AGENDA ITEM

10

Agenda Item: 10

Falkirk
Health and Social Care
Partnership

Title/Subject:	**Risk Management Strategy and Strategic Risk Register Update**
Meeting:	**Integration Joint Board**
Date:	**5 April 2019**
Submitted By:	**Chief Finance Officer**
Action:	**For Decision**

1. INTRODUCTION

1.1. The purpose of this report is to present the Integration Joint Board (IJB) with the updated Risk Management Strategy and a revised, high level Strategic Risk Register. Both reports were considered by the Audit Committee on 29 March 2019.

2. RECOMMENDATION

2.1. The IJB are asked to approve the updated Risk Management and Strategic Risk Register Update.

3. BACKGROUND

3.1. The Falkirk Integration Scheme makes specific reference to Risk Management and Support Services. In relation to Risk Management two sections below are of most relevance:

- 13.2 The Parties will commit all necessary resources to support risk management by the Integration Joint Board
- 13.10 The Parties will support the Integration Joint Board to:
    a. establish risk monitoring and reporting as set out in the RM framework; and
    b. maintain the risk information and share with the Parties within the timescales specified.

3.2. In relation to Support Services, the Integration Scheme notes that

- 4.4 The Parties will provide the corporate services agreed pursuant to paragraphs 4.2 and 4.3 to the Integration Joint Board, and the provision of such support will be reviewed annually by the Parties and Integration Joint Board to ensure that the necessary support is being provided.

- Risk management arrangements form part of the support services that partner organisations are required to provide to the IJB.

Falkirk Council

NHS Forth Valley

3.3. Previous reports to the Audit Committee have highlighted some issues with the IJB's risk management arrangements, the need to update the Risk Management Strategy and the need to refresh the IJB's strategic risk register.

4. UPDATE ON PROGRESS

Risk Management Arrangements

4.1. Up to the end of 2017, the Head of Governance within NHS Forth Valley and the Corporate Risk Coordinator from Falkirk Council worked together to produce a robust risk management system for the IJB. However, it was recognised that this system would require ongoing review and updating to ensure the risk landscape of the IJB is comprehensive and understood by all parties.

4.2. Falkirk Council have committed to continuing the Corporate Risk Coordinator support, noting that appropriate support from NHS Forth Valley will still be required.

4.3. The Head of Governance post within NHS Forth Valley has not been replaced and at present the Chief Executive of NHS Forth Valley is the lead for risk for the Health Board. NHS Forth Valley have reported that they will recruit administrative support for risk management and the post has not yet been filled. It is expected that this role will report to the Health and Safety Manager within NHS Forth Valley. It is anticipated that this resource will be available for the IJB to use to complete work associated with risk, for example organising risk workshops, meeting with key staff to assess and monitor risks etc.

Strategic Risk Register

4.4. Over the last couple of months the Leadership Team has discussed and reviewed the Strategic Risk Register. The Team agreed that the Strategic Risk Register needed to be completely refreshed with a different approach taken to the identification of risk. Members of the Leadership Team agreed that the Strategic Risk Register for the IJB should have a clear focus on risks in key areas:

- Delivery of the strategic plan
- Performance, oversight and quality control
- Specific high level risks:
    - Unscheduled care
    - Transfer of NHS operational services
    - Brexit

4.5. The revised Strategic Risk Register is at appendix 1 to this report. This appendix shows a high level summary of the risks identified. During April the Lead Officers for each risk will be asked to complete a detailed risk matrix (appendix 2). The risk matrix will set out an assessment of the likelihood of the risk materialising as well as mitigating actions that are in place or will be developed. Where necessary, the Corporate Risk Coordinator will advise and assist the Lead Officers with this work.

4.6. The Audit Committee is expected to receive an update of the Strategic Risk Register at each meeting. This will be particularly important as work continues to better embed a risk management culture within the Partnership. Whilst risk will be considered at each Leadership Team meeting, a formal review of the Strategic Risk Register will be undertaken by the Leadership Team in advance of each Audit Committee.

4.7. The Leadership Team recognised that the strategic risks of the IJB should focus on both the role of the IJB and most importantly on delivery of the strategic plan. This approach can only work where operational risks are being appropriately addressed through existing operational risk management arrangements. However, as more services are transferred to the Partnership, the Leadership Team will oversee development of an operational risk register for the Partnership.

Risk Management Strategy Update

4.8 The Council's Corporate Risk Coordinator has led a review of the Risk Strategy for the IJB. The original Risk Management Strategy, approved by the IJB in March 2016, was due to be updated by 31 March 2019.

4.9 The Council's Corporate Risk Management Policy and Framework was approved by the Executive in May 2018. The Health Board's Risk Management Strategy was approved by the Health Board in January 2019. The updated Risk Management Strategy for the IJB has drawn on both of these documents to ensure alignment across the Partnership where possible.

4.10 A summary of the key changes to the IJB's Risk Management Strategy is provided below:

- Recognition of changes to the IJB's governance structure, including for example the Clinical & Care Governance committee and the Adult Support & Protection committee
- Emphasis on the importance of a "lessons learned" culture
- Delegation of the responsibility for developing the Risk Management framework to the Chief Finance Officer along with the requirement to provide regular updates to the IJB Audit Committee.

5. NEXT STEPS

5.1 Following the identification of high level strategic risks by the IJB Leadership Team, the Lead Officers for each risk will develop a detailed risk summary, liaising with the Corporate Risk Coordinator where necessary. This will be presented to the June Audit Committee.

6. CONCLUSIONS

6.1. The report presents a high level Strategic Risk Register and an updated Risk Management Strategy.

6.2. A more detailed Strategic Risk Register will be presented to the June 2019 Audit Committee for consideration.

Resource Implications
At this stage there are no resource implications arising from this report. The embedding of risk management is currently dependent on the continued resource commitment of partner organisations. However, consideration may need to be given to identifying resource to ensure this essential role is filled.

Impact on IJB Outcomes and Priorities
Key risks are failure to identify and manage the risks associated with achieving the outcomes and priorities detailed within the Strategic Plan and other plans.

Legal & Risk Implications
The key risks are failure to effectively:

- Implement the Risk Management Strategy
- Identify and assess risks associated with delivering the Strategic Plan and other plans
- Meet the requirements of the Integration Scheme
- Mitigate the potential impact on Falkirk Council and/or NHS reputational risk
- Align risk and performance arrangements.
- Provide assurances that risks are being managed effectively.

Consultation
The revised Strategic Risk Register has been developed by the IJB Leadership Team. The revised Risk Management Strategy has been circulated for comment.

