Date: 22 November 2019
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TO: **MEMBERS OF THE EAST RENFREWSHIRE INTEGRATION JOINT BOARD PERFORMANCE AND AUDIT COMMITTEE**

Dear Colleague

**EAST RENFREWSHIRE INTEGRATION JOINT BOARD - PERFORMANCE AND AUDIT COMMITTEE**

A meeting of the East Renfrewshire Integration Joint Board Performance and Audit Committee will be held within the Eastwood Health and Care Centre, Drumby Crescent, Clarkston on **Wednesday 27 November 2019 at 9.00 am.**

The agenda of business is attached.

Yours faithfully

COUNCILLOR CAROLINE BAMFORTH
Chair

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**EAST RENFREWSHIRE INTEGRATION JOINT BOARD**
**PERFORMANCE & AUDIT COMMITTEE**
**WEDNESDAY 27 NOVEMBER 2019**
**EASTWOD HEALTH AND CARE CENTRE, DRUMBY CRESCENT**
**BARRHEAD**

## AGENDA

**1 Apologies for absence**

**2. Declaration of Interests**

**3. Minute of meeting of 25 September 2019 (copy attached, pages 5 - 10).**

**4. Matters Arising (copy attached, pages 11 - 14).**

**5. Mid-Year Performance Report (copy attached, pages 15 - 30).**

**6. Audit Actions Update (copy attached, pages 31 - 44).**

**7. Review of IJB Risk Management Policy and Strategy (copy attached, pages 45 - 66).**

**8. IJB Strategic Risk Register Update (copy to follow).**

**9. Date of Next Meeting – Wednesday 18 March 2020, Eastwood Health and Care Centre, Drumby Crescent, Clarkston.**

**AGENDA ITEM No.3**

**Minute of Meeting of the
East Renfrewshire Integration Joint Board
Performance and Audit Committee
held at 9.00am on 25 September 2019 in
the Council Offices, Main Street,
Barrhead**

**PRESENT**

Councillor Caroline Bamforth, East Renfrewshire Council (Chair)

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|---|---|
| Councillor Barbara Grant | East Renfrewshire Council co-opted Member |
| Anne Marie Kennedy | Non-voting IJB member |
| John Matthews | NHS Greater Glasgow and Clyde Board |
| Anne-Marie Monaghan | NHS Greater Glasgow and Clyde Board |
| Councillor Paul O'Kane | East Renfrewshire Council |

**IN ATTENDANCE**

| | |
|---|---|
| Lesley Bairden | Head of Finance and Resources (Chief Financial Officer) |
| Eamonn Daly | Democratic Services Manager (East Renfrewshire Council) |
| Candy Millard | Head of Adult Health and Social Care Localities |
| Michelle Blair | Chief Auditor, East Renfrewshire Council |

**ALSO IN ATTENDANCE**

| | |
|---|---|
| Elaine Barrowman | Audit Scotland |
| Aimee MacDonald | Audit Scotland |

**DECLARATIONS OF INTEREST**

**1.** There were no declarations of interest intimated.

**MINUTE OF PREVIOUS MEETING**

**2.** The committee considered and approved the Minute of the meeting of 26 June 2019.

**MATTERS ARISING**

**3.** The committee noted a report by the Chief Officer providing an update on progress regarding matters arising from the discussions which took place at the meeting of 26 June 2019.

It was noted that since the previous meeting, a further 1 whole time equivalent Advanced Practice Physiotherapist had been recruited. As this was a recent appointment it was too early to see the impact but a further update would be brought to the committee in March 2020 when measurable data was available.

It was further noted that the audit actions report would be brought to the next meeting of the committee, reflecting the new action plan resulting from the audit of the 2018/19 annual report and accounts.

The committee noted the report and the additional information.

**INTERNAL AUDIT ANNUAL REPORT 2018/19 AND PROPOSED AUDIT PLAN 2019/20**

**4.** The committee considered a report by the Chief Auditor, East Renfrewshire Council, relative to the Chief Auditor's Annual Report for 2018/19 which contained an independent opinion on the adequacy and effectiveness of the governance, risk management and internal control systems operating within the IJB. A copy of the Chief Auditor's Annual Report accompanied the report as an appendix.

The report explained in summary that the Annual Report concluded that the IJB had adequate and effective internal controls in place proportionate to its responsibilities in the year ended 31 March 2019.

In addition, details of the proposed 2019/20 audit plan, for which approval was sought, were contained in the report.

The Chief Auditor was heard further on the report and confirmed that Internal Audit were satisfied that reasonable assurance could be placed on the control environment which operated in the East Renfrewshire Integration Joint Board.

Commenting on the proposed plan, Ms Monaghan welcomed the proposed review of risk management arrangements

The Chief Auditor having confirmed in response to a question from Ms Monaghan that there was adequate contingency available to deal with unforeseen matters during the year should they arise, the committee:-

(a) noted the contents of internal audit's annual report 2018/19;

(b) noted the annual assurance statement and the conclusion that the IJB had adequate and effective internal controls in place proportionate to its responsibilities in 2018/19; and

(c) approved the proposed 2019/20 audit plan.

**AUDIT SCOTLAND REPORT**

**5.** The committee took up consideration of the external audit annual report for 2017/18, which summarised the findings arising from the 2018/19 audit of the IJB.

The report provided a number of key messages. These included that the auditor's report was unqualified; that the IJB had appropriate and effective budgetary processes in place with

budgetary processes providing timely and reliable information for monitoring financial performance; that a surplus of £0.528 million had been incurred in 2018/19 giving a total reserves balance of £5.337 million as at 31 March 2019; that medium-term financial planning detailed a funding gap of £3.1 million for 2019/20 with savings already identified to address this gap; .and that potential funding gaps could be up to £5.4 million per year or £16.2 million cumulatively over the period to 2023/24 depending on future funding levels.

Included in the appendices accompanying the report was an action plan which set out the proposed management action in respect of areas where recommendations had been made.

Councillor Bamforth introduced Elaine Barrowman and Aimee MacDonald from Audit Scotland.

Ms Barrowman having explained the background to the production of the report, Ms MacDonald then went through the report's key issues. These included that the report was unqualified, that there were no matters to be brought to the committee's attention, and that there were no misstatements or significant findings.

Ms MacDonald having referred to the 2019/20 recommendations for improvement contained in the action plan and having thanked the Chief Financial Officer and her team for their assistance in the preparation of the report, full discussion then took place.

Referring to comments in the report on EU withdrawal, Mrs Kennedy highlighted the significant role played by third sector organisations, in many cases with funding received from the EU, and that the report was silent on the potential impact on service delivery if third sector funding from the EU was reduced.

Discussion also took place on responsibility for service provision. In response to Councillor Grant, it was clarified that scheduled hospital admissions were the responsibility of NHS Greater Glasgow and Clyde (NHSGGC) whilst unscheduled admission responsibility lay with the HSCP. It was recognised that failure to deliver services either on a planned or unplanned basis could have adverse consequences for partner organisations.

Responding to comments from Mr Matthews, the Chief Financial Officer explained the structure of the Audit Scotland report. She confirmed that there had been a lot of discussion between Audit Scotland and officers from the HSCP in the production of the report.

Having commented on the proposed action in relation to a review of the Management Commentary, Ms Monaghan highlighted that the biggest concern continued to be the financial pressures facing the HSCP and questioned whether thought now needed to be given to the introduction of thresholds and/or eligibility criteria for care provision.

In reply the Chief Financial Officer reminded the committee that the 5 year medium-term financial plan had been considered in March and at that time had highlighted that service provision was based on settlement levels. She acknowledged that the cost of care packages was something that could be controlled through a review of eligibility criteria and that this may require further consideration in the future, depending on the prevailing financial circumstances.

Discussion also took place on the significant audit risks identified during planning in the course of which Ms Barrowman explained that the role of Audit Scotland was to examine the arrangements in place for the managing and reporting of risk, and confirmed that in this case Audit Scotland was satisfied that appropriate arrangements were in place.

She further clarified in response to Mr Matthews that any work carried out in relation to national policies and strategies would in most cases be led by Audit Scotland's Performance Audit or Best Value teams.

Thereafter the committee noted the report

**ANNUAL REPORT AND ACCOUNTS 2018/19**

**6.** Under reference to the Minute of the meeting of 26 June 2019, the committee considered a report by the Chief Financial Officer seeking approval for the final annual report and accounts for the IJB for the period 1 April 2018 to 31 March 2019, following the external audit of the accounts. A copy of the annual report and accounts accompanied the report.

The report referred to the establishment of IJBs and the requirements, in accordance with Section 106 of the Local Government (Scotland) Act 1973, for annual accounts to be prepared in compliance with the Code of Practice on Accounting for Local Authorities in the United Kingdom, and also to additional guidance produced by the Local Authority (Scotland) Accounts Advisory Committee.

Thereafter, the report explained that the annual report and accounts had been prepared in accordance with the relevant legislation and guidance, and that they were unqualified, met legislative requirements, had no significant issues and confirmed sound financial governance.

It was further explained that the key messages that had been highlighted when the unaudited accounts had been considered by the committee in June remained unchanged.

Commenting further, the Chief Financial Officer referred to the minor changes made to wording including further detail on care at home in the governance statement. Some presentation change to the reserves statement had also been made for ease of understanding and targets had been added to the performance information for context.

The Chief Financial Officer thanked staff for their efforts in producing the annual report and accounts.

Ms Monaghan referred to poor performance in relation to access to mental health services, and questioned why more was not being done taking into account that the accounts had shown an underspend on mental health service provision.

