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

Date	Time	Venue
Friday, 21 June 2024	10:00	Remotely by MS Teams,

MARK CONAGHAN
Clerk

Membership

Margaret Kerr (Chair) and vacancy (Vice Chair)

Councillor Fiona Airlie-Nicolson: Councillor Lisa-Marie Hughes: Ann Cameron Burns: Alan McNiven: Paul Higgins

Further Information - online meetings only

This meeting is on-line only but is a meeting which is open to members of the public by prior arrangement. 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

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Recording of Meeting

This meeting will be recorded for subsequent broadcast via the Council's internet site. If you have any queries regarding this please contact committee services on democratic-services@renfrewshire.gov.uk

To find the recording please follow the link which will be attached to this agenda once the meeting has concluded.

Recording

https://youtu.be/xydLTNbMr70?si=GTP6aOSWJo-VWP2M

Items of business

Apologies

Apologies from members.

Declarations of Interest and Transparency Statements

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

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

Date	Time	Venue
Friday, 15 March 2024	10:00	Remotely by MS Teams,

Present

Councillor Jacqueline Cameron and Councillor Fiona Airlie-Nicolson (Renfrewshire Council); Margaret Kerr and Ann Cameron Burns (Greater Glasgow & Clyde Health Board) and Paul Higgins (Health Board staff member involved in service provision).

Chair

Margaret Kerr, Chair, presided.

In Attendance

Mark Conaghan, Head of Corporate Governance (Clerk), Andrea McMahon, Chief Internal Auditor and Elaine Currie, Senior Committee Services Officer (all Renfrewshire Council); Sarah Lavers, Chief Finance Officer, Frances Burns, Head of Strategic Planning & Health Improvement, Laura Howat, Head of Mental Health, Learning Disability & Alcohol & Drugs Recovery Services, Pauline Robbie, Interim Head of Health & Social Care, David Fogg, Service Improvement Officer, James Higgins, Corporate Business Officer and John Millar, Communications Business Lead (Transformation) (all Renfrewshire Health and Social Care Partnership) and Rob Jones, Partner (Ernst & Young).

Recording of Meeting

Prior to the commencement of the meeting the Chair intimated that this meeting of the Committee would be recorded and that the recording would be available to watch on both the Council and HSCP websites.

Apology

Alan McNiven (third sector representative).

Declarations of Interest and Transparency Statements

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

1 Minute

The Minute of the meeting of the IJB Audit, Risk and Scrutiny Committee held on 17 November 2023 were submitted.

DECIDED: That the Minute be approved.

2 Rolling Action Log

The IJB Audit, Risk and Scrutiny Committee rolling action log was submitted.

DECIDED: That the action in relation to the CIPA Audit Committee Guidance – Self-assessment and Action Plan be removed as it had been completed.

3 Annual Internal Audit Plan 2024/25

The Chief Internal Auditor submitted a report relative to the Annual Internal Audit Plan 2024/25, a copy of which formed Appendix 1 to the report.

The report intimated that the Plan set out a resource requirement of 40 days and that the allocation of internal audit resources was sufficient to allow emerging priorities and provide adequate coverage of governance, risk management and internal control to inform the annual assurance statement.

The report noted that the audit universe was reviewed annually and Appendix 2 to the report detailed the revised audit universe and the anticipated coverage over 2024/25 to 2028/29. It was intended that each engagement topic would be covered once in the five-year period.

DECIDED:

(a) That the Internal Audit Plan 2024/25 be approved; and

(b) That it be noted that the Internal Audit Plan would be shared with the Local Authority and the Health Board.

4 Internal Audit Plan 2023/24 - Progress

The Chief Internal Auditor submitted a report providing an update on the progress of the Internal Audit Plan for 2023/24, a copy of which was appended to the report.

The report intimated that the engagement on performance management had been finalised and that the annual review of the adequacy and compliance with the Local Code of Corporate Governance had commenced.

DECIDED: That the progress against the Internal Audit Plan for 2023/24 be noted.

5 Summary of Internal Audit Reports

The Chief Internal Auditor submitted a report providing a summary of internal audit reports issued.

The report advised that a risk-based Internal Audit Plan for 202324 had been approved by this Committee at its meeting on 24 March 2023 and, in line with the Public Sector Internal Audit Standards, Internal Audit must report the results of each engagement to this Committee.

Appendix 1 to the report provided details of the completed audit engagement for performance management with the overall assurance rating and the number of recommendations in each risk category. The committee summary for this audit engagement formed Appendix 2 to the report.

DECIDED: That the content of the report be noted.

6 Training and Development for Audit, Risk and Scrutiny Committee Members

The Chief Internal Auditor submitted a report relative to training and development for Audit, Risk and Scrutiny members.

The report intimated that as part of the action plan arising from the recent self-assessment against the CIPFA guidance, members of the Committee undertook an assessment against the knowledge and skills framework contained in the guidance. Following an analysis of the returned questionnaires, the report proposed a programme of training briefings, as detailed in the appendix to the report, which would be delivered at meetings of this Committee.

It was noted that all members of the IJB would be invited to attend the training briefings which would be delivered as part of the IJB Audit, Risk and Scrutiny Committee meetings.

DECIDED: That the current programme of training briefings be approved.

7 External Auditor's Annual Audit Plan 2023/24

The Chief Finance Officer submitted a report relative to the Annual Audit Plan 2023/24 for the IJB which outlined Ernst & Young's proposed audit approach of the financial records for the year ended 31 March 2024, a copy of which was appended to the report.

The report advised that the proposed audit fee for the 2023/24 audit was £33,360 and was consistent with the fees for all IJBs and had been determined in line with Audit Scotland's fee setting arrangement.

Rob Young presented the Annual Audit Plan to members. Following on from discussion around how EY would benchmark the IJB's work on its Sustainable Futures Programme and what EY would use to assess the IJB against, Robb advised that EY would consider this not only with the other IJBs which EY audited but would raise the matter at national sector meetings with Audit Scotland. The Chair intimated that the standard on which the IJB was being held against was not always clear and noted that further information on benchmarking would be available in EY's report later in the year.

DECIDED: That the Annual Audit Plan, appended to the report, be noted.

8 Update on Risk and Issue Register

Under reference to item 6 of the Minute of the meeting of this Committee held on 17 November 2023, the Strategic Lead & Improvement Manager submitted a report providing an update on ongoing activity to identify and manage strategic and operational risks and updates made to the IJB's Risk and Issues Register, a copy of which was appended to the report.

The report provided further detail on the key updates to existing risks.

DECIDED: That the updates made to the Risk and Issue Register, following further assessment and engagement within the HSCP and with partners, as detailed in section 4 of the report, be noted.

9 Revised IJB Risk Management Framework: 2024 Review

The Strategic Lead and Improvement Manager submitted a report providing an update on the completion of a scheduled review of the IJB's Risk Management Framework, incorporating the IJB's Risk Policy and Risk Strategy, which had last been reviewed in March 2021.

The report intimated that the Risk Management Framework had been scheduled to be reviewed in 2023 but had been paused to enable completion of the internal audit of the IJB's risk management arrangements by Azets and reflection of any recommendations received within the updated framework.

The report set out a summary of the key changes which had been made to the Risk Framework, a copy of which was appended to the report.

DECIDED:

(a) That the summary of changes made to the IJB's Risk Management Policy and Strategy and the next steps identified, as detailed in sections 4 and 5 of the report, be noted;

(b) That it be noted that the next review date for the Risk Management Policy and Strategy would be March 2027, as detailed in section 5 of the report; and

(c) That the revised Risk Management Policy and Strategy, as appended to the report, be approved.

10 Update on RHSCP Business Continuity Workplan 2024

The Strategic Lead & Improvement Manager submitted a report providing further detail on the HSCP's Business Continuity Workplan for 2024.

The report intimated that the Workplan would continue to build on planning previously undertaken and the application of learning from these processes to ensure local plans were robust. The report noted that continued partnership working and sharing of resources with Renfrewshire Council and NHSGGC would be crucial in delivering these plans. The Workplan list of actions was appended to the report.

DECIDED: That the update provided on the HSCP's Business Continuity Workplan for 2024 be noted.

11 Health and Safety Update

Under reference to item 10 of the Minute of the meeting of this Committee held on 18 September 2023, the Interim Head of Health & Social Care submitted a report providing an update on the HSCP's incident report position for the period 1 July to 31 December 2023.

DECIDED: That the content of the report be noted.

12 Public Interactions Report for April to September 2023

Under reference to item 11 of the Minute of the meeting of this Committee held on 18 September 2023, the Lead Officer, Communications & Public Affairs submitted a report providing an update on public interactions for the period 1 April to 30 September 2023.

DECIDED: That the content of the report be noted.

13 Quality, Care and Professional Governance Mid-year Report (April to December 2023)

The Interim Head of Health & Social Care submitted a report relative to the HSCP's Quality, Care and Professional Governance Mid-year Report for the period April to December 2023, which provided a variety of evidence to demonstrate the continued delivery of the governance core components within Renfrewshire HSCP and the clinical and care governance principles specified by the Scottish Government.

The report advised that the governance core components within Renfrewshire HSCP were based on service delivery, care and interventions that were person-centred, timely, outcome focused, equitable, safe, efficient and effective.

DECIDED: That the content of the report be noted.

14 Audit Scotland Report 'NHS in Scotland 2023'

The Head of Strategic Planning & Health Improvement submitted a report relative to the Audit Scotland publication 'NHS in Scotland 2023' published on 22 February 2024, a copy of which was appended to the report.

The report intimated that Audit Scotland had warned within their report that 'significant changes are needed to ensure the financial sustainability of Scotland's health service'. Details were provided in relation to the key findings of the report.

DECIDED: That the content of the report and the Audit Scotland publication, appended to the report, be noted.

15 Mental Welfare Commission for Scotland: Inspection Reports for South Ward, Dykebar Hospital and Ward 3B, Leverndale Hospital

The Head of Mental Health, Learning Disability & Alcohol & Drug Recovery Services submitted a report relative to the announced visit by the Mental Welfare Commission to Ward 3B Leverndale Hospital on 28 November 2023 and the unannounced visit by the Mental Welfare Commission to South Ward Dykebar Hospital on 14 December 202. Copies of the reports by the Mental Welfare Commission were appended to the report.

The report provided further detail in relation to the positive findings and good practice identified together with other findings and comments in connection with both visits.

It was proposed that inspection reports be submitted to meetings of this Committee quarterly and that these reports provide detail on the action plans and follow-up activity undertaken. This was agreed.

DECIDED:

(a) That the content of the report be noted; and

(b) That inspection reports be submitted to meetings of this Committee quarterly and that these reports provide detail on the action plans and follow-up activity undertaken.

16 **Proposed Dates of Meetings of the IJB Audit, Risk and Scrutiny Committee 2024/25**

The Clerk submitted a report relative to proposed dates of meetings of this Committee in 2024/25 and arrangements for these meetings.

DECIDED:

(a) That it be noted that the next meeting of this Committee would be held at 10.00 am on 21 June 2024 and that it be agreed that this meeting would be held remotely on MS teams; and

(b) That meetings of this Committee be held at 10.00 am on 13 September and 15 November 2024 and 14 March and 20 June 2025 and that these meetings be held remotely on MS teams.

IJB Audit, Risk and Scrutiny Committee Rolling Action Log – 21 June 2024

Date of Committee	Report	Action to be taken	Officer responsible	Due date	Status
15/03/24	Inspection Reports	Submit inspection reports quarterly and providing detail on the action plans and follow-up activity undertaken.		quarterly	

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

On: **21 June 2024**

Report by: **Chief Internal Auditor**

Heading: **Internal Audit Plan 2023/24 & 2024/25 - Progress**

1. Summary

1.1 In March 2024, the Audit, Risk and Scrutiny Committee approved the current training and development plan, this report sets out the proposed changes to that plan.

1.2 The Internal Audit Plan for 2024/2025, as detailed at Appendix 2 of this report was also approved in March 2024. The plan sets out a resource requirement of 40 days, including governance work, reviewing the adequacy and compliance with the Local Code of Corporate Governance, time for follow up of previous recommendations, undertaking the annual self-assessment of the Audit Committee, training and ad-hoc advice and planning and reporting.

1.3 This report provides an update on the completion of the 2023/2024 audit plan and the progress of the internal audit plan for 2024/2025.

2. Recommendations

2.1 The Audit, Risk and Scrutiny Committee is asked to approve the revised training and development programme as detailed in Appendix 1.

2.2 That the Audit, Risk and Scrutiny Committee notes the progress against the Internal Audit Plan for 2023/24 and 2024/25.

3. Background

3.1 The 2023/2024 annual review of the adequacy and compliance with the Local Code of Corporate Governance has been finalised and a summary of the report is included on this agenda. All 2023/24 planned work has now been completed.

3.2 The Internal Audit Annual Report, including the Chief Internal Auditor's opinion on the overall internal control, risk management and governance arrangements, is also included elsewhere on this agenda.

3.3 The audit engagement on financial planning is anticipated to commence in quarter 2.

3.4 Time for planning and reporting continues to be used for regular reporting to the Audit, Risk and Scrutiny Committee.

3.5 The approved training and development plan included a briefing on governance arrangements and the value of good governance to be delivered in June 2024. As the membership of the Audit, Risk and Scrutiny Committee is due to change, it is proposed that the timetable for briefings is amended as detailed in Appendix 1.

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 risk based Audit Plan for 2024 – 2025.

11. **Privacy Impact** - none.

List of Background Papers – none.

Author: Andrea McMahon, Chief Internal Auditor

Appendix 1

Audit, Risk and Scrutiny Committee – Training and Development Programme of Briefings

Date	Topic
September 2024	Governance arrangements and the value of good governance
November 2024	Internal Audit
March 2025	Counter Fraud

Annual Audit Plan – 2024/25 Renfrewshire Integration Joint Board

Audit Category	Engagement Title	No. of days	Detailed work
Assurance	Financial planning	20	• The purpose of the audit is to review the arrangements in place for financial planning and managing the financial risks.
Governance	Local Code of Corporate Governance	5	• Annual review of the adequacy and compliance with the Local Code of Corporate Governance to inform the governance statement.
Planning & Reporting	Annual Plan, Annual Report and Audit Committee reporting & training	12	• The Chief Internal Auditor is required to prepare an annual plan and annual report for the Audit Committee, summarising the work undertaken by Internal Audit during the year and using this to form an opinion on the adequacy of the control environment of the IJB. Time is also available to facilitate the annual assessment against the CIPFA position statement on Audit Committees.
Contingency	Ad-hoc advice and Consultancy	3	• Time for advice and consultancy on relevant priorities and risks or change related projects and following up on the implementation of internal audit recommendations.

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

On: **21 June 2024**

Report by: **Chief Internal Auditor**

Heading: **Summary of Internal Audit Reports**

1. Summary

1.1 A risk based Internal Audit Plan for 2023/24 was approved by the IJB Audit Committee on 24 March 2023. In line with the Public Sector Internal Audit Standards, Internal Audit must communicate the results of each engagement to the Board.

1.2 Appendix 1 provides details of the completed audit engagement for the Annual review of the adequacy and compliance with the Local Code of Corporate Governance, with the overall assurance rating and the number of recommendations in each risk category. The committee summary is also attached at Appendix 2.

2. Recommendations

2.1 That the Integration Joint Board Audit, Risk and Scrutiny 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 for the IJB.

11. **Privacy Impact** - none.

List of Background Papers – none.

Author: Andrea McMahon, Chief Internal Auditor

Appendix 1

Integration Joint Board Audit, Risk and Scrutiny Committee

Internal Audit Service

Summary of Final Audit Reports Issued

Engagement	Assurance Rating	Recommendation Ratings			
		Critical	Important	Good Practice	Service Improvement
Governance Arrangements (Local Code of Corporate Governance)	Substantial	0	0	0	0

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.

Appendix 2

Internal Audit Report

IJB - Governance Arrangements (B0017/2024/001)

Date: May 2024

COMMITTEE SUMMARY

Audit Objectives
The Renfrewshire Integrated Joint Board (IJB) have developed local governance arrangements that are designed to ensure compliance with, 'Delivering Good Governance in Local Government: Framework,' published by CIPFA. The objectives of this audit were to review independently and report annually to the IJB Audit, Risk and Scrutiny Committee: • To provide assurance on the adequacy and effectiveness of the Local Code of Corporate Governance and the extent of compliance with it. • To support the Chief Internal Auditor's annual opinion included in the Internal Audit Annual Report and the Governance Statement included in the Annual Accounts.

Audit Scope
1. Obtained an up-to-date copy of the IJB's Local Code of Corporate Governance and selected a sample of elements for compliance testing. 2. Obtained the appropriate evidence to confirm compliance with the Code.here was adequate management oversight for the selected performance indicators.

Key Audit Assurances
1. The Local Code and Sources of Assurance for Governance Arrangements was updated and submitted to the Renfrewshire Integration Joint Board on the 23rd of June 2023. 2. Based on our sample check of the evidence used to demonstrate compliance, we would confirm that the IJB complies with the requirements of the Local Code of Corporate Governance.

Key Risks
• No key risks were identified as a result of this audit.

Overall Audit Opinion
Internal Audit has reviewed the adequacy and effectiveness of the revised Code which was presented to the Renfrewshire Integration Joint Board on the 23rd of June 2023. Based on our sample check of the evidence used to demonstrate compliance, we would confirm that the IJB complies with the requirements of the Local Code of Corporate Governance. In addition, it is evident that the Local Code has been subject to regular review and updating in line with developments in best practice.

Management Commentary
N/A as no key risks identified.

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

On: **21 June 2024**

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, Risk and Scrutiny Committee of the Internal Audit activity undertaken within these partner organisations.

2. Recommendations

2.1 That the Integration Joint Board Audit, Risk and Scrutiny Committee are asked to note the contents of the report.

3. Renfrewshire Council Internal Audit Activity

3.1 The following Internal Audit reports have been issued to the Renfrewshire Council, which are relevant to the Integration Joint Board.

Audit Engagement	Assurance Level (note 1)	Number and Priority of Recommendations (note 2)			
		Critical	Important	Good Practice	Service Improvement
Payroll Overpayment Processes	Reasonable	0	2	1	0

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

3.1.1 **Payroll Overpayment Processes**

The objectives of the review were to ascertain the main reasons for overpayments occurring and ensure that;

1. The payroll processes in place to pay employees accurately are adequate and well communicated to services to minimise the amount of overpayments occurring;
2. Overpayments arising, are recorded and employees are notified timeously;
3. Overpayment reports are regularly sent to senior management and regularly reviewed;
4. Reasons for overpayments are ascertained by service management and action is taken to strengthen controls where required;
5. Employees and former employees have been made aware of their responsibilities and action to be taken in relation to overpayments.

Key Audit Assurances

- The value of payroll overpayments has decreased in recent years although the number of overpayments has remained relatively static.

- Payroll overpayments are being identified and acted upon by Business Services employees more quickly than in previous years.

- The Salary Adjustment Policy provides clear guidance as to the responsibilities and actions to be taken in relation to recovery of payroll overpayments for employees and former employees.

Key Audit Risks

- The risk of avoidable overpayment is increased where clear and accessible guidance is not made available to services managers to inform them of the correct procedures and the required payroll deadlines.

- Where employees are not informed timeously about payroll overpayments, it can make them more difficult to recover and there may be reputational damage to the council.

Management Response

To ensure we receive notification of permanent payroll changes as quickly as possible, we are on the process of streamlining our leavers and flexible working request forms onto the Business World system and on completion, the process to be followed will be communicated to Managers. A monitoring process for the recovery of overpayments has now been put in place.

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 and Risk Committee, which are relevant to the Integration Joint Board. A summary of each has been provided, with recommendations graded from limited risk exposure to very high risk exposure and improvements graded from effective to major improvement required. The internal audit service is provided by Azets.

Audit Review	Audit Rating (note 1)	Risk Exposure and Number of Recommendations (note 2)			
		Very High	High	Moderate	Limited
Infection Prevention and Control	Minor improvement required	0	1	1	1
Consultant Job Planning	Substantial improvement required	0	3	4	0
eHealth Application Access Management	Minor improvement required	0	0	3	0
Public Health Screening	Minor improvement required	0	2	4	0
Managing Staff Attendance	Minor improvement required	0	1	4	0

Note 1 – For each audit review one of four ratings is used to express the overall opinion on the control frameworks reviewed during each audit:
Immediate major improvement required – Controls evaluated are not adequate, appropriate, or effective to provide reasonable assurance that risks are being managed and objectives should be met.
Substantial improvement required - Numerous specific control weaknesses were noted. Controls evaluated are unlikely to provide reasonable assurance that risks are being managed and objectives should be met.
Minor improvement required - A few specific control weaknesses were noted; generally however, controls evaluated are adequate, appropriate and effective to provide reasonable assurance that risks are being managed and objectives should be met.
Effective - Controls evaluated are adequate, appropriate, and effective to provide reasonable assurance that risks are being managed and objectives should be met.

Note 2 – Each audit recommendation is assigned a risk exposure rating:
Very high risk exposure - major concerns requiring immediate senior management attention.
High risk exposure - absence / failure of key controls.
Moderate risk exposure - controls not working effectively and efficiently.
Limited risk exposure - controls are working effectively but could be strengthened.

4.1.1 Infection Prevention and Control

The objectives of the review were to ensure that:

1. Up-to-date infection control policies, procedures and standards are maintained and are easily accessible to staff.
2. Training is provided to ensure that staff understand all relevant infection control standards and are clear on their roles and responsibilities.
3. Appropriate processes are in place to ensure the timely and consistent identification of any infection control cases.
4. Accurate and consistent data is recorded for infection control cases that is monitored and reported appropriately within the management and governance structures.
5. Data is analysed to identify any systemic issues, patterns or trends that may require specific action to be taken, with actions agreed and followed-up on a timely basis.
6. Progress towards the implementation of recommendations from inspection visits is regularly monitored and reported.

Good practice

- NHSGGC has a well-established Infection Control (IC) Team and their work is embedded throughout the health board. Weekly visits to all wards has enabled them to deliver a 'Theme of the week / month to provide continuous delivery of education. This was praised by all the wards we visited throughout the audit.

- There is a suite of policies and procedures for all IC related incidents and care plans for each infection that enables the timely implementation of care for all patients and staff.
- NHSGGC has an effective evaluation process in place conducted by the Learning and Education team and subject matter experts (module leads) which keeps Learnpro modules up to date. This ensures that any new legislation or changes to the operational processes are updated within the modules to best reflect the current practices.
- The IC team use ICNet to centrally record and monitor infection throughout the health board. We found the functions of the system to be effective and that ICNet supports well the monitoring of infections.
- The data team regularly report on infection rates, which enables management throughout the health board to identify trends and patterns of infection cases and where appropriate investigation and actions can take place. This information is shared and reported to four levels of management: Point of Care/Ward; Sector and Health & Social Care Partnerships; Division Acute and Health & Social Care Partnerships; NHS Board.
- The IC conduct audits on an ongoing basis to identify issues and recommend actions. These are followed up upon to ensure timely implementation.

Areas for improvement

We have identified three areas for improvement which, if addressed, would strengthen NHS GGC's control framework. These include the need to both improve the completion rates of training, and the associated monitoring of this.

4.1.2 Consultant Job Planning

The objectives of the review were to ensure that:

1. The Job planning guidance in place is being applied consistently across speciality areas, and are aligned with the requirement of the 2004 Consultants Contract.
2. Each consultant has a job plan in place that is reviewed annually and has been developed in line with the Consultant's Contract.
3. Consultants' actual activity levels are consistently monitored to ensure that the required levels are achieved, and to support matching of demand with capacity.
4. Performance against job plans is reported on a regular basis to ensure clear oversight of areas where actual activity is not in line with expectation, and allow corrective action to be taken where necessary.

Good practice

- NHSGGC uses the Electronic Job Plan (EJP) recording system to record details of activity along with the frequency of the activity and calculates the number of programmed activities within the weekly plan. All job plans follow the same format/design which is aligned to requirements noted in the Consultants Contract;

- The NHSGGC Job Planning Policy aligns with requirements set in the Consultants Contract including content of job plans, job plan review, roles and responsibilities of both clinicians and the relevant clinical manager and mediation process;

- All relevant information on the job planning process is accessible via the HR connect web site. This allows all staff involved in job planning to refer to this guidance to ensure they understand expectations; and

- Job planning communications for the current year are sent to Chiefs of Medicine by the Deputy Medical Directors. This is a crucial part of the job planning process as it informs actions required and responsibilities with regards to these actions.

Areas for improvement

We have identified several areas for improvement which, if addressed, would strengthen NHSGGC control framework:

- Ensuring that formal review of individual job plans takes place to ensure all job plans are signed off before the required deadline;

- Ensuring that the contents of job plans are reviewed and fully completed so that they reflect current service requirements;

- Ensuring that actual job plan activity monitoring is clearly defined and implemented by management; and

- Ensuring performance against job plans and responsibility for this is clearly defined and implemented.

4.1.3 **eHealth Application Access Management**

The objectives of the review were to ensure that:

1. There are adequate and up-to-date system administration and user procedures for each application.
2. There is effective user account management which ensures only authorised users have access.
3. There are effective controls over the provisioning, management and monitoring of privileged user accounts, including third party access.
4. User access levels are appropriate and ensure adequate segregation of duties in relation to the administration and operation of the system.
5. There are appropriate audit facilities to allow proactive monitoring of the application.

