.1 Communicating the results of audit engagements

3.1.1 The PSIAS encompass the mandatory elements of the Institute of Internal Auditors (IIA) International Professional Practices Framework (IPPF) and has been issued by CIPFA, who set the internal auditing standards for UK Local Authorities. The Chief Auditor has a professional duty under the PSIAS to report the results of engagements to senior management and the Board, although the PSIAS does not prescribe any specific format that should be adopted for reporting.

3.1.2 Members of the Audit Committee need to be provided with enough information to allow them to understand any significant risk exposures to the IJB's internal control environment identified through the work of Internal Audit.

3.1.3 The CIPFA "Audit Committees, Practical Guidance for Local Authorities" publication, defines that role as "reviewing the work carried out will include formal consideration of summaries of work done, key findings, issues of concern and action in hand as a result of audit work."

3.1.4 Currently, the Chief Internal Auditor reports summaries of all finalised audit engagements specific to the IJB along with those relating to adult services and completed engagements for Renfrewshire Council which are of interest or support the objectives of the IJB. NHS GGC provide the Chief Internal Auditor with summaries of audit engagements completed for the NHS Board. A report is provided to each IJB Audit Committee detailing summaries of all relevant internal audit work completed for the IJB and the partner organisations.

3.1.5 The Chief Internal Auditor is satisfied that the current reporting arrangements meet with the requirements of the PSIAS and Audit Committee best practice guidance.

3.1.6 The Chief Internal Auditor would still need to preserve the confidentiality of the information in cases where it may breach legislation or where the risk of the weakness being exploited be of such significance that she would seek to have the report heard in private, to protect the IJB's interests.

3.2 Monitoring the progress of management actions

3.2.1 The PSIAS places the responsibility for monitoring progress with the Chief Internal Auditor to ensure that management actions have been effectively implemented, or, if not, that senior management have accepted the risk of not taking action.

3.2.2 The Chief Auditor must implement a follow-up process for ensuring the effective implementation of audit results or ensuring senior management are aware of the consequences of not implementing an action point and are prepared to accept the risk of such consequences occurring. The results of this process should be communicated to the Audit Committee.

3.2.3 There is also a requirement for the Chief Internal Auditor to develop escalation procedures for cases where agreed actions have not been effectively implemented by the date agreed. These procedures should ensure that the risks of not taking action have been understood and accepted at a sufficiently senior management level. The effective involvement of the Audit Committee in the follow-up process is critical to ensuring that it works.

3.2.4 Internal Audit undertakes an annual follow up exercise. The focus of each annual follow up exercise can vary depending on the audit resources available. All critical recommendations followed up must be supported by evidence to demonstrate that they have been implemented.

3.2.5 The outcome of the annual follow up exercise is communicated to the Chief Officer with details of all partially implemented, redundant and outstanding recommendations. The Chief Internal Auditor currently reports, the number of recommendations followed up, and the current status of those recommendations in the Internal Audit Annual Report.

3.2.6 It is the Chief Internal Auditor's opinion that there is an opportunity to enhance the escalation procedures for cases where agreed actions have not been effectively implemented by the date agreed. The Chief Internal Auditor will report details of outstanding critical recommendations to the Audit Committee on conclusion of the annual follow up exercise.

3.2.7 It is our intention to develop the audit management system to facilitate 'self-service' in relation to updates on the progress of implementing recommendations. This development would facilitate more regular reporting of outstanding actions in the future.

3.3 Communicating the acceptance of risks

3.3.1 The PSIAS places certain professional obligations on the Chief Internal Auditor to report to the Board, when in the Chief Auditor's opinion, management have accepted an unacceptable level of risk. The PSIAS states, "when the chief audit executive concludes that management has accepted a level of risk that may be unacceptable to the organisation, the chief audit executive must discuss the matter with senior management. If the chief audit executive determines that the matter has not been resolved, the chief audit executive must communicate the matter to the board."

3.3.2 Instances where the Chief Internal Auditor and senior management are unable to reach an agreement on actions to mitigate a significant risk to an acceptable level are rare. However, should such an instance arise the Chief Internal Auditor will bring a report outlining the risk exposure to the Audit Committee.