Equalities Assessment
N/A

Approved for Submission by: Patricia Cassidy, Chief Officer

Author: Amanda Templeman, Chief Finance
Officer Date: 28 March 2019
List of Background Papers: n/a

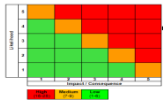
FALKIRK IJB STRATEGIC RISK REGISTER

DELIVERY OF THE STRATEGIC PLAN		
1	There is a risk that the IJB will fail to deliver its strategic objectives due to funding pressures and/or demographic pressures. This could be the result of: • Failure to plan for demographic change in the medium and longer term • Insufficient funding from partners • Delegated services not being delivered within budget • Lack of clarity around budget accountability • Failure to manage and impact on set aside budgets • Interdependency with decisions of Clackmannanshire and Stirling IJB re Forth Valley wide services	
2	There is a risk that the IJB fails to deliver its strategic objectives due to a lack of clarity and/or agreement in respect of governance arrangements, for example: • A lack of clarity around the separate roles of the IJB, HSCP, Council, NHS Board and other partners, including Clackmannanshire and Stirling IJB • An inability to influence decision making and/or a lack of agreement around where decisions should be made	
3	There is a risk that the IJB fails to develop effective links with communities, the third, independent and housing sectors and other partners, leading to poor relationships and failure to deliver the strategic outcomes.	
4	There is a risk that the IJB fails to delivery its strategic objectives due to a lack of capacity and infrastructure to deliver key roles, including effective planning, performance, risk management, information management, technology support, training and development etc. This could lead to failures in governance, scrutiny and performance arrangements.	
5	There is a risk that Directions, and therefore the Strategic Plan, are not delivered due to: • Poorly drafted Directions, which do not set out a clear decision from the IJB • Poor processes which do not ensure that Directions are the result of a collaborative approach to service redesign and transformation • A decision by the Partners to disregard the Directions.	
PERFORMANCE, OVERSIGHT & QUALITY CONTROL		
6	There is a risk that the IJB does not receive assurance from assurance providers in respect of performance and quality control. This could be the result of: • The mechanism to provide assurance are not effective • Partnership risks are not escalated appropriately	

7	There is a risk that the IJB fails to commission quality services from both statutory partners and the independent sector. This could be the result of: • Poor oversight arrangements • Lack of quality control arrangements • Lack of capacity to effectively monitor performance • Failure to adequately share information	
SPECIFIC HIGH LEVEL RISKS		
8	Unscheduled Care There is a risk that the IJB does not deliver improvements in unscheduled care. This could be the result of: • Lack of clarity around roles and responsibilities across all Partners • Lack of influence on decision making in this area • Inability to deliver a whole systems way of working • Inability to shift resources • Inability to manage demand pressures	
9	Transition of Operational Management of NHS Services to Partnerships There is the risk of: • Lack of continuity of service provision • Changes in management and oversight impacting negatively on quality of service delivery and/or the ability to transform services	
10	Brexit • Disruption to services as a result of workforce challenges and disruption to the supply chain. • Workforce and supply chain challenges may lead to increased costs and hamper transformation and financial efficiencies. • Economic risks associated with Brexit may result in reduced funding available for health and social care. • Political impact of reduced supplies on vulnerable adults and families. • A key risk is that the “unknowns” associated with Brexit mean it is difficult to plan effectively for Brexit.	

Appendix 2

IJB STRATEGIC RISK REGISTER
NEXT STEP - TEMPLATE FOR LEAD OFFICERS TO COMPLETE

Risk No. / Title			Current Risk (with controls)	Target Risk (after actions)	Change	Date Reviewed
Risk Description There is a risk of 'x' because of 'y'….		**Risk Scoring**				
Consequences This may result in (worst case) 'z'….		**Rationale for Risk Rating**				
Mitigating Controls		**Assurance / Reviews Mechanisms**				
Lead Officer		**Lead Group (if relevant)**				

Additional Actions	Action	Target Date	Status	Progress

Latest Note	

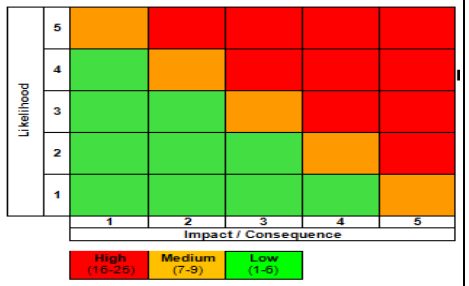
Appendix 4: Risk Scoring Guidance and Matrix

Impact / Consequence

Score	Financial	Reputational	Harm to People or Assets	Interruption to Services to Projects	Audit/ Legal/ Compliance
5. Severe	Extensive; spend exceeds available budgets	Sustained media interest, complaints, and / or loss of confidence	Multiple deaths and / or assets destroyed	Extended disruption or loss of service, or project delay	Severe penalty, criticism and / or legal action
4. Major	Major impact, but within budgets	National media interest and / or serious loss of confidence	Major injury, death, and / or assets destroyed	Major service disruption, loss of multiple services, or project delay	Major legal action, penalty, and / or criticism
3. Moderate	Manageable budget impact; spend exceeds risk owner's authority	Regional media interest and / or multiple complaints	Moderate injuries and / or damage	Some disruption to service, or project delay	Action required; and may result in criticism and / or penalty
2. Minor	Minimal budget impact; spend is within risk owner's authority	Local media interest and / or customer complaints	Minor injury and / or damage	Minor disruption to multiple services, or project delay	Action required; but unlikely to result in criticism and / or penalty
1. Negligible	None or little budget impact; spend is within risk owner's authority	None, or little, media interest; impact is in public domain, but managed	None or very minor injury and / or damage	None or little disruption to one service, or project delay	No or little query from audit body / regulator; but no criticism or action required

Likelihood

5. Almost Certain	It is fairly certain that risk will occur, or has already occurred
4. Likely	There is a strong chance of the risk occurring
3. Possible	There is a reasonable chance of the risk occurring
2. Unlikely	There is a fairly low chance of the risk occurring
1. Almost Impossible	There is little evidence that the risk is likely to occur



High risks may be either:

- within the IJB's risk tolerance (meaning that the Lead Officer considers the current controls are proportionate **and effective**); or
- above the IJB's risk tolerance (meaning that the Lead Officer considers that additional actions are necessary to reduce the risk).

If the risk is above the risk tolerance, the Strategic Risk Register should include a Target Risk Level and Actions.

Medium risks are within the IJB's risk tolerance, meaning controls / mitigation are proportionate **and effective** (additional actions are not essential, but should be recorded in the Strategic Risk Register where relevant).

These do not need to be included within Strategic Risk Register reports. Partners/ Teams should monitor these at an operational level and, if the risk increases, they should be escalated as High or Medium risks.

The definitions of H/M/L responses are still to be agreed as part of the IJB RM Strategy review.

Key: Change in Current Risk Rating:	No Change	Reduced	Increased		

Falkirk
Health and Social Care
Partnership

Falkirk Health and Social Care Partnership

Risk Management Strategy

Draft - March 2019

DOCUMENT HISTORY

Document Title:	Falkirk HSCP Risk Management Strategy	Lead Reviewer:	Chief Finance Officer
Owner:	Chief Finance Officer	Superseded Version:	Version 2: March 2017
Version No:	Draft 3.1 – March 2019	Next Review Date:	March 2021
Associated Documents:	Falkirk Council – Corporate Risk Management Policy and Framework, May 2018 NHS Forth Valley – Risk Management Strategy, January 2019		

Contents

1. Introduction – the IJB's Approach to Risk Management

1.1 This Risk Management Strategy (RMS) dove-tails with each partner's existing Risk Management Strategies. Whilst each partners' risk strategy uses different language, their aims and approach to managing risk is fundamentally very similar.

1.2 The IJB's Strategic Plan defines their approach to risk as:

"the partnership approach is to be able to identify, manage and tolerate risk, to enable staff to work in different and innovative ways to meet service user and carer personal outcomes and deliver the national and local integration priorities".