Good practice

- Processes are in place to control the provisioning and revocation of access to systems. We identified no errors in our sample testing.

Areas for improvement

We have identified areas for improvement which, if addressed, would strengthen NHS Greater Glasgow and Clyde's control framework. These include:

- The update of System Security Policies (SSPs) for each application which are currently overdue review and which do not reflect current practices for user account management.

- We sample tested 32 administrative accounts and found that an annual recertification response had only been logged for 10 of those. We noted that the review procedure does not set out the steps to take when no response from the reviewer is received.

- Auditing facilities are in place, however, these are reactive and require extraction before manual review with no set schedule for the review of the logs or automated alerting in place.

4.1.4 Public Health Screening

The objectives of the review were to ensure that:

1. Policies and procedures are in place for BSP and DES that align to guidance provided by HIS
2. Failsafe mechanisms are in place for BSP and DES that are clearly documented and adhered to
3. BSP and DES each have a steering group that governs and scrutinises programme related matters
4. Reporting is produced on the public health screening KPIs and targets set through the HIS programme guidance

Good practice

- The Bowel Screening Business Process Flowchart clearly sets out the process implemented by NHSGGC once a positive result has been communicated via SCI Gateway. We were able to confirm that the process itself clearly aligns with standards 4-6 established by Health Improvement Scotland (HIS).

- While we have recognised a potential need to articulate the failsafe mechanisms for both screening programmes, our testing revealed that staff are well versed on the controls in place to protect the efficiency and accuracy of both BSP and DES.

- There are two steering groups in place to govern and scrutinise programme related matters for both Bowel Screening and Diabetic Eye Screening. We confirmed appropriate meeting minutes are recorded for each meeting including a relevant action log to maintain a sufficient audit trail of the group's activities.

- The Public Health Screening Programme Annual Report, which is presented to the Population Health and Wellbeing Committee, collates appropriate updates and performance of each of the screening programmes within NHSGGC. We deemed this report to be sufficient in reporting against national targets and key performance indicators, which provides sufficient assurance to the appropriate governance committee.

Areas for improvement

We have identified a number of areas for improvement which, if addressed, would strengthen NHSGGC's control framework. These include:

- The timely review of local policies in respect of both bowel screening and diabetic eye screening.

- The introduction of clearly documented failsafe mechanisms in relation to bowel screening and diabetic eye screening.

- The timely review of the terms of reference for the bowel screening steering group and the diabetic eye screening steering group.

4.1.5 Managing Staff Attendance

The objectives of the review were to ensure that:

1. Managers record and manage absences in line with agreed policy and procedures, which are accessible to staff;
2. There is adequate management information, including trend analysis, provided in relation to staff absence so that any emerging issues are identified and addressed timeously;
3. Management use sickness absence data to develop and implement initiatives to improve absence management and promote attendance; and
4. The success of these initiatives at local level is subject to ongoing review to ensure that initiatives driving increased attendance can be rolled out across the wider organisation.

Good practice

- NHSGGC manages staff absences by reference to the national NHS Scotland Attendance Policy, which sets out national-level requirements to be implemented by all NHS Boards in Scotland.

- The Attendance Policy sets out the responsibilities of both staff and their respective line managers. The policy has been made available across the organisation via HR Connect pages. The policy also sets out the specific circumstances under which managers are required to take action and a number of template documents and letters have been designed to support the consistent enforcement of the policy.

- NHSGGC has effective and robust arrangements in place to collate and report absence data. Data is made available through a variety of reporting and dashboard tools, such that managers at all levels of the organisation are able to obtain information regarding absence rates within their respective areas of responsibility.

- An Attendance Action Plan is currently in place which is intended to support reduction in absence rates to a locally agreed target within NHSGGC of 5%. Actions are agreed in consultation with department/sector senior managers and the corresponding Human Resources Lead to ensure they are tailored to specific issues within each area.

- We obtained the NHSGGC Absence Action Plan and confirmed it featured numerous specific actions assigned to different individuals/departments in a bid to rectify staff attendance issues. The actions were directly aligned to issues raised during regular meetings with

Human Resources Leads and consistently included an action owner and timescale for completion.

Areas for improvement

We have identified a number of areas for improvement which, if addressed, would strengthen NHSGGC's control framework in this area:

- More clearly articulating local responsibilities within NHSGGC for ensuring compliance with the national Attendance Policy. This should include reinforcement of the role of line managers within the process, and monitoring arrangements in place by Human Resources to ensure compliance in this regard;

- Ensuring that line managers receive appropriate training to allow them to manage staff absences consistently and appropriately;

- Reinforcing the need to ensure that absences are recorded accurately within SSTS by line managers, including appropriate use of reason codes;

- Enhancing current management information to allow a more overt assessment of the extent to which the Attendance Management Policy is being correctly applied; and

- Implementing a measuring regime to ensure that the success of local initiatives to reduce absence can be reliably assessed.

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 for 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 Integration Joint Board Audit, Risk and Scrutiny Committee**

On: **21 June 2024**

Report by: **Chief Internal Auditor**

Heading: **Internal Audit Annual Report 2023/2024**

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 is to advise the Committee of the Internal Audit Annual Report including the annual opinion.

1.2 The Internal Audit Annual Report outlines the internal audit work we have carried out for the year ended 31 March 2024. 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, 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 report from Renfrewshire Council and internal audit progress reports from NHS Greater Glasgow and Clyde.

2. Recommendations

2.1 Members are asked to consider and note the contents of the IJB's Internal Audit Annual Report for 2023/2024.

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 2023-2024

June 2024

Renfrewshire Health and Social Care Integration Joint Board

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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 and Senior Management;
- 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.

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 2023/24 relating to the IJB;
- The outcome of Internal Audit reviews undertaken by partner bodies;
- Internal audit performance;
- Planned audit work for 2024/25;
- 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, the internal audit annual report from Renfrewshire Council and progress summaries from NHS Greater Glasgow and Clyde. (Appendix 1)

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 2023/2024

3.1 The Internal Audit Plan for the IJB for 2023/2024 provided for a review of performance management and the annual review of the adequacy and compliance with the Local Code of Corporate Governance. The review of performance management was reported to the IJB Audit, Risk and Scrutiny Committee on 15 March 2024. The review of compliance with the Local Code of Corporate Governance is included on today's agenda.

3.2 The Annual Report for 2022/2023 was submitted to the Integration Joint Board on 23 June 2023.

3.3 The implementation rate of audit recommendations is a measure of operational culture and effectiveness. During 2023/24, 3 recommendations were followed up and all have been fully implemented.

4. Review of Internal Audit Performance

4.1 Internal Audit produces regular reports on its performance during the year 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 2023/24

Performance measure	Target 2023/24	Actual 2023/24
% completion of audit plan for the year*	95%	92%
% engagements completed by target date	95%	98.5%
% engagements completed within time budget	95%	98.5%

* 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 The percentage completion of the audit plan is slightly below the target set for the year. This was due to the level of unplanned leave and the additional time attributed to unplanned work. It should be noted that this had no effect on the planned reviews for the IJB for 2023/24 which are 100% complete. The actual performance for the year for the two other indicators, is above the target performance level.

4.3 The PSIAS require the Chief Auditor to develop and maintain a quality assurance and improvement programme (QAIP) that covers all aspects of the internal audit activity. The QAIP must include both periodic internal self-assessments and five-yearly external assessments, carried out by a qualified, independent assessor from outwith the organisation.

4.4 We continued to participate in the Scottish Local Authorities Chief Internal Auditors' Group peer review process. Our most recent external assessment was reported to the Council's Audit, Risk and Scrutiny Board in May 2023 and included 7 recommendations for improvement, all recommendations have now been completed. The annual internal self-assessment process has concluded that the internal audit service fully complies with the PSIAS.

5. Planned Work for 2024/25

5.1 Following a risk-based assessment of the activities of the IJB and consultation with the senior management team, the Internal Audit Plan for 2024/2025 provides for 40 days of Internal Audit resource to undertake:

- A review of financial planning; 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, the annual self-assessment of the Audit Committee arrangements, ad-hoc advice, consultancy and training. The Internal Audit Plan for 2024/2025 was approved by the IJB Audit, Risk and Scrutiny Committee on 15 March 2024.

6. Audit Assurance Statement

6.1 The audit work performed in relation to the 2023/24 internal audit plan has been reported to the Chief Officer. Relevant audit work undertaken by partner organisations is reported to the Audit, Risk and Scrutiny Committee. Where areas for improvement in internal control have been identified, appropriate recommendations have been made and accepted for action by management.

6.2 There are no significant matters arising in relation to those audit engagements specific to the IJB and there have been no impairments impacting on the Chief

Auditor's independence and the team has been adequately resourced during the year.

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 There are corporate systems and processes within Renfrewshire Council and NHS Greater Glasgow and Clyde that the IJB rely upon. It can be seen from Appendix 1, that some of these processes require to be improved to provide a reasonable level of assurance.

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

- The results of the audit work in 2023/24 and the opinion's contained in the Internal Audit Annual Reports of the Local Authority and progress reports from the Health Board.

- Management self-assessment of internal control, risk management and governance arrangements.

- Management action to respond to audit recommendations.

Chief Internal Auditor

21 June 2024

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**
Local Code of Corporate Governance	**Substantial**	• None
Performance Management	**Substantial**	• None
Renfrewshire Council		
Audit Engagement	**Assurance Level**	**Significant Matters**
Cyber Security	**Reasonable**	• None
Information Asset Register	**Limited**	• There was a requirement to improve accountability by services for the upkeep of the Information Asset Register and oversight of the completeness of the register could be improved. All recommendations have now been implemented.
Disaster Recovery	**Limited**	• There is scope to improve the existing arrangements. Recommendations were made to enhance and strengthen controls; including development of a central register of critical systems, formalising ICT procurement guidance, and seeking assurance from software as a service providers regarding their ability to meet disaster recovery requirements.
Care at Home Processes	**Substantial**	• None
Debt Management	**Reasonable**	• None
Payroll Overpayment Process	**Reasonable**	• None
Health and Safety	**Limited**	• The corporate arrangements for health and safety require to be improved. It was identified that procedures require to be reviewed and updated. Improvements are required in terms of corporate oversight, compliance and performance reporting.
Purchasing Processes (Corporate Purchase Cards)	**Limited**	• The review focused on corporate purchase card procedures. The main areas for improvement identified relates to purchasing goods outwith the agreed

		procurement routes and the authorisation of goods ordered. There was also a lack of evidence relating to the authorisation of the increase of PCard spend limits.
NHS Greater Glasgow and Clyde		
Audit Engagement	**Overall Audit Rating**	**Significant Matters**
Public Protection Arrangements	Substantial Improvement Required	• Improvements were required in relation to guidance documents and training.
Use of Agency Staff	Substantial Improvement Required	• The use of agency staff in some area could not be explained by increased vacancy levels.
Moving Forward Together Implementation	High risk	• The risk reflects the ability to progress with transformational activity within an extremely challenging operating environment, with increased pressure on services and both resourcing and financial constraints, remains an area of significant uncertainty.
Infection Prevention and Control	Minor improvement required	• None
Consultant Job Planning	Substantial improvement required	• Improvements are required in relation to job planning and monitoring the delivery of these plans.
eHealth Application Access Management	Minor improvement required	• None
Public Health Screening	Minor improvement required	• None
Managing Staff Attendance	Minor improvement required	• None

To:	**Renfrewshire Integration Joint Board Audit, Risk and Scrutiny Committee**
On:	**21 June 2024**
Report by:	**Chief Finance Officer**
Heading:	**CIPFA Financial Management Code – Update**

1. Purpose

1.1. This report provides an update on progress in relation to the actions arising from the self-assessment process undertaken (in June 2023) against the CIPFA Financial Management Code.

2. Recommendation

It is recommended that the IJB Audit, Risk & Scruinty Committee:

- Note the contents of this report.

3. Background and Context

3.1. The Financial Management Code is a series of financial management standards which set out the professional standards required to meet the minimal standards of financial management acceptable to meet fiduciary duties to taxpayers and customers. As these are minimum standards, CIPFA's judgement is that compliance with them is obligatory for an organisation to meet its statutory responsibility for sound financial administration. In addition, CIPFA members, which includes the current Chief Finance Officer must comply with it as one of their professional obligations.

3.2. The Code recognises the diversity of the organisations which exist in the public sector and is therefore not prescriptive. It is for each organisation to determine what is right for them in order to comply.

3.3. The underlying principles which inform the Code are outlined below:

- Organisational **leadership** – demonstrating a clear strategic direction based on a vision in which financial management is embedded into organisational culture.
- **Accountability** – based on medium-term financial planning that drives the annual budget process supported by effective risk management, quality supporting data and whole life costs.
- Financial management is undertaken with **transparency** at its core using consistent, meaningful and understandable data, reported frequently with evidence of periodic officer action and elected member decision making.

- Adherence to professional **standards** is promoted by the leadership team and is evidenced.
- Sources of **assurance** are recognised as an effective tool mainstreamed into financial management, including political scrutiny and the results of external audit, internal audit and inspection.
- The long-term **sustainability** of local services is at the heart of all financial management processes and is evidenced by prudent use of public resources.

4. Progress and Status

4.1. As originally reported in June 2023, following completion of the template self-assessment process it is the view of the Chief Finance Officer that the IJB is compliant with the Financial Management Code.

4.2. Appendix 1 to this paper was formed the response to the self-assessment which included 3 areas for development. This has now been further updated to include an update in respect of each of the three areas for further development.

Implications of the Report

1. **Financial –** none
2. **HR & Organisational Development** – none
3. **Strategic Plan and Community Planning** – none
4. **Wider Strategic Alignment** – **none**
5. **Legal** – none
6. **Property/Assets** – none
7. **Information Technology** – none
8. **Equality & Human Rights** – none
9. **Fairer Scotland Duty** – none
10. **Health & Safety** – none
11. **Procurement** – none
12. **Risk** – Failure to comply with the Financial Management Code would be considered as a breach of the IJBs statutory responsibilities for sound financial administration.
13. **Privacy Impact** – none.

List of Background Papers – CIPFA Financial Management Code (Renfrewshire IJB, June 2023)

Author: Sarah Lavers, Chief Finance Officer

Any enquiries regarding this paper should be directed to Sarah Lavers, Chief Finance Officer (sarah.lavers@renfrewshire.gov.uk)

Appendix 1

CIPFA Financial Management Code

Self-Assessment and Action Plan with Progress Update as at June 2024

FM Ref	Requirement	What we are currently doing	Areas for Development	Progress Update (at June 2024)
1. The responsibilities of the Chief Finance Officer and Senior Management Team				

A	The leadership team can demonstrate that the services provided by the IJB provide value for money	• The IJB has the following in place to ensure best value:-
		  • Regular reports to the IJB in relation to financial performance
		  • Reports to the IJB which seek approval are clear and can include, where appropriate:-
		  ○ Options available including a value for money assessment
		  ○ Implications for service users, patients and/or carers
		  ○ Results and outputs from consultations
		  ○ Equality Impact Assessments (EQIAs)
		  ○ Financial and resource requirements and how these will be funded including the source
		  ○ Any contribution to current and future saving plans in line with our aspirations set out in the Strategic Plan and our associated Sustainable Futures Programme
		  • External inspection reports for services such as care services are reported to the IJB Audit, Risk and Scrutiny Committee to ensure appropriate oversight. A verbal update (from the Chair of the IJB Audit, Risk and Scrutiny Committee) of each meeting is also presented at the next available IJB meeting to ensure their		

FM Ref	Requirement	What we are currently doing	Areas for Development	Progress Update (at June 2024)
		awareness of the areas being considered. • The IJB receives performance reports at each meeting, and a statutory Annual Performance Report (APR) is also produced in line with legislation. • The IJB continues to develop a culture of continuous improvement underpinned by the aspirations set out in our Strategic Plan and the intrinsic links to our Sustainable Futures programme which develops and monitors the IJB's transformation agenda to identify service improvements, savings and ensuring best value. • An annual external audit process is undertaken to ensure best value is delivered for the IJB. The most recent audit concluded that the IJB has put in place appropriate arrangements to demonstrate the achievement of Best Value (IJB External Annual Audit Report 2021-22, Section 3).		

B	The IJB complies with the CIPFA Statement on the Role of the Chief Finance Officer (CFO) in Local Government (2016)	• The CFO is a core member of the HSCP's Senior Management Team. • The CFO is actively involved in all material business decisions and offers sound advice, direction, challenge and influence on decisions made. This is evidenced through the CFO's attendance and participation at key business meetings such as the IJB, IJB Audit, Risk & Scrutiny Committee, Senior Management Team, Sustainable Futures Programme Board, as well as key partner organisation meetings as required. In addition, the CFO is an active member in a range of individual transformation programme boards to support major programmes of work both within the HSCP as well as the two parent organisations to ensure connectedness to the key strategic considerations of the IJB • The CFO champions the promotion and delivery of good financial management. This is reflected in the management structure within the organisation and the reporting of financial performance to all key management groups. The existing finance division within the HSCP has well established reporting arrangements across the spectrum of services that the HSCP covers as well as the appropriate linkages to the parent organisations internal finance functions. • There is a strong forum for a strategic overview of financial management through the SMT with regular monthly reports brought		

		forward to highlight the key areas of success, challenge and demand led pressures affecting the organisation. • The IJBs Financial Regulations clearly outline the role and responsibilities of the Chief Officer, Chief Finance Officer and all budget holders in relation to financial management arrangements across the organisation. • The CFO is a professionally qualified accountant with significant experience as a CFO. The finance team is also suitably resourced and experienced in support of the CFO undertaking their role with effective links to the two parent organisations. There are well established local training and development programmes to support the continuous learning development and resilience of the team as well as a culture of encouraging self-development and progression through individual personal development opportunities.		

2. Governance and Financial Management Style				
C	The leadership team demonstrates in its actions and behaviours responsibility for governance and internal control.	• The IJB and Senior Management Team have a commitment to deliver our vision as well as the key outcomes and deliverables set out in the Strategic Plan • Behaviours are underpinned by the IJB's Code of Conduct • Employees also adhere to the respective Codes of Conduct for the parent organisations which are applicable to all staff employed. • The importance of governance and internal controls is reflected in the Financial Regulations where clear responsibilities are defined. • In addition to the above, we work collaboratively with the parent organisations to ensure that internal control submissions are completed through the year-end processes. • An annual internal audit process is undertaken to assess the HSCP's compliance with governance arrangements as per the IJB's Local Code of Corporate Governance and Sources of Assurance. • In addition to the above, further governance compliance and internal control reviews are undertaken by the CFO and the SMT as part of the respective assessments by both		

		partner bodies and is part of the annual assurance for both internal and external auditors processes. • Internal audit reviews provide assurance on a range of internal controls and are detailed in the annual audit plan. The outcome of these is reported to IJB's Audit, Risk and Scrutiny Committee with actions identified where required and progress in delivering actions monitored through the same. • The IJB is subject to an External Audit assessment to ensure arrangements are appropriate and operate effectively. The most recent audit concluded that there were no issues with arrangements in place, with feedback confirming that the IJB has appropriate governance arrangements in place to support the scrutiny of decisions by the Board (IJB External Annual Audit Report 2021-22, Section 3).		

D	The IJB applies CIPFA/SOLACE "Delivering Good Governance in Local Government: Framework (2016)".	• Through the IJB's Local Code of Corporate Governance and Sources of Assurance, it has adopted governance arrangements consistent where appropriate with the six principles of the CIPFA/SOLACE framework "Delivering Good Governance in Local Government". These systems of internal control are designed to manage risks to a reasonable level based on a risked based approach. • The internal audit process to review the above each year outlines how the IJB has complied with its Local Code. • In addition, the IJB's Annual Governance Statement is used as a mechanism to flag any new significant governance concerns.	• Discussions with NHS Greater Glasgow and Clyde will continue to seek final allocations prior to the IJB budget setting, where this can be done.	• For FY 2024/24, the IJB received allocation from Renfrewshire Council and NHSGGC in March 2024. These were taken to the IJB formally as part of the delegated budget report on 22 March 2024.

E	The Financial Management style of the IJB supports financial sustainability	• The IJB's financial management style has been established to describable as 'enabling transformation' using the CIPFA Financial Management hierarchy Model. Through the focussed work in recent years and the formation of our Sustainable Futures Programme, the IJB is committed to supporting the delivery of efficiencies that can be realised through service improvement and development. • The IJB has a range of frameworks and controls in place to manage its financial affairs including: o Financial Regulations o Financial regulations and standing orders of both Partner Bodies o Medium Term Financial Plan o Reserve Strategy • The Senior Management Team has a collaborative approach to developing financial strategies for financial sustainability and this can be evidenced in the way the budget and medium term financial outlook are updated each year with active participation and support from all services. This work is led by the CFO with support from our Finance, Planning and Improvement Manager to ensure that there remains a constant focus on this as part of our Sustainable Futures programme efforts.	• Given the scale of the financial challenge, a review of the Scheme of Delegation will be undertaken to ensure levels are still appropriate in light of the financial pressures being faced. This work has already commenced.	• The revised SoD for the IJB is still a work in progress • In the context of the financial constraints work has been undertaken to review and strengthen budget monitoring processes, which include weekly vacancy management meetings to consider all vacancies and agency requirements (with staff side/trade union representatives invited) and robust review of all care packages and associated costs. • SMT continue to receive a monthly detailed budget report which highlights any issues and includes progress and status of agreed savings.

		• The Finance Team support all services in developing financial strategies and reporting as well as acting as a centralised point of support, and direction advising staff on all finance matters. Operational teams are also supported by the finance team who, in addition, are able to provide training to operational staff to support their financial skills to assist them with managing the budgets and financial performance within their span of control. • The IJB has set a balanced budget in each year of its existence. • The Medium Term Financial Plan considers the sustainability of the IJB over the medium term, including an assessment of funding, cost and demand pressures and the risks over the medium term. This includes a review of reserves. The annual budget process for 2023- 24 identified a risk in relation to the level of general reserves and the scale of risk which exists for the IJB both in 2023-24 and over the medium term.		

3. Medium to Long-term Financial Management				
F	The IJB has carried out a credible and transparent financial resilience assessment	• The Medium Term Financial Plan considers the sustainability of the IJB over the medium term, including an assessment of funding, cost and demand pressures and the risks over the medium term. This includes a review of reserves. • The Medium Term Financial Plan includes sensitivity analysis which identifies the implications if planning assumptions change and what the impact of this would be for the financial position of the IJB. • The IJB has an established Reserves Policy which forms part of the Financial Regulations and is a key part of the IJB's corporate governance arrangements.	• The outturn report which will be presented to the IJB in June will include an update on the reserves position including a recommendation to increase the level of general reserves by the year-end underspend which will assist in giving the IJB a greater level of financial sustainability.	• The report presented to the IJB in June 2023 included the position with regards to general reserves. • It is important for IJB members to be aware that given the current financial climate and the pressures that the IJB budget faces going forward, it is unlikely that the general reserves position will remain within the IJB agreed 2% of net expenditure. Indeed, it is likely that the general reserves will be fully depleted over the next two years.

G	The IJB understands its prospects for financial sustainability in the longer term and has reported this clearly to members.	• The IJB's Annual Budget, Annual Accounts, Medium Term Financial Plan and Risk Register reflect the main risks in relation to sustainability. These are subject to regular review, as appropriate, to ensure these remain robust and relevant for the IJB. The frequency of these reports are annually to the IJB, with the exception of the Risk Register for which an update is provided at each meeting of the IJB's Audit, Risk and Scrutiny Committee. • The Medium Term Financial Plan assesses both cost and demand pressures as well as forecasts for funding and uses this to develop a financial strategy over the medium term to address these risks. This is used by the CFO and the Senior Management Team to support the development of plans which aim to deliver financial balance over the longer term as part of wider service improvement and redesign efforts. These longer term areas of focus are monitored through the Sustainable Futures programme. • Development Sessions with IJB members are provided as part of the annual budget process and these include an overview of the longer term financial sustainability and risks based on the Medium Term Financial Plan. In addition, this is updated and reported to the IJB on an annual basis through the annual delegated budget update report.	

H	The IJB complies with the CIPFA Prudential Code for Capital Finance in Local Authorities	• This is not relevant as the IJB does not have capital programmes or borrowing powers, however, the CFO has strategic responsibility for delegated property assets from the parent organisations and acts as the senior link into both with regards to matters of property and capital to ensure an effective interface with the IJB.	
I	The IJB has a rolling multi-year medium-term financial plan consistent with sustainable service plans.	• The IJB has a Medium Term Financial Plan which is reviewed and updated annually and presented to the IJB for approval in support of delivering the IJB's Strategic Plan given the intrinsic links. • The Medium Term Financial Plan is underpinned by a range of other strategies including commissioning and market facilitation strategies, workforce planning, property, ICT and digital strategies which also support delivery of the IJB's Strategic Plan. • The Medium Term Financial Plan is reflective of all significant demand and cost pressures being experienced both at a local and national level. The plan also considers the strategy for responding to these challenges. • The Medium Term Financial Plan includes sensitivity analysis which identifies the implications if planning assumptions change and what the impact of this would be for the financial position of the IJB.	