3.4 Performance Reporting

3.4.1 Currently, Internal Audit produces regular reports on its performance during the year to the IJB Audit Committee and to Renfrewshire Council's Audit, Risk and Scrutiny Board, against a range of measures set annually by Renfrewshire Council's Director of Finance and Resources. These targets are set for all

internal audit engagements and include Renfrewshire Council and other associated bodies, for which the team provides internal audit services.

3.4.2 The IJB Audit Committee Terms of Reference and Procedural Standing Orders state that part of the remit for the Audit Committee is "overseeing the independence, objectivity, performance and professionalism of internal audit as far as it relates to those services delegated to the Integration Joint Board".

3.4.3 As the Internal Audit function is provided under a service level agreement with the IJB, there are no performance targets which are specific to those services delegated to the IJB. To ensure continued compliance with the PSIAS, the Chief Internal Auditor will report to each Audit Committee progress against those planned engagements in the IJB audit plan. Overall, performance of the internal audit function in relation to the targets set by the Director of Finance and Resources will continue to be reported quarterly to Renfrewshire Council's Audit, Risk and Scrutiny Board and will be reported to the IJB in the internal audit annual report.

4. Conclusion

4.1 The Chief Internal Auditor is satisfied that these enhanced reporting arrangements fully supports the Audit Committee in their role, complies with the PSIAS and meets the best practice standard as set out in the CIPFA "Audit Committees, Practical Guidance for Local Authorities" publication.

For further information please contact Andrea McMahon on 0141-618-7017

Or via e-mail at andrea.mcmahon@renfrewshire.gov.uk

To:	**Integration Joint Board Audit Committee**
On:	**29 June 2018**
Report by:	**Chief Officer**
Heading:	**IJB & HSCP Risk Registers**

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 8 June 2018. 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 HSCP 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.

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 **4** 'live' risks on the IJB Risk Register with **2** 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.

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

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.17.01.02 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 (g) Compliance with new statutory requirements 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

Renfrewshire HSCP Risk Register

Report Type: Risks Report
Generated on: June 2018
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 in partner organisations *Staff training and awareness sessions under way	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 Chief Nurse HSCP Chief Officer, HSCP Clinical Director, HSCP	*Quality assurance process of working on shift to identify areas of good practice and additional care pressures. *Vacancies are recruited to follow risk assessment and review of staffing profile with minimum delay in accordance with Board process *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. *Chief Nurse overview of workforce recommendations in line with local/ Board/ national review *Systems in place to support all professional 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
A practice handing back their contract and the HSCP has to run the practice		Heads of Health & Social Care (West	*Early warning systems in place *Prioritise at risk practices for additional resources *Work with Primary Care Support to support practices *Cluster support for 'struggling' practices	04	05	12 High

		Renfrewshire and Paisley);				
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, including mandatory and statutory 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 (3) Challenges of meeting workload demands and improving services in conjunction with identification of savings (4) Ensuring alignment with Scottish Government and Board strategic direction in terms of workforce	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 *Ensuring that there is professional as well as operational overview of any savings discussions *Assurance that robust risk management process in place to justify any decisions and describe alternative service delivery to ensure safe, effective and person centred care *Professional leads have process in place to record and, if necessary, escalate concerns	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

To:	**Renfrewshire Integration Joint Board Audit Committee**
On:	**29 June 2018**
Report by:	**Head of Administration**
Heading:	**General Data Protection Regulations (GDPR) and new Data Protection Act**

1. Purpose and Background

1.1. To provide the IJB Audit Committee with an overview of the changes and implications arising from new Data Protection laws and the implementation of the Public Records (Scotland) Act 2011.

1.2. Members will be aware, from 25 May 2018, the existing Data Protection Act 1998 was replaced by new legislation in the form of the General Data Protection Regulation (GDPR) and a new Data Protection Act.