1.3 The IJB and partners have a clear process for identifying, assessing, reviewing, and (where necessary) escalating risks. Risk management is an integral part of decision making and broader governance arrangements – including audit, clinical and care governance, and performance management. The risk and governance arrangements are set out as follows:

- Appendix 1: IJB Governance Structure
- Appendix 2: NHS Forth Valley - Risk Reporting Framework;
- Appendix 3: Falkirk Council – Risk Reporting Framework.
- Appendix 4: Risk Scoring Guidance and Matrix

1.4 Sound governance and risk management is essential to delivering the IJB's Strategic Plan.

1.5 This strategy encourages decision makers to be 'risk aware' rather than 'risk averse'. This includes encouraging innovation and recognising 'opportunity risks', which are integral to improving care and transforming Services - provided that the risks are assessed and justified in the context of the anticipated benefits for service users, staff, unpaid carers, and the IJB.

1.6 Good risk management will result in:

- improved communication and understanding of risk, resulting in fewer surprises;
- more resilient Services and communities;
- fewer incidents, and better response;
- better evidence to support risk based decisions;
- improved audit and inspection results;
- improved performance and outcomes;
- measureable Council, Project, and Partnership Plans; and
- improved assurance.

2. Risk Management Process

2.1 If the HSCP is to manage risk effectively, they need to demonstrate that risks are managed in a systematic and structured manner and reviewed regularly. This includes:

- **Strategic Risks**
  This includes the risks to achieving the IJB's Strategic Plan. These are recorded on the IJB's Strategic Risk Register (SRR) and managed by the HSCP Leadership Team;

- **Corporate Risks**
  This includes the risks (opportunity or threat) to achieving individual partners' corporate / strategic plans. These are managed by each partners' Leadership Team, and escalated to the HSCP Leadership Team as necessary;

- **Operational Risks**
  This includes the risks to individual teams, which are managed at locality/Service/Team Manager level. Where a risk affects multiple units and / or requires more senior leadership they should be escalated to the partnership or partners' Leadership team;

- **Project Risks**
  This includes the risks (opportunity or threats) to successfully delivering change. These are managed by the appropriate working group or Project Board.. Where a risk could impact the IJB's Strategic Plan, they should be escalated to the HSCP Leadership Team; and

- **Care and Clinical Risks**
  This includes risks of harm to employees and patients / service users. These are managed every day, by all staff, and there are established review frameworks – such as health & safety and care & clinical governance. The IJB has a Clinical and Care Governance Committee.

2.2 The (reasonable worst case) consequences of taking risks must be asssessed to enable informed decisions to be made. This includes harm to people, financial loss, service interruption, reputational damage, legal action, and adverse incidents / audits / inspections.

2.3 Risks will be owned by / assigned to whoever is best placed to manage / monitor the risks.

2.4 The Risk Scoring Guidance (at **Appendix 4**) provides a framework for assessing the consequences of risks, and deciding what is an appropriate level of risk and controls. These are supplemented, as necessary, by policy and guidance on managing different types of risk.

2.5 The IJB will seek to develop a Risk Appetite Statement (or guiding principles) for assessing whether existing control measures are reasonable, or additional actions are necessary.

2.6 The IJB will demonstrate a commitment to a 'lessons learned' culture that seeks to learn from both good and poor experience, replicate good practice, and reduce adverse. The IJB has already embeeded this through, for example:

- Care and Clinical Governance Committee which reviews adverse incidents which have caused harm or had the potential to cause harm to service users and considers Care Inspectorate reports, including monitoring the delivery of improvement plans;

- Audit Committee which reviews audits and inspections undertaken by a range of assurance providers at a national and local level;

- A Duty of Candour is now embedded wihtin the Scottish Social Services Council (SSSC) Code of Conduct.

3. Governance, Roles and Responsibilities

3.1. 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;
- ensuring they are aware of any risks linked to recommendations from the Chief Officer concerning new priorities / policies and the like (e.g. inclusion of a 'risk implications' section on Board papers); and
- ensuring that the Chief Officer and the IJB Leadership Team implements and monitors mitigating actions and reports progress.

3.2. 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.

3.3. Chief Financial Officer

The Chief Financial Officer has been delegated responsibility for developing the IJB's risk management framework and providing risk and assurance udpates to the IJB Audit Committee and Leadership Team.

3.4. HSCP Leadership Team

Members of the HSCP Leadership 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;
- ensuring that the Lead Officers for each strategic risk (in conjunction with work streams, where appropriate) provide regular udpates to the Leadership Team;
- 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; and
- reporting back to the IJB on risks.

3.5. Audit Committee

The Audit Committee are responsible for reviewing and seeking assurance on risk management arrangements and receiving regular risk management updates and reports. The Terms of Reference for the Audit Committee is at Appendix 5.

3.6. Care and Clinical Governance Committee

The role of the CCGC is to ensure that there is effective clinical and care governance within the Partnership that provides assurance to patients, service users, unpaid carers and their families, clinical and care staff, managers, and members of the IJB. The Framework for Care and Clinical Governance arrangements for Falkirk IJB is at Appendix 6.

3.7. Adult Support and Protection Committee

The Adult Support and Protection Committee (ASPC) has a role in ensuring co-operation and communication within and between agencies to promote appropriate support and protection as set out in section 42 (2) of the Adult Support and Protection (Scotland) Act 2007. The Terms of Reference for the ASPC is at Appendix 7.

3.8. Employees / 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 patient's / service user's / (unpaid) carer's / others at risk of harm; to identified hazards and implement safe working practices developed within their service areas; and to report near misses and incidents of harm so that these can be investigated and lessons learnt.

3.9. Others / Specialists

It is the responsibility of relevant specialists from the partner bodies to attend meetings as necessary to consider the implications of risks and provide relevant advice. This includes internal audit, external audit, chief legal / risk officers, Lead Officers for risks, (sub) committees, clinical and non clinical risk managers / advisors (including Lead Officers and work streams for risks) and health and safety advisors.

3.10. Corporate Management Teams of Partner Bodies

Falkirk Council's Corporate Risk Management Policy and Framework and NHS Forth Valley's risk Management Strategy set out their broad roles and responsibilities.

Corporate management teams of partner bodies are responsible for:

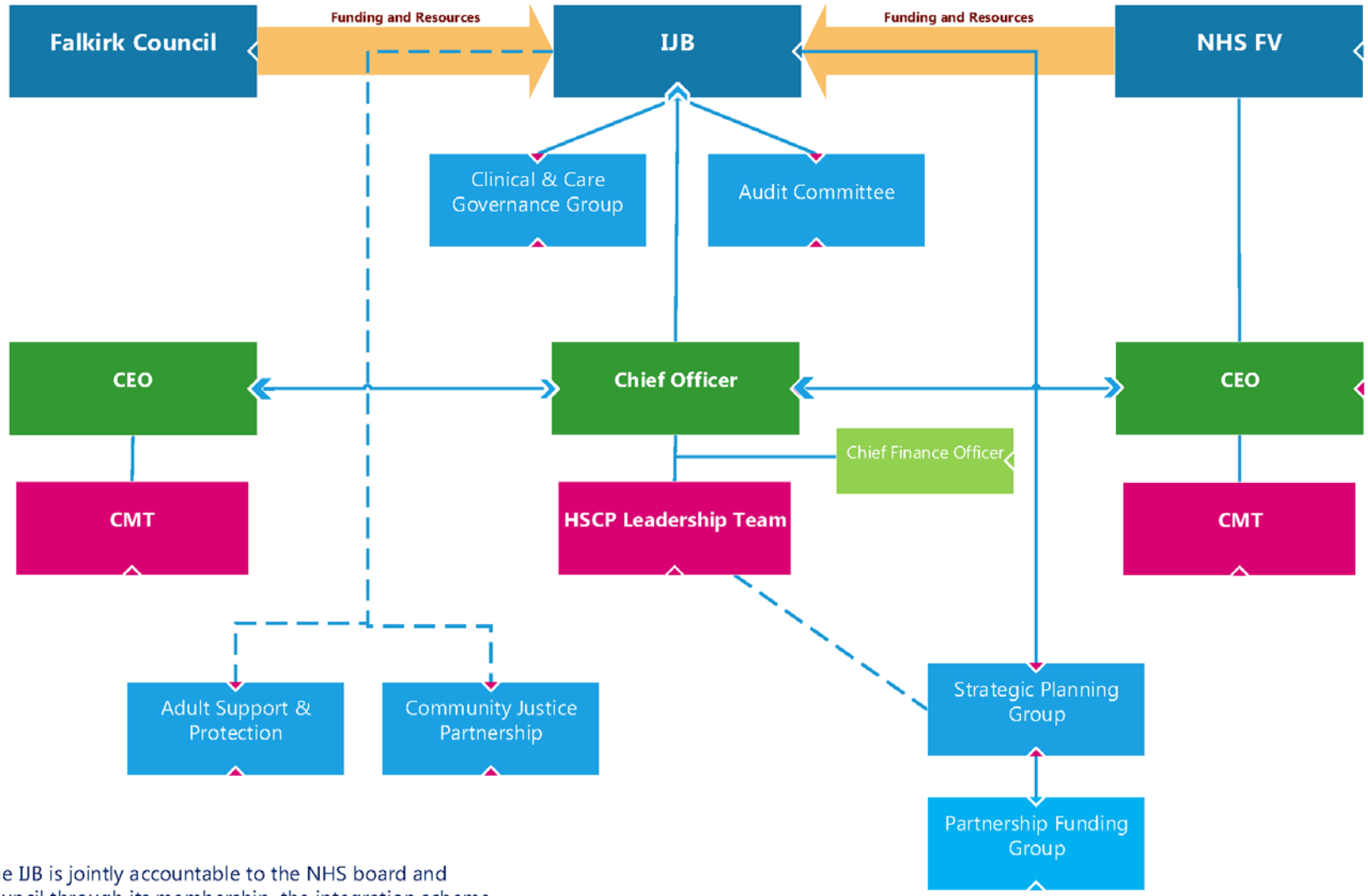
- ensuring that they routinely seek to identify any residual risks and liabilities they retain in relation to the activities under the direction of the IJB; and
- escalating and reporting risks to the HSCP Leadership Team and IJB when they exceed their risk tolerance and / or where they may affect the achievement of the IJB's Strategic Plan.

4. Communication and Training

4.1. This strategy will be communicated/cascaded to all employees by the HSCP Leadership Team.

4.2. Suitable guidance and training will be developed, and agreed with the HSCP Leadership Team, to ensure that this strategy is implemented effectively at all levels.

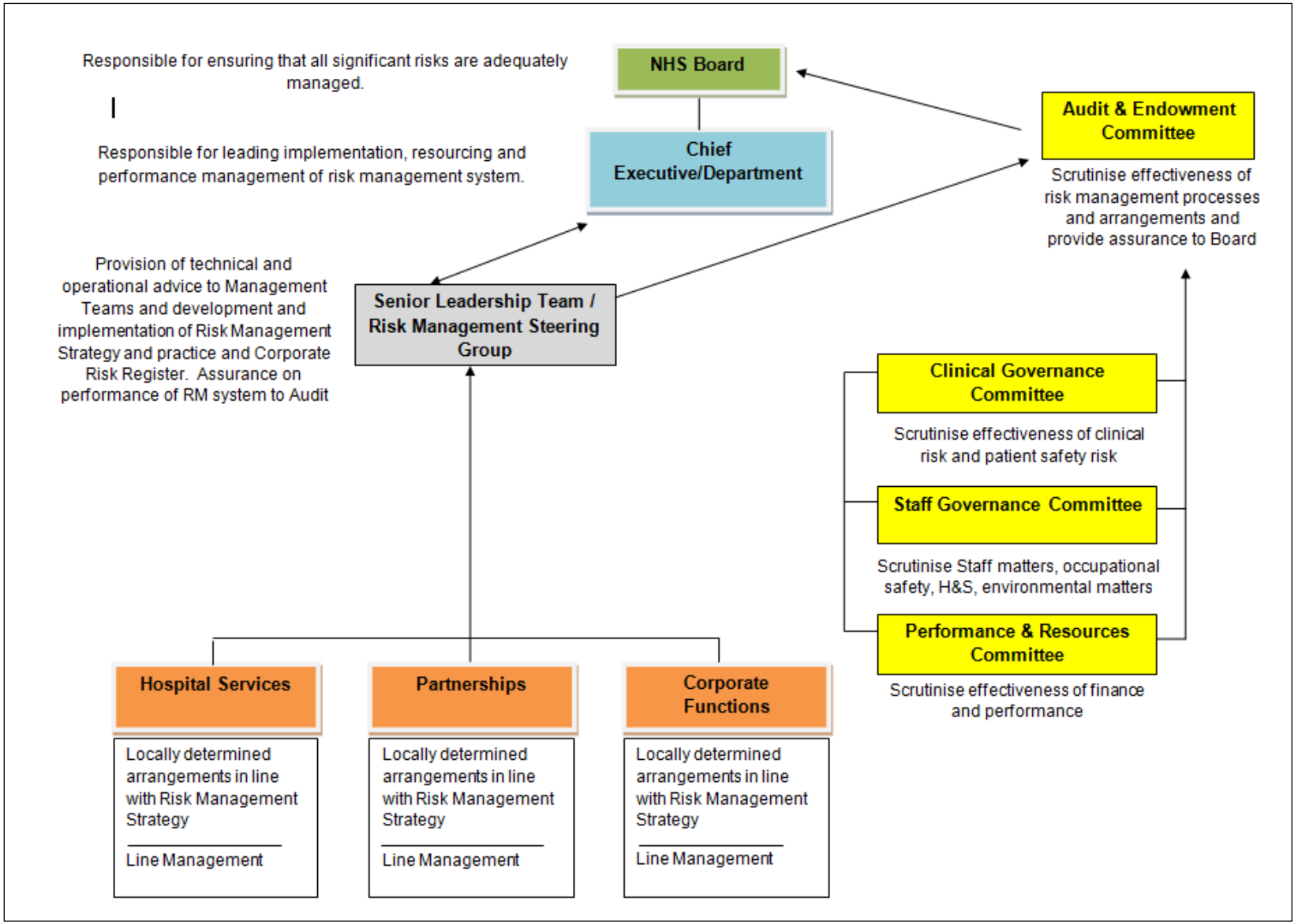
Appendix 1: Falkirk IJB Governance Structure



The IJB is jointly accountable to the NHS board and council through its membership, the integration scheme and the strategic plan