In reply the Chief Financial Officer acknowledged the poor performance, highlighting that the table referred to by Ms Monaghan contained all those services where it was recognised improvement was required. Furthermore, she explained the reasons behind the underspend, and that the format of the revenue budget monitoring report submitted to each meeting of the IJB had been amended to provide more information in relation to service expenditure.

The position regarding Bonnyton House was also outlined it being noted that service provision had not been maximised as the property was to be the subject of refurbishment. This was scheduled to commence early in 2020, following which service provision would be maximised. It was noted that the refurbishment would require the decant of residents and clients but that a satisfactory temporary accommodation solution had been identified.

Thereafter, the committee agreed that the audited annual report and accounts be remitted to the IJB for approval.

**PERFORMANCE UPDATE REPORT – QUARTER 1 2019/20**

**7.** The committee considered a report by the Chief Officer providing an update on progress against the strategic performance measures during the period 1 April to 30 June 2019.

Commenting on the report the Chief Financial Officer explained that due to timing issues from the various sources, only one third of the measures provided contained new data. As a result the normal "traffic light" performance summary had not been included but would be reintroduced for subsequent reports.

Thereafter the Chief Financial Officer was heard on the report. Comment was made on a number of performance highlights and other areas of strong performance as well as examples where further improvement was sought or where performance had declined.

Referring to waiting times for Children and Adolescent Mental Health Services (CAMHS) Mrs Kennedy enquired if the introduction of the Family Wellbeing Service had led to a drop in demand for CAMHS services. It was noted that this information could be provided.

Commenting on the "Notes and History" column of the performance report Ms Monaghan suggested that it would helpful to see more about timescales and targets. In reply, the Chief Financial Officer explained that the report was "backwards looking" and expressed concerns that adding further columns in relation to forward planning activity to the report could impact on the format and dilute its impact. Notwithstanding, discussions would take place to see if this could be achieved.

Full discussion also took place on absence levels. It was clarified that that NHSGGC and the HSCP used different methods for recording absence. Notwithstanding it was acknowledged that performance was not as strong as had been hoped and there was room for further improvement. In addition the age profile of the work force was highlighted along with the fact that in some cases absences were for a longer period in order not to potentially have an adverse impact on the health of clients. Absence costs both in financial and opportunity cost terms were considered by the senior management team and work was ongoing with officer from the Council's Human Resources service to identify appropriate supports for staff.

It was further suggested that having some benchmarking information in the report in relation to absence levels would be useful.

The committee:-

(a) noted the report;

(b) noted that officers would review the report format with a view to forward planning and benchmarking information being included in future.

**IJB STRATEGIC RISK REGISTER UPDATE**

**8.** The committee considered a report by the Chief Officer providing an update on the Integration Joint Board Strategic Risk Register.

Having set out the risk matrix used to calculate risk scores, the report then provided further details in respect of those areas considered to be high risks, these being supported by additional information provided by the Head of Finance and Resources (Chief Financial Officer).

The report explained that no risks had been removed since the last update on 26 June 2019 and although 4 risks had been updated, with a summary of the changes being provided, there had been no changes to any of the scores.

It was highlighted that financial sustainability remained high/red risk as last reported and that this was still considered red post-mitigation reflecting the current economy and unknown Brexit implications. There also remained the future year risk that the HSCP could become unsustainable due to one of a number of causes as set out in the report.

In addition it was noted that the In-House Care at Home Service and Failure of a Provider risks were scored at 9 after mitigation had been taken into account.

Commenting on the risk in relation to the Care at Home Service. Ms Monaghan questioned whether the description of the risk should be reviewed to reflect as a potential risk the implications of a failure to comply with the Care Inspectorate recommendations.

In response the Head of Adult Health and Social Care Localities confirmed that officers would reflect on that to determine whether or not a rewording was required.

The committee noted the report.

**CONTRACTS AND EXCEPTIONS UPDATE TO JUNE 2019**

**9.** The committee considered a report by the Chief Officer providing information about direct spend through the HSCP framework contracts; grant activities; and non-framework spend together with spend activity on national framework agreements. In addition, the report also provided information in relation to exceptions to ERC Contract Standing Orders along with business reasons for such exceptions.

In response to Ms Monaghan, the Chief Financial Officer confirmed that the introduction of Self Directed Support could potentially lead to an increase in off-framework spend. She explained that people who did self-manage would always be encouraged to purchase services through the framework agreements in place, but that purchasing services off-framework would always remain open to them.

The committee noted the report.

**DATE OF NEXT MEETING**

**10.** It was reported that the next meeting of the committee would take place on Wednesday 27 November 2019 at 9.00 am in the Eastwood health and Care Centre, Clarkston.

CHAIR

**AGENDA ITEM No. 4**

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

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|---|---|
| **Meeting of East Renfrewshire Integration Joint Board**<br><br>**Held on** | Performance and Audit Committee<br><br>27 November 2019 |
| **Agenda Item** | 4 |
| **Title** | Matters Arising |
| **Summary**<br><br>The purpose of this paper is to update Performance and Audit Committee members on progress regarding matters arising from the discussion which took place at the meeting of 25 September 2019. | |
| **Presented by** | Lesley Bairden, Head of Finance and Resources (Chief Financial Officer) |
| **Action Required**<br><br>Performance and Audit Committee members are asked to note the contents of the report. | |

**EAST RENFREWSHIRE INTEGRATION JOINT BOARD**

**PERFORMANCE AND AUDIT COMMITTEE**

**27 November 2019**

**Report by Chief Officer**

# MATTERS ARISING

## PURPOSE OF REPORT

1. To update the Performance and Audit Committee on progress regarding matters arising from the discussion which took place at the meeting of 25 September 2019.

## RECOMMENDATION

2. Performance and Audit Committee members are asked to note the contents of the report.

## REPORT

Advanced Practice Physiotherapists

3. An update on Advanced Practice Physiotherapists has been scheduled for the March 2020 meeting of the Performance and Audit Committee as requested by members.

Annual Report and Accounts 2018/19

4. The Integration Joint Board approved the annual report and accounts at its meeting on 25 September 2019 and authorised the Chair, Chief Officer and Chief Financial Officer to accept and sign the annual report and accounts on behalf of the IJB.

Audit Scotland Report

5. An update on the 2018/19 action plan set out in the Audit Scotland Annual Audit Report is detailed at appendix 3 of the Audit Actions Update paper, included on today's agenda.

Performance Report – Family Wellbeing Service

6. Data requested is relation to the reduction in CAMHS appointments as a result of the introduction of the Family Wellbeing Service will not be available until the next reporting period which will be late Spring/Summer 2020.

## RECOMMENDATIONS

7. Performance and Audit Committee members are asked to note the contents of the report.

## REPORT AUTHOR AND PERSON TO CONTACT

Lesley Bairden, Head of Finance and Resources (Chief Financial Officer)
lesley.bairden@eastrenfrewshire.gov.uk; 0141 451 0746
November 2019

Chief Officer, IJB: Julie Murray

**AGENDA ITEM No.5**

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

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|---|---|
| **Meeting of East Renfrewshire Health and Social Care Partnership** | Performance and Audit Committee |
| **Held on** | 27 November 2019 |
| **Agenda Item** | 5 |
| **Title** | Mid-Year Performance Report 2019-20 |

**Summary**

This report provides the Performance and Audit Committee with the performance measures developed to monitor progress in the delivery of the strategic priorities set out in the HSCP Strategic Plan 2018-2021. Where data is available mid-year this is included.

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| **Presented by** | Steven Reid<br>Policy, Planning and Performance Manager |

**Action Required**

Performance and Audit Committee is asked to note and comment on the Mid-Year Performance Report 2019-20.

**EAST RENFREWSHIRE INTEGRATION JOINT BOARD**

**PERFORMANCE AND AUDIT COMMITTEE**

**27 November 2019**

**Report by Chief Officer**

# MID-YEAR PERFORMANCE REPORT 2019-20

## PURPOSE OF REPORT

1. This report provides Performance and Audit Committee with the performance measures developed to monitor progress in the delivery of the strategic priorities set out in the new HSCP Strategic Plan 2018-2021. Where data is available mid-year this is included.

## RECOMMENDATION

2. Performance and Audit Committee is asked to note and comment on the Mid-Year Performance Report 2019-20.

## BACKGROUND

3. The last meeting Performance and Audit Committee discussed the report on the development of performance measures to monitor progress in the delivery of the strategic priorities set out in the new HSCP Strategic Plan 2018-2021.

## REPORT

4. The attached report contains performance measures and actions set out under the new strategic priorities, with mid-year data provided where available.

   - Mental wellbeing is improved among children, young people and families in need
   - People are supported to stop offending and rebuild their lives through new community justice pathways
   - Wellbeing is improved in our communities that experience shorter life expectancy and poorer health
   - People are supported to maintain their independence at home and in their local community.
   - People who experience mental ill-health are supported on their journey to recovery
   - Unplanned admissions to hospital are reduced
   - People who care for someone are able to exercise choice and control in relation to their caring activities

5. The final section contains a number of organisational indicators relating to our staff and customers. Annex 1 contains a list of the performance measures that will be included in the end of year report for which mid-year data is not available.

6. The report presents each indicator with a RAG status in relation to the target for the reporting period (where a target is set), along with long-term and short-term trend arrows and commentary on performance. Where performance is weak we include commentary on remedial action that is underway and planned for the future.

