DATA LABEL: Public

West Lothian Integration Joint Board Audit, Risk and Governance Committee

West Lothian Civic Centre
Howden South Road
LIVINGSTON
EH54 6FF

25 November 2021

A meeting of the **West Lothian Integration Joint Board Audit, Risk and Governance Committee** will be held within the **Virtual Meeting Room** on **Wednesday 1 December 2021** at **2:30pm**.

For Chief Executive

BUSINESS

Public Session

1. Apologies for Absence

2. Declarations of Interest - Members should declare any financial and non-financial interests they have in the items of business for consideration at the meeting, identifying the relevant agenda item and the nature of their interest

3. Order of Business, including notice of urgent business and declarations of interest in any urgent business

4. Confirm Draft Minutes of Meeting of West Lothian Integration Joint Board Audit, Risk and Governance Committee held on Wednesday 08 September 2021 (herewith)

Public Items for Decision

5. Review of Standing Orders, Scheme of Delegations and Committee Remits - report by Standards Officer (herewith)

6. CIPFA Financial Management Code Compliance/Financial Regulations Update - report by Chief Finance Officer (herewith)

Public Items for Information

7. High Risks - report by Chief Officer (herewith)

8. Internal Audit Charter - report by Internal Auditor (herewith)

9. Governance Issues 2020/21 - Update on Progress - report by Standards Officer (herewith)

10. Audit and Risk Committee Principles - report by Internal Auditor (herewith)

11. NHS Lothian : Internal Audit of Risk Management at a Divisional/HSCP Level - report by Internal Auditor (herewith)

12. Risk Management Annual Reports 2020/21 - report by Risk Manager (herewith)

13. Self Assessment Survey - Results - report by Project Officer (herewith)

14. IJB Audit, Risk & Governance Committee Action Tracker (herewith)

15. Workplan (herewith)

NOTE **For further information please contact Val Johnston, Tel No.01506 281604 or email val.johnston@westlothian.gov.uk**

CODE OF CONDUCT AND DECLARATIONS OF INTEREST

This form is to help members. It is not a substitute for declaring interests at the meeting.

Members should look at every item and consider if they have an interest. If members have an interest they must consider if they have to declare it. If members declare an interest they must consider if they have to withdraw.

NAME	MEETING	DATE

AGENDA ITEM NO.	FINANCIAL (F) OR NON-FINANCIAL INTEREST (NF)	DETAIL ON THE REASON FOR YOUR DECLARATION (e.g. I am Chairperson of the Association)	REMAIN OR WITHDRAW

The objective test is whether a member of the public, with knowledge of the relevant facts, would reasonably regard the interest as so significant that it is likely to prejudice your discussion or decision making in your role as a councillor.

Other key terminology appears on the reverse.

If you require assistance, please ask as early as possible. Contact Julie Whitelaw, Monitoring Officer, 01506 281626, julie.whitelaw@westlothian.gov.uk, James Millar, Governance Manager, 01506 281695, james.millar@westlothian.gov.uk, Carol Johnston, Chief Solicitor, 01506 281626, carol.johnston@westlothian.gov.uk, Committee Services Team, 01506 281604, 01506 281621 committee.services@westlothian.gov.uk

March 2019

SUMMARY OF KEY TERMINOLOGY FROM REVISED CODE

The objective test

"…whether a member of the public, with knowledge of the relevant facts, would reasonably regard the interest as so significant that it is likely to prejudice your discussion or decision making in your role as a councillor"

The General Exclusions

- As a council tax payer or rate payer or in relation to the council's public services which are offered to the public generally, as a recipient or non-recipient of those services
- In relation to setting the council tax.
- In relation to matters affecting councillors' remuneration, allowances, expenses, support services and pension.
- As a council house tenant, unless the matter is solely or mainly about your own tenancy, or you are in arrears of rent.