2. Recommendation

It is recommended that the IJB Audit Committee:

- Note the actions outlined in the report
- Read and note the requirement to comply with the guidance
- Approve the proposed arrangements for the IJB to ensure compliance.

Implications of the Report

1. **Financial –** Failure to comply with GDPR and the new Data Protection Act requirements could lead to significant financial penalties.
2. **HR & Organisational Development** – GDPR and Data Protection Act upholds and strengthens the information rights of individuals and ensures that their personal data is processed appropriately and lawfully.
3. **Community Planning** – None.
4. **Legal –** The Integration Scheme between Renfrewshire Council and NHS Greater Glasgow and Clyde sets out certain information-sharing and data requirements. The ISP ensures there is appropriate and lawful information sharing between the relevant parties, thereby ensuring compliance with GDPR and the new Data Protection Act.
5. **Property/Assets –** None.

6. **Information Technology –** Managing information and making information available may require ICT input.
7. **Equality & Human Rights –** None.
8. **Health & Safety** – None.
9. **Procurement** – None.
10. **Risk** – Failure to adhere to GDPR and the new Data Protection Act could have a serious impact on the IJB's ability to meet its statutory obligations under data protection legislation leading to major financial and legal penalties, as well as significant reputational damage for the organisation**.**
11. **Privacy Impact** – None.

List of Background Papers –
Guide to the General Data Protection Regulation – UK Information Commissioner
https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr

Draft Data Protection Bill – UK Information Commissioner
https://ico.org.uk/for-organisations/data-protection-act-2018/

Author: Jean Still, Head of Administration

GENERAL DATA PROTECTION REGULATIONS (GDPR) REQUIREMENTS FOR INTEGRATION JOINT BOARD

1. Background

1.1 Data Protection laws changed on 25 May 2018. EU General Data Protection Regulations (GDPR) came into force on that date.

1.2 The legislation introduced new rules on how personal data is collected and processed to ensure individuals have greater control and privacy rights for their information we hold. It shortens timescales for certain processes and significantly increases penalties for failure to comply.

1.3 There is a need for greater transparency. Formal notifications of the nature of, reason for and parties involved in data processing and data sharing are mandatory. These are referred to as Privacy notices.

1.4 As the IJB is a statutory authority, it is subject to the new regulations. However, the IJB in practice handles very little personal data and the impacts on the IJB specifically, as opposed to the partner organisations, is anticipated to be quite limited.

1.5 There are a wide range of activities across Renfrewshire Council and NHS Greater Glasgow & Clyde aimed at putting suitable arrangements in place for these changes.

1.6 A more limited range of activities will require to be progressed for IJB itself to ensure compliance with the new legislation. All members should have awareness of these changes.

2. Key Actions for IJB

2.1 **Public Records Plan** – as part of existing legislation – The Public Records (Scotland) Act 2011 – we are required to establish an IJB Records Management Plan and submit this when requested by the Keeper.

Currently all the IJB information is held on the Council's Electronic Document Records Management System (EDRMS) so these records require a management plan to be established outlining details of the file location, what information is held and the retention periods for the storage of this data.

2.2 **Fair processing notice** – a Privacy Statement must be created for the IJB which will outline what personal data the IJB processes and why, the legal basis for processing, how this information is stored and retained and with whom it is shared.

2.3 **Data Protection Officer** – Given that any personal data processed by the IJB is likely to be held on Council or NHS Information systems, then it is proposed that we utilise Renfrewshire Council and NHS Greater Glasgow & Clyde's DPOs for the handling of Data Breaches.

To: **Renfrewshire Health and Social Care Integration Joint Board Audit Committee**

On: **29 June 2018**

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 was approved at the Audit Committee on 26 January 2018. To facilitate an early introduction to the work of Audit Scotland, it is proposed to amend the dates for the programme of training briefings. Appendix 1 provides details of the revised dates.

1.3 Appendix 2 provides an outline of the briefing to be delivered by the External Auditors providing and overview of the work of Audit Scotland.