7. We are working to continuously improve the quality of reporting including the commentaries provided with performance indicators. New Business Analyst posts are being established at the HSCP to support performance and we will provide training to ensure a high quality and consistent approach to reporting (including writing commentary).

8. The available data shows strong performance in relation to: supporting children subject to child protection measures; helping people subject to Community Payback Orders (CPOs) to look at how to stop reoffending; supporting women who have experienced domestic abuse; adult protection; helping people to stop smoking, and supporting older people and people with long-term conditions to live independently at home. There has also been strong performance on reducing delayed discharges from hospital, reducing hospital admissions, supporting unpaid carers and handling complaints to the HSCP.

9. Areas that remain challenging include: waiting times for CAMHS and psychological therapies (although we have seen improving performance for both in the first half of the year following targeted activity); completing CPOs within court timescales; reducing attendances at A&E; and staff absence.

**RECOMMENDATIONS**

10. Performance and Audit Committee is asked to note and comment on the Mid-Year Performance Report 2019-20.

**REPORT AUTHOR AND PERSON TO CONTACT**

Steven Reid, Policy, Planning and Performance Manager
Steven.Reid@eastrenfrewshire.gov.uk

November 2019

Chief Officer, IJB: Julie Murray

**BACKGROUND PAPERS**

25-09-2019 PAC Paper: Performance Update Report – Quarter 1 2019-20
https://www.eastrenfrewshire.gov.uk/CHttpHandler.ashx?id=25172&p=0

# HSCP Strategic Implementation Plan - Mid Year Report 19-20

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|---|---|
| **Green** | performance is at or better than the target |
| **Amber** | Performance is close (approx 5% variance) to target |
| **Red** | Performance is far from the target (over 5%) |

**Trend arrows point upwards where there is <u>improved</u> performance (inc. where we aim to decrease the value).**

ERC ODP measures

| ***Scorecards Title*** | | | | | | | |
|---|---|---|---|---|---|---|---|
| ***1 - Mental wellbeing is improved among children, young people and families in need*** | | | | | | | |
| Description | Last Update | Current Value | Current Target | Performance Data Traffic Light | Long Term Trend | Short Term Trend | Notes & History Latest Note |
| DECREASE -Child & Adolescent Mental Health - longest wait in weeks at month end | H1 2019/20 | 37 | 18 | Red | ↓ | ↓ | The monthly average longest wait during the first half of 2019/20 was 37 weeks. This was a slight increase from 34 weeks at end-year. We continue to perform below the NHSGGC average on this measure. Improving access and waiting times for CAMHS remains a key area of focus for the HSCP. We are taking forward a local action plan for CAMHS which includes regular review and the introduction of group based support which will increase team capacity. We are also continuing to roll out our Family Wellbeing Service which supports children and young people with mental and emotional wellbeing concerns. |
| INCREASE - Percentage of positive response to Viewpoint question "Do you feel safe at home?" | H1 2019/20 | 95% | 91% | Green | ↓ | ↑ | This measure captures the % of positive responses of children subject to child protection measures and those looked after at home and away from home. Staff continue to use Signs of Safety approaches to capture children's' perceptions of their safety. Response in the first half of 2019/20 was low with just 8 respondents. We plan to review our method of capturing this data to ensure a stronger response in future. |

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|---|---|---|---|---|---|---|---|
| INCREASE - Children and young people starting treatment for specialist Child and Adolescent Mental Health Services within 18 weeks of referral | H1 2019/20 | 76% | 90% | Red |  |  | At the half year point the average weekly performance was 76% of children on the CAMHS waiting list having waited no more than 18 weeks. While we continue to miss target on this measure although there has been improved performance in the first half of the year – up from 73% for the previous six months. Performance was at or above 80% throughout September. The latest weekly performance figure (17 Oct) showed that 78% of those on the waiting list had been waiting for no more than 18 weeks. Of the 95 children accessing CAMHS services in the first half of 19/20, 56 (59%) were seen within 18 weeks. We are taking forward a local action plan for CAMHS which includes regular review and the introduction of group based support which will increase team capacity. |
| INCREASE - % of children/ young people attending Family Wellbeing Service with improved emotional health at end of programme | 2018/19 | 93% | 100% | Red |  |  | Latest annual figure for 2018/19 is based on 29 children/young people whose participation with the programme has ended. This PI will be replaced by the new PIs agreed by Robertson Trust and HSCP. Following the successful pilot of the service we will continue to roll out the service across East Renfrewshire. |

| ***Scorecards Title*** | | | | | | | |
|---|---|---|---|---|---|---|---|
| ***2 - People are supported to stop offending and rebuild their lives through new community justice pathways*** | | | | | | | |
| Description | Last Update | Current Value | Current Target | Performance Data Traffic Light | Long Term Trend | Short Term Trend | Notes & History Latest Note |
| INCREASE - Community Payback Orders - Percentage of unpaid work placement completions within Court timescale. | H1 2019/20 | 72% | 80% | Red |  |  | In the first half of the year 72% of placements were completed within timescales set out by court (13 out of a total of 18). There has been a fall in performance in regard to placement completions on the same period last year. This is largely due to a number of people with employment commitments being unable to complete their unpaid work requirements within short 3 to 6 month timescales imposed by courts. This in turn has led to an increase in the number of extension requests to courts. To address this issue, we have strengthened monitoring processes in order to be able to make appropriate representation to the court where an extension is required for completion of an Order. |
| INCREASE - Criminal Justice Feedback Survey - Did your Order help you look at how to stop offending? | H1 2019/20 | 100% | 100% | Green |  |  | Results of the 21 completed survey forms from the first half of 2019/20 reveals a 100% positive response. |

| Description | Last Update | Current Value | Current Target | Performance Data Traffic Light | Long Term Trend | Short Term Trend | Notes & History Latest Note |
|---|---|---|---|---|---|---|---|
| INCREASE - % Change in women's domestic abuse outcomes | H1 2019/20 | 75% | 70% | Green |  |  | From April 2019 to September 2019 East Renfrewshire Women's Aid service reported significant change and improvement for women across all reported outcomes with 75% of women assessed (31 of 41) noting an improvement in progress in their outcomes overall. Reduction in risk is reflected in the significant increases in the areas of safety with 70% improvement, health and wellbeing 80% and empowerment and self-esteem 75%. |
| INCREASE - People agreed to be at risk of harm and requiring a protection plan have one in place | H1 2019/20 | 100% | 100% | Green |  |  | All residents identified as at risk of harm by the HSCP have a bespoke protection plan in place. |

| ***Scorecards Title*** |
|---|
| ***3 - Wellbeing is improved in our communities that experience shorter life expectancy and poorer health*** |

| Description | Last Update | Current Value | Current Target | Performance Data Traffic Light | Long Term Trend | Short Term Trend | Notes & History Latest Note |
|---|---|---|---|---|---|---|---|
| INCREASE - Increase the number of smokers supported to successfully stop smoking in the 40% most deprived SIMD areas. (This measure captures quits at three months and is reported 12 weeks in arrears.) | Q1 2019/20 | 5 | 3 | Green |  |  | In 2018/19 the management of the smoking cessation service transferred from HSCP to the Public Health Directorate at NHSGGC. Latest data is to Q1 19/20. Of 20 attempts, 5 people had quit smoking at 3 months. This is an improvement on previous quarters and is meeting our new NHSGGC provisional target of for the quarter. |

| ***Scorecards Title*** |
|---|
| ***4 - People are supported to maintain their independence at home and in their local community.*** |

| Description | Last Update | Current Value | Current Target | Performance Data Traffic Light | Long Term Trend | Short Term Trend | Notes & History Latest Note |
|---|---|---|---|---|---|---|---|
| INCREASE - Number of people self-directing their care through receiving direct payments and other forms of self-directed support. | 2018/19 | 514 | 600 | Red |  |  | This is a provisional figure for 2018/19. A total of 514 people were in receipt of SDS 1 and 2 Option payments. A further 612 people were covered under SDS Option 3. We plan to review the appropriateness of the target for this measure. Going forward we will continue to promote all SDS options and ensure the necessary support is in place for individuals to take up the option most appropriate to their circumstances. |

| Description | Last Update | Current Value | Current Target | Performance Data Traffic Light | Long Term Trend | Short Term Trend | Notes & History Latest Note |
|---|---|---|---|---|---|---|---|
| INCREASE - Percentage of those whose care need has reduced following re-ablement | H2 2018/19 | 69% | 60% | Green | ↑ | ↓ | Latest figure relates to October-Mar 2018/19. Of the 89 people receiving reablement, care was reduced or stopped for 61 (68.5%). |
| INCREASE - Percentage of people aged 65+ who live in housing rather than a care home or hospital | H1 2019/20 | 95.9% | 97% | Green | ↓ | - | Latest data released Oct 2019. This indicator is still under development and may change in future. Due to different configurations of services, figures for the hospital/hospice categories may not be comparable across partnership areas. |
| INCREASE - People reporting 'living where you/as you want to live' needs met (%) | H1 2019/20 | 89% | 90% | Green | ↑ | ↓ | In the first six months of 2019/20 of the 372 valid responses 330 respondents reported their needs met. |