Particular Dispensations

- As a member of an outside body, either appointed by the council or later approved by the council
- Specific dispensation granted by Standards Commission
- Applies to positions on certain other public bodies (IJB, SEStran, City Region Deal)
- Allows participation, usually requires declaration but not always
- Does not apply to quasi-judicial or regulatory business

The Specific Exclusions

- As a member of an outside body, either appointed by the council or later approved by the council
- The position must be registered by you
- Not all outside bodies are covered and you should take advice if you are in any doubt.
- Allows participation, always requires declaration
- Does not apply to quasi-judicial or regulatory business

Categories of "other persons" for financial and non-financial interests of other people

- Spouse, a civil partner or a cohabitee
- Close relative, close friend or close associate
- Employer or a partner in a firm
- A body (or subsidiary or parent of a body) in which you are a remunerated member or director
- Someone from whom you have received a registrable gift or registrable hospitality
- Someone from whom you have received registrable election expenses

MINUTE of MEETING of the WEST LOTHIAN INTEGRATION JOINT BOARD AUDIT, RISK AND GOVERNANCE COMMITTEE held within VIRTUAL MEETING ROOM, on 8 SEPTEMBER 2021.

Present – Martin Connor (Chair, NHS Lothian Non-Executive Director) and Bill McQueen (NHS Lothian Non-Executive Director); Councillors George Paul and Damian Doran-Timson

In Attendance – Alison White (Chief Officer), Kenneth Ribbons (IJB Internal Auditor); James Millar (IJB Standards Officer), Patrick Welsh (IJB Chief Finance Officer); Tim Ward (Social Policy), Lorna Kemp (IJB Policy Officer); and Stephen Reid (EY, External Auditor)

Apologies – Stevie Dunn (West Lothian Council, Staff Representative)

1. DECLARATIONS OF INTEREST

No declarations of interest were made.

2. MINUTE

The committee approved the Minute of its meeting held on 17 June 2021.

3. AUDIT OF THE 2020/21 ANNUAL ACCOUNTS

The committee considered a report (copies of which had been circulated) by the IJB Chief Finance Officer providing the outcome of the 2020/21 audit and to also provide a summary of the key points arising from the Auditors Annual Report

It was recommended that the committee :-

1. Considers the audited 2020/21 Annual Accounts for the West Lothian Integration Joint Board

2. Considers the Auditors 2020/21 Annual Audit Report including the management action plan

3. Considers any recommendations to be made to the Board in advance of when it meets to agree the Annual Accounts for signature on 21 September 2021

Decision

1. To note the content of the Audited Annual Accounts 202/21;

2. To make no further recommendations to the IJB than those already contained in the report

3. To thank Patrick Welsh and Stephen Reid and their respective

teams for the preparation of the accounts in what had been very challenging times;

4. To note that some minor cosmetic changes were still to be made to the final documents before presenting to the IJB.

4. IJB RISKS - REPORT BY CHIEF OFFICER

The committee considered a report (copies of which had been circulated) by the Chief Officer advising of the IJB's risks.

It is recommended that the Audit, Risk and Governance Committee considers the risks identified, the control measures in place, and the risk actions in progress to mitigate their impact.

Decision

1. To note the content of the report;

2. To ask officers to consider how recommendations on future reports were framed;
3. To ask officers to review the information in the following areas of the risk register: -

   - Page 2 – review the date the revised strategic plan was approved by the IJB
   - Page 3 - IJB19014 – consider and update the following wording "Revised cycle of reports to be submitted to IJB in January 2020;
   - Consider the inclusion of a risk relating to social care; and
   - Consider the issues of staff being moved in/out St Michaels Hospital.

5. LOCAL CODE OF CORPORATE GOVERNANCE - REVIEW

The committee considered a report (copies of which had been circulated) by the IJB Standards Officer asking committee review the Board's Local Code of Corporate Governance as instructed in September 2019 and make appropriate recommendations to the Board

It was recommended that committee:-

1. To note the present structure and content of the Local Code of Corporate Governance and the process followed for its use in governance reporting.

2. To note that the Code was last reviewed in September 2019 when the Board instructed a further review in 2021/22

3. To consider and review the Code and in particular to agree the following recommendations to the Board for its approval:-
   a) To agree that there are no changes required to the standards in the Code or its overall structure and content

b) To continue the practice of monitoring progress on governance issues and populating the Code through the integrated senior management team (paragraph 4)

c) To continue the practice of reporting the populated Code once each year and progress on governance issues twice each year to the committee to inform the annual governance statement(paragraph 6)

d) To agree any future review of the Code is carried out by the committee as part of the annual governance reporting process rather than conducting and reporting a separate periodic review ,with the committee's conclusion reported to the Board as part of the annual report on the Board's accounts and external audit report (paragraph 7)

Decision

To approve the terms of the report.