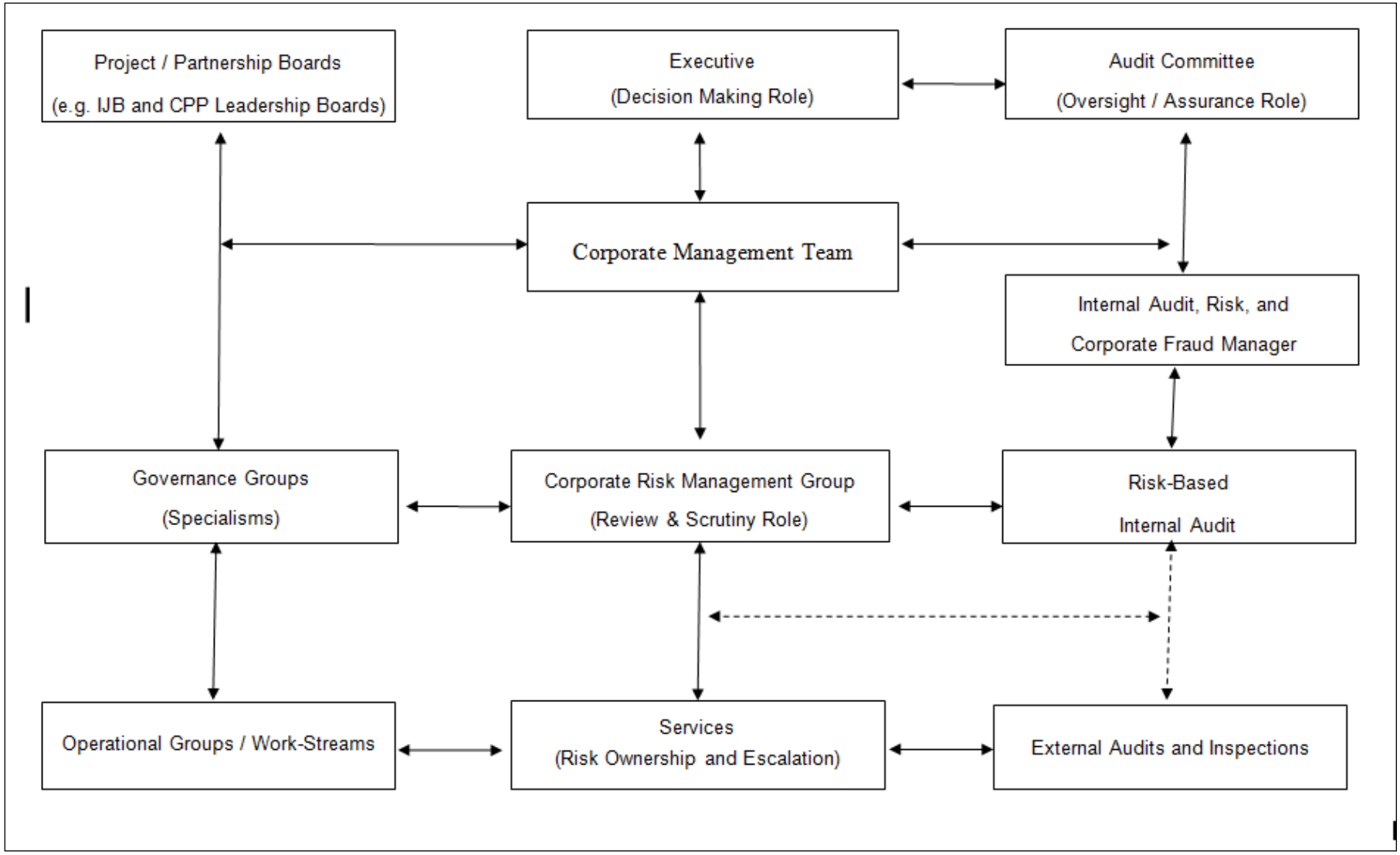
Appendix 2: Strategic Risk Management Reporting Frameworks - NHS Forth Valley

(Source: Draft Risk Strategy January 2019)



Appendix 3: Strategic Risk Management Reporting Frameworks - Falkirk Council

Source: Corporate Risk Management (CRM) Framework – Approved May 2018



Appendix 4: Risk Scoring Guidance and Matrix

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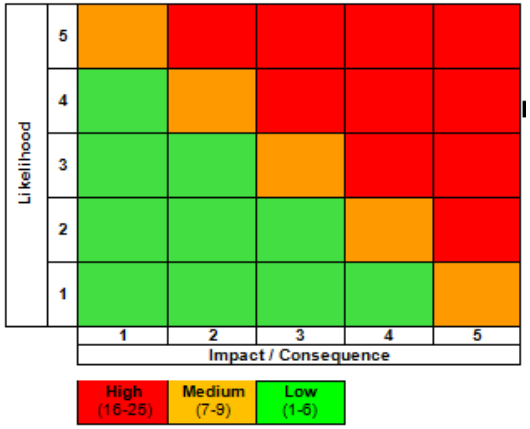


Appendix 5

Falkirk Health and Social Care Partnership

FALKIRK HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD (IJB)
AUDIT COMMITTEE DRAFT TERMS OF REFERENCE

Constitution
The IJB shall appoint the Committee. The Committee should agree the professional advisors it requires on a regular and adhoc basis. The Committee is required to review its terms of reference on an annual basis.

The Committee will meet at least twice per annum. The Committee will be supported and serviced by the Chief Finance Officer. The Audit Committee should report to the IJB.

Chairperson
The Chairperson of the Committee will be a voting member nominated by the IJB, noting that the Chairperson of the IJB would not normally be a member of the Audit Committee

Quorum
Half of the voting members will constitute a quorum.

Functions Referred
The following functions of the IJB shall stand referred to the Audit Committee –

1. Assess the adequacy and effectiveness of the IJB's internal controls and corporate governance arrangements and consider the annual governance reports and assurances to ensure that the highest standards of probity and public accountability are demonstrated;

2. Ensure existence of and compliance with an appropriate Risk Management Strategy. Review risk management arrangements and receive regular risk management updates and reports;

3. Review and approve the Internal Audit Annual Plan on behalf of the IJB, receive reports and oversee and review progress on actions taken on audit recommendations and report to the IJB on these as appropriate;

4. Consider the External Audit Annual Plan on behalf of the IJB, receive reports and consider matters arising from these and management actions identified in response before submission to the IJB. The Audit Committee may also consider relevant national audit reports particularly those relating to Health and Social Care Integration from Audit Scotland.

5. Approve the annual financial accounts before submission to and approval by the IJB.

6. The Committee is responsible for ensuring best value for those delegated functions.

7. The Committee is authorised by the IJB to investigate any activity within its terms of reference, and in so doing, may seek any information it requires.

Falkirk
Health and Social Care
Partnership

Falkirk Health and Social Care Partnership

CLINICAL AND CARE GOVERNANCE FRAMEWORK

The Scottish Government, National Health and Wellbeing Outcomes: A framework for improving the planning and delivery of integrated health and social care services:

"Health and social care services should focus on the needs of the individual to promote their health and wellbeing, and in particular, to enable people to live healthier lives in their community. Key to this is that people's experience of health and social care services and their impact is positive; that they are able to shape the care and support that they receive; and that people using services, whether health or social care, can expect a quality service regardless of where they live."

Public Bodies (Joint Working) (Scotland) Act 2014

28 March 2018

1. Introduction

The main purpose of the integration of health, social work and social care services in Scotland is to improve the wellbeing of people who use such services, in particular those whose needs are complex and who require services and support from both health and social care.