| ***Scorecards Title*** | | | | | | | |
|---|---|---|---|---|---|---|---|
| ***5 - People who experience mental ill-health are supported on their journey to recovery*** | | | | | | | |
| Description | Last Update | Current Value | Current Target | Performance Data Traffic Light | Long Term Trend | Short Term Trend | Notes & History Latest Note |
| INCREASE - Percentage of people waiting no longer than 18 weeks for access to psychological therapies | H1 2019/20 | 63% | 90% | Red | ↓ | ↓ | At the half year point the average weekly performance was 63% of people on the waiting list having waited no more than 18 weeks. The weekly figure improved steadily from 53% at the start of April to 73% in August but began to fall again during September. The latest weekly performance figure (17 Oct) showed that 50% of those on the waiting list had been waiting for no more than 18 weeks. Of the 246 eligible patients accessing psychological therapies in the first half of 19/20, 113 (54%) were seen within 18 weeks. We have a targeted improvement plan in place to tackle waiting times and have seen good progress over the first half of the year. Going forward we will continue to implement the plan. |

| ***Scorecards Title*** | | | | | | | |
|---|---|---|---|---|---|---|---|
| ***6 - Unplanned admissions to hospital are reduced*** | | | | | | | |
| Description | Last Update | Current Value | Current Target | Performance Data Traffic Light | Long Term Trend | Short Term Trend | Notes & History Latest Note |
| DECREASE - people (18+) waiting more than 3 days to be discharged from hospital into a more appropriate care setting including AWI (NHSGGC Acute data only) | H1 2019/20 | 3 | 0 | Red | ↑ | ↑ | We have performed well on delayed discharges since May 19 with between 1 and 3 delays each month. This is based on data extracted from GGC delayed discharge dashboard. This provides more up to date data than ISD. We will continue to monitor this measure on a weekly basis and use project management disciplines around the home from hospital team to drive and support improvement. |
| DECREASE - people (18+) waiting more than 3 days to be discharged from hospital into a more appropriate care setting including AWI (ISD data) | August 2019 | 4 | 0 | Red | ↑ | ↑ | We have performed well on delayed discharges in the first half of the year. ISD data is available for the first 5 months of the year, up to August 19. We will continue to monitor the latest available data for this measure and use project management disciplines around the home from hospital team to drive and support improvement. |
| DECREASE - Delayed discharges bed days lost to delayed discharge (NHSGGC acute data only) | H1 2019/20 | 499 | 946 | Green | ↑ | ↑ | In line with positive performance on delayed discharge, bed days lost have reduced significantly in the first half of the year from 961 for the preceding 6 months. |
| DECREASE - Delayed discharges (ISD) bed days lost to delayed discharge (REDUCE) | H1 2019/20 | 671 | 946 | Green | ↑ | ↑ | Bed days lost to delayed discharge have been reducing and we are within target for the first half of the year. Days lost reduced significantly from 1,039 in the previous six months. |
| DECREASE - No. of A & E Attendances – Adults (NHSGGC data) | H1 2019/20 | 9,001 | 9,168 | Green | ↓ | ↓ | Data relates to NHSGGC figures – attendances at A&E and MIUs (18+ only). We continue to work with GPs and care homes to reduce A&E attendances and will continue to undertake detailed 'flow' analysis to better understand the diagnostic and population profile of those attending A&E. |
| DECREASE - No. of A & E Attendances - Adults (MSG) | 2018/19 | 20,212 | 18,332 | Red | ↓ | ↓ | Latest complete MSG data to March 2019 (Oct 2019). Adult attendances for the year increased from 19,342 in 2017/18. We continue to work with GPs and care homes to reduce A&E attendances and will continue to undertake detailed 'flow' analysis to better understand the diagnostic and population profile of those attending A&E. |
| DECREASE - No. of A & E Attendances - All (MSG) | 2018/19 | 27,850 | 26,844 | Amber | ↓ | ↓ | Latest complete MSG data to March 2019 (Oct 2019). Attendances (all ages) increased from 26,993 in 2017/18. |
| DECREASE - Number of Emergency Admissions: Adults (NHSGGC data) | H1 2019/20 | 3,422 | 3,562 | Green | ↓ | ↑ | Target for 2019/20 set at 7,124 (10% of 2015/16 baseline) approved by Integrated Joint Board. We are ahead of |

| Description | Last Update | Current Value | Current Target | Performance Data Traffic Light | Long Term Trend | Short Term Trend | Notes & History Latest Note |
|---|---|---|---|---|---|---|---|
| | | | | | | | target (3,562) at the mid year point (3,422 adult admissions). |
| DECREASE - Number of Emergency Admissions: Adults (MSG) | 2018/19 | 7,255 | 8,748 | Green |  |  | Latest complete MSG data to March 2019 (Oct 2019). Data shows continuing improvement on emergency admissions – down from 8,252 for the previous year. |
| DECREASE - Occupied Bed Days (Adult – non-elective) (NHSGGC data) | H1 2019/20 | 29,595 | 28,528 | Amber |  |  | Emergency inpatient bed days (18 years+) have increased in the first half of the year from 26,062 for the same period in 2018/19. We will continue to focus on reducing unplanned hospital stays in order to meet our target for this measure by the end of 2019/20. |
| DECREASE - A & E Attendances from Care Homes (NHSGGC data) | H1 2019/20 | 192 | 200 | Green |  |  | A&E attendances from care homes continue to reduce with the figure falling from 217 in the second half of 2018/19, now within our target. |
| DECREASE - Emergency Admissions from Care Homes (NHSGGC data) | H1 2019/20 | 113 | 120 | Green |  |  | Admissions from care homes continue to reduce (from 131 at H2 2018/19) following targeted work. |

| ***Scorecards Title*** | | | | | | | |
|---|---|---|---|---|---|---|---|
| ***7 - People who care for someone are able to exercise choice and control in relation to their caring activities*** | | | | | | | |
| Description | Last Update | Current Value | Current Target | Performance Data Traffic Light | Long Term Trend | Short Term Trend | Notes & History Latest Note |
| INCREASE - People reporting 'quality of life for carers' needs fully met (%) | Q1 2019/20 | 87% | 72% | Green |  |  | In the first six months of 2019/20 of the total 87 valid responses 76 reported their needs met. |

| ***Scorecards Title*** |
|---|
| ***8 - Organisational outcomes*** |

| ***Scorecards Title*** | | | | | | | |
|---|---|---|---|---|---|---|---|
| ***8.1 Our customers*** | | | | | | | |
| Description | Last Update | Current Value | Current Target | Performance Data Traffic Light | Long Term Trend | Short Term Trend | Notes & History Latest Note |
| DECREASE - Average time in working days to respond to complaints at stage one (HSCP) | H1 2019/20 | 4.5 | 5 | Green |  |  | This relates to 28 frontline complaints in the first half of 2019/20. |
| DECREASE - Average time in working days to respond to complaints at investigation (stage 2 and esc combined) (HSCP) | H1 2019/20 | 19.6 | 20 | Green |  |  | This relates to 44 investigation stage complaints in the first half of 2019/20. |
| INCREASE - Percentage of HSCP (NHS) complaints received and responded to within timescale (5 working days Frontline, 20 days Investigation) | H1 2019/20 | 83% | 70% | Green |  |  | In the first half of 2019/20 there were 4 frontline NHS complaints - all responded to within timescale. There were 2 investigation stage complaints with one responded to outwith timescale. We will continue to work to improve our complaints handling processes and meet timescales and will deliver further training to staff in the second half of the year. |
| INCREASE - Percentage of HSCP (local authority) complaints received and responded to within timescale (5 working days Frontline; 20 days Investigation) | H1 2019/20 | 68% | 100% | Red |  |  | Of the 33 frontline complaints received by the HSCP (ERC) in the first half of 2019/20 30 (91%) were responded to within timescale. of the 49 investigation stage complaints received 26 (53%) were responded to within timescale. We will continue to support staff to meet complaints handling statutory requirements through training and supervision. |
| DECREASE - The total number of complaints received - HSCP | H1 2019/20 | 125 | | Data Only |  |  | This equates to 0.83 complaints per 1,000 people. |

| ***Scorecards Title*** | | | | | | | |
|---|---|---|---|---|---|---|---|
| ***8.3 Our People*** | | | | | | | |
| Description | Last Update | Current Value | Current Target | Performance Data Traffic Light | Long Term Trend | Short Term Trend | Notes & History Latest Note |
| DECREASE - Percentage of days lost to sickness absence for HSCP NHS staff | H1 2019/20 | 7.3% | 4.0% | Red |  |  | Although there has been a slight increase in the half-yearly average from last year, absence rates have fluctuated each month with a dip during the summer months. With small numbers of staff within teams any absence results in a high percentage rate and we work continuously to support employees who are absent from work to return as soon as possible. We will continue to hold monthly absence support panels with both HSCP and LD In-Patient Managers to ensure that the Attendance Management Policy is being applied appropriately and consistently. As absence rates are greatest within LD In-Patients Services we have agreed to put in place dedicated support from the HRSAU especially for the complex cases. Stress and Anxiety is the most common reason for absence across the HSCP and Learning Disabilities. Stress Audits have been carried out by several teams with action plans in place to address the issues highlighted and we will continue with this approach. Learning Disabilities are currently working on a programme of support for employees including the possibility of Mindfulness Sessions. |
| INCREASE - Percentage of staff with an electronic Knowledge and Skills Framework review recorded on TURAS Appraisal System | H1 2019/20 | 50.4% | 80% | Red |  |  | There has been a gradual improvement from the beginning of April 2019 when 45.5% compliance was recorded to 50.4% compliance at the end of September 2019. Compliance is varied across the HSCP. Two large sections with good compliance (Child Health and Learning Disability Inpatient) have a positive impact on the overall average. Health and Community Care is a large section with poor compliance which lowers the overall. The following actions are being taken forward to improve compliance: In–house information sessions delivered directly to Reviewers by NHS Learning and Education; Distribution of information and links to how-to guides and forms; Offer to assist managers with detailed reporting on compliance within their section (taken up by some sections); Assistance with the process of having alignments updated when they are causing faulty reporting (taken up by some sections); Regular reporting to the SMT In sections where compliance is lower, proactive sending of detailed information about where the gaps are. |