4. The Annual Budget			
J	The IJB complies with its statutory obligations in respect of the budget setting process.	• The IJB is fully aware of the need to set a balanced budget as established in s108(2) of the Local Government (Scotland) Act 1973 and s93(3) of the Local Government Finance Act 1992. The need to meet this requirement is set out within the annual budget report. • A balanced budget was agreed by the IJB on 22/03/2023 for 2023/24.	
K	The budget report includes a statement by the CFO on the robustness of the estimates and the statement on the adequacy of the proposed financial reserves.	• Not applicable. The requirement for a CFO statement in relation to this is a specific legislative requirement in England and Wales, but not in Scotland. If there was a requirement to do so then this would be included within the budget report. • The 2023/24 Budget report includes a statement from the CFO on the implications of the budgets on general reserves and the adequacy of these reserves in relation to the financial risks which face the IJB. • This report also highlights where there are risks linked to financial estimates. An example of this in 2023/24 is the uplift to the NCHC contract where the negotiations had not been concluded when the IJB considered the budget. • The Medium Term Financial Plan includes sensitivity analysis which demonstrates the implications if estimates differ from assumptions and the potential impact this could have on IJB finances.	

		• The IJB has a reserve policy which is based on national recommended practice. The Medium Term Financial Plan, the budget report and the IJB outturn report provide information on levels of general reserves and whether they are sufficient to ensure ongoing sustainability. These reports include actions where these are required to improve the position.	
5. Stakeholder Engagement and Business Cases			
L	The IJB has engaged where appropriate with key stakeholders in developing its long-term financial strategy, medium-term financial plan and annual budget.	• The IJB undertakes comprehensive engagement with all stakeholders when it develops its Strategic Plan which determines the strategic priorities which the IJB sets out to deliver over the medium term. This engagement, led through our well established Strategic Planning Group (SPG), provides stakeholders with an opportunity to have their say on what their priorities are and this is used to shape the Strategic Plan, which is then used in determining the budget both annually and over the medium term. • The IJB engages with key and relevant stakeholders in developing its annual budget. This can be in relation to specific budget proposals, for example where stakeholders are part of the development of transformation plans and also where the impact of savings require detailed EQIAs and therefore consultation with stakeholders.	

		• Core stakeholders are well represented on the IJB and are able to participate in the discussion as plans are developed and presented to the IJB both in terms of the annual budget and the medium term financial plan. As well as formal reporting via the IJB, this engagement and participation is a core part of our IJB development sessions with IJB members as the budget develops. • In preparing the annual budget each year, the Chief Officer and CFO engage fully with both parent organisations to ensure that pressures are fully understood as well as the implications of changes to funding for services.	
M	The IJB uses an appropriate documented option appraisal methodology to demonstrate the value for money of its decisions.	• As part of the annual budget process consideration is given to options for savings. This process includes a detailed assessment of impacts on service users, patients, carers as well as any operational delivery and financial risks. Where relevant this will also include a consideration of options and a recommendation in relation to the preferred option. • Option appraisal is also used as part of capital planning for the IJB when making investment decisions. This is well documented and business case and options appraisal follow project management methodology in line with the processes established by both the Council and Health Board. • Options appraisals are also used, where relevant, as part of transformation activity being led through our Sustainable Futures programme. These are well	

		documented and, where relevant, and are reported to the IJB with a clear assessment and recommendation for the IJB to consider and, in line with best practice, all options appraisals include both qualitative and quantitative assessments for consideration.	
6. Monitoring Financial Performance			
N	The leadership team takes action using reports, enabling it to identify and correct emerging risks to its budget strategy and financial sustainability.	• The Medium Term Financial Plan is prepared in conjunction with respective Heads of Service who are asked to identify any emerging risks for consideration as part of the annual budget strategy and the medium term financial outlook. • This discussion is also used to identify specific pieces of work required to mitigate risks moving forward and to agree actions to deliver on this. • Financial performance reports are presented routinely to a variety of leadership groups including the SMT and the IJB which identify major areas of variations from budget plans. These are discussed and remediation identified where required to bring income or expenditure back in line with expectations. • Regular detailed budget management meetings take place around areas of significant pressure and this includes analysis of historic trends and forecasting of future trends. These meetings also review the impact of actions taken to reduce expenditure to understand the impact being achieved and play an active part in our Sustainable Futures efforts.	

		• Financial forecasting is undertaking every period to understand changes to in-year budget plans and the impact on financial sustainability. This is reported formally to the IJB and provides the IJB with an opportunity to agree a financial strategy to resolve issues in-year as appropriate. • Through our established risk management arrangements, representatives from core areas review risk on a regular basis and this is recorded on the risk register. This is reviewed and reported regularly to the SMT and IJB's Audit, Risk and Scrutiny Committee to ensure oversight and governance. This is also used to highlight emerging risks including those which would impact on the budget.	
O	The leadership team monitors the elements of its balance sheet that pose a significant risk to its financial sustainability.	• Regular reports are produced in relation to the balance sheet showing the movement in balances. This is reviewed by the finance team to ensure that historical balances are reviewed and debtor and creditor balances remain under constant review. • A more detailed report is provided in respect of reserves, detailing all draw down of reserves. • Financial reports include an update to the IJB on the level of reserves drawn down and or contribution to reserves. The use of reserves is also further referenced routinely in the budget report, outturn report, annual accounts and the medium term financial plan.	

7. External Financial Reporting			
P	The chief finance officer has personal responsibility for ensuring that the statutory accounts provided to the local IJB comply with the Code of Practice on Local IJB Accounting in the United Kingdom.	• The CFO is responsible for the preparation of the IJB's Annual Accounts in accordance with the Code of Practice on Local Authority Accounting in the United Kingdom and by the deadlines set in legislation. These responsibilities are set out in the Statement of Responsibilities included in the annual accounts, which is signed by the CFO. • The CFO oversees the production of the accounts and ensures those completing them gave access to the Code of Practice and are trained and offered professional guidance as required. • These responsibilities are also included in the CFO's job description. • The IJB has met all of its statutory reporting deadlines for the submission of draft accounts to the external auditor each year, including during the COVID-19 pandemic when deadlines were extended owing to the response efforts.	
Q	The presentation of the final outturn figures and variations from budget allow the leadership team to make strategic financial decisions.	• The IJB's financial outturn for year-end is presented to the IJB along with a comprehensive analysis of variations to budget and the drivers of any such variation. • Information from the final outturn is used strategically to inform future budget-setting exercises for future financial years.	

To:	**Renfrewshire Integration Joint Board Audit, Risk and Scrutiny Committee**
On:	**21 June 2024**
Report by:	**Chief Finance Officer**
Heading:	**Unaudited Annual Governance Statement 2023/24**

1. Purpose

1.1 To present to the IJB Audit, Risk and Scrutiny Committee, the Unaudited Annual Governance Statement for the Renfrewshire Integration Joint Board for 2023/24 and:

- To provide the Audit, Risk and Scrutiny Committee, with the opportunity to provide comment on and approve the Annual Governance Statement; and,
- To agree that assurances on the governance framework can be provided to Renfrewshire Council and NHS Greater Glasgow and Clyde (NHSGGC).

2. Recommendation

It is recommended that the IJB Audit, Risk and Scrutiny Committee:

- Approve the draft Annual Governance Statement, as set out in Appendix 1.

3. Background

3.1. The Integration Joint Board (IJB) is responsible for ensuring that its business is conducted in accordance with the law and appropriate standards, that public money is safeguarded, properly accounted for, and used economically, efficiently and effectively. The IJB also aims to foster a culture of continuous improvement in the performance of the IJB's functions and to make arrangements to secure best value.

3.2. In discharging these responsibilities, the Chief Officer has a reliance on NHSGGC and Renfrewshire Council's systems of internal control which support compliance with both organisations' policies and promotes achievement of each organisation's aims and objectives, as well as those of the IJB.

3.3. The IJB has adopted governance arrangements consistent, where appropriate, with the principles of CIPFA and the Society of Local Authority Chief Executives (SOLACE) framework "Delivering Good Governance in Local Government" and the CIPFA Financial Management Code (FM Code). The Annual Governance statement explains how the IJB has complied with these governance arrangements and meets the requirements of the Code of Practice on Local Authority Accounting in the UK, which includes the requirement for an Annual Governance Statement.

3.4. In addition, the Annual Governance Statement which forms a key part of the Annual Accounts provides readers of the Accounts with assurance that the governance framework is fit for purpose.

3.5. The Annual Governance Statement for 2023/24 is attached and has been prepared in accordance with the relevant regulation and guidance taking account of the Internal Audit Annual Report and the Chief Officer's evaluation of the operation of the governance arrangements within each service area.

3.6. The Governance Statement is subject to statutory audit by the Council's External Auditors as part of their review of the Annual Accounts.

Implications of the Report

1. **Financial –** none
2. **HR & Organisational Development** – none
3. **Strategic Plan and Community Planning** – none
4. **Wider Strategic Alignment** – none
5. **Legal –** none
6. **Property/Assets –** none
7. **Information Technology –** none
8. **Equality & Human Rights –** none
9. **Fairer Duty Scotland –** none
10. **Health & Safety** – none
11. **Procurement** – none
12. **Risk** – The Annual Governance Statement provides information on the effectiveness of the IJB Governance Framework. Specific risks identified from the Chief Auditor's Annual Report and the assessments of the CO are disclosed in the statement.
13. **Privacy Impact** – none.

List of Background Papers – none

Author: Sarah Lavers, Chief Finance Officer

Any enquiries regarding this paper should be directed to Sarah Lavers, Chief Finance Officer (sarah.lavers@renfrewshire.gov.uk)

Appendix 1

Annual Governance Statement

The Annual Governance Statement explains the IJB's governance arrangements and reports on the effectiveness of the IJB's system of internal control.

Scope of Responsibility

The IJB is responsible for ensuring that its business is conducted in accordance with the law and appropriate standards, that public money is safeguarded, properly accounted for, and used economically, efficiently, and effectively. The IJB also aims to foster a culture of continuous improvement in the delivery of the IJB's functions and to make arrangements to secure best value.

To meet this responsibility, the IJB has established arrangements for governance which includes a system of internal control. The system is intended to manage risk to support the achievement of the IJB's policies, aims and objectives. Reliance is also placed on the NHSGGC and Renfrewshire Council systems of internal control which support compliance with both organisations' policies and promotes achievement of each organisation's aims and objectives.

This system can only provide reasonable and not absolute assurance of effectiveness.

The IJB has adopted governance arrangements consistent, where appropriate, with the principles of the Chartered Institute of Public Finance and Accountancy (CIPFA) and the Society of Local Authority Chief Executives (SOLACE) framework "Delivering Good Governance in Local Government" and the CIPFA Financial Management Code (FM Code). This statement explains how the IJB has complied with the governance arrangements and meets the requirements of the Code of Practice on Local Authority Accounting in the UK, which details the requirement for an Annual Governance Statement.

Purpose of the Governance Framework

The governance framework comprises the systems and processes, and culture and values, by which the IJB is directed and controlled. It enables the IJB to monitor the achievement of the objectives set out in the IJB's Strategic Plan. The governance framework is continually updated to reflect best practice, new legislative requirements, and the expectations of stakeholders.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the IJB's objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them effectively.

Governance Framework and Internal Control System

The Board of the IJB comprises the Chair and seven other voting members. Overall, four are Elected Members nominated by Renfrewshire Council, and four are non-executive members of NHSGGC Board. There are also a number of non-voting professional and stakeholder members on the IJB including representatives from the third and independent sector bodies, carers, service users and trade unions. Professional members include the Chief Officer, Chief Finance Officer and the Chief Social Work Officer. The IJB, via a process of delegation from NHSGGC and Renfrewshire Council, and its Chief Officer, has responsibility for the planning, resourcing and operational delivery of all delegated health and social care services within its geographical area.

The main features of the governance framework in existence during 2023/24 were:

- Principles
    - The IJB follows the principles set out in CoSLA's Code of Guidance on Funding External Bodies and Following the Public Pound for both resources delegated to the IJB by the Health Board and Local Authority and resources paid to its Local Authority and Health Service partners.

- Formal frameworks
    - The IJB is formally constituted through the Integration Scheme agreed by Renfrewshire Council and NHSGGC and approved by Scottish Ministers.
    - The IJB operates within an established procedural framework. The roles and responsibilities of Board members and officers are defined within: Standing Orders and Scheme of Administration; Contract Standing Orders; Scheme of Delegation, and Financial Governance arrangements; these are subject to regular review.
    - A Local Code of Corporate Governance Arrangements is in place to ensure that the IJB's governance arrangements are robust and informed by good practice. The Local Code is subject to regular review, with the most recent iteration having been approved by the Audit, Risk and Scrutiny Committee (ARSC) in June 2023. The IJB also abides by a Code of Conduct which sets out how members should conduct themselves in undertaking duties. The current Code was revised in 2022 following updated Scottish Government guidance, and approved by the Scottish Government on 29 June 2022.
    - Board members are supported by induction and ongoing training and development. Staff 'Performance and Personal Development' (PPD) schemes are also in place, the aim of which is to focus on performance and development that contributes towards achieving service objectives.
    - The HSCP has a robust Quality, Care and Professional Governance Framework and supporting governance structures which are based on service delivery, care and interventions that are: person centred, timely, outcome focused, equitable, safe, efficient, and effective. This is reported annually to the IJB and provides a variety of evidence to demonstrate the delivery of the core components within the HSCP's Quality, Care and Professional Governance Framework and the Clinical and Care Governance principles specified by the Scottish Government. The most recent report – covering the period April 2022 to March 2023 - was reviewed by the IJB in September 2023. It noted that governance arrangements are in place to support enhanced multidisciplinary arrangements to support care homes which aim to provide scrutiny and support, including ongoing assurance visits and oversight of care homes across Renfrewshire.

- Strategic planning
    - The overarching strategic vision and objectives of the IJB are detailed in the IJB's Strategic Plan 2022-25 which sets out the key outcomes the IJB is committed to delivering with its partners.
    - The Strategic Planning Group sets out the IJB's approach to engaging with stakeholders. Consultation on the future vision and activities of the IJB (such as the development of the IJB's Strategic Plan) is undertaken with this group which includes

stakeholders from NHSGGC, Renfrewshire Council, Renfrewshire Carers Centre and third sector organisations. Further engagement with the IJB's partners NHSGGC and Renfrewshire Council is through agreed governance structures. As part of the strategic planning approach, services also utilise Care Planning Groups to support engagement with stakeholders. The IJB also considers and publishes information about its performance regularly as part of its public performance reporting. This information is available through the IJB's published papers.

- The Medium-Term Financial Plan 2022-25 is aligned to and complements the Strategic Plan 2022-25 and highlights the key financial challenges the IJB faces, as well as the strategic aims that it aspires to deliver and the community priorities that it strives to meet.
- The Workforce Plan 2022-25 aligns with the IJB's Strategic Plan and Medium-Term Financial Plan covering the same period. It reflects national ambitions to deliver the recovery, growth, and transformation of our workforce in coming years, and is underpinned by the Scottish Government's five pillars to guide workforce development actions: (i) Plan; (ii) Attract; (iii) Employ; (iv) Train; and (v) Nurture. A supporting delivery plan is monitored through the HSCP's Workforce Planning and Organisational Development group.
- The Palliative and End of Life Care Strategy 2022-25 describes how we will endeavour to improve the quality of life of patients and their families in Renfrewshire who are living and dealing with a life limiting illness, ensuring everyone receives person-centred, dignified, and compassionate care which reflects individual choices.
- The Unpaid Adult Carers' Strategy 2022-25, Short Breaks Services Statement for Adult Carers 2022, and Adult Carer Eligibility Criteria 2022, reaffirm the value we place on unpaid carers and the contribution they make to the wider community of Renfrewshire and reflect the feedback received in consultation with carers, staff, and partners.
- Additional to the continued delivery of the above noted strategies:
    - In June 2023 the IJB published its Market Facilitation Plan 2023-2025. The Plan aims to inform, influence and adapt service delivery to ensure the right services are available at the right time, and to help providers of local Health and Social Care services make informed business decisions and plan for future service delivery in Renfrewshire.
    - In September 2023 the IJB approved its Strategic Delivery Plan for Year 2 of the Strategic Plan 2022-25, providing an overview of the deliverables to be taken forward to the end of March 2024.
    - In November 2023 the IJB approved the Refresh of the Strategy for Mental Health Services in Greater Glasgow and Clyde 2023-2028. Produced by the Greater Glasgow and Clyde Mental Health Programme on behalf of all six HSCPs within NHSGGC, this Strategy spans across both Adult Mental Health Inpatient and Community Services to ensure services are modern, patient focused, effective and efficient. It takes a whole system approach, linking the planning of services across NHSGGC, incorporating the planning priorities of the six HSCPs, and is aligned with delivery of the Scottish Government's Mental Health Strategy 2017–27.

- Oversight

- Effective scrutiny and service improvement activities are supported by the formal submission of reports, findings and recommendations by Inspectorates and the appointed Internal Audit service to the HSCP's SMT, the IJB and the IJB ARSC, as appropriate.
- Performance management, monitoring of service delivery and financial governance is provided by the HSCP to the IJB, who are accountable to both the Health Board and the Local Authority. It reviews reports on the effectiveness of the integrated arrangements including the financial management of the integrated budget. This ensures there is regular scrutiny at senior management, committee, and Board level. Performance is linked to delivery of objectives and is reported regularly to the IJB. Information on performance can be found in the Annual Performance Report published on the IJB website.

- Risk management
  - The IJB's risk management processes are well developed. The Risk Management Framework sets out the principles by which the HSCP and IJB identify and manage strategic and operational risks impacting upon the organisation and forms a key strand of the IJB's overall governance mechanisms. This Risk Framework is reviewed every two years.
  - In June 2023 the IJB received a favourable internal audit of the Risk Framework, following which, in August 2023 the bi-annual review of the framework was undertaken by the HSCP. The review took cognisance of the internal audit and proposed minor changes to the framework to reflect compound risk, consistency across services, refinement around the residual risk score, and further clarity on the routes of escalation.
  - As part of a planned review of the IJB's Risk Policy and Strategy, IJB members were consulted in January and February 2024 on their risk appetite across key risk categories. This reflected a recommendation from the internal audit review of the IJB's existing risk management arrangements and was to enable the identification of the IJB's average risk appetite position across the risk categories. A consolidated risk appetite position was also developed. The associated risk appetite statements were considered by the IJB ARSC on 15 March 2024 and were approved alongside the IJB's updated Risk Policy and Strategy.
  - The IJB's approach to managing its obligations with regards public records as set out in the Public Records (Scotland) Act 2011 is outlined in the IJB Records Management Plan.
  - Staff are made aware of their obligations to protect client, patient, and staff data. The NHS Scotland Code of Practice on Protecting Patient Confidentiality has been issued to all staff.
  - Staff are also required to undertake annual mandatory training on information security.

- Financial control
  - Responsibility for maintaining and operating an effective system of internal financial control rests with the Chief Finance Officer. The system of internal financial control is based on a framework of regular management information, Financial Regulations and Standing Financial Instructions, administrative procedures (including segregation of duties), management and supervision, and a system of delegation and accountability.

Development and maintenance of these systems is undertaken by managers within the HSCP supported by NHSGGC and Renfrewshire Council in relation to the operational delivery of health and social care services.

- Sustainable Futures
    - An overarching theme of the Strategic Plan 2022-25, Sustainable Futures was defined to ensure that available resources in the health and social care system across Renfrewshire are used effectively, whilst recognising that further reform of services would be required alongside an ongoing focus on the delivery of savings within a challenging financial context. In June 2023 the IJB formally approved an approach and scope for the implementation of the **Sustainable Futures** programme, succeeding the IJB's Recovery and Renewal programme which had been in delivery since summer 2020, and focussed on closing the significant budget gap projected over the medium term.

Roles and Responsibilities

The Chief Officer is the Accountable Officer for the IJB and has day-to-day operational responsibility to monitor delivery of integrated services, with oversight from the IJB.

The IJB complies with the CIPFA Statement on "The Role of the Chief Finance Officer in Local Government 2014". The IJB's Chief Finance Officer has overall responsibility for RHSCP's financial arrangements and is professionally qualified and suitably experienced to lead the IJB's finance function and to direct finance staff.

The IJB complies with the requirements of the CIPFA Statement on "The Role of the Head of Internal Audit in Public Organisations 2019". The IJB's appointed Chief Internal Auditor has responsibility for the IJB's internal audit function and is professionally qualified and suitably experienced to lead and direct internal audit staff. The purpose, authority and responsibility of Internal Audit has been formally defined in an internal audit charter.

Board members and officers of the IJB are committed to the concept of sound internal control and the effective delivery of IJB services. The IJB's ARSC operates in accordance with CIPFA's Audit Committee Principles in Local Authorities in Scotland and CIPFA's Audit Committees Position Statement 2022. Additionally, and in line with CIPFA guidance the ARSC undertook a self-assessment process in October 2023 to support the planning of the audit committee work programme and training plans, and also inform the annual report.

The Committee's core function is to provide the IJB with independent assurance on the adequacy of the risk management framework, the internal control environment and the integrity of the financial reporting and governance arrangements.

Review of Adequacy and Effectiveness

The IJB has responsibility for conducting, at least annually, a review of effectiveness of the system of internal control and the quality of data used throughout the organisation. The review is informed by the work of the SMT (who have responsibility for the development and maintenance of the internal control framework environment), the work of the internal auditors and the Chief Internal Auditor's annual report, and reports from external auditors and other review agencies and inspectorates.

The Internal Audit service operates in accordance with the CIPFA "Public Sector Internal Audit Standards 2017" which require the Chief Internal Auditor to deliver an annual opinion and report to inform the IJB's governance statement.

The review of the IJB's governance framework is supported by a process of self-assessment and assurance certification by the Chief Officer. The Chief Officer completes "Self-assessment Checklists" as evidence of review of key areas of the IJB's internal control framework, these assurances are provided to Renfrewshire Council and NHSGGC. The SMT has input to this process through the Chief Finance Officer. In addition, the review of the effectiveness of the governance arrangements and systems of internal control within the Health Board and Local Authority partners places reliance upon the individual bodies' management assurances in relation to the soundness of their systems of internal control. There were no internal control issues identified by the review. In addition, the Chief Officer and Chief Finance Officer are satisfied that the organisation has adopted a response that is appropriate for its fraud and corruption risks and commits to maintain its vigilance to tackle fraud.

Internal Audit undertakes an annual programme of reviews following an assessment of risk completed during the strategic audit planning process. The appointed Chief Internal Auditor provides an annual report to the ARSC and an independent opinion on the adequacy and effectiveness of the governance framework, risk management and internal control.

Due to the nature of IJB Board Membership, a conflict of interest can arise between an IJB Board Member's responsibilities to the IJB and other responsibilities that they may have. The IJB has arrangements in place to deal with any conflicts of interest that may arise. It is the responsibility of Board and Committee Members to declare any potential conflicts of interest, and it is the responsibility of the Chair of the relevant Board or Committee to ensure such declarations are appropriately considered and acted upon.

The arrangements continue to be regarded as fit for purpose in accordance with the governance framework and the FM Code.

Internal audit opinion

No system of internal control, nor Internal Audit, can provide absolute assurance. On the basis of audit work undertaken during the reporting period and the assurances provided by the partner organisations, the Chief Internal Auditor is able to conclude that a reasonable level of assurance can be given that the system of internal control, risk management and governance is operating effectively within the organisation as evidenced in the Internal Audit Annual Report for 2023/24.

Certification

On the basis of assurances provided, we consider that the internal control environment operating during the reporting period provides reasonable and objective assurance that any significant risks impacting upon the achievement of our principal objectives will be identified and actions taken to avoid or mitigate their impact. Systems are in place to continually review and improve the internal control environment and the following action plan is in place to identify areas for improvement.

Action Plan

Following consideration of the review of adequacy and effectiveness the following action plan has been agreed to ensure continual improvement of the IJB's governance. Regular updates on progress of the agreed actions will be monitored by the IJB ARSC.