Falkirk Integration Scheme, drawn up for the Falkirk Integration Joint Board (IJB) is intended to arrange services that can deliver better outcomes for the people of Forth Valley. Services will be set up to deliver the national health and wellbeing outcomes that are prescribed by Scottish Ministers in Regulations under Section 5(1) of the Public Bodies (Joint Working) (Scotland) Act 2014[1].

The national health and wellbeing outcomes apply across all integrated health and social care services, and ensure that Health Boards, Local Authorities and IJBs are clear about responsibility and accountability for the delivery of shared priorities. Scottish Ministers will also bring together performance management arrangements for health and social care. National health and wellbeing outcomes, together with the integration planning and delivery principles, are grounded in a human rights based and social justice approach.

2. Purpose of the framework

The context in which the clinical and care governance framework, for the IJB will be implemented is one of a developing legislative framework with a wide range of policy drivers. Partner organisations across Falkirk and NHS Forth Valley will work to deliver services that are responsive, integrated and coordinated to meet the needs of individuals and communities in line with the strategic intentions expressed in law and policy.

Improved outcomes and effective services for service users and their unpaid carers require alignment of culture, values and language. This framework is intended to empower clinical and care staff to contribute to the improvement of quality of care. To make care safer, more effective and person centred – by making sure that there is a strong voice of the people and communities who use services.

The clinical and care governance arrangements described in this framework are designed to assure Falkirk IJB, NHS Forth Valley and the Council, that the quality and safety of services delivered by its staff, and the outcomes achieved from delivery of those services, are the best possible and make a positive difference to the lives of the people of Forth Valley. The diagram at Figure 1 illustrates lines of accountability for the Falkirk IJB, NHS Forth Valley Board and Falkirk Council.

It is acknowledged that this framework will be updated to reflect experience of joint working and as local requirements for services are better understood and evolve.

In addition the framework will evolve as service delivery models change and the workforce become more integrated and changes to regulation occur.

[1] Power to prescribe national outcomes Public Bodies (Joint Working) (Scotland) Act 2014

3. Definition of Clinical and Care Governance

The Scottish Government's National Framework, to guide Health and Social Care Partnerships on the setting up of their clinical and care governance arrangements has served as a useful foundation document for the Falkirk IJB Framework.

3.1. Annex C of the National Clinical and Care Governance Framework sets out in some detail the working definition to be applied to Integrated Health and Social Care Services in Scotland. This working definition is as follows:

a) Clinical and care governance is the process by which accountability for the quality of health and social care is monitored and assured. It should create a culture where delivery of the highest quality of care and support is understood to be the responsibility of everyone working in the organisation – built upon partnership and collaboration within teams and between health and social care professionals and managers.

b) It is the way by which structures and processes assure Integration Joint Boards, Health Boards and Local Authorities that this is happening – whilst at the same time empowering clinical and care staff to contribute to the improvement of quality – making sure that there is a strong voice of the people and communities who use services, their unpaid carers and their families.

c) Clinical and Care Governance should have a high profile, to ensure that quality of care is given the highest priority at every level within integrated services. Effective clinical and care governance will provide assurance to patients, service users, unpaid carers, clinical and care staff, managers, and members of the Integration Joint Boards.

- Quality of care, safety of service users, effectiveness and efficiency drive decision making about the planning, provision, organisation and management of services.
- The planning and delivery of services take full account of the perspective of patients, service users, unpaid carers, and their families.
- Unacceptable clinical and care practice will be detected and addressed.

d) Effective Clinical and Care Governance is not the sum of all these activities; rather it is the means by which these activities are brought together into this structured framework and linked to the corporate agenda of Integration Authorities, NHS Boards and Local Authorities.

e) An important element of clinical and care governance is to support staff in continuously improving the quality and safety of care. However, it will also ensure that wherever possible poor performance is identified and addressed.

f) Clinical and care governance issues may relate to the organisation and management of services rather than to individual decisions. All aspects of the work of Integration Authorities, Health Boards and Local Authorities should be driven by and designed to support efforts to deliver the best possible quality of health and social care. Clinical and care governance is principally concerned with those activities which directly affect the care, treatment, protection and support people receive whether delivered by individuals or teams.

4. Role of a Clinical and Care Governance Committee in monitoring and assuring the quality of care and services

The work of the IJB will be outlined in the Strategic Plan. This will link closely with Falkirk's Strategic Outcome Local Delivery Plan (SOLD) developed by the Community Planning Partnership. Successful strategic planning will result in partnership working to deliver and plan services that focus on people and their outcomes. Each IJB will have a plan that sets out its arrangements for integrated health and social care and how those arrangements will lead to the improvement of the outcomes for the communities it serves.

The quality of care provided within Falkirk Council and Forth Valley NHS partnership will be overseen by a Clinical and Care Governance Committee (CCGC) reporting to the IJB. This will provide assurance to the IJB, NHS Forth Valley and Falkirk Council that clinical and care governance as part of the planning and delivery of services, is being delivered effectively.

To maintain their independence as required by statute, the quality of decision making by Mental Health Officer's with regard to practice (including Adults with Incapacity and Guardianship responsibilities) will remain the responsibility of Falkirk Council.

The members of the Clinical Care Governance Committee will include:-

Members of the Committee:

- 4 members of the IJB to include 2 voting members, a third sector or public representative and a staff representative

In attendance as professional advisors:

- Chief Social Work Officer
- Chief Officer
- Professional Lead – GP*
- Professional Lead – Nurse/AHP*
- Head of Social Work Adult Services
- Head of Clinical Governance

* The Medical Director and Director of Nursing will provide support and advice to the Professional leads

The role of the CCGC will be to ensure that there is effective clinical and care governance within the Partnership that provides assurance to patients, service users, unpaid carers and their families, clinical and care staff, managers, and members of the IJB.

The CCGC will be responsible for ensuring that the five key principles outlined in the National Framework of clinical and care governance is delivered by the IJB:

1. The partnership has clearly defined governance functions and roles are performed effectively.

2. Values of openness and accountability are promoted and demonstrated through actions.

3. Informed and transparent decisions are taken to ensure continuous quality improvement.

4. Staff are supported and developed.

5. All actions are focused on the provision of high quality, safe, effective and person-centred services underpinned by a human rights based ethos.

The basis for the work of each CCGC is set out as five process steps in the National Framework:

1. Information on the safety and quality of care is received
2. Information is scrutinised to identify areas for action
3. Actions arising from scrutiny and review of information are documented
4. The impact of actions is monitored, measured and reported
5. Information on impact is reported against agreed principles.

This will include review and scrutiny as appropriate of key information including that relating to:

- The National Health and Wellbeing outcomes
- National Care Standards
- The quality and safety of integrated health and social care services, including health and safety issues
- Service user and carer engagement
- Thematic analysis of adverse event data including complaints
- Significant adverse events including significant case reviews
- Impact assessment and learning from external publications (including policies, guidelines, inquiries , monitoring and standards)
- Professional regulation and fitness to practice
- Responses to external scrutiny and internal investigation
- The quality of decision making by Mental Health Officers
- The quality of practice in relation to Adults with Incapacity, Adult Support & Protection and Mental Health Care and Treatment statutory framework
- Clear delineation of responsibility/accountability around the roles and interdependencies of the Chief Officer and the Chief Social Work Officer.