| Description | Last Update | Current Value | Current Target | Performance Data Traffic Light | Long Term Trend | Short Term Trend | Notes & History Latest Note |
|---|---|---|---|---|---|---|---|
| DECREASE - Sickness absence days per employee - HSCP (LA staff) | H1 2019/20 | 8.0 | 4.9 | Red |  |  | Although there has been an increase in the half-yearly average from last year, absence rates have fluctuated each month with a dip during the summer months. With small numbers of staff within teams any absence results in a high percentage rate and we work continuously to support employees who are absent from work to return as soon as possible. We will continue to hold monthly absence support panels with HSCP Managers to ensure that the Attendance Management Policy is being applied appropriately and consistently. Stress and Anxiety is the most common reason for absence across the HSCP. Stress Audits have been carried out by several teams with action plans in place to address the issues highlighted and we will continue with this approach. |
| INCREASE - iMatter Response Rate - HSCP | 2019/20 | 67% | | Data Only |  |  | Decrease in performance from last year (71%). This was anticipated since care at home staff are now included. We expected a lower response from this group due to use of paper copies and the fact they had been asked to complete 3 surveys already this year. |
| INCREASE - iMatter Employee Engagement Index (EEI) score - HSCP | 2019/20 | 75% | | Data Only |  |  | The EEI score declined slightly by 3% on the previous year. However, overall results are very positive with the majority of indicators green (only 3 yellow and none red). |
| INCREASE - % of teams with an iMatter Action Plan in place - HSCP | 2019/20 | 96% | 80% | Green |  |  | We remain committed to developing action plans based on feedback from staff in the iMatter survey. Participation in action planning is now 96% - up from 93% last year and above target. |
| INCREASE - % Staff who report 'I am given the time and resources to support my learning growth' in iMatter staff survey. | 2019/20 | 77% | 90% | Red |  |  | Based on 636 responses. iMatter Survey Report July 2019. While performance has continued to rise this year (77% from 76% last year and 70% the previous year) we are missing our ambitious target of 90%. |

## Appendix – Indicators with no new update for Mid-Yr

| Indicator |
|---|
| Percentage of children looked after away from home who experience 3 or more placement moves |
| Accommodated children will wait no longer than 6 months for a Looked After Review meeting to make a permanence decision |
| % looked after children and care experienced young people accessing mental health supports |
| 100% of parents of children who have received an autism diagnosis have opportunity to access Cygnet post diagnostic programme within 12 months of receiving diagnosis. |
| % Mothers confirming they have received information about close and loving relationships from staff |
| Increase in improved outcomes for children after parent/carer completion of POPP |
| SCHN09: Balance of Care for looked after children: % of children being looked after in the Community |
| % Child Protection Re-Registrations within 18 months |
| % Looked After Children with more than one placement within the last year (Aug-Jul) |
| % of service users moving from treatment to recovery service. |
| % Change in individual drug and alcohol recovery Outcome Score |
| % Increase in the number of people being referred through diversion from prosecution. |
| % Positive employability and volunteering outcomes for people with convictions. |
| Male life expectancy at birth in 15 per cent most deprived communities |
| Female life expectancy at birth in 15 per cent most deprived communities |
| NI-11: Premature mortality rate per 100,000 persons aged under 75. (European age-standardised mortality rate) |
| NI-18: The number of adults (18+) receiving personal care at home or direct payments for personal care, as a percentage of the total number of adults needing care. |
| NI-2: Percentage of adults supported at home who agreed that they are supported to live as independently as possible. |
| NI-3: Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided |
| % of people with an outcome-focused support plan |
| SW02: Direct payments spend on adults 18+ as a % of total social work spend on adults 18+ |
| SW03: Percentage of people aged 65+ with intensive needs receiving care at home. |
| Mental health hospital admissions (age standardised rate per 1,000 population) |
| Primary Care Mental Health Team (Bridges) wait for referral to 1st appointment offered - within 4 weeks (% patients). |
| Primary Care Mental Health Team (Bridges) wait for referral to 1st treatment appointment offered - within 9 weeks (% patients). |
| Delayed discharges bed days lost to delayed discharge for Adults with Incapacity (AWI) |
| Health and Social Care Integration - Core Suite of Indicators NI-12: Emergency admission rate (per 100,000 population) for adults. |
| NI-13: Emergency bed day rate (per 100,000) for adults |

| |
|---|
| NI-14: Number of re-admissions to an acute hospital within 28 days of discharge per 1,000 admissions. |
| NI-15: Proportion of last 6 months of life spent at home or in a community setting |
| NI-16: Rate per 1,000 population of falls that occur in the population (aged 65 plus) who were admitted as an emergency to hospital. |
| NI-19: The number of bed days due to delay discharge that have been recorded for people aged 75+ resident within the Local Authority area, per 1,000 population in the area. |
| NI-21: Percentage of people admitted to hospital from home during the year, who are discharged to a care home |
| NI-22: Percentage of people who are discharged from hospital within 72 hours of being ready |
| NI-8: Total combined % carers who feel supported to continue in their caring role. |
| NI-17: Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections |
| NI-4: Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated |
| NI-5: Total % of adults receiving any care or support who rated it as excellent or good. |
| NI-6: Percentage of people with positive experience of the care provided by their GP Practice. |
| NI-7: Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life |
| NI-9: Percentage of adults supported at home who agreed they felt safe. |
| Payment of invoices: Percentage invoices paid within agreed period (30 days) |
| NI-20: Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency |
| Expenditure on end of life care, cost in last 6 months per death |
| SCHN08a: The gross cost of "children looked after" in residential based services per child per week £ |
| SCHN08b: The gross cost of "children looked after" in a community setting per child per week £ |
| SW01: Older Persons (Over65) Home Care Costs per Hour |
| SW05: The Net Cost of Residential Care Services per Older Adult (+65) per Week |
| Percentage of HSCP local authority staff with a Performance Review and Development (PRD) plan in place. |
| NI-10: Percentage of staff who say they would recommend their workplace as a good place to work |

**AGENDA ITEM No.6**

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

| | |
|---|---|
| **Meeting of East Renfrewshire Health and Social Care Partnership**<br><br>**Held on** | Performance and Audit Committee<br><br>27 November 2019 |
| **Agenda Item** | 6 |
| **Title** | Audit Actions Update |


**Summary**

This report provides the Performance and Audit Committee (PAC) with updates on the three audit action plans previously reported to PAC on 20 March 2019:

- CareFirst Finance audit action plan (MB1044RL) detailed at Appendix 1.
- IJB Governance (MB1046RM) detailed at Appendix 2.
- Action plan from the Audit Scotland annual report and accounts for 2018/19 detailed at Appendix 3.

The committee should also note that we continue to work closely with ERC Finance colleagues to ensure that following the implementation of the new council financial system we are able to maintain our current level of financial integrity, governance and control.

It should be noted that the updates provided in the supporting appendices are all subject to internal and external audit follow up respectively.


| | |
|---|---|
| **Presented by** | Lesley Bairden, Head of Finance and Resources (Chief Financial Officer) |

**Action Required**

The Performance and Audit committee is requested to note the progress to date against recommendations in the action plans

**APPENDIX 1**

**MB1044RL - CareFirst Finance**
Audit Actions Update

| Ref | Recommendation | Comments | Responsible Officer | Timescale for Completion | Update at 18 Nov 2019 | Date considered closed |
|---|---|---|---|---|---|---|
| 4.1.1 | Priority needs to be given to ensure that annual review takes place for each client with an authorised service agreement however the Head of Finance and Resources stated that it is not possible to undertake a full annual review on every care package and that this operates on a risk based approach. Details of the risk based approach needs to be documented and approved by the IJB | A risk based approach was agreed a number of years ago. The policy will be revised and taken to the IJB for approval. | Head of Adult Health & Social Care Localities | 31-Mar-2019 | Staff transitioned to new roles in May 2019 and work commenced on review process. However due to high demands and pressures across adult services the review service had to be disbanded in October. The review process is currently under review. | |
| 4.1.2 | Operational Managers need to review and prioritise cases to ensure that those most likely to have changed are addressed first. In practice these cases should have been reviewed under routine work. | Will be in line with revised policy to be taken to IJB (SEE 4.1.1) | Head of Adult Health & Social Care Localities | 31-Mar-2019 | As above | |
| 4.2.1 | Action is required by operational managers to ensure that varies processed are appropriate to the client and that service agreements reflect clients' needs accurately. Operational managers should prioritise checking of vary reports to approve all varies processed and to take action to update service agreements where appropriate. | This is already in place, however the formal sign off recording will be strengthened. To avoid duplication of effort and issues the sign off will incorporate some of the points below, as we suggested during the audit. | Head of Finance and Resources | Revised to 31-Dec-2019 | Finance Support Officers (FSO) send vary reports to managers. A traffic light approach has been introduced to highlight the riskiest varies (anything over profiled spend and any large underspends) to aid with a targeted approach. Once individual budgets are fully implemented, along with | |