Agreed Action	Responsible Person	Status
The Board should agree an updated approach to report on hosted services activity. This should include the IJB's audit trail requirements to support the disclosure in the financial statements. The CFO will work with the other five CFOs across Greater Glasgow and Clyde to develop a revised process for reporting on hosted services activity.	Chief Finance Officer	Complete
The IJB should work with partners to ensure that medium term financial planning is updated regularly and reflects the ability of the IJB to deliver financial sustainability.	Chief Officer & Chief Finance Officer	Ongoing
The ARSC should conduct a self-assessment against updated good practice guidance for local government audit committees.	Chief Internal Auditor	Complete

Actions Completed in 2023-24

Agreed Action	Responsible Person	Status
Develop and implement the Strategic Delivery Plan for Year 2 of the Strategic Plan - informed by relevant Care Planning Groups – setting out success measures and milestones, to evidence how the agreed strategic objectives will be progressed each year.	Head of Strategic Planning and Health Improvement	Complete

Outstanding Actions

Agreed Action	Progress	Responsible Person	Status
Assess the implications of agreed recommendations taken forward following the Independent Review of Adult Social Care (Feeley Review), with a particular focus on implications for IJB governance, and provide regular assessments to the IJB.	Draft legislation on the creation of the National Care Service was published by the Scottish Parliament in June 2022. Following multiple delays at Stage 1 of the parliamentary process, the Bill progressed to Stage 2 in March 2024. This action remains on hold pending further updates from the Scottish Government.	Chief Officer	Ongoing
Carry out a review of the Renfrewshire Integration Scheme in line with the Public Bodies (Joint Working) (Scotland) Act 2014).	Following joint review of the Renfrewshire Integration Scheme, undertaken by a pan-GGC HSCP working group, a consultation draft of the revised Scheme was approved by Renfrewshire Council Leadership Board in February 2024. On completion of the consultation period, the final Scheme will be submitted to the Leadership Board	Chief Officer	Ongoing

	and through NHSGGC governance routes in Spring 2024. Submission of the Scheme to the Cabinet Secretary will be contingent on approval from both Renfrewshire Council and NHSGGC. It is currently anticipated that the Integration Scheme will be considered through partner governance arrangements in late Summer 2024, following which the final version will be submitted to the Scottish Government approval. The version approved by the Scottish Government will be submitted to the IJB for noting and published on the HSCP's website.		
Working with our partners, explore and implement new ways of working to effect change and reform in HSCP service delivery, to assist in addressing the budget gap projected in the medium term and to ensure financial sustainability.	Through its Sustainable Futures programme, the IJB has agreed a rolling suite of savings and reform proposals for delivery over the medium term. Proposals to a value of c£2490k have been delivered in 2023/24. A further c£958k has been agreed for delivery in 2024/25, with a number of additional proposals in development for delivery in 2024/25 and beyond.	Chief Officer	Ongoing

Conclusion and Opinion on Assurance

While recognising the importance of continuous improvement, as detailed above, it is our opinion that reasonable assurance can be placed upon the adequacy and effectiveness of the IJB's governance arrangements.

We consider that the internal control environment provides reasonable and objective assurance that any significant risks impacting on the IJB's principal objectives will be identified and actions taken to avoid or mitigate their impact.

Systems are in place to regularly review and improve the internal control environment and the implementation of the action plan will be monitored by the HSCP Senior Management Team throughout the year.

Cllr Jennifer Adam, Chair, Renfrewshire Integration Joint Board Date: _____

Christine Laverty, Chief Officer Date: _____

To:	**Renfrewshire Integration Joint Board Audit, Risk and Scrutiny Committee**
On:	**21 June 2024**
Report by:	**Head of Strategic Planning and Health Improvement**
Heading:	**Local Code and Sources of Assurance for Governance Arrangements**

1. Summary

1.1. The purpose of this report is to seek approval from the IJB Audit, Risk and Scrutiny Committee on the annual review of the Local Code and Sources of Assurance for Governance Arrangements, as detailed within Appendix 1.

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

1.3. The Local Code includes identified sources of assurance which enable the IJB to review and assess its governance arrangements, against which it will measure itself in Annual Governance Statements from 2018/19 onwards.

2. Recommendations

It is recommended that the IJB Audit, Risk and Scrutiny Committee:

- Review and approve the Local Code of Corporate Governance and Sources of Assurance, as attached in Appendix 1; and
- Note any recommendations arising from the internal audit of the Local Code and Sources of Assurance will be taken forward by the relevant officers, and progress reported back to the IJB's Audit, Risk and Scrutiny Committee.

3. Background

3.1. Within its 2015/16 Annual Governance Statement, the IJB confirmed that it had adopted governance arrangements that were consistent with the principles of CIPFA's and the Society of Local Authority Chief Executives' (SOLACE) framework 'Delivering Good Governance in Local Government: Framework' and the Statement explained how the IJB complied with the Framework and also met the Code of Practice on Local Authority Accounting in the UK.

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

3.3. Renfrewshire IJB operates through a governance framework based on this legislative requirement, governance principles and management processes. The IJB has worked to ensure that its governance arrangements are robust and informed by good practice.

3.4. On 22 March 2019 the IJB agreed that a regular review and, where appropriate, update and refresh, would be considered by the IJB's Audit Committee (now known as Audit Risk & Scrutiny Committee) on an annual basis, ensuring that the areas within were still relevant and accurate.

3.5. As previously reported, there have been a range of key developments in recent years including our development and approach of a new IJB Risk Management Framework. This has advanced and regular reporting is now trailed through each meeting of the IJB's Audit, Risk and Scrutiny Committee to keep this agenda visible to members owing to the range of areas covered within.

3.6. In late 2023 the IJB Audit, Risk and Scrutiny Committee underwent a self-evaluation process against new CIPFA (Chartered Institute of Public Finance and Accountancy) guidance specific to local authority Audit Committees. This process highlighted the good practice in place and allowed for the identification of key actions to be taken forward, including the update of its Terms of Reference reflecting the fuller remit it covers.

3.7. In addition, within the listed examples there have been elements of refinement reflecting changes in terminology and titling of key documentation that have evolved since the document was initially established.

3.8. The Local Code and Sources of Assurance has been subject to Internal Audit in the last year. It is expected that an update will be brought to the Audit, Risk and Scrutiny Committee in June, noting the outcome of this. The findings from this are also shared with the management team of the HSCP and, as is practice, any recommendations arising from the audit

will be taken forward by the relevant officers, and progress reported back via the established routes.

4. Sources of Assurance

4.1. The Local Code includes identified sources of assurance which enable the IJB to review and assess its governance arrangements, against which it will measure itself in Annual Governance Statements from 2018/19 onwards.

5. Compliance with Local Code

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

5.2. The Local Code of Corporate Governance is subject to ongoing review to ensure that internal controls, risk management and other governance arrangements are improved through the implementation of the framework.

Implications of the Report

1. **Financial –** None
2. **HR & Organisational Development –** None
3. **Community Planning and Strategic Plan –** None
4. **Wider Strategic Alignment –** None
5. **Legal –** The Local Code and Sources of Assurance ensures that the Integration Joint Board is compliant with the Integrated Resource Advisory Group guidance in relation to audit provision and the Local Authority Accounts (Scotland) Regulations 2014.
6. **Property/Assets –** None
7. **Information Technology –** None
8. **Equality & Human Rights –** The recommendations contained within this report have been assessed in relation to their impact on equalities and human rights. No negative impacts on equality groups or potential for infringement have been identified arising from the recommendations contained in the report. If required following implementation, the actual impact of the recommendations and the mitigating actions will be reviewed and monitored, and the results of the assessment will be published on the Council's website.
9. **Fairer Scotland Duty –** None
10. **Health & Safety –** None
11. **Procurement –** None
12. **Risk –** Without a Local Code and Sources of Assurance, there is a risk that the Integration Joint Board does not have an effective framework for the assessment of its governance arrangements.
13. **Privacy Impact** – None.

List of Background Papers – None

Author: James Higgins, Corporate Business Officer

Any enquiries regarding this paper should be directed to Frances Burns, Head of Strategic Planning and Health Improvement (Frances.Burns@renfrewshire.gov.uk)

A. Behaving with integrity, demonstrating strong commitment to ethical values, and respecting the rule of law

Good Governance Code

Public Sector organisations are accountable not only for how much they spend, but also for how they use the resources under their stewardship. This includes accountability for outputs, both positive and negative, and for the outcomes they have achieved. In addition, they have an overarching responsibility to serve the public interest in adhering to the requirements of legislation and government policies. It is essential that, as a whole, they can demonstrate the appropriateness of all their actions

Ref	Sub Principles	Behaviours and actions that demonstrate good governance in practice	Examples of systems, processes, documentation and other evidence demonstrating compliance
A1.1	Behaving with Integrity	Ensuring IJB members and officers behave with integrity and lead a culture where acting in the public interest is visibly and consistently demonstrated thereby protecting the reputation of the organisation. Demonstrating, communicating and embedding the standard operating principles or values through appropriate policies and processes which are reviewed on a regular basis to ensure that they are operating effectively	• Standards and Codes of Conduct / updates by Standards Officer • Individual sign off with regard to compliance with code • Induction for IJB members and staff on standard of behaviour expected • Performance appraisals for staff • Decision making systems • Declarations of interests made and recorded at all Board and Committee meetings • Conduct at meetings • Development sessions to support decision making on specific issues • Anti-fraud policies are working effectively • Up-to-date register of interests • Up-to-date register of gifts and hospitality • Complaints policy and examples of responding to complaints about behaviour • Changes/improvements as a result of complaints received and acted upon
A2.1	Demonstrating strong commitment to ethical values	Seeking to establish, monitor and maintain the organisation's ethical standards and performance.	• Scrutiny of decision making • Championing ethical compliance at governing body level

		Underpinning personal behaviour with ethical values and ensuring they permeate all aspects of the organisation's culture and operation. Developing and maintaining robust policies and procedures which place emphasis on agreed ethical values.	• Provision of ethical awareness training • Appraisal processes take account of values and ethical behaviour • Staff appointments policy • Procurement policy
A3.1	Respecting the rule of law	Ensuring IJB members and officers demonstrate a strong commitment to the rule of the law as well as adhering to relevant laws and regulations. Creating the conditions to ensure that the statutory officers and IJB members are able to fulfil their responsibilities in accordance with legislative and regulatory requirements. Striving to optimise the use of the full powers available for the benefit of communities and other stakeholders. Dealing with breaches of legal and regulatory provisions effectively. Ensuring corruption and misuse of power are dealt with effectively.	• Statutory provisions and guidance is followed • Job description/specifications • Compliance with CIPFA's Statement on the Role of the Chief Financial Officer in Local Government (CIPFA, 2016) • Standing Orders • Committee support • Legal advice provided by officers • Monitoring provisions • Record of legal advice provided by officers • Statutory provisions

B. Ensuring openness and comprehensive stakeholder engagement

To ensure the HSCP is run for the public good, the organisation should ensure openness in its activities. Clear, trusted channels of communication and consultation should be used to engage effectively with all groups of stakeholders, such as individual citizens and service users, as well as institutional stakeholders.

Ref	Sub Principles	Behaviours and actions that demonstrate good governance in practice	Examples of systems, processes, documentation and other evidence demonstrating compliance
B1.1	Openness	Ensuring an open culture through demonstrating, documenting and communicating the organisation's commitment to Openness Providing clear reasoning and evidence for decisions in both public records and explanations to stakeholders and being explicit about the criteria, rationale and considerations used. Ensuring that the impact and consequences of those decisions are clear.	• Annual Performance Report • Freedom of Information Act and Publication Scheme online • Organisational values • IJB papers published in advance of meetings • Record of decision making and supporting materials • Meeting reports show details of advice given • Discussion among all IJB members and officers on the information needs of members to support decision making e.g. developing Performance Framework • Agreement on the information that will be provided and timescales • Calendar of dates for submitting, publishing and distributing timely reports is adhered to.
B2.1	Engaging comprehensively with all stakeholders	Effectively engaging with stakeholders to ensure that the purpose, objectives and intended outcomes are clear so that outcomes are achieved successfully and sustainably. Developing formal and informal partnerships with stakeholders to allow for recourse to be used more efficiently and outcomes achieved more effectively based on:	• Communication Strategy[1] • Database and mapping of stakeholders with whom the IJB engages • Strategic Planning Groups/Care Planning Groups • Partnership working embedded throughout IJB • SPG meet regularly and interlinks with IJB

[1] Note it is planned to refresh this publication over 2024/25.

		• Trust • a shared commitment to change • a culture that promotes and accepts challenge among partners and that the added value of partnership working is explicit.	
B3.1	Engaging all stakeholders effectively	Establishing a clear policy on the type of issues that the organisation will meaningfully consult with to ensure that service (or other) provision is contributing towards the achievement of intended outcomes. Ensuring communication methods are effective and that members and officers are clear about their roles with regard to community engagement. Encouraging, collecting and evaluating the views and experiences of communities, service users and organisations of different backgrounds and implementing effective feedback mechanisms in order to demonstrate how their views have been taken into account.	• Record of public consultations • Partnership working embedded throughout the IJB • Communication Strategy • Market Facilitation Plan • Processes for dealing with competing demands within the community, for example a consultation.

C. Defining outcomes in terms of sustainable economic, social, and environmental benefits

The long term nature and impact of many of the organisation's responsibilities mean that it should define and plan outcomes and that these should be sustainable. Decisions should further the organisation's purpose, contribute to intended benefits and outcomes, and remain within the limits of authority and resources. Input from all groups of stakeholders is vital to the success of this process and in balancing competing demands when determining priorities for the finite resources available.

Ref	Sub Principles	Behaviours and actions that demonstrate good governance in practice	Examples of systems, processes, documentation and other evidence demonstrating compliance
C1.1	Defining Outcomes	Having a clear vision which is an agreed formal statement of the organisation's purpose and intended outcomes containing appropriate performance indicators, which provides the basis for the organisation's overall strategy, planning and other decisions. Specifying the intended impact on, or changes for, stakeholders and delivering defined outcomes on a sustainable basis within the resources that will be available. Identifying and managing risks to the achievement of outcomes. Managing service users' expectations effectively with regard to determining priorities and making the best use of the resources available.	• Vision used as a basis for corporate and service planning • Community engagement and involvement • Corporate and service plans • Regular reports on progress • Performance trends are established and reported upon within bi-annual Scorecard • Risk management protocols • An agreed set of quality standard measures for each service element are included in service plans • Processes for dealing with competing demands within the community
C2.1	Sustainable economic, social and environmental benefits	Considering and balancing the combined economic, social and environmental impact of policies, plans and decisions when taking decisions about service provision. Taking a longer term view with regard to decision making, taking account of risk and acting transparently where there are potential conflicts between the organisation's intended outcomes and	Placing reliance on Partners Capital investment protocol to ensure these are structured to achieve appropriate life spans and adaptability for future use so that resources are spent on optimising social, economic and environmental wellbeing: o Capital programme

		short-term factors such as the political cycle or financial constraints. Determining the wider public interest associated with balancing conflicting interests between achieving the various economic, social and environmental benefits, through consultation where possible, in order to ensure appropriate trade-offs. Ensuring fair access to services	o Capital investment strategy Reliance on Partners Climate Change Planning • Discussion between members and officers on the information needs of members to support decision making • Record of decision making • Protocols for consultation • Protocols ensure fair access and statutory guidance is followed

D. Determining the interventions necessary to optimise the achievement of the intended outcomes

The organisation will achieve its intended outcomes by providing a mixture of legal, regulatory, and practical interventions. Determining the right mix of these courses of action is a critically important strategic choice that local government has to make to ensure intended outcomes are achieved They need robust decision-making mechanisms to ensure that their defined outcomes can be achieved in a way that provides the best trade-off between the various types of resource inputs while still enabling effective and efficient operations. Decisions made need to be reviewed continually to ensure that achievement of outcomes is optimised.

Ref	Sub Principles	Behaviours and actions that demonstrate good governance in practice	Examples of systems, processes, documentation and other evidence demonstrating compliance
D1.1	Determining interventions	Ensuring decision makers receive objective and rigorous analysis of a variety of options indicating how intended outcomes would be achieved and including the risks associated with those options.	• Discussion between members and officers on the information needs of members to support decision making • Consultations and planned engagement processes • Decision making protocols • Option appraisals • Agreement of information that will be provided and timescales
D1.2	Determining interventions	Considering feedback from the public and service users when making decisions about service improvements or where services are no longer required in order to prioritise competing demands within limited resources available including people, skills, land and assets and bearing in mind future impacts.	• Consultations • Strategic Plan • Medium Term Financial Plan linked to Strategic Plan
D2.1	Planning interventions	Establishing and implementing robust planning and control cycles that cover strategic and operational plans, priorities and targets.	• Calendar of dates for developing and submitting plans and reports that are adhered to

D2.2	Planning interventions	Engaging with internal and external stakeholders in determining how services and other courses of action should be planned and delivered.	• Communication Strategy • Market Facilitation Plan
D2.3	Planning interventions	Considering and monitoring risks facing each partner when working collaboratively including shared risks.	• Risk Management Policy and Risk Registers
D2.4	Planning interventions	Establishing appropriate key performance indicators (KPIs) as part of the planning process in order to identify how the performance of services and projects is to be measured.	• KPIs have been established and approved for each service element and included in the service plan and are reported upon regularly
D2.5	Planning interventions	Ensuring capacity exists to generate the information required to review service quality regularly.	• Reports include detailed performance results and highlight areas where corrective action is necessary
D3.1	Optimising achievement of intended outcomes	Ensuring the Medium Term Financial plan integrates and balances service priorities, affordability and other resource constraints and sets the context for ongoing decisions on significant delivery issues or responses to changes in the external environment that may arise during the budgetary period in order for outcomes to be achieved while optimising resource usage.	• Feedback surveys and exit/ decommissioning strategies • Changes as a result • Medium Term Financial plan

E. Developing the entity's capacity, including the capability of its leadership and the individuals within it

The organisation needs appropriate structures and leadership, as well as people with the right skills, appropriate qualifications and mind-set, to operate efficiently and effectively and achieve their intended outcomes within the specified periods. A local government organisation must ensure that it has both the capacity to fulfil its own mandate and to make certain that there are policies in place to guarantee that its management has the operational capacity for the organisation as a whole. Because both individuals and the environment in which an authority operates will change over time, there will be a continuous need to develop its capacity as well as the skills and experience of the leadership of individual staff members. Leadership is strengthened by the participation of people with many different types of backgrounds, reflecting the structure and diversity of communities.

Ref	Sub Principles	Behaviours and actions that demonstrate good governance in practice	Examples of systems, processes, documentation and other evidence demonstrating compliance
E1.1	Developing the entity's capacity	Reviewing services, performance and use of assets on a regular basis to ensure their continuing effectiveness.	• Regular reviews of activities, outputs and planned outcomes
E1.2	Developing the entity's capacity	Recognising the benefits of partnership and collaborative working where added value can be achieved.	• Effective operation of partnerships which deliver agreed outcomes e.g. development of Strategic Planning Group, Joint Staff Partnership Forum, Unscheduled Care Local Group, Carers Group, Care and Quality Governance Groups (Executive and Locality), Acute/HSCP Interface Meeting
E1.3	Developing the entity's capacity	Developing and maintain an effective workforce plan.	• Workforce Plan 2022-25
E2.1	Developing the capability of the entity's leadership and other individuals	Developing protocols to ensure that IJB members and officers interact with each other regarding their respective roles early on in the relationship and that a shared understanding of roles and objectives is maintained and ensuring the IJB Chair and the Chief Officer have clearly defined and distinctive leadership roles within a structure, whereby the	• Job descriptions • Regular review of communication arrangements • Clear statement of respective roles and responsibilities of the Chief Officer and IJB Chair and how they will be put into practice

		Chief Officer leads the organisation in implementing strategy and managing the delivery of services and other outputs set by members and each provides a check and a balance for each other's authority.	• Access to courses/ information briefings on new legislation • Induction programme • Personal development plans
E2.2	Developing the capability of the entity's leadership and other individuals	Ensuring that there are structures in place to encourage public participation.	• Stakeholder forums • Strategic partnership frameworks
E2.3	Developing the capability of the entity's leadership and other individuals	Taking steps to consider the leadership's own effectiveness and ensuring leaders are open to constructive feedback and peer review and inspections.	• Reviewing individual member performance on a regular basis taking account of their attendance and considering any training for development needs

F. Managing risks and performance through robust internal control and strong public financial management

The organisation needs to ensure that its and governance structures that it oversees have implemented, and can sustain, an effective performance management system that facilitates effective and efficient delivery of planned services. Risk management and internal control are important and integral parts of a performance management system and crucial to the achievement of outcomes. Risk should be considered and addressed as part of all decision making activities.

A strong system of financial management is essential for the implementation of policies and the achievement of intended outcomes, as it will enforce financial discipline, strategic allocation of resources, efficient service delivery, and accountability. It is also essential that a culture and structure for scrutiny is in place as a key part of accountable decision making, policy making and review. A positive working culture that accepts, promotes and encourages constructive challenge is critical to successful scrutiny and successful delivery. Importantly, this culture does not happen automatically, it requires repeated public commitment from those in authority.

Ref	Sub Principles	Behaviours and actions that demonstrate good governance in practice	Examples of systems, processes, documentation and other evidence demonstrating compliance
F1.1	Managing Risk	Recognising that risk management is an integral part of all activities and must be considered in all aspects of decision-making. Implementing robust and integrated risk management arrangements and ensuring that they are working effectively.	• Risk management strategy/policy formally approved, adopted, reviewed and updated on a regular basis (last updated March 2024).

		Ensuring that responsibilities for managing individual risks are clearly allocated.	
F2.1	Managing Performance	Monitoring service delivery effectively.	• Performance map showing all key activities have performance measures • Benchmarking information, where appropriate • Calendar of dates for submitting, publishing and distributing timely reports
F2.2	Managing Performance	Making decisions based on relevant, clear objective analysis and advice pointing out the implications and risks inherent in the organisation's financial, social and environmental position and outlook.	• Discussion between members and officers on the information needs of members to support decision making • Publication of agendas and minutes of meetings • Agreement on the information that will be needed and timescales
F3.1	Robust internal control	Aligning the risk management strategy and policies on internal control with achieving objectives. Ensuring effective counter fraud and anti-corruption arrangements are in place. Ensuring additional assurance on the overall adequacy and effectiveness of the framework of governance, risk management and control is provided by the internal auditor.	• Risk management strategy • Audit plan • Audit reports • Compliance with the Code of Practice on Managing the Risk of Fraud and Corruption (CIPFA, 2014) • Annual Governance Statement • Effective internal audit service is resourced and maintained
F3.2	Robust internal control	Ensuring an Audit Committee or equivalent group or function which is independent of the executive and accountable to the governing body: • provides a further source of effective assurance regarding arrangements for managing risk and maintaining an effective control environment • that its recommendations are listened and acted upon.	• IJB Audit, Risk & Scrutiny Committee complies with best practice – see Audit Committees: Practical Guidance for Local Authorities and Police (CIPFA, 2013 and subsequent updates) • Terms of reference • Membership Training

F4.1	Managing data	Ensuring effective arrangements are in place for the safe collection, storage, use and sharing of data, including processes to safeguard personal data.	• Data management framework and procedures • Data protection officers in place via NHS and Local Authority • Data protection policies and procedures • Data sharing agreement • Data sharing register • Data processing agreements
F4.2	Managing data	Reviewing and auditing regularly the quality and accuracy of data used in decision making and performance monitoring.	• Data quality procedures and reports • Data validation procedures
F5.1	Strong public financial management	Ensuring well developed financial management is integrated at all levels of planning and control, including management of financial risks and controls and that it supports both long-term achievement of outcomes and short-term financial and operational performance.	• Budget monitoring reports • Financial management supports the delivery of services and transformational change as well as securing good stewardship

G. Implementing good practices in transparency, reporting, and audit to deliver effective accountability

Accountability is about ensuring that those making decisions and delivering services are answerable for them. Effective accountability is concerned not only with reporting on actions completed, but also ensuring that stakeholders are able to understand and respond as the organisation plans and carries out its activities in a transparent manner. Both external and internal audit contribute to effective accountability.

Ref	Sub Principles	Behaviours and actions that demonstrate good governance in practice	Examples of systems, processes, documentation and other evidence demonstrating compliance
G1.1	Implementing good practices in transparency	Writing and communicating reports for the public and other stakeholders in an understandable style appropriate to the intended audience and ensuring that they are easy to access and interrogate.	• Standard IJB report format • Published IJB agendas, reports and minutes in clear standard formats • Website • Annual report (online and paper copies)

		Striking a balance between providing the right amount of information to satisfy transparency demands and enhance public scrutiny while not being too onerous to provide and for users to understand.	• Strategic documents and reports published in summary format and available in easy read and other languages upon request • IJB and Audit, Risk and Scrutiny Committee meetings recorded and available to view online.
G2.1	Implementing good practices in reporting	Reporting at least annually on Performance. Ensuring members and officers own the results.	• Performance reported at each IJB meeting • Formal Annual Performance Report • Annual financial statements • Appropriate approvals • Annual Governance Statement
G2.2	Implementing good practices in reporting	Ensuring the performance information that accompanies the financial statements is prepared on a consistent and timely basis and the statements allow for comparison with other similar organisations.	• Format follows best practice
G3.1	Assurance and effective accountability	Ensuring an effective internal audit service with direct access to members is in place which provides assurance with regard to governance arrangements and recommendations are acted upon and that recommendations for corrective action made by audit are acted upon. Welcoming peer challenge, reviews and inspections from regulatory bodies and implementing recommendations.	• Compliance with CIPFA's Statement on the Role of the Head of Internal Audit (2010) • Compliance with Public Sector Internal Audit Standards • Audit recommendations have informed positive improvement
G3.2	Assurance and effective accountability	Gaining assurance on risks associated with delivering services through third parties and that this is evidenced in the annual governance statement.	• Annual Governance Statement
G3.3	Assurance and effective accountability	Ensuring that when working in partnership, arrangements for accountability are clear and that	• Integration Scheme

		the need for wider public accountability has been recognised and met.	

To:	**Renfrewshire Integration Joint Board Audit, Risk and Scrutiny Committee**
On:	**21 June 2024**
Report by:	**Strategic Lead and Improvement Manager**
Heading:	**Update on Risk and Issue Register**

1. Summary

1.1. This paper provides an update on ongoing activity to identify and manage strategic and operational risks, following the previous update to the Committee in March 2024. This report notes updates made to the IJB's risk and issues register, including any changes to risks/issues previously identified, and any new items added to the register during this period.