2. Recommendations

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

2.2 That the IJB Audit Committee not the content of the overview of Audit Scotland briefing

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

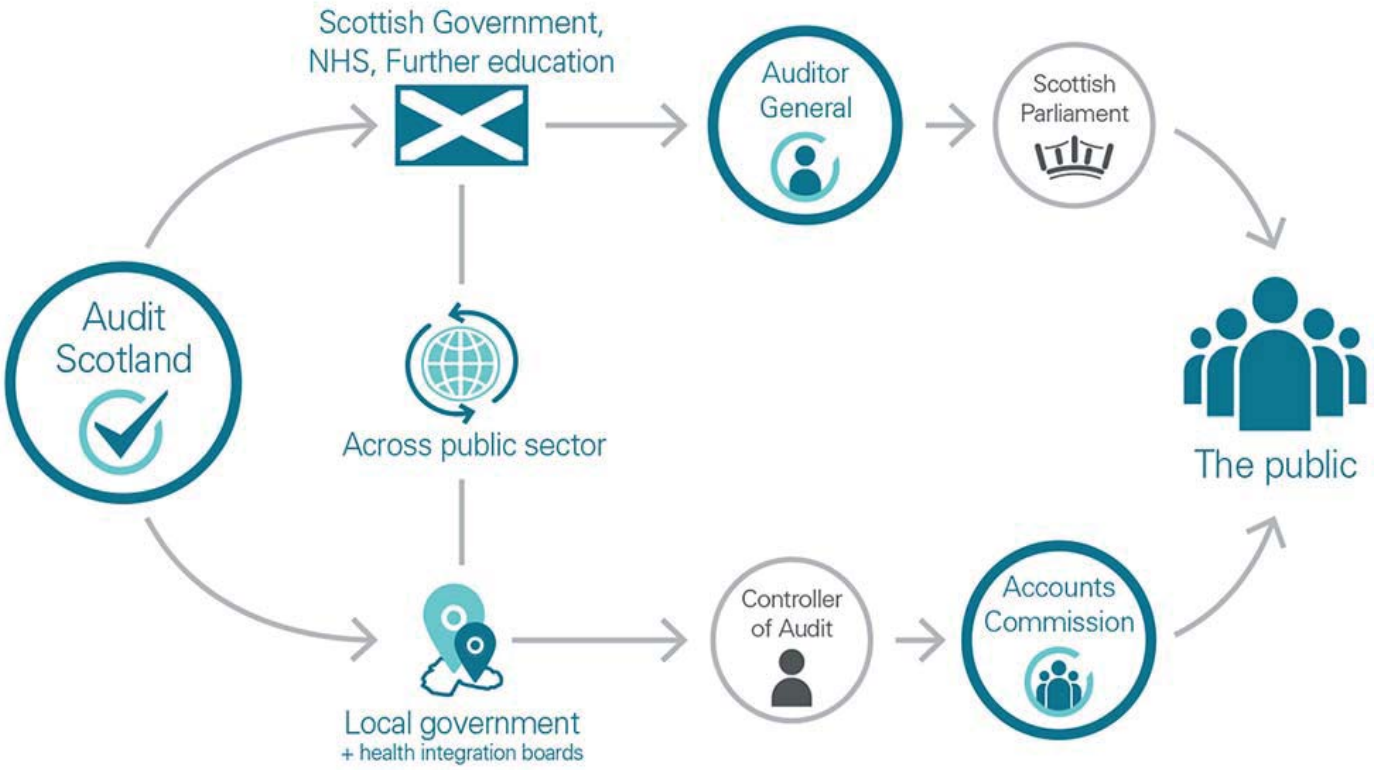
Appendix 1

Date	Topic
29 June 2018	Overview of Audit Scotland
14 Sept 2018	Risk Management
25 Jan 2019	The Role of Internal Audit

Audit Scotland - Overview

AUDIT SCOTLAND

Who we are


Scottish Government,
NHS, Further education
Auditor General
Scottish Parliament
Audit Scotland
Across public sector
The public
Controller of Audit
Accounts Commission
Local government
+ health integration boards