The CCGC will establish an information sharing and strategic relationship with the Chief Officers Public Protection Group.

5. Roles and Responsibilities

The National Framework identifies clear roles for members of the IJB and how they fulfil these.

<u>Chairs, Council Leaders, NHS Non-Executive Directors & Elected Members will:-</u>

- Create an organisational culture that promotes human rights and social justice, values partnership working through example; affirms the contribution of staff through the application of best practice including learning and development; is transparent and open to innovation, continues learning and improvement.

- Establish that integrated clinical and care governance policies are developed and regularly monitor their effective implementation.

- Seek reassurance that practice and standards related to public protection are robust.

- Require that rights, experience, expertise, interests and concerns of service users, unpaid carers and communities inform and are central to the planning, governance and decision-making that informs quality of care.
- Ensure that transparency and candour are demonstrated in policy, procedure and practice.

- Seek assurance that effective arrangements are in place to enable relevant Health and Social Care professionals to be accountable for standards of care including services provided by the third and independent sector.

- Require that there is effective engagement with all communities and partners to ensure that local needs and expectations for health and care services and improved health and wellbeing outcomes are being met.

- Ensure that clear robust, accurate and timely information on the quality of service performance is effectively scrutinised and that this informs improvement priorities. This should include consideration of how partnership with the third and independent sector supports continuous improvement in the quality of health and social care service planning and delivery.

- Seek assurance on effective systems that demonstrate clear learning and improvements in care processes and outcomes.

- Seek assurance that staff are supported when they raise concerns in relation to practice that endangers the safety of service users and other wrong doing in line with local policies for whistleblowing and regulatory requirements.

<u>Chief Executives, Chief Officers, Directors or Equivalent will:-</u>

- Embed a positive, sharing and open organisational culture that creates an environment where partnership working, openness and communication is valued, staff supported and innovation promoted.

- Provide a clear link between the organisational and operational priorities of NHS Forth Valley and Falkirk Council served by the IJB; objectives and personal learning and development plans, ensuring staff have access to necessary support and education.

- Implement quality monitoring and governance arrangements that include compliance with professional codes, legislation, standards, guidance and that these are regularly open to scrutiny. This must include details of how the needs of the most vulnerable people in communities are being met.

- Implement systems and processes to ensure a workforce with the appropriate knowledge and skills to meet the needs of the local population.

- Implement effective internal systems that provide and publish clear, robust, accurate and timely information on the quality of service performance.

- Develop systems to support the structured, systematic monitoring, assessment and management of risk.

- Implement a coordinated risk management, complaints, feedback and adverse events/incident system, ensuring that this focuses on learning, assurance and improvement.

- Lead improvement and learning in areas of challenge or risk that are identified through local governance mechanisms and external scrutiny.

- Develop mechanisms that encourage effective and open engagement with staff on the design, delivery, monitoring and improvement of the quality of care and services.

- Promote planned and strategic approaches to learning, improvement, innovation and development, supporting an effective organisational learning culture.

- Ensure compliance with professional standards, codes of practice and performance requirements and alignment of activities with organisational objectives and service user outcomes.

- Promote learning from good practice, adverse incidents, complaints and risks.

- Create an environment that supports the contribution of staff, their safety and professional development as well as supporting and enabling innovation.

- Establish clear lines of communication and professional accountability from point of care to Executive Directors and Chief Professional Officers accountable for clinical and care governance:

- This will include a relationship of accountability between the Adult Support and Protection Committee, the Child Protection Committee, the Strategic Oversight Group, MAPPA, the Alcohol and Drugs Partnership and Gender Based Violence. It is expected that the Public Protection Chief Officers Group would undertake this function.

- It is expected that this will include articulation of the mechanisms for taking account of the training environment for all health and social care professionals training (in order to be compliant with all professionals' regulatory requirements).

6. Professional Leadership

The Chief Social Work Officer, the NHS Medical Director and the NHS Nursing Director (together, "the CCG Leads") will take the lead role in relation to Clinical and Care Governance. The NHS Medical and Nursing Directors will have arrangements in place for co-ordinating these functions across clinical groups. The Chief Social Work Officer will have arrangements in place for co-ordinating these functions across social care groups.

NHS Medical Director

The NHS Medical Director is the individual appointed by NHS Forth Valley to provide the professional leadership for medical services and appointed by the Scottish Ministers as an Executive Board Member of NHS Forth Valley.

NHS Nursing Director

The NHS Nursing Director is the individual appointed by NHS Forth Valley to provide the professional leadership for nursing and midwifery services and appointed by the Scottish Ministers as an Executive Board Member of NHS Forth Valley.

Chief Social Work Officer

The role of the Chief Social Work Officer (CSWO) is to provide professional advice on the provision of social work services which assists authorities in understanding many of the complexities which are inherent across social work services. The principal functions relate to governance, management of risk, protection and the deprivation of liberty. The CSWO is a 'proper officer' in relation to the social work function: an officer given particular responsibility on behalf of a local authority, where the law requires the function to be discharged by a specified post holder. The CSWO has responsibility to advise on the specification, quality and standards of services commissioned.

The Medical Director and the Chief Social Work Officer will be responsible for providing professional advice to the IJB and the Chief Officer including any risks inherent in relation to any proposed actions.

All those providing care & services

Each individual professional is expected to ensure that their professional practice and continuing educational development is evidence based with a focus on regulatory and continuous professional development requirements and standards therefore they will:-

- Practice in accordance with their professional standards, codes of conduct and organisational values.
- Be responsible for upholding professional and ethical standards in their practice and for continuous development and learning that should be applied to the benefit of the public.
- Understand their responsibilities relating to Public Protection.
- Have the necessary policies and procedures in place to report and manage incidents of suspected, witnessed or actual harm.
- Ensure the best possible care and treatment experience for service users and families.
- Provide accurate information on quality of care and highlight areas of concern and risk as required.
- Work in partnership with management, service users, unpaid carers and other key stakeholders in the designing, monitoring and improvement of the quality of care and services.

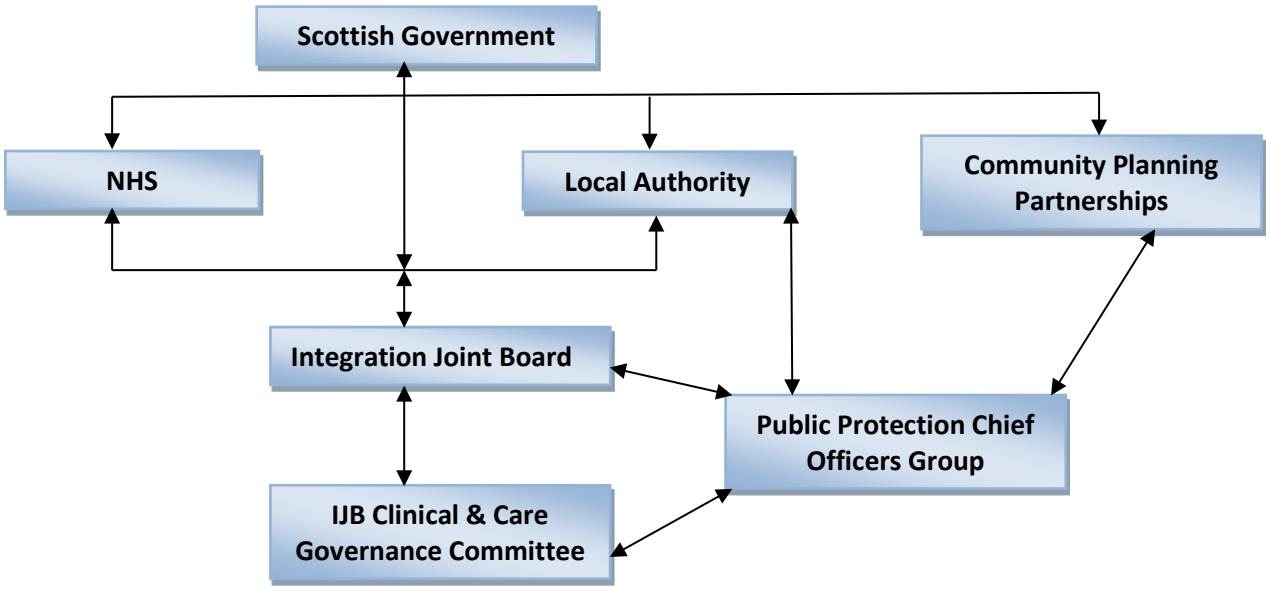
- Speak up when they see practice that compromises the safety of patients or service users in line with local whistleblowing policy and regulatory requirements.