2. Recommendations

It is recommended that the Audit, Risk and Scrutiny Committee:

- Approve the updates made to the risk and issue register (Section 4).
- Approve the request to close RSK20, 'Concerns and potential challenges on current proposals'.

3. Background

3.1. The IJB's risk management framework sets out the principles by which the HSCP and IJB identify and manage strategic and operational risks impacting upon the organisation. This framework forms a key strand of the IJB's overall governance mechanisms and is encapsulated within the IJB's Risk Management Policy and Strategy, which was reviewed and agreed by the Committee in March 2024. It sets out how risks and issues should be identified, managed and reported and it informs the development of this report and supporting appendix. This is also underpinned by supporting Risk Framework guidance for HSCP staff which is being updated to reflected agreed changes to the Risk Management Policy and Strategy.

4. Updates to the IJB Risk Register

4.1. The HSCP's ongoing assessment and review of risks has identified necessary changes to existing risks and issues. In this period there has been one new risk, but no new issues added to the IJB Register. In addition, there has been

one change to the risks and issue ratings, while a further risk is proposed for closure. All risks and issues have been updated to reflect the latest position regarding completed and outstanding actions, and this paper reflects the changes made since the last update.

4.2. It should be noted that the risk outlook continues to remain highly challenging, with most risks and issues remaining within the categories of moderate and high. The current financial and operating context remains extremely difficult across the public sector, and this is reflected in the nature of risks being identified. This is expected to continue through the remainder of this financial year and into following years.

4.3. In summary, the key updates to existing risks include:

The risk scores for 'Changing financial and demographic pressures' (RSK01) and 'Financial challenges causing financial instability for the IJB' (RSK02) continue to remain at the highest rating available. These continue to be reinforced by the 'IJB Financial Resilience' issue (ISS02) as the ongoing financial context for the IJB remains highly challenging and uncertain. As reported previously, the tracking of agreed Sustainable Futures Programme savings continues, and further savings proposals were considered and approved or rejected by the IJB in March and April 2024. The risk remains that savings identified will not fully bridge the financial gap projected in future years.

- The risk 'Disruption from further waves of COVID' (RSK05) has been reduced to reflect the reduction in COVID cases and staff absence evidenced since the last report.

- The risk 'National Care Service' (RSK06) and 'National risk of litigation and potential local financial and reputational impact arising from the public enquiry into COVID response' (RSK09) have both been updated to reflect the revised timelines associated with the NCS bill and ongoing Covid enquiry.

- The risk 'Concerns and potential challenges on current proposals' (RSK20) was previously focused on specific proposals considered by the IJB in March and April 2024. However, following the IJB's related decision-making at those meetings this risk has been revised to document the ongoing risk of possible challenges to savings proposals developed through the course of the Sustainable Futures programme, or to decisions made by the IJB or HSCP.

- A new risk 'Potential impacts of financial recovery' (RSK21) has been added to the log. This risk details the potential impacts that could arise if the IJB is required to enter financial recovery at a later date.

4.4. For the Committee's awareness, the HSCP continues to remove historic mitigations and preventing actions from the quarterly report to streamline the individual risk and issue summaries. This reporting period a number of actions have been moved to the completed summary. Actions completed in the last twelve months will continue to be maintained, with historic actions being

available in previous iterations of the report and within the overarching risk and issue log if further detail is required.

Implications of the Report

1. **Financial –** No direct implications from this report*
2. **HR & Organisational Development** – The risk framework guidance has been further updated and was approved by the Committee in March 2024, training for staff will be updated and issued in Autumn 2024.
3. **Community Planning** – No direct implications from this report*
4. **Legal –** Supports the implementation of the provisions of the Public Bodies (Joint Working) (Scotland) Act 2014.
5. **Property/Assets –** No direct implications from this report*
6. **Information Technology –** No direct implications from this report*
7. **Equality and Human Rights** – No direct implications from this report*
8. **Health & Safety –** No direct implications from this report*
9. **Procurement** – No direct implications from this report*
10. **Risk –** This paper and attachments provide an update to the IJB's risk and issue registers.
11. **Privacy Impact** – No direct implications from this report*

**Although there are no direct implications from this report, specific risks are likely to impact on these areas and will have specific mitigations identified.*

List of Background Papers – N/A

Author: Angela McCarthy, Senior Risk and Programme Management Officer

Any enquiries regarding this paper should be directed to David Fogg, Strategic Lead, and Improvement Manager (David.fogg@renfrewshire.gov.uk)

Risk and Issue Register Executive Summary **Appendix 1**

This document reflects the status of the risks and issues in the IJB log at the end of May 2024. This report also features issues as part of the agreed risk framework approach. The summaries reflect the changes to risks since the last report and items which have been identified as new or those proposed to close since the last report. For any proposed closures we have included summaries to detail the final position and the rationale for closure. If these are agreeable, they will be removed from the next report.

Introduction and Background.

This document is prepared in advance of each IJB Audit, Risk and Scrutiny Committee meeting to support Renfrewshire Integration Joint Board (IJB), and members of the IJB's Audit, Risk and Scrutiny Committee, in the application of the IJB's Risk Management Policy and Strategy. It sets out those Strategic Risks and Issues currently identified which have the potential to prevent the IJB from achieving its desired outcomes and objectives, and the mitigating actions put in place to manage these risks and issues. **Further information on the IJB's approach can be found in Renfrewshire IJB's Risk Management Policy and Strategy, recently updated and approved in March 2024.**

Approach to assessing risks.

All risks identified are assessed considering (i) the likelihood of the risk materialising; and (ii) the consequent impact of said risk should it materialise. To reflect the range of eventualities this assessment provides a score of between 1 and 5 for each of these criteria (where 1 is least likely and low impact, and 5 is very likely and very high impact). This enables each risk to have an overall score where the likelihood and impact ratings are multiplied together, and a RAG (Red, Amber, Green rating applied) as per the matrix below. Risk scores guide the IJB's response to risks identified.

Approach to assessing issues.

The same applies regards impact, however for issues, the priority and the resolution is considered instead of likelihood. Issues are simply risks which have occurred and they have a rating of between 1 and 5 where 1 is low/no impact ranging to 5 extreme impacts.

Risks

Likelihood	Risk Consequence Impact Rating				
	1	2	3	4	5
5	5	10	15	20	25
4	4	8	12	16	20
3	3	6	9	12	15
2	2	4	6	8	10
1	1	2	3	4	5

Issues

Impact	Issue Rating
1	Insignificant
2	Minor
3	Moderate
4	Major
5	Extreme

Risk Profile

Total Risks	High Risks	Moderate Risks	Low Risks	Very Low Risks
18	11	6	1	0

Likelihood	Consequence Impact				
	1	2	3	4	5
5	5	10	15	20	25
				5	6
4	4	8	12	16	20
				2	
3	3	6	9	12	15
			1	2	2
2	2	4	6	8	10
1	1	2	3	4	5

Issue Profile

Total Issues	2
Extreme Issues	2
Major Issues	
Moderate Issues	
Minor Issues	
Insignificant Issues	

Risk or Issue Ref	Risk or Issue Type	Summary Description	Current Risk / Issue Score and ROYG Rating	Risk or Issue Movement
RSK01	Strategic	Changing financial and demographic pressures affecting service provision	25 High	No Change
RSK02	Financial	Financial Challenges causing financial instability for the IJB	25 High	No Change
RSK03	Operational	Increase in physical and mental health inequalities	20 High	No Change
RSK05	Operational	Disruption from further waves of COVID	09 Low	Reduced
RSK06	Operational	National Care Service	20 High	No Change
RSK07	Operational	Workforce planning and service provision	25 High	No Change
RSK09	Strategic	National risk of litigation and the potential local financial and reputational impact arising from the public inquiry into COVID response	15 Moderate	No Change
RSK10	Operational	Failure or loss of major service provider	25 High	No Change
RSK11	Clinical	Delivery of the GP Contract / Primary Care Improvement Plan	16 Moderate	No Change
RSK12	Strategic	Failure to achieve targets and key performance indicators	20 High	No Change
RSK13	Strategic	Cyber threats pose an increasing risk	20 High	No Change
RSK14	Strategic	Capital funding and complexities of property planning in an integrated setting	25 High	No Change
RSK15	Operational	Compliance with Essential Training	16 Moderate	No Change
RSK16	Strategic	Delivery of Addictions Support in Renfrewshire	12 Moderate	No Change
RSK18	Operational	Impact of potential power outages on critical services	15 Moderate	No Change
RSK19	Operational	Disruption from a further pandemic / outbreak	12 Moderate	No Change
RSK20	Strategic	Potential challenges to savings proposals or decision-making	20 High	Revised description
RSK21	Strategic	Potential impacts of financial recovery	25 High	New
ISS01	Operational	Issues regards attracting & retaining staff	05 Extreme	No Change
ISS02	Financial	IJB budgetary position	05 Extreme	No Change

RSK01 Changing financial and demographic pressures affecting service provision

Risk Statement	Risk Owner	Risk Description	Movement	Reason for Movement if applicable	
The changing financial and demographic pressures facing services poses a significant risk to the HSCP being able to successfully deliver services at the current level to the most vulnerable people in Renfrewshire.	HSCP SMT	There is a risk that if financial and demographic pressures on services are not effectively planned for and managed over the medium to longer term, there would be an impact on the ability of the HSCP to deliver services at the current to the most vulnerable people in Renfrewshire. This needs to be considered with regards: • Medium- and long-term financial planning • Corporate and service review activities including Sustainable Futures activity. • Strategic commissioning approach and the strategic planning process • Service design ensuring the development of cost-effective care models and models which encourage prevention and self-management. • Increased costs such as utilities, salaries, and supplies are also having an impact on budgets across the HSCP and our partners. Partners and providers are managing additional costs which may lead to an increase in our costs and further budget constraints. • Increasing impacts of cost-of-living crisis on some demographics has the potential to further increase service demands and levels of need. • The overall financial outlook for the next financial year and beyond remains uncertain and challenging.	No Change	Not applicable	
			Risk Code	**Category**	**Risk Management Approach**
			RSK01	Strategic	Treat
			Current Likelihood	**Current Impact**	**Current Evaluation**
			05	05	25 High
			Previous Likelihood	**Previous Impact**	**Previous Evaluation**
			05	05	25 High

Mitigating / Preventing Actions Complete or Ongoing	Assigned to	Date	Status
A number of actions are in place to help mitigate this risk including: Regular risk reporting to the Integration Joint Board and the IJB Audit, Risk and Scrutiny committee. **Financial Planning and Strategic Planning** - Long term financial planning processes - Budget monitoring processes are in place and regularly reviewed and reported upon - Implementation of the IJB's Strategic Plan 2022-25 and Medium-Term Financial Plan 2022-25 - Implementation of the Sustainable Futures Programme with further savings initiatives to be identified throughout the year - Continuous review and assessment of changes within the external economic and funding context	HSCP Senior Management Team	Subject to continual review under Sustainable Futures programme	Subject to ongoing review

Mitigating / Preventing Actions Planned	Assigned to	Date	Status
Ongoing deployment of the above	N/A	N/A	N/A

RSK02 Financial Challenges causing financial instability for the IJB

Risk Statement	Risk Owner	Risk Description	Movement	Reason for Movement if applicable	
There are a number of financial challenges facing the IJB and if not adequately addressed, these could affect the financial sustainability of the partnership with a potential consequent impact to service delivery.	HSCP SMT	There are a number of aspects contributing to this risk as follows: **1.** Service Areas individually, or in combination, experience expenditure levels which exceed funding allocations negatively impacting on the overall financial position of the partnership due to: • Pay growth (inflation, annual pay award proposals). • Prescribing. • Sickness & Absence cover. • Community equipment expenditure. • Impact arising from Resource Allocation Model. • Financial impact of any clinical failures. • Compliance with new statutory requirements. • Increased service demand. • Ongoing increased supply chain costs. • Ongoing challenging financial outlook for IJB. • Significant levels of non-recurring funding does not support long term service sustainability. • Additional rate uplifts requested arising from external providers. • Possible implications arising from the Verity House Agreement. • The regrading of care at home staff will incur additional costs. **2.** The requirement for savings to be delivered as part of the Medium-term Financial Plan could have an impact on the delivery of existing front-line services, subject to options identified and related decisions made by the IJB. The Sustainable Futures paper which encompassed a range of savings proposals was approved at IJB in March 2023. Further updates have been provided to each IJB since and further savings proposals have been approved in March 2024 for implementation. The risk remains that savings identified and agreed may not fully bridge the projected financial gap. **3.** As widely reported, Councils and Health Boards across Scotland continue to face significant financial challenges. Increasingly difficult choices about spending priorities will be required in this financial year and future years. **4.** At the March 2024 IJB a balanced budget was agreed including the need to draw down from the IJB's reserves in order to achieve financial balance at year end. Further updates on this will be included in the financial reporting provided separately to each IJB meeting.	No Change	Not applicable	
			Risk Code	**Category**	**Risk Management**
			RSK02	Financial	Treat
			Current Likelihood	**Current Impact**	**Current Evaluation**
			05	05	25 High
			Previous Likelihood	**Previous Impact**	**Previous Evaluation**
			05	05	25 High

Mitigating / Preventing Actions Complete or Ongoing	Assigned to	Date	Status
Supporting frameworks & strategies: - Financial management framework implemented. - Strategic Plan 2022-2025 approved by IJB March 2022 and Strategic Delivery Plan in June 2022 - Medium Term Financial Plan for 2022-2025 approved by IJB March 2022 **Reporting/monitoring at strategic fora:** - Financial information is reported regularly to the Integration Joint Board and the Senior Management Team. - 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.	HSCP Senior Management Team	Historic	Ongoing

- Ongoing discussion at GP forum on importance of prescribing efficiencies. - Robust financial monitoring and budget setting procedures including regular budget monitoring with budget holders. - Prudent application of our reserves policy **Sustainable Futures programme** - Savings agreed by the IJB in March 2023 and March 2024.			
Mitigating / Preventing Actions Planned	**Assigned to**	**Date**	**Status**
- Implementation and ongoing monitoring of identified savings and transformation options. - Ongoing presentation of Sustainable Futures programme updates at IJB including potential savings proposals to be brought for consideration. Further savings to be identified across the year. - Active vacancy management continues. All vacancies reviewed by Finance and approved by CFO prior to recruitment, then submitted to the weekly Vacancy Management Group for final approval (include staff side and union reps and all SMT members). - Ongoing budget discussions with funding partners.	N/A	Subject to continual review under Sustainable Futures programme workstreams	Ongoing

RSK03 Increase in physical and mental health inequalities

Risk Statement	Risk Owner	Risk Description	Movement	Reason for Movement if applicable	
There are a risk that physical and mental health inequalities increase, meaning that service users and patients present with higher levels of need, lower levels of resilience and fewer opportunities to participate fully in their communities.	Head of Strategic Planning & Health Improvement	It is recognised that physical and mental health inequalities are increasing and are highly likely to continue to increase. These may result from long-term conditions, an ageing population, long term impacts of COVID on mental health and Long COVID itself, increasing poverty due to the cost-of-living crisis, increased 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. This must be actively considered with regards to the creation of any Health Improvement plans and Partnership working agreements.	No Change	Not applicable	
			Risk Code	**Category**	**Risk Management Approach**
			RSK03	Operational	Treat
			Current Likelihood	**Current Impact**	**Current Evaluation**
			05	04	20 High
			Previous Likelihood	**Previous Impact**	**Previous Evaluation**
			05	04	20 High

Mitigating / Preventing Actions Complete or Ongoing	Assigned to	Date	Status
• There has been a continued focus on inequalities across a range of HSCP initiatives. A number of teams which maintain a focus on this aspect are in place, including the Community Links and Health Improvement teams. • In addition, following a review of our Strategic Plan priorities several activities are underway which includes delivery of a community-led approach to health and wellbeing with targeted approaches to raise awareness. • The HSCP tracks performance within the health inequalities outcome (number 5 in National H&W Outcomes) and continues to monitor population data and trends. • Inclusion of health, wellbeing, and inequalities within development of Strategic Plan 2022-25. • Additional monies secured as part of winter funding directed to equalities projects, befriending. • Supporting strategic development plans to underpin the Strategic Plan approved by IJB in June 2022. • The HSCP worked with partners to develop and implement cost-of-living and community-based support through the winter 22/23 and 23/24 period (through the Winter Connections Programme).	Strategic Planning & Health Improvement	Historic	Complete

Mitigating / Preventing Actions Planned	Assigned to	Date	Status
• Ongoing work with SPG partners to focus on improving health and wellbeing. • Health Improvement Team continue to progress local priorities and have established an equalities action planner. • Health conditions local employability partnership sub-group has supported improving access to low level mental health support and is developing a toolkit for staff. • Ongoing projects continue; infant feeding, oral health, tackling child poverty and mental health & wellbeing. • Two new projects now making good progress; 'Thrive under five' which focuses on tackling child health weight, healthy eating, and poverty in two neighbourhoods, and \a further project 'Stronger Start' which aims to embed a money and advocacy service within the Royal Alexandra Hospital to support the most vulnerable maternity groups. • Continuing work on the STAR project with ROAR to provide volunteer befriending to clients identified through the assessment process as requiring some additional contact. • Bereavement network established to support those who experienced loss through COVID, has continued. • Macmillan partnership remains and continues to offer clients support via the 'Improving the Cancer Journey' pathway. • Renfrewshire Health and Wellbeing survey report to be considered by IJB in June 2024, after which work will progress with Community planning Partners to develop responsive actions.	Head of SP & HI	Next Review August 2024	Ongoing

RSK05 Disruption from further waves of COVID

Risk Statement	Risk Owner	Risk Description	Movement	Reason for Movement if applicable	
There is a risk that further waves of COVID could have significant impacts on HSCP operational arrangements, particularly staffing, service provision, and overarching IJB governance.	Chief Officer	The risk is that further disruption to the delivery of strategic and transformation plans, in addition to operational day to day commitments because of: • The HSCP needing to implement support measures to prevent the spread of a new variant of COVID-19 • The impact of COVID-19 on services users and demand on services arising from: a) Increased levels of care required due to Long Covid and increased mental health issues. b) The impact on staff; sickness, mental health, and utilisation to support services. c) Impact of increasing levels of demand and client expectations d) The suitability, affordability, and stakeholder support to achieve the NHS Recovery Plan, Renfrewshire Council's recovery plans and ultimately the HSCP's overall plan. e) Any requirement to re-introduce Covid measures and adjust service provision	Reduced	Cases of COVID are now managed through standard processes. We will continue to monitor and review for closure in the next report.	
			Risk Code	**Category**	**Risk Management Approach**
			RSK05	Operational	Treat
			Current Likelihood	**Current Impact**	**Current Evaluation**
			03	03	09
			Previous Likelihood	**Previous Impact**	**Previous Evaluation**
			04	03	12 Moderate

Mitigating / Preventing Actions Complete or Ongoing	Assigned to	Date	Status
• Meetings will continue to be conducted in person, in hybrid format, and remotely using a video and/or audio service that will enable participation. • The risk management framework and policy has been updated to reflect on learnings from COVID and provide the flexibility needed regards risk tolerance required within a pandemic. This is in the process of being rolled out. • Public health measures have been implemented; including vaccinations in all years since 2020/2021 and current planning for and delivery of vaccinations in Winter 2023/24 is now underway. • Winter plans incorporated the necessary staffing response to manage increased levels of staff absence which were evidenced in the first months of 2023, and the plan for winter 2023/24 was updated to reflect this. Festive staffing rotas for services included contingency to cater for increased absence rates.	N/A	Historic	Complete

Mitigating / Preventing Actions Planned	Assigned to	Date	Status
• The ongoing monthly review of risks across services, with escalation measures implemented as necessary – continues to consider staff absence and the impact that higher levels of COVID pose. These have been carefully monitored through the risk network. Indications this period are that there are fewer cases currently. • If required in the future additional meetings of the IJB can take place and / or delegations to the Chief Officer can be revisited if deemed appropriate. • Delivery of Recovery Plans, including the NHS Recovery Plan and the Sustainable Futures Programme. • National Guidance continues to be monitored and any necessary adjustments reflected locally across services. • Winter Planning for the HSCP is set to commence in August 2024, and COVID will be considered within the planning approach as in previous years.	Chief Officer	Next Review August 2024	Ongoing

RSK06 National Care Service

Risk Statement	Risk Owner	Risk Description	Movement	Reason for Movement if applicable	
There is a risk that the creation of a National Care Service results in potentially significant structural, organisational and governance change which could be challenging to resource alongside operational commitments.	Chief Officer	The published analysis of NCS consultation responses showed support for the wide-ranging proposals made and the implementation of these is therefore likely to place significant demands on HSCP resources to deliver, alongside the delivery of ongoing operational and strategic plans. The Scottish Government have now published a high-level Bill to enable creation of the NCS. Detail remains lacking but this is expected to have significant impact on IJBs role and governance through creation of Local Care Boards. Further impacts on staffing, finance, property, and technology may also occur. There remains a significant number of questions which still cannot be answered at the current stage of the process. Parliamentary Committees have also released reports setting out their views on the current status of the Bill. The level of risk therefore remains high, though this has reduced with the introduction of the initial partnership agreement which sets out a proposed accountability framework for the creation of an NCS, establishing legal accountability between NHS, Scottish Government and Local Government. This also confirmed that staff and assets would remain with Local Government. The timescale for implementation for NCS at an operational local level has now shifted from 2025/26 to 2028/29 – with the National Care Service Board expected to be established in 2025/26. NCS bill timelines remain uncertain.	No Change	Not Applicable	
			Risk Code	**Category**	**Risk Management Approach**
			RSK06	Operational	Treat
			Current Likelihood	**Current Impact**	**Current Evaluation**
			05	04	20 High
			Previous Likelihood	**Previous Impact**	**Previous Evaluation**
			05	04	20 High

Mitigating / Preventing Actions Complete or Ongoing	Assigned to	Date	Status
• There are likely to be recommendations which are phased for delivery over the term of this and the next Parliament, to enable some prioritisation of resource. • IJB response submitted to Scottish Government consultation on proposals for National Care Service • RHSCP representation at the Annual NCS forum 30th October 2023 • Scottish Government consultation results have been shared and these have been reviewed and discussed across the HSCP to understand the impacts. Impacts have since changed due to the new partnership agreement. • Draft Bill published by the Scottish Government and engagement sessions are now complete. • Review of all published resources and attendance at all NCS briefings and seminars continues to ensure understanding of the breadth of change and any preparation actions that can be undertaken.	Chief Officer	Historic	Complete
Mitigating / Preventing Actions Planned	**Assigned to**	**Date**	**Status**
• The HSCP has a Change and Improvement team that can be directed to key areas of activity requiring delivery, and to work alongside the local authority. • Continued review of the progress of recommendations progressing through Parliament to assess resource implications. • Implementation of Strategic Plan to consider the need for flexibility in delivery. • Continued monitoring of emerging information and stakeholder engagement. • Continued engagement in related fora by CO, CFO, and partnership staff.	Chief Officer	Review September 2024	Ongoing

RSK07 Workforce planning and service provision

Risk Statement	Risk Owner	Risk Description	Movement	Reason for Movement if applicable	
There is a risk that a range of factors may impact on the ability to fully implement workforce plans and could lead to longer term workforce difficulties, shortages in some skill sets, therefore potential impact on service delivery and the IJB's ability to deliver upon the strategic plan. *Please also see Issue ISS01: Issues attracting and retaining staff	HSCP SMT	A flexible, skilled, and suitably certified workforce is essential to service provision and delivery of the IJB's Strategic Plan. Workforce risks can result in increased financial costs and include: • Prolonged vacancies within services which are further impacted by the vacancy management measures introduced. Specific pressures exist around medical staffing (specific roles are in national shortage), District Nursing and Care at Home services. • Sufficient numbers of qualified staff with the correct registrations. • Pressures resulting from additional planning structures which require managerial and clinical input. • GP practice handing back their contract and the HSCP having to run the practice on a temporary basis. • High levels of fatigue within staff groups resulting in increased absence • Additional risks to meeting service demand posed by sickness/absence levels and an ageing workforce leading to increased levels of future retirements. • Vacancies or absence within providers, and or providers making decisions to hand back care agreements or not accept new packages/residents. • Timely access to the correct tools and accommodation for staff; laptops, mobiles, systems access, uniform, and sufficient space for services to undertake their roles. • Utilisation of non-recurring funding for roles does not make the roles attractive due to their temporary nature. • Availability of staff capacity to progress agreed actions within the Workforce Plan.	No Change	Not applicable	
			Risk Code	**Category**	**Risk Management Approach**
			RSK07	Operational	Treat
			Current Likelihood	**Current Impact**	**Current Evaluation**
			05	05	25 High
			Previous Likelihood	**Previous Impact**	**Previous Evaluation**
			05	05	25 High