6. SELF ASSESSMENT QUESTIONNAIRE - REPORT BY PROJECT OFFICER (HEREWITH)

The committee considered a report (copies of which had been circulated) by the Project Officer asking committee to consider arrangements for carrying out periodic self-assessment of the Committee's administrative arrangements and activity and to approve the questionnaire for issue to members

It was recommended that committee:-

1. Consider carrying out the annual self-assessment of the Committee's effectiveness by the use of the questionnaire in the appendix.

2. Agrees to the questionnaire being issued to members and the results reported to the December meeting of the Committee.

Decision

1. To approve the terms of the report; and

2. To agree to continue to carry out the self-questionnaire on an annual basis.

7. IJB AUDIT, RISK & GOVERNANCE COMMITTEE ACTION TRACKER

The committee noted the content of the Action Tracker, copies of which had been circulated.

Decision

To note the content of the action tracker.

8. WORKPLAN

A workplan and reporting cycle had been circulated for information.

Decision

To note the contents of the workplan and reporting cycle; and

Date	1 December 2021
Agenda Item	5

INTEGRATED HEALTH AND SOCIAL CARE
WEST LOTHIAN
WORKING FOR WELLBEING

Report to: Audit Risk & Governance Committee

Report Title: Review of Standing Orders, Scheme of Delegations and Committee Remits

Report By: Standards Officer

Summary of Report and Implications	
Purpose	This report: (tick any that apply).
	- seeks a decision [X]
	- is to provide assurance [ ]
	- is for information [ ]
	- is for discussion [ ]
	To review the Board's Standing Orders, Scheme of Delegations and Committee Remits as instructed in January 2020 and make appropriate recommendations to the Board.
Recommendations	1. To note that a periodic review by the Board of its Standing Orders, Scheme of Delegations and committee remits is required and that the committee may make recommendations for the Board's consideration 2. To note that no changes are being recommended to these documents 3. To agree recommendations that should be made to the Board to assist in its review and decision-making
Directions to NHS Lothian and/or West Lothian Council	A direction is not required.
Resource/ Finance/ Staffing	N/A
Policy/Legal	Public Bodies (Joint Working) (Scotland) Act 2014; Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014; Board's Standing Orders, Scheme of Delegation and committee remits
Risk	IJB001, Governance Failure. Good governance leads to good decision making and improved outcomes and will assist in delivering health and wellbeing outcomes

West Lothian Council NHS Lothian

Equality, Health Inequalities, Environmental and Sustainability Issues	The report has been assessed as having no relevance with regard to equality or the Public Sector Equality Duty. As a result, an equality impact assessment has not been conducted.
Strategic Planning and Commissioning	N/A
Locality Planning	N/A
Engagement	N/A

Terms of Report

Background

1 The Board's governance arrangements are set out in a number of constitutional documents. Those have been approved by the Board at various times since its inception in September 2015. Through those decisions and as a matter of good governance they are subject to periodic review to ensure they remain legally compliant and are serving the Board's purposes in performing its statutory role and delivering its agreed outcomes. It is generally accepted that good governance assists and promotes good decisions and good performance.

2 The constitutional documents currently due for review are Standing Orders, Scheme of Delegations, the remit of Audit Risk & Governance Committee, and the remit of the Appointments Committee. These documents are attached in the four appendices to this report. The committee is invited to consider those documents and the following information and then determine what recommendations it should make to the Board to assist in carrying out its formal review of those documents. A report will be required to the Board in any event to conclude the formal review process. A further review will be carried out in 2023/24.

Standing Orders

3 The Board's Standing Orders are in Appendix 1 and are available to the public on the internet. They were first adopted on 20 October 2015 and have been adjusted on 5 April 2016, 5 December 2017, 24 September 2018 and 21 January 2020. The last of those was a full periodic review at which time it was agreed that a further review would take place after two years.

4 The Board is required by legislation to make Standing Orders. Some of the content of those Standing Orders is set by legislation, such as the quorum requirement and the Chair not having a casting vote. Standing Orders were at adoption and still are legally compliant. In other aspects, the Board has flexibility to set its own procedural rules, subject to good governance standards.