| Ref | Recommendation | Comments | Responsible Officer | Timescale for Completion | Update at 18 Nov 2019 | Date considered closed |
|---|---|---|---|---|---|---|
| | | | | | approval panels, this process will be amended if necessary.<br><br>It should be recognised that changes in staffing structure mean that some managers need to take additional time to review areas / cases new to them.<br><br>The approval panel is expected to commence in live operation in December 2019. | |
| 4.2.2 | A positive response should be obtained by the Finance Team from each operational manager regarding review and approval of vary reports to ensure that each case is addressed and the manager is confirming an awareness of the differences and any required actions. This could be combined with the quarterly client verification check (which covers existence of client, commitment value and provider) and signed off within budget monitoring to avoid numerous verification checks. | As 4.2.1 | Head of Finance and Resources | 31-Mar-2019 | As per 4.2.1 above, this now forms part of the budget monitoring minute. It should also be noted that due to recent restructure of operational teams, managers may be having to familiarise themselves with a new service area. | |
| 4.3.1 | Operational managers should be reminded that service agreements must be authorised as a priority to avoid backlogs in payments to providers. | Reminder issued 24 May 2018. However the planned centralised entry of service agreements will also improve authorisation times. | Head of Finance and Resources | 31-Mar-2019 | Email issued 24.5.18.<br><br>This will be superseded by the centralised entry of service agreements once implemented. | 24/05/2018 |

| Ref | Recommendation | Comments | Responsible Officer | Timescale for Completion | Update at 18 Nov 2019 | Date considered closed |
|---|---|---|---|---|---|---|
| | | | | | The timing will be dependent on the review of business support functions however interim arrangements will be put in place to support the approvals panel. | |
| 4.3.2 | Social Workers should be instructed that updating the CFF system is essential and that this must be done before the service agreement commences where possible. | See 4.3.1 | Head of Finance and Resources | 31-Mar-2019 | Email issued 24.5.18 attached to scorecard outcome | 24/05/2018 |
| 4.4.1 | Regular review of provider rates should take place within the commissioning team and appropriate action taken where anomalies are found. Evidence of this review should be held. | Report developed, will inform actions and any compliance issue will be taken to DMT | Head of Finance and Resources | 31-Mar-2019 | Commissioning, CareFirst and Finance meet weekly to discuss any new rate anomalies. Records are maintained by CareFirst. | 24/05/2018 |
| 4.4.2 | The report should be presented to DMT in line with procedures to obtain approval of rates not set by commissioning. | See 4.4.1 | Head of Finance and Resources | 31-Mar-2019 | Commissioning report to DMT annually when rates are reviewed. HOS approval for individual non-framework rates is now delegated to locality managers per 4.6.1. the Commissioning team also have access to business objects reports to check rates on an ad-hock basis. | 13/11/2018 |
| 4.5.1 | A review of the uprating process should take place to address the processing of varies where a rate has been approved to | See 4.2.1 and 4.4.1 However the planned centralised entry of | Head of Finance and Resources | 31-Dec-2019 | This will form one of the compliance reports taken on by | |

| Ref | Recommendation | Comments | Responsible Officer | Timescale for Completion | Update at 18 Nov 2019 | Date considered closed |
|---|---|---|---|---|---|---|
| | be paid but needs to be updated on a service agreement. Service agreements should be identified and subject to independent review and update prior to processing the next period invoice. | service agreements will mitigate. | | | the FSOs to raise with operational teams.<br><br>This will be superseded by the centralised entry of service agreements. This will go live in December with the approvals panel. | |
| 4.5.2 | Processing staff should be reminded to check the number of hours charged to the service agreement to ensure that varies processed for rate changes do not also cover increased charges for additional hours. | Reminder issued during audit and will be routinely reviewed | Head of Finance and Resources | 31-Mar-2019 | Team were reminded at time of audit. This is also included within the procedures to deal with invoice variations. | 24/05/18 |
| 4.5.3 | Housekeeping checks should be implemented ensuring that all of the adjustments processed that are intended to be offset at a later date are actually matched up and cleared. | This was deemed low risk, when team is fully staffed will be a routine process | Head of Finance and Resources | 31-Mar-2019 | Invoice processors now regularly complete a tidy action for their allocated providers, ensuring any un-invoiced periods are promptly raised with the provider.<br><br>Given the dynamics of care package profiles and actual spend there are a large volume of varies, often not significant and routinely reviewed by the invoice processors.<br><br>Where a Service Agreement does need revision the FSOs will escalate any issues with operational staff. | |

| Ref | Recommendation | Comments | Responsible Officer | Timescale for Completion | Update at 18 Nov 2019 | Date considered closed |
|---|---|---|---|---|---|---|
| 4.6.1 | Head of service approval must be seen by the carefirst team before they enter a non-framework rate. | Sign off process being refreshed | Head of Finance and Resources | 31-Mar-2019 | This requirement was causing a delay in Service Agreements going onto the system, due to the demands already on HOS. As agreed with the Chief Officer, this has now been delegated to Locality Managers. | 13/11/2018 |
| 4.7.1 | The deceased clients with open service agreements report should be reviewed and service updated to:<br>- Remove clients whose service agreements were not authorised<br>- Ensure that service agreements effectively ended do not appear Appropriately end agreements on the system. | Reminder issued 24 May 2018 and also see 4.2.1 | Head of Finance and Resources | 31-Mar-2019 | The deceased clients report was updated in July 2018 to ensure cancelled and ended service agreements do not appear on the report. Incomplete/unauthorised service agreements are still included in the report as these require action; i.e. cancelled or completed and authorised. | 01/07/2018 |
| 4.7.2 | Homecare Managers should be instructed of the procedure and the requirement to end the service agreements promptly of clients who have died. | See 4.7.1 | Head of Finance and Resources | 31-Mar-2019 | All managers instructed, per email of 24th May 2018. Weekly reports are sent to Intensive Services Manager. Any outstanding service agreements are discussed as part of the routine budget meetings. | 24/05/2018 |

**APPENDIX 2**

**MB1046RM - IJB Governance**
Audit Actions Update

| Ref | Recommendation | Comments | Timescale for Completion | Responsible Officer | Update | Completion Date |
|---|---|---|---|---|---|---|
| 4.1.1 | The IJB should develop a protocol with the auditors to ensure all internal audit reports that affect the IJB are made available to its performance and audit committee. | We will agree a protocol with NHS Internal Audit ensuring that a copy of any Internal audits that impact on IJB will be forwarded to the next available Performance and Audit Committee following the submission of audit response to Internal Audit Section. | 31-Oct-2018 | Business Support Manager | The Financial Governance Manager, NHS GGC has confirmed that the current process is that after each meeting of the NHSGGC Audit and Risk Committee, a paper is prepared which summarises Integration Joint Boards the internal audit activity within NHSGGC. Where a report has a direct impact on an IJB, that report is shared with the IJB. | 07-Nov-2018 |
| 4.2.1 | A Workforce and Development Plan and an Organisational Development Strategy should be put in place as stipulated in the Integration Scheme. | We will meet this requirement through the production of a workforce plan and a learning & development plan. | 31-Mar-2019 | HR Business Partner/L&D Team | Learning & Development staff are working with our partners to deliver an integrated approach which will form the basis of new L&D plan. Due to staffing difficulties, the plan has not yet been finalised, however the Lead Officer: Policy and Practice Development has been appointed and took up post in November. It is anticipated that the plan will be available for sign-off by 31 January 2020.<br><br>Our workforce planning group is established and the 2019/20 workforce plan update complete. The Workforce Plan for 2020-23 will be developed following receipt of guidance from Scottish Government. | |
| 4.3.1 | The two members of the IJB | The code of conduct will be | 31-Aug-2018 | Democratic | This was confirmed as complete at the | 27-Jun-2018 |

| Ref | Recommendation | Comments | Timescale for Completion | Responsible Officer | Update | Completion Date |
|---|---|---|---|---|---|---|
| | who have not signed a code of conduct undertaking should be requested to do so. | forwarded to the two members for sign off. | | Services Manager | meeting on 27 June 2018. | |
| 4.4.1 | A carer's representative should be invited to join the membership of the Clinical and Care Governance Committee as soon as possible in accordance with the Integration Scheme and the IJB decision of 17 June 2016. | A carer representative will be invited to join Clinical and Care Governance Committee. | 31-Oct-2018 | Public Engagement Officer | 2 carer representatives have been identified and are attending meetings of the new Clinical and Care Governance Group. | Jun-2019 |
| 4.5.1 | All documents relating to the IJB should comply with the requirements of the Records Management Plan. | The IJB has received advanced notice from the Keeper of Scottish Records to produce an IJB Records Management Plan (RMP). The Keepers office indicated they will write formally in October 2018 and ask the IJB to produce an RMP within three months. Meantime we will review IJB documents and ensure they comply with ERC RMP | 31-Oct-2018 | Business Support Manager | The RMP was sent to the Keeper of Records Scotland following approval of the both the RMP and MoU at the IJB on 30 January 2019, however the MoU was awaiting signoff by the Chief Executive of NHSGGC. The MoU has now been signed and submitted.<br><br>The Keeper of Records Scotland has now reviewed the RMP and supporting evidence and agrees that combined they set out proper arrangements for the management of the IJBs public records. The assessment will be published on the National Records of Scotland website. | Oct-2019 |
| 4.6.1 | The risk management policy's | We will review the existing | 31-Oct-2018 | Business | The risk register is reviewed by the DMT | 1-Nov-18. |

| Ref | Recommendation | Comments | Timescale for Completion | Responsible Officer | Update | Completion Date |
|---|---|---|---|---|---|---|
| | requirement of quarterly review of the risk profile by the HSCP Management Team should be amended to reflect actual practice. | risk management policy and amend where required. | | Support Manager | prior to submission to every Performance and Audit Committee. In addition, the HSCP key risks are regularly updated with our partners. | |