- Engage with colleagues, patients, service users, communities and partners to ensure that local needs and expectations for safe and high quality health and care services, improved wellbeing and wider outcomes are being met.

7. Reporting Arrangements

**Note - the governance diagram will be developed in the first development session of the new CCGC members, in advance of the inaugural committee.

The diagram below illustrates lines of accountability and reporting. They will send reports directly to the NHS Forth Valley Clinical and Care Governance Group and to the Falkirk Scrutiny Committee responsible for overseeing the quality of social work and social care services.



8. Information, Governance and Sharing

Existing information management and data sharing protocols will continue to be applied, and the standing principles that pertain to information governance will remain.

Appendix 7

Falkirk Adult Protection Committee

Terms of Reference

1.	**The Committee** will be known as the Falkirk Adult Protection Committee
1.1	Membership will be by nomination of the Chief Officers of the agencies listed: Falkirk Health and Social Care Partnership Falkirk Council Social Services NHS Forth Valley Police Scotland Falkirk Council Criminal Justice Service Falkirk Council Housing Department Falkirk Council Trading Standards Scottish Fire and Rescue Scottish Ambulance Service Forth Valley Advocacy Voluntary/3rd Sector Interface Independent Sector/Scottish Care Care Inspectorate Other agencies that may take a place on the Committee include: Procurator Fiscal Service Mental Welfare Commission and Office of the Public Guardian.
1.2	The Committee may invite other agencies or persons with a contribution to make to join the Committee as a co-opted member for a specified period, which will be renewable. Such members will have equal status with other Committee members.
1.3	The Chair will be independent of the bodies represented on the Committee.
1.4	Falkirk Council will be responsible for the administering the appointment and remuneration of the Independent Chair.
1.5	For a meeting to commence a quorum of 3 (three) agencies, plus the Chair, must be present. If there is no quorum, the meeting will not proceed and business will be carried over to the next agreed meeting.
1.6	In the absence of the Independent Chair from a planned Committee meeting the vice chair of the Committee will assume the chair role so the Committee meeting may continue.

2	**Role of the Committee**
2.1	The purpose of the Committee is to: • promote the safety of adults at risk of harm; • identify the role, responsibility, authority and accountability of each agency or service to protect adults at risk; • promote cooperation and communication between agencies in relation to adult protection; • monitor and oversee the development of policies and procedures to support adult protection processes and support the implementation of these; • establish robust performance management arrangements to drive forward service improvement; • agree performance reporting frameworks for adult protection and oversee the development of quality indicators; • analyse performance, including trends and benchmarking, and take appropriate action for improvement; • engage with service users and carers to assure their contributions are taken into account in the work of the Committee.
2.2	The Committee will address the following matters: • establish mechanisms to develop. review and update policies and strategies; • develop systems/processes and procedures that identify adult protection concerns and the means of responding to referrals; • commission and participate in Significant Case Reviews and oversee the implementation of the learning that has emanated from the process; • design, implement and evaluate learning and development programmes; • monitor, audit and review the implementation and impact of legislation and policy and procedures; • monitor performance and report to the Scottish Government as required • oversee the publication of public information and engage in awareness raising activity; • establish mechanisms for engaging service users and carers in the work of the Committee.

3.	**Committee Procedures**
3.1	The Committee will meet no fewer than 5 (five) times each year.
3.2	Decisions of the Committee will be by consensus. Where a consensus is not achievable, the decision will be by majority agency vote. Where necessary, the Chair will have the casting vote.
3.3	The Committee will prepare a biennial report which will be submitted to the Scottish Government.
3.4	An Improvement Plan outlining the work of the Committee will be published with the biennial report.
3.5	The Committee will liaise with the Clackmannanshire and Stirling Adult Protection Committee through the Independent Chair and, through national meetings, with all other Chairs
4.	**Sub-groups**
4.1	Sub-groups may be established to support the work of the Committee, including the delivery of the Action Plan.
4.2	The Terms of Reference of sub-groups will be agreed by the Committee.
4.3	Membership will be by nomination by agencies represented on the Adult Protection Committee
4.4	Membership will reflect the agencies represented on the Committee.
4.5	Sub-groups may agree to invite other persons with a contribution to make to join the sub group for a specified period to assist in specific issues.
4.6	Frequency of meetings is to be determined by the work to be undertaken at any given time but is likely to be quarterly as a minimum
4.7	Sub groups may be integrated with Clackmannanshire and Stirling Adult Protection Committee sub groups for areas of work where consistency is essential for Forth Valley partner agencies
4.8	Sub groups may be integrated with those of other public protection bodies, e.g. Child Protection Committee, on areas of common interest
5.	**Short Life Working Groups**
5.1	The Committee may periodically remit development work to be undertaken by a short life working group.
5.2	The Committee will agree the Terms of Reference, timeframe and reporting arrangements for any Short life working group.

5.3	Membership will reflect but not be restricted to the agencies represented on the Committee, with members invited for their expertise in the area of work.
5.4	Working groups will meet at a frequency necessary for the completion of the work within an agreed timescale and duration.
5.5	Working groups may be integrated with the Clackmannanshire and Stirling Adult Protection Committee working groups for areas of common interest and where consistency is desirable for Forth Valley partner agencies.
5.6	Working groups may be integrated with those of other public protection bodies, e.g. Child Protection Committee, on areas of common interest.
6.	**Governance arrangements**
6.1	The Chair of the Adult Protection Committee will report on the work of the Committee to the Public Protection Chief Officers Group.
6.2	Chairs of sub-groups and short life working groups will report on the work of the group to the Committee as required.
7.	**Relationships with other public protection bodies**
7.1	The Committee will liaise with the Clackmannanshire and Stirling Adult Protection Committee to promote a consistent approach to policy, practice and training across Forth Valley
7.2	The Adult Protection Committee will liaise with the other local public protection partnerships to identify cross cutting issues and propose and undertake joint work, including: Forth Valley MAPPA, Child Protection Committee, Alcohol and Drugs Partnership, Gender-Based Violence Partnership and Community Justice.

FALKIRK ADULT PROTECTION COMMITTEE
GOVERNANCE STRUCTURE and RELATIONSHIPS