5 Overall, it is considered that the current version of Standing Orders has served the Board well. It has allowed the Board to carry out its statutory role in a consistent and accountable way, and have assisted it to meet its objectives and agreed outcomes. In particular, it was of assistance and operated flexibly and clearly in the Board's response to the pandemic in 2020 and 2021. Meetings were initially suspended with urgent decisions taken through delegated powers, and then remote-access meetings were put in place without having to amend these rules. There have been no legislative changes that require to be incorporated. No changes are therefore proposed.

Scheme of Delegations

6 There is no statutory requirement for there to be a Scheme of Delegations but it has been considered by the Board to be good practice to show the powers delegated and to define the areas of accountability of its officers. The current Scheme was approved on 29 January 2017 and was amended by the Board on 21 January 2020. The current Scheme is in Appendix 2 and is available on the internet. The Scheme has been kept up to date to reflect Board decisions. For example, the adoption of the Financial Management Code led to an addition to the responsibilities of the Chief Finance Officer; the imposition of first responder duties under the Civil Contingencies Act 2004 led to an addition to the responsibilities on the Chief Officer.

7 The Scheme is also felt to have served the Board well. In particular, the process for the use of emergency decision-making powers worked well at the start of and during the pandemic, and, more recently, in relation to the temporary closure of St Michael's Hospital. No changes are proposed.

Committee remits

8 The Audit Risk & Governance Committee's remit was agreed by the Board in February and April 2016. It has been updated following Board decisions on 5 December 2017, 1 May 2018, 24 September 2018 and 21 January 2020. The present remit is in Appendix 3. Again, the remit is considered still to be fit for purpose. It has enabled the committee to work in its roles as an advisory body (making recommendations on decisions the Board ought to take) and as a scrutiny body (assisting with statutory compliance and sound performance, financial, risk management and corporate governance arrangements). The committee carries out an annual self-assessment exercise and the feedback from those has not disclosed any concerns about the committee's operations or remit and powers. It is not considered that changes are called for.

9 The remit of the Appointments Committee was approved on 8 December 2015. It was amended slightly on 21 January 2020. The remit is in Appendix 4. The committee is required to meet only occasionally and did so in June 2019 and in April 2021 to conclude the process of appointing a new Chief Officer on each occasion. It was flexible enough to be used as part of the tripartite recruitment and appointment process put in place on both occasions. No changes are proposed or suggested to this committee's remit

Other factors

10 The present versions of these four documents are key elements in the evidence relied on in the population and scoring each year of the Local Code of Corporate Governance. They inform the Internal Auditor's conclusion on the annual review of the effectiveness of the Board's system of internal control. They are part of the framework relied on in the assurance given in the annual governance statement. They were given a "green" assessment, and arrangements for periodic reviews are a key part of that.

11 In the wider-scope part of its annual audit, EY commented on the Board's arrangements in relation to governance and transparency. An overall "green" assessment was made and those comments included:-

- The key features of good governance at the IJB are in place and operating effectively, and remained so throughout 2020/21 despite the impact of lockdown arrangements
- The annual internal audit assurance report offers substantial assurance in respect of West Lothian IJB's overall arrangements for risk management, governance, and control for the year to 31 March 2021, and was not impacted by delays resulting from lockdown arrangements

12	An email was sent to all Board members and senior officers on 22 October 2021 advising of the review and inviting comments and concerns to be fed back. No concerns have been expressed or changes suggested.

Appendices	None
References	Public Bodies (Joint Working) (Scotland) Act 2014, section 13 Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 Standing Orders for Meetings Scheme of Delegations
Contact	James Millar, Standards Officer 01506 281613, james.millar@westlothian.gov.uk

APPENDIX 1

STANDING ORDERS

FOR THE

PROCEEDINGS

OF

THE WEST LOTHIAN

INTEGRATION JOINT

BOARD

To be reviewed in the last meeting of every second calendar year (IJB, 5 December 2017)	
20 October 2015	Adopted by IJB for use for IJB and its committee proceedings
5 April 2016	Amendments to Standing Order 9.12 to give effect to change in statutory regulations concerning decisions about members withdrawing from meetings after declaring an interest
5 December 2017	Amendment to Standing Order 15.16 in relation to role of Audit Risk & Governance Committee in considering annual accounts and audit report
24 September 2018	Remit and Powers amended to reflect changes in process and responsibilities for dealing with the Board's unaudited and audited accounts
21 January 2020	Biennial reviewed concluded. Changes to SO2, SO5.5, SO15.14, SO17.5 and Category 1 of private Information. Director re-titled as Chief Officer. Changes effective from 1 February 2020

CONTENTS

APPENDICES

1 General

1.1 These Standing Orders regulate the conduct and proceedings of the West Lothian Integration Joint Board.

1.2 The terms used in these Standing Orders are defined in Appendix 1.

1.3 Any statutory provision, regulation or direction by Scottish Ministers shall have precedence if these Standing Orders conflict with them.