Mitigating / Preventing Actions Complete or Ongoing	Assigned to	Date	Status
• Operational – management of risk and staff deployment through forward planning of rosters, quality assurance re shifts good practice and daily/weekly reviews of service staffing. Utilisation of bank/agency staff / overtime where required. • HR & Recruitment – vacancy risk assessment undertaken, reduced timescales from request to advert, robust application of absence management processes, regular review / refresh of statutory and essential training and professional registration / revalidation and adherence to application checklists (e.g., disclosure), process for monitoring clinical references. Completion of two job fairs to attract staff and service meetings established to manage recruitment and retention issues collaboratively. • Business Continuity – winter planning alignment with ongoing business continuity and risk management to identify issues early. Staffing review undertaken to understand staff willingness to volunteer and deploy in other services should the need arise. • Winter funding – specific group established to track the progress regards spend / recruitment of additional and new roles. • Independent Contractors – collaborative working with Primary Care and cluster support for GP practices / services, through delivery of the Primary Care Improvement Plan. • Integrated workforce plan for 2022 to 25 was approved by the IJB in November 2022. • Workforce planning group met on the 16th October where year 1 progress was reviewed, and year 2 actions agreed. Updates to the year 1 and 2 plan were submitted to the Scottish Government on 28th November 2023. • Workforce planning group again met on the 16th January and 23rd April where a review of at-risk deliverables was undertaken.	N/A	Historic	Ongoing

Mitigating / Preventing Actions Planned	Assigned to	Date	Status
• Integrated workforce delivery plan created and continues to be monitored by the HSCP's Workforce Planning Group. • The next meeting is scheduled for 2nd July 2024.	Head of SP&HI	October 2024	Ongoing

RSK09 National risk of litigation and potential local financial and reputational impact arising from the public inquiry into COVID response

Risk Statement	Risk Owner	Risk Description	Movement	Reason for Movement if applicable	
There is a national risk of litigation and reputational damage across integrated health and social care services following the UK-wide and Scottish public enquiries into the handling of the COVID pandemic, commencing from 2022. We are not aware of any increased comparative risk in Renfrewshire.	HSCP SMT	There is a risk of litigation and reputational damage applicable across health and social care nationally and facing all integrated health and social care service providers, as a result of the UK-wide public inquiry into the handling of the COVID pandemic. The Scottish Government has also committed to completing an inquiry in Scotland and the Terms of Reference for this was updated on 9 June. There continues to be significant media interest both locally and nationally, and there have been some recent cases which have resulted in financial award. There is no evidence that this risk is any higher for Renfrewshire than for any other integrated health and social care service. Responses to the UK and Scottish Government public enquiries will be provided where requested, working with partners. The UK enquiry hearings commenced in Summer 2023. Health and social care impact hearings for the Scottish public enquiry commenced in October 2023, with a pause undertaken in January 2024 to 12 March 2024. Hearings were then scheduled between 15 April and 31 May 2024. The Inquiry's Health and Social Care Impact Hearings have now concluded. Closing statements will take place on 27–28 June 2024.	No Change	Not applicable	
			Risk Code	**Category**	**Risk Management Approach**
			RSK09	Strategic	Treat
			Current Likelihood	**Current Impact**	**Current Evaluation**
			03	05	15 Moderate
			Previous Likelihood	**Previous Impact**	**Previous Evaluation**
			03	05	15 Moderate

Mitigating / Preventing Actions Complete or Ongoing	Assigned to	Date	Status
• Implementation of Local Response Management Team and Recovery and Renewal governance during pandemic, and ongoing input into NHS GGC and Renfrewshire Council governance. • Vaccination programme rolled out across Renfrewshire; in alignment with National Vaccination guidance; all staff and care home residents have been offered the vaccine and a third vaccination/booster. Programme also performing well for residents and service users. • Testing of all residents and staff in care homes implemented as per National Guidance • Daily huddles and multi-agency assurance and support for Care Homes in place. • Clinical support and leadership through general practice and district nursing. • Local proactive support arrangements for infection control, training, practice, supervision and for implementing social distancing and other measures such as reduced or no visiting policies. • PPE arrangements established and monitored locally. • Dashboards and reports developed to allow identification of any COVID 'hotspots' and trends. • Regular reporting from Renfrewshire Council, NHS GGC and Renfrewshire HSCP to Scottish Government. • Contribution to partner-led responses to requests for UK enquiry evidence.	HSCP Senior Management Team	Historic	Complete
Mitigating / Preventing Actions Planned	**Assigned to**	**Date**	**Status**
• Continuation of relevant actions above. • Ongoing working with partners to submit responses and evidence as required.	N/A	N/A	N/A

RSK10 Failure or loss of major service provider or independent contractors

Risk Statement	Risk Owner	Risk Description	Movement	Reason for Movement if applicable	
There is a risk that we may experience failure, loss, or reduced quality (either permanent or temporary loss) of a major service provider, which may impact on our capacity to deliver services, protect vulnerable children and adults, and may impact on additional costs to cover key services.	HSCP SMT	The context of this risk is with regards to the failure, removal of or reduced quality of provision by independent providers of care homes, care services, mental health provision or GP practices. There is financial instability within the sector due to longer-term impacts of COVID-19, the cost-of-living crisis, and additional impacts from Brexit. Since the recording of this risk independent contractors were added to due to increased pressures within this area. For example, some providers confirmed they were unable to take new commitments, cancelled all current outreach and or reduced other commitments. In addition, GP practices were reflected as to the HSCP was required to manage a practice as a 2c practice prior to its closure, after which patients were migrated to other local practices. The HSCP also supported a practice merger in Oct 2023. Providers and contractors continue to notify the HSCP of financial challenges.	No Change	Not Applicable	
			Risk Code	**Category**	**Risk Management Approach**
			RSK10	Operational	Treat
			Current Likelihood	**Current Impact**	**Current Evaluation**
			05	05	25 High
			Previous Likelihood	**Previous Impact**	**Previous Evaluation**
			05	05	25 High

Mitigating / Preventing Actions Complete or Ongoing	Assigned to	Date	Status
Procurement and commercial processes • Appraisal of providers and independent contractors conducted as part of procurement process. • Purchasing patterns monitored by Finance Team and senior managers. • Programme of reviews of all service providers. • Contract compliance, performance monitoring and reviews for service providers and the two hospices **Support arrangements** • Provider Sustainability programme continued until the end of June 22, with the Social Care Staff fund extended to September 2022 and financial support for testing and vaccinations extended until end March 2023. • 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. Care Inspectorate also included in discussions. • Providers have also been directed to the National and Scottish Government guidance which outlines these various actions including ensuring links to their supply chains and ensuring robust business continuity arrangements are in place. • Enhanced governance arrangements for care homes implemented across Health Boards at the direction of the Cabinet Secretary in response to COVID-19 and extended beyond the pandemic. • The options for managing disruption to GP practices have been documented and clear processes are in place.	N/A	Historic	Complete

Mitigating / Preventing Actions Planned	Assigned to	Date	Status
Procurement and commercial processes • Appraisal of providers and independent contractors conducted as part of procurement process. • Purchasing patterns monitored by Finance Team and senior managers. • Programme of reviews of all service providers. • Contract compliance, performance monitoring and reviews for service providers and hospices to ensure best value. • Frequent sessions are being undertaken with partners and independent providers at which they can discuss risks and issues.	N/A	Review September 2024	Ongoing

RSK11 Delivery of the GP Contract / PCIP

Risk Statement	Risk Owner	Risk Description	Movement	Reason for Movement if applicable	
There is a risk that the HSCP will not be able to deliver services as outlined within the GP Contract / PCIP by the required timelines, due to the scale of work required, workforce availability and allocated funding.	Clinical Director and Chief Officer	Current proposed funding will not cover the full cost implementation of the contract and therefore we have created a model which is affordable against the Primary Care Improvement funding (PCIF) provided. Initial scope included 6 MOU areas. There remains a greater priority on 3 of these: pharmacotherapy, VTP and CTAC which have all been delivered by the required date; end of March 2023. The 3 remain but with no firm timeline for full transfer of responsibility. In order to deliver the GP Contract additional fit for purpose property accommodation is required and also to support the growth in the sizes of the teams created for the purpose of multi-disciplinary service delivery. There is an ongoing risk that transitional payments may need to be applied. Work remains ongoing to determine this with the Scottish Government.	No Change	Not Applicable	
			Risk Code	**Category**	**Risk Management Approach**
			RSK11	Clinical	Treat
			Current Likelihood	**Current Impact**	**Current Evaluation**
			04	04	16 Moderate
			Previous Likelihood	**Previous Impact**	**Previous Evaluation**
			04	04	16 Moderate

Mitigating / Preventing Actions Complete or Ongoing	Assigned to	Date	Status
• Updated MoU published on 2nd August 2021.Clinical Director providing support and guidance to GP services reporting challenges in recruitment and capacity. • Regular reporting to the Scottish Government regards progress and to inform National direction. Deep dives were completed in collaboration with the government to look at the needs within some of the key MOU areas. Issue regarding funding available to support full delivery of the GP Contract / PCIP was previously escalated to the NHS GGC Primary Care Board, SMT and the Scottish Government. • We have now delivered the required treatment rooms to support all 27 practices. Issues with available space in Bridge of Weir arose but these have now been addressed by procurement of a mobile treatment outreach bus. The expectation is that this will be live by Autumn. • The Renfrewshire pharmacy hubs went live from August 2022, with plans for longer-term accommodation needs continuing to be developed.	Clinical Director	Complete	Ongoing
Mitigating / Preventing Actions Planned	**Assigned to**	**Date**	**Status**
• Continuation with the above • Projects continue to complete feasibility studies via NHS capital planning to identify suitable accommodation. • Ear Care offering is now implemented in one geographical location with a further site due to go live soon. • Assuring the ongoing offering of the treatment rooms and continued service improvement. • Four demonstrator sites have been selected (not including Renfrewshire) to trial the full implementation of two priority areas of the 2018 GP contract in line with a shared local understanding of service requirements and population healthcare needs. This activity will be monitored on an ongoing basis.	Clinical Director	Review August 2024	N/A

RSK12 Failure to achieve targets and key performance indicators

Risk Statement	Risk Owner	Risk Description	Movement	Reason for Movement if applicable	
There is a risk that failure to deliver upon the required Strategic Plan targets and standards, and other key performance indicators, could result in a decreased level of service for patients and service users.	HSCP SMT	There are multiple components to this risk: • The IJB and HSCP's ability to achieve all indicators could be at risk as the financial context remains challenging. • The IJB and HSCP's ability to define an appropriate local Strategic Plan • The IJB and HSCP's ability to deliver upon said Strategic Plan • The IJB and HSCP's ability to evidence that we have achieved the outcomes required within the Strategic Plan. • There is also a risk that the dependencies between our strategic plan and national planning, and partner strategies are not aligned. • The ability to continue to deliver upon key national and partner targets, for example in relation to delayed discharges. • The potential for increased focus on particular targets or savings proposals to divert resource away from other activities. • The dependencies between the delivery of targets and wider risks relating to financial and workforce challenges remain (Risks 1, 2, 7 and Issue 1 and 2) We continue to have strong alignment between our strategic, medium term financial and workforce plans. National policy changes pose a risk but mitigated by annual review of Strategic Plan. However, it is now recognised that financial and workforce challenges may impact delivery.	No Change	Not Applicable	
			Risk Code	**Category**	**Risk Management Approach**
			RSK12	Strategic	Treat
			Current Likelihood	**Current Impact**	**Current Evaluation**
			05	04	20 High
			Previous Likelihood	**Previous Impact**	**Previous Evaluation**
			05	04	20 High

Mitigating / Preventing Actions Complete or Ongoing	Assigned to	Date	Status
• Performance reports presented to all IJB meetings with full scorecard presented 6-monthly and annual reports produced to support monitoring and planning. • Organisational Performance Reviews with Chief Executives of NHSGGC and Renfrewshire Council • Regular review of key performance indicators with performance support available to all service areas • Review of systems used to record, extract and report data and development of data capture systems • Review of integration scheme in line with legislation and development of strategies in line with statutory guidance • Undertaking equality impact assessments to evidence how plans and strategies will support those in need. • Ongoing budget monitoring and management to meet service demands. • Staffing resources are flexed to meet priorities/demand. • Quality care and professional governance arrangements • Ongoing maintenance of performance management framework agreed by IJB September 2021, with further updates to the scorecard for 23/24 approved by IJB in September 2023. • Strong alignment between our Strategic Plan, Medium-term Financial Plans, and our Workforce Plan • Annual Performance update provided to IJB in January 2024.	SMT	Review September 2024	Ongoing
Mitigating / Preventing Actions Planned	**Assigned to**	**Date**	**Status**
• Continuation of the above • Ongoing alignment of the Strategic Plan within action plans and performance monitoring processes • Draft Annual Performance Report for 23/24 to be submitted to the IJB in June 2024. • IJB to consider proposal to extend Strategic Plan by 2 years as its meeting in June 2024.	Head of SP&HI	Review September 2024	Ongoing

RSK13 Cyber threats pose an increasing risk

Risk Statement	Risk Owner	Risk Description	Movement	Reason for Movement if applicable	
Cyber threats are an increasing risk to the HSCP and our respective partner organisations and there is a risk that either partner could be targeted to disrupt key infrastructure.	NHS - Director of eHealth Council - Head of Digital, Transformation and Customer Services	Cyber threats are a dynamic and growing threat to the HSCP and our partner organisations; NHS GGC and Renfrewshire Council. Until recently, much of the focus of such threats was the theft of financial data, not personal or patient/service user information. However, there is now a growing risk that public bodies will be targeted in order to disrupt a key component of critical national or local infrastructure. As the HSCP's ICT infrastructure is provided by NHS GGC and Renfrewshire Council, the responsibility for addressing this risk sits with our partner organisations however shall be maintained in this log for monitoring. NHS GGC and Renfrewshire Council continue to identify and address any attempts to cause cyber disruption. The HSCP continues to focus our Business Continuity Review on how the Partnership would operate in the event of a data or systems breach and work with partners is ongoing. We now have access to a cloud-based solution, and we are working to create the appropriate file structure and data provision to support our services in any data outage/loss scenario.	No Change	Not applicable	
			Risk Code	**Category**	**Risk Management Approach**
			RSK13	Strategic	Treat via Partners (Transfer)
			Current Likelihood	**Current Impact**	**Current Evaluation**
			05	04	20 High
			Previous Likelihood	**Previous Impact**	**Previous Evaluation**
			05	04	20 High

Mitigating / Preventing Actions Complete or Ongoing	Assigned to	Date	Status
• HSCP staff are reminded to follow the relevant GDPR and Information Security policies for their employment organisation. • Renfrewshire Council continue to reinforce their Information Security Policy and release regular comms to staff regarding security of data and data protection generally. The Council have also conducted several Council-wide phishing scam tests to raise awareness of the practice and inform lessons learned. • NHS GGC operates a multi layered security model to defend against cyber threat. • Both NHS GGC and Renfrewshire Council maintain appropriate information governance controls and governance structures to monitor and manage risks. • The eHealth Directorate and Renfrewshire Council continue to build upon cyber defences with controls in place. • Further implementation of additional cyber security prevention in alignment with National guidance by both partner organisations. • A Cyber Risk deep dive performed against the Council infrastructure and processes although assured as controlled, identified actions for implementation through 2023, which are now being progressed.	NHS - Director of eHealth Council – Head of Digital, Transformation and Customer Services	Historic	Ongoing
Mitigating / Preventing Actions Planned	**Assigned to**	**Date**	**Status**
• Continuation of the above • Further discussion with NHS e-Heath and Council regards the availability of key systems and alternative data access in the event of a cyber event. • Robust plans to assure access to critical service data in the event of a data/systems breach with supporting operational processes have been developed and will be implemented through winter 2024/25.	N/A	Review September 2024	Ongoing

RSK14 Capital funding and complexities of property planning in an integrated setting

Risk Statement	Risk Owner	Risk Description	Movement	Reason for Movement if applicable	
There is a risk that limited capital funding and the complexities of co-ordinating relevant property strategies and planning between partner organisations could create additional challenges in delivering the IJB's Strategic Plan in the medium- to long-term.	Chief Officer and CFO	• There is a risk that limited capital funding, and the complexities of coordinating a property strategy consistently across both NHS and Council properties, could create additional challenges in delivering the IJB's strategic aims in the medium to long term. • Capital planning is reserved to the IJB's partner organisations. As such the ability to influence property strategies on an ongoing basis is required. • Ongoing maintenance requirements across the estate. • An increase in staff to support service recovery is also adding accommodation pressure. • Budget challenges will require ongoing assessment of the property portfolio currently in use. Since the last report, the Scottish Government has paused all new NHS capital planning projects for two years, pending the publication of a revised healthcare infrastructure programme in the Spring. NHS Boards have been advised to prioritise essential maintenance works.	No Change	Not applicable	
			Risk Code	**Category**	**Risk Management Approach**
			RSK14	Strategic	Treat via Partners (Transfer)
			Current Likelihood	**Current Impact**	**Current Evaluation**
			05	05	25 High
			Previous Likelihood	**Previous Impact**	**Previous Evaluation**
			05	05	25 High

Mitigating / Preventing Actions Complete or Ongoing	Assigned to	Date	Status
• Property Strategy workstream established within the HSCP to gather key data to understand the current position across all our services including the challenges faced. Working directly with Renfrewshire Council to determine staff workplace requirements and NHS Estates team regards the property actions required. • Primary Care Property Strategy submitted to IJB 25 June 2021. • A property data gathering exercise completed to support the determination of property priorities. • Refreshed HSCP Property Strategy Group commenced 11th May 2022. • Ongoing attendance at the NHS Board/HSCP Capital Planning Group.	Chief Finance Officer	Review September 2024	Ongoing

Mitigating / Preventing Actions Planned	Assigned to	Date	Status
• Refreshed assessment of service and team needs as HSCP transitions in line with Scottish Government Strategic Framework • An update paper was brought to IJB in September 2023, with a draft Property Strategy expected to follow when the required information is available from our partner organisations. Work remains underway with the partner organisations and good progress has been made through a series of accommodation moves and remedial works. These have been undertaken to improve and maximise the use of spaces available and in turn helping to mitigate some operational accommodation risks and issues. • A significant capital project to address the ligature risk in wards has been commenced in Spring 2024, this work will continue for at least 18 months.	Chief Finance Officer	Review September 2024	Ongoing

RSK15 Compliance with Essential Training

Risk Statement	Risk Owner	Risk Description	Movement	Reason for Movement if applicable	
There is a risk ongoing pressures on staffing caused by service demands and workforce constraints following the pandemic, and differences in reporting systems, will impact on the timeous completion of and accurate reporting of mandatory training. This could impact on the provision of a safe working environment for staff and patients / service users.	SMT	Staff within the HSCP are required to undertake a range of essential training as part of their duties and responsibilities. Initially when recorded this risk was in relation to the pressures introduced by the pandemic, however it has now been updated to reflect: 1. Recruitment and retention issues and the subsequent increased demands on staff which make it very challenging for appropriate time and devices to be allocated to undertake training; and 2. Differences in our reporting systems which can make recording and comparison between employing organisations difficult. 3. The availability of appropriate courses, trainers, and venues to complete the required number of hours required.	No Change	Not Applicable	
			Risk Code	**Category**	**Risk Management Approach**
			RSK15	Operational	Treat with Partners (Transfer)
			Current Likelihood	**Current Impact**	**Current Evaluation**
			04	04	16 Moderate
			Previous Likelihood	**Previous Impact**	**Previous Evaluation**
			04	04	16 Moderate

Mitigating / Preventing Actions Complete or Ongoing	Assigned to	Date	Status
• Continued compliance with Staff Governance standards. • Collaborative working between the NHS and Council regards to Health and Safety, via a network of advisors ensures that the partnership correctly applies the required H&S standards. • Recording of incidents, including violent incidents are reviewed by Service Managers with data presented on a regular basis prior to them being reviewed via the Joint Health and Safety Committee (includes trade unions) • Workforce planning activity will reinforce Health and Safety as a core objective. • Completion of individual risk assessments for clients and warning flag system in place on electronic care records. • Guidance for safe clinical and care environments is regularly reviewed and maintained. • Ongoing programme of staff training, including essential and statutory training, on health and safety issues • Appropriate processes are in place in cases of adverse weather for community-based services. • Following investigations of significant adverse events (including RIDDOR reportable), process improvements are identified and implemented, being overseen via the most appropriate governance structure. • Occupational Health services and staff support services are available and regularly communicated to staff. • Renfrewshire Council policies and procedures regards DSE assessments are regularly monitored.	Head of Health and Social Care	Historic	Ongoing
Mitigating / Preventing Actions Planned	**Assigned to**	**Date**	**Status**
• Monthly review of training compliance has continued in 2024. • Additional course providers are being identified and train the trainer events taking place. • Ad hoc training requirements and accommodated; changes to SFRS legislation and incident response as examples. • Work being undertaken to assess availability of devices upon which staff can complete their training. • Work has been undertaken to simplify and consolidate the courses available on iLearn and staff have been directed to complete specific modules. The take up rates continue to be monitored.	SMT	Review September 2024	Ongoing

RSK16 Delivery of Addictions Support in Renfrewshire

Risk Statement	Risk Owner	Risk Description	Movement	Reason for Movement if applicable	
There is a risk that the support provided to those with Addictions in Renfrewshire by the range of partners within the ADP, and the recommendations being implemented from the Alcohol and Drug Commission, may not prevent future increases in the number of drug and alcohol related deaths within the area.	SMT	The National Records of Scotland published drug related death figures for 2020 and in Renfrewshire 67 people sadly lost their lives. For 2021, figures show 50 people died, and in 2022 recently published statistics from NRS show that 39 people died. Statistics released by NRS on 29 August 2023 identified 42 alcohol-related deaths in Renfrewshire in 2022. This was a reduction from 53 in 2021. Every life lost because of drug or alcohol harm is a tragedy. Statistics show that around 66% drug deaths are individuals not known to services or in treatment at time of death. Partners across Renfrewshire continue to work closely and collaboratively to develop services to support to those with addictions, and a range of actions are outlined in the mitigating / preventing actions below. However, in response to the latest figures on drug deaths, it is important that the HSCP and ADP partners continue to review existing strategy and plans to ensure that those at risk can be reached and supported as early as possible to prevent drug and alcohol-related deaths in the future	No Change	Not Applicable	
			Risk Code	**Category**	**Risk Management**
			RSK16	Strategic	Treat with ADP
			Current Likelihood	**Current Impact**	**Current Evaluation**
			03	04	12 Moderate
			Previous Likelihood	**Previous Impact**	**Previous Evaluation**
			03	04	12 Moderate

Mitigating / Preventing Actions Complete or Ongoing	Assigned to	Date	Status
• Extended distribution of Naloxone and establishment of a Naloxone action plan to ensure safe and wide distribution. • Continued access to residential rehabilitation services which has increased in their take up. • Close collaboration with colleagues from the emergency department at the RAH following near fatal overdoses, and near fatal overdose pathway implemented. • Ensure that rapid restart of treatment is available following relapse. • Assertive outreach approach is embedded within the service. • Prison release Standard Operating Procedure approved which also includes a prison to rehab pathway. • Drug Deaths Prevention Action Plan implemented. • Continuing to implement the recommendations of the Alcohol and Drug Commission • Harm reduction unit established in December 2021 remains in place (HaRRT - Harm and reduction response team) • Specialist Alcohol Outreach Team project complete and learnings / best practice embedded within service delivery. • CIRCLE Recovery Hub service model evaluated.	ADP Head of MH, LD, and Addictions	Review August 2024	Ongoing

Mitigating / Preventing Actions Planned	Assigned to	Date	Status
• Updated figures on drug deaths to be received quarterly rather than annually to support quick review and identification of learning. • A multi-agency Drug Death Review Group (DDRG) is now operational in Renfrewshire. The DDRG will be held accountable for the production, implementation and monitoring of review processes, and findings of investigations into to drug-related deaths. Outcomes reports completing following case reviews will be submitted to the ADP Drug Death Prevention Group. • A Near Fatal Overdose Pathway has been established to ensure engagement, assessment, support, and management of people with problematic substance use who have recently experienced a non-fatal overdose or addiction related crisis intervention. • The Drug Death Prevention Group continue to progress activity outlined within the Renfrewshire Preventing Drug Deaths Action Plan, which covers the period 2021 – 2024. • Ongoing planning continues around alcohol and drug services to address the requirements of the wider Renfrewshire community. This work will address any requirements aligned to the delivery of the National MAT standards and alcohol quality principles. • Renfrewshire ADRS completed the impact assessment for the implementation of the alcohol recovery pathway as requested by ADRS Care Governance Committee. This benchmarking assessment will inform the Alcohol Specific Deaths Action Plan following recent recruitment of a dedicated post.	ADP Head of MH, LD, and Addictions	Review August 2024	Ongoing

• There is now an Alcohol Provision Standard Operating Procedure in place which addresses some of the deficits we have e.g., alcohol home detox is now a routine treatment option. Ongoing consideration of the next steps for the alcohol transition team. • Renfrewshire's Naloxone training calendar has been widely distributed to ensure safe and effective distribution and administration. • ADRS Social Care Staff require Hepatitis A and B vaccinations, and this is being progressed in conjunction with Health and Safety colleagues via Occupational Health • Use of Locum Consultant Psychiatrist, however recognition that this has a significant financial impact and is not a long-term solution to the stability of medical provision within ADRS. • Development of an updated ADP Strategy.			