Financial Statements Audit


Renfrewshire Health & Social Care Partnership

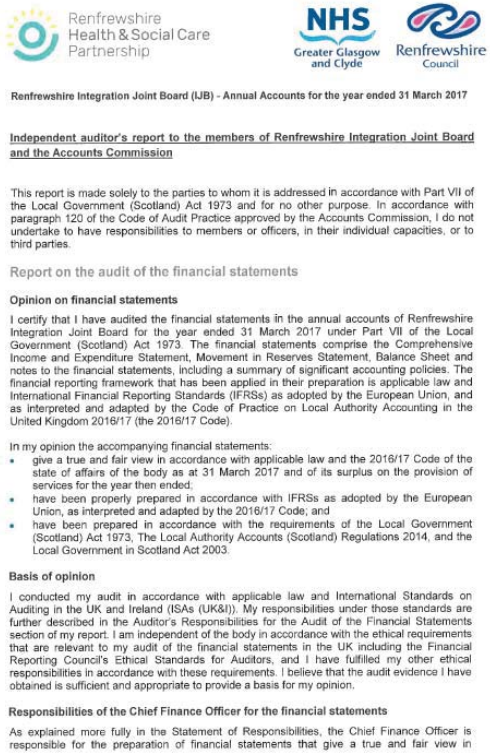
NHS Greater Glasgow and Clyde

Renfrewshire Council

Renfrewshire

Integration Joint Board

Annual Accounts 2016/17


Renfrewshire Health & Social Care Partnership

NHS Greater Glasgow and Clyde

Renfrewshire Council

Renfrewshire Integration Joint Board (IJB) - Annual Accounts for the year ended 31 March 2017

Independent auditor's report to the members of Renfrewshire Integration Joint Board and the Accounts Commission

This report is made solely to the parties to whom it is addressed in accordance with Part VII of the Local Government (Scotland) Act 1973 and for no other purpose. In accordance with paragraph 120 of the Code of Audit Practice approved by the Accounts Commission, I do not undertake to have responsibilities to members or officers, in their individual capacities, or to third parties.

Report on the audit of the financial statements

Opinion on financial statements

I certify that I have audited the financial statements in the annual accounts of Renfrewshire Integration Joint Board for the year ended 31 March 2017 under Part VII of the Local Government (Scotland) Act 1973. The financial statements comprise the Comprehensive Income and Expenditure Statement, Movement in Reserves Statement, Balance Sheet and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Code of Practice on Local Authority Accounting in the United Kingdom 2016/17 (the 2016/17 Code).

In my opinion the accompanying financial statements:

- give a true and fair view in accordance with applicable law and the 2016/17 Code of the state of affairs of the body as at 31 March 2017 and of its surplus on the provision of services for the year then ended.
- have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2016/17 Code; and
- have been prepared in accordance with the requirements of the Local Government (Scotland) Act 1973, The Local Authority Accounts (Scotland) Regulations 2014, and the Local Government in Scotland Act 2003.

Basis of opinion

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK and Ireland (ISAs (UK&I)). My responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of my report. I am independent of the body in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standards for Auditors, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Responsibilities of the Chief Finance Officer for the financial statements

As explained more fully in the Statement of Responsibilities, the Chief Finance Officer is responsible for the preparation of financial statements that give a true and fair view in

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Public Sector Audit

Also includes assessing:

Annual Audit Cycle

Audit Cycle- Timeline

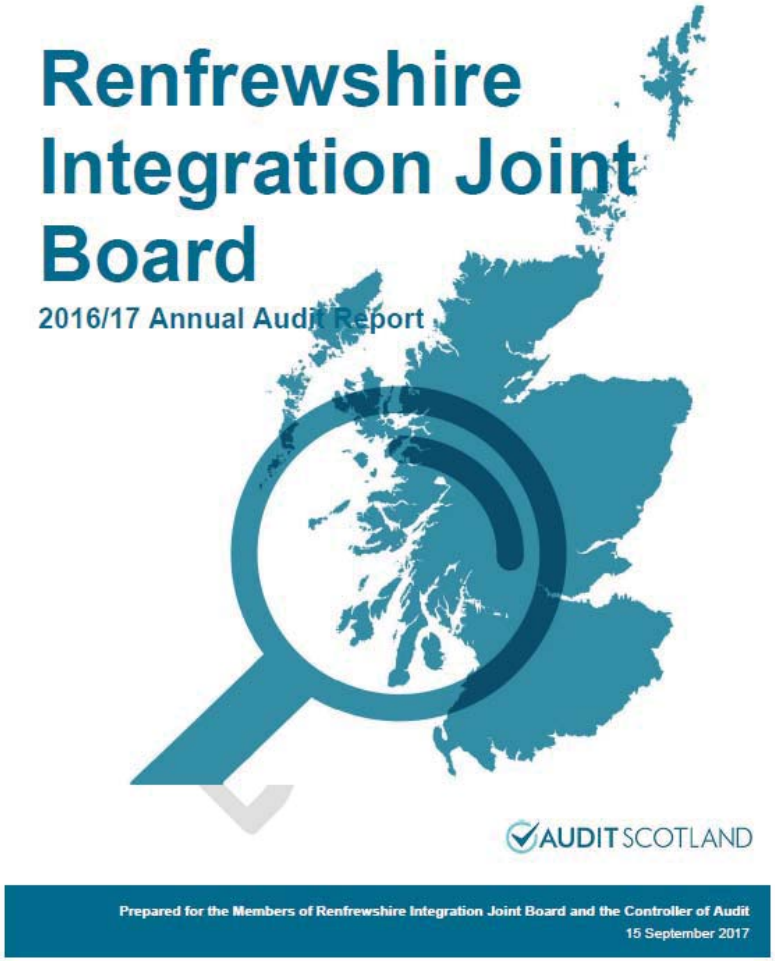
Timing	Audit Work	Audit Output
October / November to January	Risk Assessment	Annual Audit Plan
July to September	Financial Statements	Annual Audit Report
September to October	Completion	

Financial statements timetable

Key stage	Date
Consideration of unaudited financial statements by those charged with governance	29 June 2018
Latest submission date of unaudited annual accounts with complete working papers package	29 June 2018
Latest date for final clearance meeting with Chief Financial Officer	Early September 2018
Issue of letter of representation and proposed independent auditor's report	By 30 September 2018
Agreement of audited unsigned annual accounts	By 30 September 2018
Issue of Annual Audit Report including ISA 260 report to those charged with governance	By 30 September 2018
Independent auditor's report signed	By 30 September 2018

Annual Audit Plan

Annual Audit Report



To: **Renfrewshire Integration Joint Board Audit Committee**

On: **29 June 2018**

Report by: **Clerk**

Heading: **Proposed Dates of Meetings of the Audit Committee 2018/19**

1. Summary

1.1 At the meeting of the Joint Board held on 15 September 2017 the IJB approved its timetable for future meetings of the IJB and the Audit Committee to June 2018. It is proposed that the Audit Committee consider its timetable of meeting dates in 2018/19.

1.2 Arrangements for meetings of the Audit Committee are governed by the provisions of Standing Order 5.1 of the Audit Committee's Terms of Reference and Procedural Standing Orders which state that:-

"5.1 The Audit Committee shall meet at least three times per year."

1.3 The suggested dates and times are set out below, with meetings being held on Fridays at 9.00 am prior to meetings of the IJB:

14 September 2018
25 January 2019
28 June 2019.

1.4 It is proposed that meetings of the Audit Committee are 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.

1.5 A further report will be presented to the Audit Committee in due course to agree meetings post June 2019.

2. Recommendations

2.1 That the Audit Committee approve the dates and times of meetings for 2018/19 as detailed in section 1.3 of the report; and

2.2 That meetings of the 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, to determine an alternative venue.

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** - 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 NHS GC&C website.

8. **Health & Safety** - none.
9. **Procurement** - none.
10. **Risk** - none.
11. **Privacy Impact** - none.

List of Background Papers – none.

Author: Elaine Currie, Senior Committee Services Officer
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