**Actions from Audit Scotland Action Plan - Appendix 1** **Appendix 3**

https://www.eastrenfrewshire.gov.uk/CHttpHandler.ashx?id=25170&p=0

**2018/19 recommendations for improvement**

| No | Issue | Risk | Recommendation | Agreed Management Action | Responsible Officer | Timing | Comments |
|---|---|---|---|---|---|---|---|
| **1** | **Financial Pressures** | | | | | | |
| B/F* | The IJB is facing a funding gap of £3.1 million in 2019/20. A savings plan of £3.6 million has been identified to address this gap. The 2020/21 savings requirement is estimated between £3.1 million- £3.5 million and a savings plan has yet to be identified. | The IJB may not be able to deliver future savings without adversely impacting service delivery. | The IJB should develop savings plans for 2020/21 which link to, and support, the Fit for the Future programme and which reflect an assessment of the potential impact on service delivery Paragraph 43-51 | As detailed in the MTFP the savings requirement will be dependent on our budget settlement. Should we be required to make significant savings the backstop to balancing future budgets will be to take a backwards step and look at implementing criteria-based assessment so only those with the highest level of need would receive support. | Chief Financial Officer | 31-Mar-20 | We have identified c£0.5 million that we coud potentially take from nine front line services. The balance would come from a prioritsed approach to care packages. The actual savings required will be be dependant on the Scottish Government budget settlement for 2020/21. |
| **2** | **Management Commentary** | | | | | | |
| | Disclosures within the management commentary could be improved, particularly those regarding the key performance indicators against which the main strategic objectives will be measured. | The management commentary does not meet reporting requirements. | The Management Commentary should clearly detail the key performance indicators by which achievement of the IJB's seven strategic priorities will be measured and document the IJB's performance against them. Paragraph 69 | We will review the management commentary for our 2019/20 annual report and accounts. | Chief Financial Officer | 30-Jun-20 | This will be reflected in the annual report and accounts for 2019/20. |
| **3** | **Best Value** | | | | | | |
| | The annual performance report does not include an assessment of how the IJB is meeting its best value duties in the delivery of services. | The IJB does not have appropriate arrangements in place for securing best value. | The IJB should assess how it is meeting its best value duties in the delivery of services and publish a summary and conclusion of the assessment within its Annual Performance Report. Paragraph 75 | We will review how we report on best value for our 2019/20 annual performance report. | Chief Financial Officer | 30-Jun-20 | This will be reflected in the annual performance report for 2019/20. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **4** | **Care at Home** | | | | | | |
| | A report published by the Care Inspectorate during 2018/19 identified a number of concerns and areas for improvement regarding the IJB's Care at Home service. The IJB have developed a comprehensive improvement plan to address the report findings. | The issues identified within the Care Inspectorate report are not adequately addressed and no improvement is seen within the Care at Home Service, impacting on the achievement of strategic priorities within the strategic plan. | Defined to enable the IJB to monitor and review progress and initiate remedial action if required. Paragraph 79-80 | All future inspections and all new inspection reports will be reported to the IJB. | Head of Adult Health and Care Localities | The timeline will be determined by independent external scrutiny. | The latest update and action plan is being presented to the IJB 27/11/19. |
| **5** | **Strategic Plan** | | | | | | |
| B/F* | The current strategic plan 2018-2021 does not include the key performance measures/targets by which the IJB intend to measure progress. | The key performance measures by which the IJB intends to measure progress against the strategic plan is not clear. | The IJB should update the Strategic Plan to include the key performance measures and targets against which performance against key strategic priorities will be assessed. Paragraph 81-82 | The annual implementation plan includes this information and will be appended to the Strategic Plan. | Chief Financial Officer | 31-Mar-20 | The key performance measures to be sent to Communications Team for inclusion on the website - this will be live by end Nov |

*Those items marked with B/F are brought forward from the 2017/18 Annual Audit Report

**AGENDA ITEM No.7**

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

| | |
|---|---|
| **Meeting of East Renfrewshire Health and Social Care Partnership**<br><br>**Held on** | Performance and Audit Committee<br><br>27 November 2019 |
| **Agenda Item** | 7 |
| **Title** | Review of Integration Joint Board Risk Management Policy and Strategy |


**Summary**

This report provides the Performance and Audit Committee with an update on the review of the IJB Risk Management Policy and Strategy and recommended changes to the original document, which was endorsed by the Integration Joint Board in August 2016.


| | |
|---|---|
| **Presented by** | Lesley Bairden, Head of Finance and Resources (Chief Financial Officer) |

**Action Required**

Performance and Audit Committee is asked to:-

- Note the content of the report
- Endorse the amendments to the Risk Management Policy and Strategy and remit to the IJB for approval

**EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP**

**PERFORMANCE & AUDIT COMMITTEE**

**27 November 2019**

**Report by Lesley Bairden, Head of Finance & Resources (Chief Financial Officer)**

# REVIEW OF INTEGRATION JOINT BOARD RISK MANAGEMENT POLICY AND STRATEGY

## PURPOSE OF REPORT

1. This report provides the Performance and Audit Committee with an update on the IJB Risk Management Policy and Strategy review including recommended changes to the original document following a consultation exercise.

## RECOMMENDATION

2. It is recommended that the Performance and Audit Committee:-

   - Note the content of the report
   - Endorse the amendments to the Risk Management Policy and Strategy and remit to the IJB for approval

## BACKGROUND

3. The IJB Risk Management Policy and Strategy was considered by the Performance and Audit Committee (PAC) in March 2016. At this meeting the PAC asked for some amendments to be made. In June 2016 the PAC accepted the amendments and remitted the policy and strategy to the IJB. The IJB endorsed this policy during August 2016.

4. The policy and strategy stated that the document would be reviewed every two years.

## REPORT

Review Process

5. The existing Risk Management Policy and Strategy document was circulated to:-

   - Existing owners of operational risk registers within the HSCP
   - Head of Finance & Resources,(Chief Financial Officer), East Renfrewshire HSCP
   - Chief Nurse, East Renfrewshire HSCP
   - Business Support Manager, East Renfrewshire HSCP
   - Responsible officer for risk management, East Renfrewshire Council
   - Risk and Litigation manager, NHS Greater Glasgow & Clyde

6. In addition the existing policy and strategy document was shared with other HSCPs to allow for peer review and identify any learning opportunities.

7. Officers were asked to review and comment on the existing IJB Policy and Strategy.

8. It should also be noted that internal audit are currently reviewing the IJB risk register.

Feedback received

| From | Note of feedback | Recommendation/ Action |
|---|---|---|
| **Operational Risk Register Owners** | A request for more training and guidance on implementing the policy and strategy | Risk management training is sourced for officer requiring initial or refresher training |
| **NHSGGC Risk and Litigation manager** | It was noted that the policy was fit for purpose, although the scoring matrix used is not the standard 5x5 scoring matrix used by NHSGGC. The Council 4x4 scoring matrix is currently used. | Noted |
| **ERC Risk Manager** | Really good piece of work and was hoping to do something similar in relation to Risk Management within the Council so expect a similar document heading your way in due course.<br><br>Section 1 Perhaps a recognition and link to the ERC Strategic Risk Register (SRR) within section 1 and more generally within the document. There are currently a number of HSCP risks included within this document and HSCP Chief Officer is actively involved in the discussion of this as a member of CMT.<br><br>Section 3 – reporting. The SRR (including HSCP risks) is considered by the Audit & Scrutiny Committee twice a year and annually by the Cabinet. | Noted<br><br>The policy and strategy document be amended to reflect this<br><br>The policy and strategy document be amended to reflect this |
| **HSCP Head of Finance and Resources** | Requested that it be highlighted in the document that “Service Managers have a responsibility to report any changes to their own operational risk register” | Document amended to add text |

## RECOMMENDATIONS

9. It is recommended that the Performance and Audit Committee:-

- Note the content of the report
- Endorse the draft IJB Strategic Risk Register and amendments to the Risk Management Policy and Strategy and remit to the IJB for approval.

## REPORT AUTHOR AND PERSON TO CONTACT

Stuart McMinigal, Business Manager, Finance & Resources
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Lesley Bairden, Head of Finance & Resources (Chief Financial Officer)
Lesley.Bairden@eastrenfrewshire.gov.uk

Chief Officer, IJB: Julie Murray

## BACKGROUND PAPERS

17-08-2016 IJB Paper: IJB Risk Management Policy and Strategic Risk Register
https://www.eastrenfrewshire.gov.uk/CHttpHandler.ashx?id=17355&p=0

29-06-2016 PAC Paper: Risk Management Policy and Strategic Risk Register Update
https://www.eastrenfrewshire.gov.uk/CHttpHandler.ashx?id=17085&p=0

16-03-2016 PAC Paper: Risk Management Policy and Strategic Risk Register
https://www.eastrenfrewshire.gov.uk/ChttpHandler.ashx?id=16335&p=0

18-12-2015 PAC Paper: Risk Management Policy and Strategy
https://www.eastrenfrewshire.gov.uk/CHttpHandler.ashx?id=15894&p=0

# East Renfrewshire Integration Joint Board

# Risk Management Policy and Strategy

## CONTENTS

# Policy – the risk management approach

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

1.2 In doing so the Joint Board aims to provide safe and effective care and treatment for patients and clients, and a safe environment for everyone working within the Joint Board and others who interact with the services delivered under the direction of the Joint Board.