RSK18 Impact of potential power outages on critical services

Risk Statement	Risk Owner	Risk Description	Movement	Reason for Movement if applicable	
The Scottish Government have requested that Category One Responders create plans to cater for the impacts of potential power outage on our critical services. This should reflect both planned and unplanned power outages.	Chief Officer	The Scottish Government have requested that Category One Responders prepare plans to ensure, as far as possible, the delivery of critical services during instances of power outage. This risk arises from two potential scenarios: • Planned power outages being possible over the winter period due to energy shortages (in a reasonable worst-case scenario) • Unplanned power outages due to a network failure or severe weather event e.g., an event like Storm Arwen. This has been widely reported within the media. The UK Government recently completed the testing of a UK alert system via the mobile network and a test exercise in readiness for Winter 2023-24. The National UK Risk Register continues to reflect an increase in the likelihood and impact of this risk.	No Change	Not applicable	
			Risk Code	**Category**	**Risk Management Approach**
			RSK18	Operational	Treat
			Current Likelihood	**Current Impact**	**Current Evaluation**
			03	05	15 Moderate
			Previous Likelihood	**Previous Impact**	**Previous Evaluation**
			03	05	15 Moderate

Mitigating / Preventing Actions Complete or Ongoing	Assigned to	Date	Status
• Planning activity has been undertaken across the partners and services to look at the potential impacts of a power outage on our operational service delivery. • Services have undertaken a RAG process to understand the level of service user needs and service provision within a power outage event. • An approach to data management has been signed off to support service management and maintenance in such events, and work is underway to fully implement this.	Chief Officer	Historic	Ongoing
Mitigating / Preventing Actions Planned	**Assigned to**	**Date**	**Status**
• Work remains underway to develop communications and robust plans for staff to support in the event of such an event. Additional planning includes but is not limited to: o Review of our buildings with back-up generators, and completion of a business case and feasibility studies in support of procuring generators. Council tender ongoing for Care Home estate. o Agreement of (and subsequent testing of) a contingency catering provision with our NHS partner. o Working with the Council and other partners regards any humanitarian responses required. o Sessions completed with our independent providers and contractors to support them with their planning. o Training for staff on loggist requirements and incident response protocols o Winter planning preparations to commence August 2024.	Chief Officer	Next review September 2024	Ongoing

RSK19 Disruption from a further pandemic / outbreak

Risk Statement	Risk Owner	Risk Description	Movement	Reason for Movement if applicable	
The UK Government have re-introduced a new risk to the annual National Risk Register, published on the 3rd of August 2023, which indicates that there is a moderate likelihood of a new pandemic /outbreak occurring.	Chief Officer	The risk from any further pandemic is that an emergency response would be required which would direct resources away from day-to-day operational commitments and would cause further disruption to the delivery of strategic and transformation plans as a result of: • The HSCP needing to implement support measures to prevent and manage the spread of any outbreak. • The impact of any outbreak on local communities, service users / patients and any associated increased demand on services. • The impact of any outbreak on staffing levels.	No Change	Not Applicable	
			Risk Code	**Category**	**Risk Management Approach**
			RSK18	Operational	Treat
			Current Likelihood	**Current Impact**	**Current Evaluation**
			03	04	12 Moderate
			Previous Likelihood	**Previous Impact**	**Previous Evaluation**
			03	04	12 Moderate

Mitigating / Preventing Actions Complete or Ongoing	Assigned to	Date	Status
• The work undertaken through the COVID-19 pandemic has changed the approach to service delivery and supported preparation for a further pandemic. • The ongoing business continuity and winter planning work being undertaken to support national power outage also provides us with the foundation from which to prioritise services and service users across the HSCP. • Winter plans created for 2023-2024 have staffing contingency actions identified.	Chief Officer	Historic	Ongoing

Mitigating / Preventing Actions Planned	Assigned to	Date	Status
• Ongoing monitoring of the situation alongside risk RSK05, further waves and variants of COVID will continue. Ongoing work to support services regards winter planning; staff shortages and redeployment for severe weather will also complete and be supportive of mitigating this risk. • Winter planning for winter 24-25 will commence in August, and this too will ensure staffing contingency actions are identified.	Chief Officer	Next Review August 2024	Ongoing

RSK20 Potential challenges to savings proposals or decision-making

Risk Statement	Risk Owner	Risk Description	Movement	Reason for Movement if applicable	
There is a risk that savings proposals identified, or IJB and HSCP decision-making, are subject to external challenge such as petitions, Council or Parliamentary motions or judicial review. These may prevent progression of proposals, should the IJB be minded to approve them.	IJB / Chief Officer	This risk details the potential for external challenge relating to current or future savings proposals and/or to decisions made by the IJB or HSCP. These challenges may include (i) local petitions submitted to Renfrewshire Council's Petitions Board; (ii) Petitions for Judicial reviews; or (iii) Council or Parliamentary motions. These challenges may in respect of the approach to engagement adopted, the nature of EQIAs developed or the process followed to develop a proposal or reach a decision where there is public opposition. A robust process to developing equality impact assessments (EQIAs) and options appraisals is in place, including review by expert colleagues, and supported by robust decision-making processes. This risk has been observed in respect of previous proposals considered by the IJB and has also been identified through judicial reviews lodged against other IJBs and local authorities.	No Change	Revised description	
			Risk Code	**Category**	**Risk Management Approach**
			RSK20	Strategic	Treat
			Current Likelihood	**Current Impact**	**Current Evaluation**
			05	04	20 High
			Previous Likelihood	**Previous Impact**	**Previous Evaluation**
			05	04	20 High

Mitigating / Preventing Actions Complete or Ongoing	Assigned to	Date	Status
• Proposal documentation including options appraisals prepared to the best standard possible using available data and feedback from engagement sessions. • Sustainable Futures Programme Board in place to review proposals, options analysis and decisions made or proposed. • Ongoing management of externally received enquiries, complaints, and FOIs (Freedom of Information Act requests) • Completion of extensive engagement, offering multiple sessions in person and online, and also offline submission of engagement feedback forms or emails to a centrally managed mailbox. • Drafting of EQIAs in line with good practice and including review by NHSGGC's dedicated team.	IJB (Chief Officer)	Historic	Complete

Mitigating / Preventing Actions Planned	Assigned to	Date	Status
• IJB development session held 24th May 2024. • IJB to consider next steps for the Sustainable Futures programme at its meeting in June 2024.	IJB (Chief Officer)	Next Review July 2024	Ongoing

RSK21 Potential impacts of financial recovery

Risk Statement	Risk Owner	Risk Description	Movement	Reason for Movement if applicable	
There is a risk that the IJB could be required to enter financial recovery if it is not possible to identify, agree and implement savings proposals which bridge the projected financial gap in future financial years.	IJB / Chief Officer	Financial recovery will be required if the IJB is unable to set a balanced budget. Non-recurring actions have been identified to support a balanced budget in 2024/25 however these actions (e.g. use of reserves) will not be available to the extent required in following financial years. By moving to implement financial recovery actions, the following impacts could be expected: • Vacant posts could be held without recruitment, therefore impacting on service provision. • Reductions in service provision could be required, which could include waiting lists for service packages to be put in place, and/or the reduction in operating hours. • Increased pressure on an already stretched workforce, with an impact on staff wellbeing and subsequent absence levels. • This could also result in lower performance against key indicators, e.g., delayed discharge. • The IJB may need to consider a request for additional funding from partners, to be repaid on an agreed basis, as set out in the Integration Scheme.	New	Not Applicable	
			Risk Code	**Category**	**Risk Management Approach**
			RSK21	Strategic	Treat
			Current Likelihood	**Current Impact**	**Current Evaluation**
			05	05	25 High
			Previous Likelihood	**Previous Impact**	**Previous Evaluation**
			NA	NA	NA

Mitigating / Preventing Actions Complete or Ongoing	Assigned to	Date	Status
• A range of savings proposals were developed and continue to be developed to bridge the financial gap for 2024/25. Savings agreed to date do not eliminate the projected gap. Work continues to identify savings and further priorities / proposals for consideration.	IJB / Chief Officer	August 2024	Ongoing

Mitigating / Preventing Actions Planned	Assigned to	Date	Status
• IJB to consider next steps for Sustainable Futures programme at its meeting in June 2024. • Frequency and length of Development Sessions to be reviewed and amended as required.	IJB / Chief Officer	August 2024	Planned

ISS01 Issues regards attracting & retaining staff

Issue Statement	Issue Owner	Issue Description	Movement	Reason for Movement if applicable	
Challenges in attracting and retaining staff across a range of roles within HSCP services, because of a range of factors, is contributing to constraints in service delivery.	SMT	It has become increasingly difficult to attract and retain the right staff for various roles across the HSCP. A number of services are now experiencing significant challenges with recruitment due to the following: • Changes due to the Scottish Government nursing agenda has resulted in some posts more attractive than others and also altering the role requirements (specified nursing degrees). • Varying rates of pay and conditions across HSCPs. • A general shortage locally and nationally for specific roles. • The amendments to accountability for services under draft NCS proposals may reduce the current uncertainty for the future of social care roles.	No Change	Not applicable	
			Issue Code	**Category**	**Issue Management Approach**
			ISS01	Operational	Treat
			Current Impact	**Current Evaluation**	
			05	Extreme	
			Previous Likelihood	**Previous Evaluation**	
			05	Extreme	

Mitigating and Recovery Actions Complete or Ongoing	Assigned to	Date	Status
• HR & Recruitment – risk assessment undertaken re vacancies, reduced timescales from request to advert, robust application of absence management processes, regular review / refresh of statutory and mandatory training and professional registration / revalidation and adherence to application checklists (e.g., disclosure) • Implementation of alternative recruitment routes where possible in agreement with HR & OD • Development of interim workforce plan 2021-22, and a workforce plan for 2022 to 25 which approved by the IJB in November 2022 • Winter planning – 3-month forward plan completed to ensure adequate staffing and contingency. Scenario planning completed with services – to identify any possible additional staffing mitigations. This has been revisited for Winter Plan 2023/24. • Contingency exercise completed to identify staff who are willing to volunteer to support other services should the situation arise. • Completion of two job fairs to attract staff completed with a good success rate. • Ongoing delivery of action plan underpinning workforce plan for 2022-25, Year 2 of which was provided to IJB on 24 November	HSCP SMT	Review October 2024	Ongoing
Mitigating / Recovery Actions Planned	**Assigned to**	**Date**	**Status**
• Work continues with services and partners to work collaboratively to identify and complete actions to improve staff retention and recruitment, defining innovative approaches to recruitment. • Continued review of vacancies through Vacancy Management Panel. • NHS GGC work to 'grow our own' professionals underway allowing candidates to earn whilst they train. • Independent Providers – collaborative working continues with Primary Care and cluster support for GP practices / services. A job fair has been undertaken in May for GP practices.	HSCP SMT	Review October 2024	Ongoing

ISS02 IJB Financial Resilience

Issue Statement	Issue Owner	Issue Description	Movement	Reason for Movement if applicable	
The IJB's Budgetary position in 2023/24 and future financial years is extremely challenging. Utilisation of reserves is likely to be required to deliver a balanced budget in this financial year, alongside the delivery of a programme of financial savings.	SMT	In March 2023, the IJB agreed the proposed budget and the Sustainable Futures paper which outlined phase 1 savings proposals for delivery in 23/24 and 24/25. Subsequently in March 2024, the IJB agreed a further set of phase 2 savings proposals for delivery in 24/25 and 25/26. The likely use of reserves to facilitate budgetary balance in 2024/25 may leave the IJB with a general reserve below the 2% target outlined in the IJBs Reserves Policy. This an ongoing significant risk to the IJB's financial resilience. The use of non-recurring support to balance the 2024/25 budget also means savings required in future years will need to bridge this gap plus the additional projected gap. As noted in Risks 2 and 21, the recurring savings identified through Sustainable Futures phase 2 activity will not at present fully bridge the financial gap projected in 24/25. Detailed updates continue to be provided to the IJB. This will have an impact on our ability to deliver on the IJB's Strategic Plan, what can be delivered and when. In order to ensure financial sustainability and affordability of existing services the IJB will need to make difficult decisions on the prioritisation of activity and services. The approval of the Verity House Agreement in June 2023 also creates further uncertainty over future Adult Social Care budget settlements. However, for 2024/25 Renfrewshire Council passed over all budget allocations in full including a prorated share of additional resources for the pay award.	No Change	Not Applicable	
			Issue Code	**Category**	**Issue Management Approach**
			ISS02	Financial	Accept
			Current Impact	**Current Evaluation**	
			05	Extreme	
			Previous Likelihood	**Previous Evaluation**	
			05	Extreme	

Mitigating and Recovery Actions Complete or Ongoing	Assigned to	Date	Status
• Due diligence on proposed recharges completed. • Direction of travel for Sustainable Futures agreed by IJB in March 2023 • Savings for 24/25 agreed by IJB in March 2023 and March 2024	HSCP SMT	Review August 2024	Ongoing
Mitigating / Recovery Actions Planned	**Assigned to**	**Date**	**Status**
• A programme of activity to identify, scope and implement a range of savings proposals is under development through a Sustainable Futures programme. • Eight proposals were approved for further consideration and investigation in November 2023. Of these proposals the March IJB approved three and rejected two. The further three remain ongoing and updates will be brought to IJB as the work progresses.	HSCP SMT	Review August2024	Ongoing

[This concludes the RHSCP Risk and Issue Report for 21 June 2024 IJB Audit, Risk & Scrutiny Committee]

To:	**Renfrewshire Integration Joint Board Audit, Risk and Scrutiny Committee**
On:	**21 June 2024**
Report by:	**Head of Mental Health, Learning Disability and Alcohol and Drugs Recovery Services**
Subject:	**Inspection of The Anchor Day Service Support Service by the Care Inspectorate**

1. Summary

1.1 Social care services are subject to a range of audit and scrutiny activities to ensure that they are undertaking all statutory duties and are providing appropriate care and support to vulnerable individuals and groups. Care services in Scotland cannot operate unless they are registered with the Care Inspectorate. The Care Inspectorate inspect, award grades, and help services to improve. The Care Inspectorate also investigate complaints about care services and can take action when standards of care are not met.

1.2 Since 1 April 2018, the Health and Social Care Standards have been used across Scotland. They were developed by Scottish Government to describe what people should experience from a wide range of care and support services. They are relevant not just for individual care services, but across local partnerships. The Care Inspectorate's expectation is that they will be used in planning, commissioning, assessment and in delivering care and support.

1.3 This report summarises the findings from the unannounced inspection conducted at The Anchor Day Service in March 2024. A copy of the full report is available within Appendix 1 as attached.

2. Recommendations

It is recommended that the IJB Audit, Risk and Scrutiny Committee:

- Note the content of this report.

3. Background and Context

3.1 The Anchor Day Service is a purpose-built centre that is registered to provide a day service to a maximum of 52 people with Learning

Disabilities and complex support needs. At the time of the inspection the service was supporting 32 people. The registered manager is supported by a team leader, 8-day service officers and 16-day service assistants. Registration did include a time-limited condition in relation to providing care at home, this was implemented during the Pandemic due to exceptional circumstances and has since been removed.

3.2 The Anchor Day Service adopts a person-centred approach and works with service users to support them to achieve their desired outcomes. The aims of the five key theme areas of the HSCP Strategic Plan 2022-25: shaping our future, are woven into the practice of the Anchor Day Service staff and leadership team and this is evidenced in the findings of the recent Inspection report.

3.3 The HSCP Strategic Plan 2022-25, seeks to shape the HSCP's future around each person and has focussed activity on five key areas. These are: Healthier Futures: prevention and early intervention, Connected Futures: community support, Enabled Futures: clinically safe and specialist services and Empowered Futures: choice, control, and flexibility.

3.4 The inspection evaluated how the Anchor Day Service supports people's wellbeing and assessed the quality of the leadership. Protecting and safeguarding service users and staff continues to be a key priority for the HSCP.

3.5 The Care Inspectorate use a quality framework that sets out the elements that address key questions about the difference care is making to people and the quality and effectiveness of the aspects contributing to those differences.

The quality framework is framed around six key questions:

- How well do we support people's wellbeing?
- How good is our leadership?
- How good is our staff team?
- How good is our setting?
- How well is our care planned?
- What is our overall capacity for improvement?

3.6 Under each key question, there are three or four quality indicators, covering specific areas of practice.

Quality indicators are evaluated against a six-point scale:

6 Excellent - Outstanding or sector leading
5 Very Good - Major strengths
4 Good - Important strengths, with some areas for improvement
3 Adequate - Strengths just outweigh weaknesses.
2 Weak - Important weaknesses and priority action required.
1 Unsatisfactory - Major weaknesses and urgent remedial action required.

3.7 On conclusion of an Inspection, the Care Inspectorate publish a report which details: feedback from families/carers; their observations throughout the Inspection including strengths and areas for improvement; any requirements, recommendations, or enforcement; and an evaluation. In addition, the Care Inspectorate will also consider any areas for improvement identified in previous inspections to the care home.

4. Inspection of the Anchor Day Service

4.1 On 12 and 13 March 2024, the Care Inspectorate began an unannounced inspection of the Anchor Centre.

4.2 The inspection evaluated how the Anchor Day Service support people's wellbeing and assessed the quality of the leadership. The breakdown of the key questions considered during the inspection and the quality indicators are as follows:

How well do we support people's wellbeing? 5 -Very Good.

How good is our leadership? 4 -Good

4.3 In making their evaluation of the service, the inspection was conducted by one inspector who spoke with:

- Two people using the service and 5 of their relatives.
- 19 staff and the management team.
- The inspector also observed practice and daily life, reviewed documents and connected with professionals linked to the service.

4.4 Key messages from the inspection:

- The report was overall very positive and provided some key findings to evidence this. These are noted as follows:
- People received reliable and consistent support from a familiar staff team with whom they have a positive, trusting, and caring relationships. People benefitted from flexible, personalised, and responsive support.
- Staff skilfully used their knowledge of people to manage and minimise risks. Support was provided by a skilled staff team, who received specialised training aligned to the needs of people.
- Family members felt involved, well informed, and satisfied with the care and support. Specialised resources were available to enable people to participate in a range of activities to support them to meet their needs and outcomes. Quality assurance systems should be developed further to ensure the quality of support and practice development.

4.5 The report noted significant strengths in the aspects of the care provided, and how these supported positive outcomes for people.

4.6 The report acknowledged that support was provided from a core group of staff who knew people well and were familiar with their needs, choices, and preferences. This enabled a flexible person-centred support to enhance people's quality of life.

4.7 Staff showed kindness and consideration towards the people they supported, and interactions observed were warm, caring, and natural. A service user shared, "I love coming here. I had a great time out shopping for onions and potatoes for the garden, and I went to meditation".

4.8 The report noted that people were supported to get involved in a wide range of activities, both within the service and in the community. These included interactive creative movement, sensory storytelling, and drumming.

4.9 The report suggested that it would be good to explore if there are other opportunities for people to engage with. There was a focus on staff developing an understanding of people's sensory needs and linking this closely with the activities supported. Staff encouraged choice, participation, and engagement.

4.10 The service has a hydro pool located within the building, which unfortunately has been under repair for some time and therefore, not useable. Staff and other professionals have shared that this is a big loss to people using the Service. They are keen to have repairs carried out and the pool functioning again.

4.11 Champion roles have been introduced for key areas across the service, so that learning and knowledge can be shared amongst the staff team. The report acknowledged that this was a great opportunity for staff to get more involved in particular areas of support delivery and development.

4.12 The report indicated that the content of the care plans was variable. Some contained good person centred and strengths-based information, however, it was not always clear how support should be provided. The report highlighted the importance of having a link between the support plan (with measurable outcomes set), risk assessment, review and updating of the care plan.

4.13 The report noted that systems were in place to ensure that medication was being managed safely and effectively, with clear guidance in relation to supporting with 'as required' medication.

4.14 People benefitted from their support being provided from a knowledgeable and skilled team. Where a specific need was identified, training was provided to a small group. The report

indicated that it would be helpful to widen these learning opportunities to ensure that all staff are trained to deliver safe and consistent practice. It was acknowledged that there is a culture of continuous learning with high levels of training compliance.

4.15 The report suggested that the management team demonstrated their knowledge of the service, and a clear understanding of areas for development and improvement. They were very responsive to feedback throughout the inspection.

4.16 The report noted that there is no current service development plan in place, but that management were planning to investigate this over the coming months, involving staff in the process. The report suggested that it would be good to explore creative ways of capturing feedback from service users, in ways that are meaningful to them.

4.17 The report acknowledged that there had been systems in place to check the quality of the service, however, observed that this had not been as regular and robust as it could be. It highlighted the importance of having routine audits in key areas such as: care planning, medication, the environment and to ensure there is a consistent quality standard across the service.

4.18 The manager requires to have clear overview of the health and safety of the building and equipment used. Cleaning schedules and an up-to-date log of the equipment with review dates noted. It was suggested that a quality assurance framework be devised informing what key activities require to be carried out when and by who. The report noted that the service had a small number of incidents and forms were completed online by staff. Staff were provided with effective debriefing and feedback on further actions required.

4.19 Staff noted improvements in supervision, but some had not had supervision for some time. Supervision records demonstrated a good balance between discussion around workload, reflective practice, and personal development. Regular team meetings were in place and staff appreciated having the opportunity to come together.

5. Requirements and Recommendations

5.1 To further the improvement journey and build on the good work already progressed it was suggested that the Anchor Day Service continue to embed their quality assurance system. This could be achieved through identifying short, medium and long-term priorities. The plan should include contributions from staff, service users and families.

5.2 It was recommended that the manager have a greater oversight of the service, and on-going key activities including information relating to people supported, audits, training and health and safety.

5.3 It was suggested that systems should be in place for delivering and monitoring of practice such as supervision and appraisal to ensure on-going practice development in accordance with operational procedures.

5.4 It was acknowledged that progress had been made since the previous inspection and that there was evidence of improvement. Supervision was noted to have been increasing. There was a greater overview of when supervision was taking place, tasks set, and things achieved.

5.5 Staff development was being prioritised and senior staff have undertaken leadership and management qualifications to develop their knowledge and skills.

Implications of the Report

1. **Financial** – None
2. **HR & Organisational Development** – None
3. **Strategic Plan and Community Planning** – None
4. **Wider Strategic Alignment** – None
5. **Legal** – None
6. **Property/Assets** – None
7. **Information Technology** – None
8. **Equality & Human Rights** – None
9. **Fairer Duty Scotland** – None
10. **Health & Safety** – None
11. **Procurement** – None
12. **Risk** - Failure by services to meet and exceed the National Care Standards could lead to poor inspection results and enforcement action from the Care Inspectorate, as well as negative outcomes for service users and carers
13. **Privacy Impact** – None

List of Background Papers – None

Author: Stephanie MacGregor-Cross, Service Manager – Renfrewshire Learning Disability Services

Any enquiries regarding this paper should be directed to Laura Howat, Head of Head of Mental Health, Learning Disability and Alcohol and Drugs Recovery Services, laura.howat@renfrewshire.gov.uk.

Anchor Centre
Support Service

51-53 Stock Street
Paisley
PA2 6NG

Telephone: 01416 186 536

Type of inspection:
Unannounced

Completed on:
14 March 2024

Service provided by:
Renfrewshire Council

Service provider number:
SP2003003388

Service no:
CS2003001244

About the service

The Anchor Centre is registered to provide a day service to a maximum of 52 people with autism and complex support needs .

The service is based in and operates from a purpose built centre which is situated close to Paisley town centre. People using the service benefit from a range of specialist resources enabling increased meaningful activity and community connections.

Registration included a time limited condition in relation to providing care at home, which is currently being removed.

At the time of the inspection, the service was supporting 32 people. The registered manager was supported by a team leader, eight day service officers, and 16 day service assistants.

About the inspection

This was an unannounced inspection which took place on 12 and 13 March 2024. The inspection was carried out by one inspector from the Care Inspectorate.

To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration information, information submitted by the service, and intelligence gathered since the last inspection.

In making our evaluations of the service we:

- spoke with two people using the service and five of their relatives
- spoke with 19 staff and management
- observed practice and daily life
- reviewed documents
- connected with professionals linked to the service.

Key messages

- People received reliable and consistent support from a familiar staff team with whom they had positive, trusting and caring relationships.
- People benefitted from flexible, personalised and responsive support.
- Staff skilfully used their knowledge of people to manage and minimise risks.
- Support was provided by a skilled staff team, who received specialised training particular to the needs of people.
- Family members felt involved and well informed, telling us they were very satisfied with care and support provided.
- Specialised resources within the centre enable people to participate in a range of sensory, physical, and meaningful activity to improve their quality of life.
- Quality assurance systems should be developed to ensure quality of support and ongoing development of practice.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	5 - Very Good
How good is our leadership?	4 - Good

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing? 5 - Very Good

We found significant strengths in aspects of the care provided, and how these supported positive outcomes for people, therefore, we evaluated this key question as very good.

Support was provided from a core group of staff who knew people well. They were very familiar with the needs of individuals, their choices and preferences. This enabled flexible person centred support to be provided to enhance people's quality of life. A relative told us, "Staff know x well and adapt support and activities based on how she is feeling."

Staff demonstrated a very good knowledge of people's likes, dislikes and what was important to them, even if people were not able to verbally express this. This person-centred approach supported a recognition that people are the experts on their own experiences, needs and wishes.

Staff showed consideration and kindness towards the people they supported. Observed interactions were caring, warm and natural. This enabled effective support when people were upset, anxious, or needed reassurance and encouragement. A person supported shared with us, "I love coming here. I had a great time out shopping for onions and potatoes for the garden, and I went to meditation."

People were supported to get involved in a wide range of activities, both within the service and in the community. Within the service, there was a range of specialised spaces and resources available to support and stimulate people. We observed interactive creative movement, sensory storytelling and drumming groups, which were very effective in engaging people really well. Some people were involved in meaningful therapeutic activities. It would be good to explore if there are other opportunities available for people to engage with. A relative said, "X requires attention most of the time. She is well stimulated at the centre and is occupied throughout the day. She actually gets upset when she comes home sometimes."

There was a focus on developing staff understanding of people's sensory needs and linking this closely to the activities supported. Staff utilised their knowledge and understanding of people to build confidence and skills. We observed staff encouraging people to be involved in activities of their choosing, and promoting engagement and participation. The language used by staff when interacting with people was positive and encouraging, which was reinforcing the positive message.

The service has a hydro pool located within the building, which unfortunately has been under repair for sometime and therefore, not usable. Staff and other professionals have shared that this is a big loss to people using the centre and are keen for the repairs to be carried out and to have the pool functioning again. The centre has made creative use of the space available enabling a number of sensory spaces to be created, large multi-purpose rooms, as well as smaller group or one to one rooms.

Champion roles have been introduced for key areas across the service, with the aim of the knowledge and information gained being passed along to other staff. This was a great opportunity for staff to get more involved in particular areas of support, delivery and development of the service that they have an interest in.

Staff had a very good awareness of how best to support people's health needs. We saw clear communication between the service and families in relation to people's health and wellbeing needs, with concerns being quickly picked up and passed on. Families told us that they were confident that staff have a good understanding of their loved ones health and wellbeing needs, and how this impacts on them day-to-day. A relative said, "There was concerns regarding x's peg feed recently, staff were good at feeding back their observations and actions they had taken throughout the day." Staff sought advice and support from healthcare professionals when there were changes in people's health.

The content of care plans was variable. Some contained good person centred and strengths based information, however, it was not always clear how support should be provided. It is important there is a link between the support plan (with measurable outcomes set), risk assessment, review and updating of the care plan. This has the potential to impact on the consistency of support and people's outcomes.

There were systems in place to ensure that medication was being managed safely and effectively, with clear guidance in relation to supporting with 'as required' medication. We were confident that medication was being supported safely.

People benefitted from their support being provided from a knowledgeable and skilled team. Where a specific need has been identified, training was provided to a small group of staff, however, it would be helpful to ensure that all staff are trained to ensure safe and consistent practice. There was a culture of continuous learning with high levels of training compliance.

How good is our leadership? 4 - Good

We made an evaluation of good for this key question, as several important strengths taken together, clearly outweighed areas for improvement. Whilst some improvements were needed, the strengths identified had a significant positive impact on people's experiences.

The management team demonstrated their knowledge of the service, and a clear understanding of areas for development and improvement. They were very responsive to feedback throughout the inspection.

There is no current service development plan in place. We heard that the management were planning to re-instigate this over the coming months, involving staff in the process. It would be good to explore creative ways of capturing feedback from service users, in ways that are meaningful to them.

Staff shared that they feel the current management team is approachable, and they are encouraged to share their ideas and give feedback on the service and this will be heard and acted upon.

There had been systems in place to check the quality of the service, however, from what we have observed, this has not been as regular and robust as it could be. It is important that there is audits in place for key areas such as care planning, medication, the environment, to ensure there is a consistent quality standard across the service. The manager requires to have a clear overview of the health and safety of the building and equipment used. Cleaning schedules and an up-to-date log of the equipment with service dates should be in place. It may be helpful to devise a quality assurance framework that details what key activities should be carried out, when, and by who. **(See area for improvement 1)**

We heard that currently the management team are exploring formats for staff competency checks which will be implemented across the service, giving assurance regarding staff practice.

Staff shared with us that although there has been improvements in supervision over the past few months, a number of staff haven't had supervision for sometime. Supervision records demonstrated good balance between discussion around workload, reflective practice and professional development.

Regular team meetings were in place, which staff appreciate having the opportunity to get together with their colleagues. It was good to hear of the upcoming developments, to use the sessions as meaningfully as possible.

The service has a small number of incidents. We saw that incident forms are completed online by staff, with debriefing and further actions required, then completed to prompt learning.

Areas for improvement

1. To further the improvement journey, the provider should continue to develop and embed their quality assurance system.

This should include, but not be limited to:-

a) development of a service improvement plan, identifying short, medium and long term service priorities. The plan should include contributions from staff, people supported and families, influence improvement actions and be reviewed regularly;

b) the registered manager having complete oversight of the service, and ongoing key activities including information relating to people supported, audits, training, and health and safety of the service;

c) quality audits and action plans including environmental, care planning and medication must be completed regularly and lead to the necessary action to achieve improvements; and

d) systems for the delivering and monitoring of practice such as supervision and appraisal, and practice development are implemented in accordance with organisational policies.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (HSCS 4.19).

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

To support the personal and professional development of staff, the manager should ensure that supervisions and appraisals are being undertaken as per the organisation's policy. They should also ensure that support is given to supervisors to ensure that a consistently good standard of recording is maintained.

National Care Standards: Support Services - Standard 2 - Management and staffing arrangements.

This area for improvement was made on 2 February 2024.

Action taken since then

Supervision across the service has been increasing over recent months, however, due to changes in the management team, this has yet to be rolled out across all staff. Supervision that has been carried out, demonstrates a good balance between discussion about workload, personal and professional development.

An overview has been put in place to track supervision sessions planned and carried out, giving the registered manager a clear understanding of what has been done and when.

Senior staff have undertaken leadership and management qualifications to develop their skills in relation to leading and developing staff.

At this time, this area for improvement has not been met and will be incorporated into Area for Improvement 1, Key Question 2 "How good is our leadership."

Previous area for improvement 2

The manager should ensure that there are regular quality monitoring tasks undertaken to continually assess and review the standard of service being provided, and compliance with legislation and best practice guidance.

National Care Standards: Support Services - Care Standard 2- Management and staffing arrangements.

This area for improvement was made on 2 February 2017.

Action taken since then

There has been a number of changes to the management team over the past year. This has had an impact on the quality assurance activities that have been undertaken. Whilst the current management team have an awareness of what should be in place, there is a number of areas where this should be developed to ensure the quality of care and support is maintained, and the manager has a clear oversight of all of the key areas across the service.

This area for improvement has not been met, and will be incorporated into Area for Improvement 1, Key Question 2 "How good is our leadership."

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com

Detailed evaluations

How well do we support people's wellbeing?	5 - Very Good
1.1 People experience compassion, dignity and respect	5 - Very Good
1.2 People get the most out of life	5 - Very Good
1.3 People's health and wellbeing benefits from their care and support	5 - Very Good

How good is our leadership?	4 - Good
2.2 Quality assurance and improvement is led well	4 - Good

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ਬੇਨਤੀ 'ਤੇ ਇਹ ਪ੍ਰਕਾਸ਼ਨ ਹੋਰ ਰੂਪਾਂ ਅਤੇ ਹੋਰਨਾਂ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਉਪਲਬਧ ਹੈ।

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To:	**Renfrewshire Integration Joint Board Audit, Risk and Scrutiny Committee**
On:	**21 June 2024**
Report by:	**Head of Mental Health, Learning Disability and Alcohol & Drug Recovery Services**
Subject:	**Mental Welfare Commission for Scotland: Inspection Report for Ward 37, Royal Alexandra Hospital**

1. Summary

1.1 The Mental Welfare Commission for Scotland (MWC) is an independent organisation that is accountable to the Scottish Government for its statutory duties. They are responsible for safeguarding the rights and welfare of people in Scotland with a mental illness, learning disability or other mental disorder. They carry out their statutory duties by focussing on five main areas of work: visiting people/services, monitoring the Acts; investigations; information, and advice; and influencing and challenging.

1.2 MWC visits to adult mental health wards are facilitated in two ways. Planned visits are communicated directly to the ward, and Operational Managers 6 weeks in advance of a visit. Posters and letters are provided by the MWC to inform service users and carers of the visit to give them the opportunity to provide feedback to the MWC on family/carer involvement and patient care within the ward. The MWC review patient records and legal documentation to ensure that statutory duties are being met and that the quality of care provided meets expected standards.

1.3 Unannounced visits involve the MWC visiting a ward without prior communication. These visits concentrate on legal documentation, quality of care and progress on the recommendations from previous visits.

1.4 Following both types of visits, the MWC provide a written report on their findings and recommendations on improvements. An action plan, based on the recommendations, must be completed, and returned to the MWC within three months of receipt of the report.

1.5 Renfrewshire HSCP ensures action plans are progressed and monitored through Mental Health and HSCP-wide Clinical and Care Governance structures.

1.6 All NHSGGC-wide MWC reports, and action plans are collated and circulated on a quarterly basis, with progress and monitoring of action plans managed by NHSGGC Board-wide MH Clinical and Care Governance and Programme Board structures.

1.7 This report summarises the announced visit to Ward 37, Royal Alexandra Hospital, on 28 February 2024. Ward 37 is a Specialist Dementia Admission ward. The report is appended in Appendix 1 to this report.

2. Recommendations

It is recommended that the IJB Audit, Risk and Scrutiny Committee:

- Note the content of this report.

3. Background and Context

3.1 The MWC arranged an announced visit to Ward 37, Royal Alexandra Hospital, for 28th February 2024. Following the visit, the MWC made four recommendations for Ward 37.

3.2 The MWC met with and reviewed the care of six individual patients. They also met with six carers, who had made appointments with them. Feedback provided by carers was positive, with staff described as welcoming and helpful, that the nursing care could not be faulted and that the patients were well cared for.

Summary of Recommendations

1. **Managers should ensure nurses are provided with education on person-centred care planning and ensure nursing care plans are person centred, address all identified risks and reflect the current care needs of each person, setting out clearly the interventions and support required for the individual.**

The MWC found that care plans varied in quality. The majority of the care plans reviewed lacked person-centred information, were completed shortly after admission and had not been updated to reflect changes in the individual's presentation or care needs However, the MWC did say that changes in presentation and treatment were being documented in care plan evaluations and the chronological notes. The MWC also stated that whilst risk assessments had been completed for the people reviewed, not all risks that had been identified were addressed in the care plans.

2. **Managers should ensure an audit of all DNACPR forms to ensure that, where relevant, all welfare guardians/powers of attorney have been consulted and their opinion recorded.**

The MWC found that there were two 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms which did not record a consultation with the proxy decision maker. The Scottish Government policy on DNACPR states that where an adult cannot consent and there is a guardian or welfare attorney with the relevant powers, the guardian or attorney must participate in any advance decision to give, or to not give, CPR.

3. **Managers should ensure that relatives are given the opportunity to attend or otherwise contribute their views to MDT reviews and should put in place a system for providing feedback where relatives do not attend.**

The MWC found that Multidisciplinary Team (MDT) reviews were well documented, with clear actions and outcomes. However, the MWC could not find evidence of families attending MDT reviews, or of any structured feedback from these meetings. The MWC did find a number of letters inviting relatives to upcoming MDT review.

4. **Managers should ensure that where a proxy decision maker has powers to consent to medical treatment this person must be consulted and their consent sought; the manager must ensure that this process and outcome is clearly recorded.**

If a person does not have capacity and there is a proxy such as a Welfare Attorney, Welfare Guardian or person authorised under an intervention order, they can give consent on behalf of the person and a Section 47 certificate must be completed. Treatment cannot automatically proceed if the proxy refuses consent and in such an event the practitioner with overall responsibility must contact the Mental Welfare Commission to seek a second opinion.

The MWC found that a number of section 47 certificates that were reviewed, either had not been completed to confirm the proxy decision maker had been consulted, or where the proxy had signed the form this had been done several weeks after the form had been completed by medical staff. Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act (AWIA) must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form.

Positive findings and Good Practice:

- Where a patient had granted a Power of Attorney (POA) or was subject to guardianship order under the AWIA, information advising of this and providing contact details for the proxy decision maker and copies of the powers were available in all the files reviewed.
- Completed Getting to Know Me documentation was found in all of the files reviewed, and “What Matters to Me” forms were available at bed areas. This is a one-page summary of key information about the patient that assists staff to provide care and engage with the individual.
- Person-centred visiting was well established within the ward, and the MWC observed leaflets advising of this at the ward entrance.
- Carers informed the MWC that they were made to feel welcome, and were encouraged to continue to be involved in their loved one’s care
- There was a range of therapeutic and recreational activities available for the patients on a one-to-one and group basis. The MWC found evidence of activities being provided to the patients within patient’s chronological care records
- The ward has actively worked towards resuming a range of face-to-face volunteer supports, such as therapet and music therapy
- A new heating and water system had been installed and the showers, were now suitable for the care needs of the patients in the ward

Other findings and comments

- Several relatives raised concerns regarding the laundry service at the time of the visit. The RAH patient laundry service was not available for a period of six weeks due to the need to replace faulty machines. A contingency plan was in place to manage patient laundry but there were some delays in laundry returning.
- The MWC noted that the ward is some distance from the main hospital or any local facilities such as shops or cafes. Relatives informed the MWC that due to this and limited parking on site, it was difficult to take patients off the ward during visits.
- Despite improvements being made to the ward environment, the MWC stated that the ward was not a suitable environment in which to provide care to the current patient group.

3.5 The MWC published their report for Ward 37 on 17 April 2024.

4. Next Steps

4.1 Action plan recommendations will be progressed, and progress monitored through relevant HSCP and Boardwide governance structures.

Implications of the Report

1. **Financial** – None
2. **HR & Organisational Development** – None
3. **Strategic Plan and Community Planning** – None
4. **Wider Strategic Alignment** – None
5. **Legal** – None
6. **Property/Assets** – None
7. **Information Technology** – None
8. **Equality & Human Rights** – None
9. **Fairer Duty Scotland** – None
10. **Health & Safety** – None
11. **Procurement** – None
12. **Risk** - Failure by services to meet and exceed the MWC Standards could lead to poor inspection results, as well as negative outcomes for service users and carers.
13. **Privacy Impact** – None

List of Background Papers – None

Author: Jason McLaughlan, Adult Mental Health, In-Patient Service Manager

Any enquiries regarding this paper should be directed to Laura Howat, Head of Mental Health, Learning Disability and Alcohol & Drug Recovery Services (laura.howat@renfrewshire.gov.uk)

Mental Welfare Commission for Scotland

Report on announced visit to:

Ward 37, Royal Alexandra Hospital, Corsbar Rd, Paisley PA2 9PJ

Date of visit: 28th February 2024

Where we visited

Ward 37 Royal Alexandra Hospital is a 20-bedded unit, situated on a District General Hospital site, providing assessment and treatment for older adults with dementia from East Renfrew and Renfrewshire.

On the day of our visit, there were no vacant beds.

We last visited this service in December 2022 and made recommendations relating to the environment, care planning and proxy decision makers.

The response we received from the service was that these issues were being addressed; audits were being carried out regularly and staff training had been provided. With regard to the environment there is a review of older adults' mental health provision across the health board area; the outcome of this will address the issues of accommodation in the longer term.

Meanwhile the ward had been decanted for a period of several months to allow for the installation of a new heating and water system, returning to its current location in December 2023 once this was completed.

On the day of this visit, we wanted to follow up on the previous recommendations and to hear about activities and communication with relatives.

Who we met with

We met with, and reviewed the care of six people, three who we met with in person and three who we reviewed the care notes of. We also met with six relatives.

We spoke with the service manager, the senior charge nurse, charge nurse and consultant psychiatrist. We also met with the occupational therapist and practice development nurse.

Commission visitors

Mary Hattie, nursing officer

Douglas Seath, nursing officer

What people told us and what we found

The relatives we met with spoke positively about the permanent staff team, saying they generally found them welcoming and helpful, and that their relatives were well cared for. They commented that though the nursing care could not be faulted, the nurses all seemed to be exceptionally busy, and a number did express concern that there are often staff on duty who were unfamiliar with the ward and the individuals being cared for.

Several of the relatives we spoke with held power of attorney (POA). We asked whether they felt involved and consulted regarding their relatives' care; for instance, were they invited to attend or contribute their views to multidisciplinary team (MDT) meetings. The majority of the relatives we spoke with had not been invited to the MDT meetings, nor were they being asked for their views in advance or receiving feedback.

From our discussions it also became clear that, whilst POA's were informed of changes to their relative's treatment, such as being commenced on antibiotics after it had occurred, they were not being appropriately consulted and their consent was not sought at the time. Several relatives also advised us that in the fortnight prior to our visit they had been approached by staff and asked to sign documents such as section 47 certificates or care plans, to indicate they had been consulted, when in fact the documents had been completed by staff some months previously, without them having been consulted or informed.

It is essential that proxy decision makers are involved and consulted appropriately with regard to decisions around care and treatment. Informing them retrospectively is not in keeping with the legislation and is not acceptable. A system needs to be in place to ensure appropriate consultation and involvement in decisions takes place and is recorded.

All of the relatives we met with told us about difficulties with the laundry system, with significant amounts of clothing going missing over recent months. The staff advised us that there have been ongoing problems, with the personal laundry service, with machines being out of service for around six weeks, resulting in a significant backlog and delays in items being returned. We were told his had been so bad that staff on night shift were taking laundry by taxi to another hospital, which had a ward-based machine, and were washing it themselves. We were told that the machines are supposed to be back in service this week and the situation should improve.

Staff also told us that previously there was a system in place for relatives who wished to take laundry home to wash. Each wardrobe was lockable and had a drawer where dirty laundry was stored for collection by the family. However, the majority of the locks were damaged in transit following the decant of the ward. This has resulted in an increase in clothing going missing, as confused people may pick up other patients clothing. As a result, a bid is being submitted for new furniture to ensure clothing can be securely stored.

We were concerned to hear about the inadequate laundry service and expect this to be resolved as soon as possible. The concerns highlighted to us were discussed with the service manager and senior charge nurse on the day.

Care, treatment, support and participation

Care records

Information on care and treatment was held in three ways; there was a paper file, the electronic record system EMIS and the electronic medication management system. The health board is in the process of transitioning across to a fully electronic system. Copies of POA's, guardianships and care plans are currently held in the paper system. MDT reviews and chronological notes were held on EMIS along with Mental Health Act paperwork.

We found completed Getting to Know Me documentation in all of the files we reviewed, and "What Matters to Me" forms at bed areas. This is a one-page summary of key information about the individual that assists staff to provide care and engage with the individual. Care plans varied considerably in quality. The majority of the care plans we reviewed lacked person-centred information, were completed shortly after admission and had not been updated to reflect changes in the individual's presentation or care needs, despite these being documented in care plan evaluations and chronological notes. Whilst risk assessments had been completed for the people we reviewed, not all risks that had been identified were addressed in the care plans.

We had previously made a recommendation in relation to care planning for stress and distress. In a number of the files we reviewed, we found that the individual did experience stress and distress, however we did not find person-centred care plans for the management of this, or with the setting out of information on individual triggers and strategies for managing this, despite, in some cases, a Newcastle formulation having been completed. The Newcastle model is a framework and process, developed to help nursing and care staff understand and improve their care for people who may present with behaviours that challenge.

Recommendation 1:
Managers should ensure nurses are provided with education on person-centred care planning and ensure nursing care plans are person centred, address all identified risks and reflect the current care needs of each person, setting out clearly the interventions and support required for the individual.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:
https://www.mwcscot.org.uk/node/1203

In the files we reviewed, we found two DNACPR forms which did not record any consultation with the proxy decision maker. The Scottish Government produced a revised policy on DNACPR in 2016 (http://www.gov.scot/Resource/0050/00504976.pdf). This makes it clear that where an adult cannot consent and there is a guardian or welfare attorney with the relevant powers, the guardian or attorney must participate in any advance decision to give, or to not give, CPR. Where there is no guardian or attorney for a person who cannot consent to a decision about CPR, it is a requirement to consult with the close family, as well as taking what steps are possible to establish the wishes of the person. In all cases, this involvement or consultation should be recorded.

Recommendation 2:
Managers should ensure an audit of all DNACPR forms to ensure that, where relevant, all welfare guardians/powers of attorney have been consulted and their opinion recorded.

Multidisciplinary team (MDT)

The unit has a multidisciplinary team of nursing staff, psychiatrists, occupational therapy staff, a physiotherapist and psychology staff. Referrals can be made to all other services as and when required. MDT reviews were well documented, with clear actions and outcomes. In the notes we reviewed, we could not find evidence of proxy decision makers, or of families attending MDT reviews, or of any structured feedback from these meetings; however we found a number of letters inviting relatives to upcoming MDT's.

Recommendation 3:
Managers should ensure that relatives are given the opportunity to attend or otherwise contribute their views to MDT reviews and should put in place a system for providing feedback where relatives do not attend.

The senior charge nurse post was being filled on an acting basis, with no date set for recruitment to the post on a permanent basis. We heard that the ward has a number of registered nursing staff vacancies, and this combined with staff absence results in bank staff having to be utilised when there are high levels of clinical activity or observations.

Use of mental health and incapacity legislation

On the day of the visit, five people were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). All documentation relating to the Mental Health Act was in place.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

All patients were under the Adults with Incapacity (Scotland) Act 2000 (the AWIA).

Where the individual had granted a Power of Attorney (POA) or was subject to guardianship order under the AWIA, we found information advising of this and providing contact details for the proxy decision maker. Copies of the powers were available in all the files we reviewed.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. However, a number of s47 certificates that we reviewed, either had not been completed to confirm the proxy decision

maker had been consulted, or where the proxy had signed the form this had been done several weeks after the form had been completed by medical staff.

Recommendation 4:
Managers should ensure that where a proxy decision maker has powers to consent to medical treatment this person must be consulted and their consent sought; the manager must ensure that this process and outcome is clearly recorded.

Where covert medication was in place, all appropriate documentation was in order.

Rights and restrictions

The ward continues to operate a locked door policy, commensurate with the level of risk. Doors are controlled by a keypad and information on how to access/egress the ward is displayed beside the doors.

We heard that the ward has implemented person-centred visiting, and observed leaflets advising of this were available at the ward entrance. We saw visitors arriving in the ward throughout our visit and heard from them that they were made to feel welcome, and were encouraged to continue to be involved in their loved one's care.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

The ward had input from an occupational therapist, a support worker and an occupational therapy technician, who provided a range of therapeutic and recreational activities on a one-to-one and group basis. The ward has actively worked towards resuming a range of face-to-face volunteer supports, such as therapet and music therapy.

The occupational therapy team continued to provide a range of group and individual activities including using reminiscence boxes provided by Glasgow Museums. There was an activity programme on display in the dining area. In the chronological notes we reviewed, we saw evidence of activities being provided.

The physical environment

The Commission has made recommendations in relation to the poor physical environment of Ward 37 over a number of years. Our last report made special mention of the temperature of the ward and the unsuitable shower facilities. We were therefore pleased to find that following a recent decant, a new heating system and water system had been installed and the showers, whilst no longer anti ligature compliant, were suitable for the care needs of the people in the ward. Staff told us that the new system has made a significant improvement to the temperature on the ward.

We heard from the service manager that the older adult's mental health service review, which includes a review of the inpatient provision, is progressing to public consultation over the next few months and it is hoped this will report in the autumn.

The layout of the ward consists of five single en-suite rooms, and three, five bed dormitories. Toilets are well signposted and dementia friendly. There is an activity room, used by occupational therapy for small group activities, a dining room and a large sitting room with conservatory attached, from which the ward garden can be accessed.

Whilst both sitting and dining rooms are large and bright, there is little to provide stimulation in the environment. In the sitting room the furniture is very institutional and is arranged in rows facing the television. In the dining room there is a large activity timetable. Visitors use the dining room or individual bedrooms for visits.

The ward is some distance from the main hospital or any local facilities such as shops or cafes. Relatives commented to us that due to this and limited parking on site, it is difficult to take their loved one off the ward during visits.

The garden space is limited to a long and narrow stretch, bordered on one side of the ward and on the other by a wall and high bank. The area is secure, and work has been done to make it as pleasant as possible with murals on the wall, several benches and chairs, and flower beds.

We found posters advising of our visit in the entrance to the ward along with information about the local advocacy service.

Despite the improvements which have been made since our last visit it remains our view that the ward is not a suitable environment in which to provide care to the current patient group. We look forward to hearing about the outcome of the older adults' review, and how it will impact on the ward at our next visit.

Summary of recommendations

Recommendation 1:
Managers should ensure nurses are provided with education and support on person centred care planning and ensure nursing care plans are person centred, address all identified risks and reflect the current care needs of each person, setting out clearly the interventions and support required for the individual.

Recommendation 2:
Managers should ensure an audit of all DNACPR forms to ensure that, where relevant, all welfare guardians/powers of attorney have been consulted and their opinion recorded.

Recommendation 3:
Managers should ensure that relatives are given the opportunity to attend or otherwise contribute their views to MDT reviews and should put in place a system for providing feedback where relatives do not attend.

Recommendation 4:
Managers should ensure that where a proxy decision maker has powers to consent to medical treatment this person must be consulted, and their consent sought; the manager must ensure that this process and outcome is clearly recorded**.**

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Claire Lamza
Executive director (Nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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