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

**Key benefits of effective risk management:**

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

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

1.5 In normal circumstances the Joint Board's appetite/tolerance for risk is as follows:

Risk matrix with score and tolerance ratings

| **Risk Score** | **Overall rating** |
|---|---|
| 11-16 | High /Red/Unacceptable |
| 5-10 | Medium /Yellow/Tolerable |
| 1-4 | Low/Green/Acceptable |

The table below shows risk levels considering Likelihood and Severity

| **Likelihood** | Score | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Certain | 4 | Low (Green) | | Medium ( Yellow) | | High (Red) | | High (Red) | |
| Likely / probable | 3 | Low ( Green) | | Medium ( Yellow) | | Medium (Yellow) | | High (Red) | |
| Possible/could happen | 2 | Low ( Green) | | Low ( Green) | | Medium (Yellow) | | Medium ( Yellow) | |
| Unlikely | 1 | Low ( Green) | | Low ( Green) | | Low ( Green) | | Low( Green) | |
| **Impact** | | Minor | 1 | Significant | 2 | Serious | 3 | Major | 4 |

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

1.7 The Joint Board will receive assurance reports (internal and external) not only on the adequacy but also the effectiveness of its risk management arrangements and will consequently value the contribution that risk management makes to the wider governance arrangements of the Joint Board.

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

# Strategy - Implementing the policy

## 1. Introduction

1.1 The primary objectives of this strategy will be to:

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

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

1.3 **Strategic risks** represent the potential for the Integration Joint Board (IJB) to achieve (opportunity) or fail to meet (threat) its desired outcomes and objectives as set out within the Strategic Plan, and typically these risks require strategic leadership in the development of activities and application of controls to manage the risk. The Strategic Risks Register will be shared with East Renfrewshire Council and NHS GGC. IJB risks maybe noted on those organisations Strategic Risk Register if deemed appropriate.

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

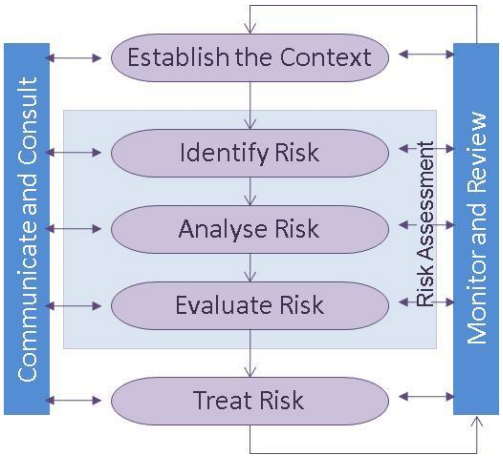
1.5 All risks will be analysed consistently with an evaluation of risk as being as follows
High /Red/Unnaceptable, Medium /Yellow/Tolerable and Low/Green/Acceptable

Risks identified as High/Red/Unaccepatble will be subject to an exception report presented to the Performance and Audit Committee and the IJB.

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

## 2. Risk management process

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




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

## 3. Application of good risk management across the IJB activities

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

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

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

3.1.3 Categorisation of risk under the headings below:

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

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

3.1.5 Consistent application of the agreed risk matrix to analyse risk in terms of likelihood of occurrence and potential impact, taking into account the effectiveness of risk control measures in place. The risk matrix and guide to terms and scoring to be used is attached in Appendix 1.

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

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

3.1.8 Reporting of strategic risks and key operational risks to the IJB on a annual basis and to the PAC on a bi annual basis linked to the Strategic Plan and performance reporting. In addition ERC Strategic Risk Registers which may contain IJB risks are reported to East Renfrewshire Council

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

Audit and Scutiny Committee twice a year and cabinet once a year. Likewise high level NHSGGC riskd from the Strategic Risk Register are reported to the Board every quarter.

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

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

# Realising the risk management vision

## 4. Risk management vision and measures of success

**Vision Stratement:**

To ensure that risk management is clearly and consistently integrated in the culture of East Renfrewshire Integrated Joint Board.

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

4.2 The measures of success for this vision will be:

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

# Risk leadership and accountability

## 5. Governance, roles and responsibilities

5.1 Integration Joint board

Members of the Integration Joint Board are responsible for:

- oversight of the IJB's risk management arrangements;
- receipt and review of reports on strategic risks and any key operational risks that require to be brought to the IJB's attention; and,
- ensuring awareness of any risks linked to recommendations from the Chief Officer concerning new priorities/ policies.

5.2 Chief Officer

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

5.3 Chief Financial Officer

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

5.4 Senior Management Team

Members of the Senior Management Team are responsible (either collectively, or by nominating a specific member of the team) for:

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

5.5 Individual Risk Owners

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

- risks assigned to them are analysed in keeping with the agreed risk matrix;
- data on which risk evaluations are based are robust and reliable so far as possible;
- risks are defined clearly to make explicit the scope of the challenge, opportunity or hazard and the consequences that may arise;
- risk is reviewed not only in terms of likelihood and impact of occurrence, but takes account of any changes in context that may affect the risk;
- controls that are in place to manage the risk are proportionate to the context and level of risk.
- Service Managers have a responsibility to report any changes to their servcie's Operational Risk Register to the Directorate Management Team.

5.6 All persons working under the direction of the IJB

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

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

5.7 Partner Bodies

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

5.8 Senior Information Risk Owner

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

# Resourcing risk management

### 6. Resourcing the risk management framework

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

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

### 7. Resourcing those responsible for managing specific risks

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

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

## Training, learning and development

### 8. Risk management training and development opportunities

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

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

## Monitoring activity and performance

### 9. Monitoring risk management activity

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

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

9.3 All strategic and shared risks and key operational risks will be considered by the Senior Management team every quarter.

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

### 10. Monitoring risk management performance

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

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

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

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

# Communicating risk management

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

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

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

11.3 The Policy and Strategy (version 1.0) was approved by the Integration Joint Board at its meeting of **17/08/2016**.

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

# Appendix 1 Risk Matrix

Risk matrix

| **Likelihood** | Score | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Certain | 4 | Low | | Medium | | High | | High | |
| Likely / probable | 3 | Low | | Medium | | Medium | | High | |
| Possible/could happen | 2 | Low | | Low | | Medium | | Medium | |
| Unlikely | 1 | Low | | Low | | Low | | Low | |
| **Impact** | | Minor | 1 | Significant | 2 | serious | 3 | Major | 4 |

# Appendix 2 Guide to Terms and Scoring

RISK CRITERIA FOR IMPACT

| Factor | Score | Effect on Service | Embarrassment/reputation | Personal Safety | Personal privacy infringement | Failure to provide statutory duties/meet legal obligations | Financial | Effect on Project Objectives |
|---|---|---|---|---|---|---|---|---|
| Major | 4 | Major loss of service, including several important areas of service and /or protracted period.<br><br>Service Disruption 5+ Days | Adverse and persistent national media coverage<br><br>Adverse central government response, involving (threat of) removal of delegated powers<br><br>Officer(s) and/or Members forced to resign | Death of an individual or several people | All personal details compromised/ revealed | Litigation/claims/fines from Departmental £250k +<br><br>Corporate 500k+ | Costing over £500,000<br><br>Up to 75% of Budget | Complete failure of project/ extreme delay – 3 months or more |
| Serious | 3 | Complete loss of an important service area for a short period<br><br>Major effect to services in one or more areas for a period of weeks<br><br>Service Disruption 3-5 Days | Adverse publicity in professional/municipal press, affecting perception/standing in professional/local government community<br><br>Adverse local publicity of a major and persistent nature | Major injury to an individual or several people | Many individual personal details compromised/ revealed | Litigation/claims/fines from<br><br>Departmental £50k to £125k<br><br>Corporate £100k to £250k | Costing between £50,000 and £500,000<br><br>Up to 50% of Budget | Significant impact on project or most of expected benefits fail/ major delay – 2-3 months |
| Significant | 2 | Major effect to an important service area for a short period<br><br>Adverse effect to services in one or more areas for a period of weeks<br><br>Service Disruption 2-3 Days | Adverse local publicity /local public opinion aware Statutory prosecution of a non-serious nature | Severe injury to an individual or several people | Some individual personal details compromised/ revealed | Litigation/claims/fines from Departmental £25k to £50k Corporate £50k to £100k | Costing between £5,000 and £50,000 Up to 25% of Budget | Adverse effect on project/ significant slippage – 3 weeks–2 months |
| Minor | 1 | Brief disruption of important service area<br><br>Significant effect to non-crucial service area Service Disruption 1 Day | Contained within section/Unit or Directorate<br><br>Complaint from individual/small group, of arguable merit | Minor injury or discomfort to an individual or several people | Isolated individual personal detail compromised/ revealed | Litigation/claims/fines from Departmental £12k to £25k Corporate £25k to £50k | Costing less than £5,000 Up to 10% of Budget | Minimal impact to project/ slight delay less than 2 weeks |

RISK CRITERIA FOR LIKELIHOOD

| Factor | Score | THREATS-DESCRIPTION | INDICATORS |
|---|---|---|---|
| Certain | 4 | More than 75% chance of occurrence | Regular occurrence<br>Circumstances frequently encountered – daily/weekly/monthly |
| Likely | 3 | 40% - 75% chance of occurrence | Likely to happen at some point in the next 1-2 years<br>Circumstances encountered a few times per year. |
| Could happen | 2 | 10% - 40% chance of occurrence | Only likely to happen 3 or more years |
| Unlikely | 1 | Less than 10% chance of occurrence | Has rarely happened/ never before |