1.4 These Standing Orders may be amended, varied or revoked at a meeting of the Board provided the notice for the meeting at which the proposal is to be considered states that there is a proposal to amend the Standing Orders, states what that proposal is, and the proposal itself does not result in the Board not complying with any statutory provision or regulation.

1.5 These Standing Orders shall apply at every meeting of the Board, and may not be suspended in any way, for any reason or at any time.

2 Membership

2.1 The membership of the Board shall comprise:-

a) Those voting and non-voting members prescribed by law

b) Those additional non-voting members appointed by the Board of its own volition

2.2 If and when a person ceases to hold the office or post as a result of which he or she became a member of the Board then that person shall cease to be a member of the Board.

2.3 If a voting member is unable to attend a meeting of the Integration Joint Board, the relevant constituent authority is to use its best endeavours to arrange for a suitably experienced substitute, who is either a councillor, or, as the case may be, a member of the health board. The substitute voting member may vote on decisions put to that meeting, but may not preside over the meeting.

2.4 If a non-voting member is unable to attend a meeting of the Integration Joint Board, that member may arrange for a suitably experienced substitute to attend the meeting.

2.5 When a member fails to attend three consecutive Board meetings the Clerk shall notify the Chair and Vice-Chair immediately after the third absence and shall contact the member to seek an explanation for the absences and an indication if there is any continuing difficulty with the member attending in future. At the next appropriate Board meeting the Board shall consider the member's position and information provided to determine if it accepts the explanation or if membership should cease.

3 Chair and Vice-Chair

3.1 Members shall be appointed to, and shall hold the positions of, Chair and Vice-Chair in accordance with the Integration Scheme.

3.2 The Chair will preside at every meeting of the Integration Joint Board that he or she attends.

3.3 In the absence of the Chair the Vice-Chair shall preside at the meeting of the Integration Joint Board.

3.4 In the absence of both the Chair and Vice Chair, the voting members present at the meeting shall choose a voting Integration Joint Board member to preside. In the event of a tied vote, the decision as to who shall preside shall be determined by lot.

4 Ordinary and special meetings

4.1 The Board shall at least annually approve a timetable of ordinary meetings, which shall be held at least six times in each financial year.

4.2 The Board may amend or adjust that timetable of ordinary meetings from time to time, provided that at least six such meetings are held in each financial year.

4.3 The Chair may change the date and/or time of an ordinary meeting, but may not cancel an ordinary meeting.

4.4 The Chair may call a special meeting of the Board at any time by delivering a signed requisition to the Clerk specifying the business to be transacted.

4.5 A request for a special meeting of the Board may be made in the form of a requisition specifying the business to be transacted, signed by at least two thirds of the number of voting members, and presented to the Clerk. If the Chair does not call that meeting within seven days of receiving the requisition, the members who signed the requisition may call a meeting by delivering a notice, signed by them all, calling the meeting.

4.6 Upon receipt of a requisition for a special meeting, the Clerk shall make arrangements for the meeting to be held as soon as reasonably practicable, but in any event within 14 days of the Chair's requisition, or the members' notice, as the case may be.

4.7 No business shall be transacted at a special meeting other than that specified in the requisition.

5 Calling meetings

5.1 All meetings of the Board, ordinary and special, shall be convened and shall take place in accordance with these Standing Orders.

5.2 A notice shall be sent, or its availability intimated, to every Board member at least five clear days before the meeting.

5.3 The notice shall be in the form of an agenda approved by the Chair or, in the absence of the Chair, by the Vice-Chair, and shall specify the date, time and place of the meeting and the business to be transacted.

5.4 Reports and other supporting papers shall be attached to the notice and delivered with it.

5.5 Reports shall be prepared using a standard template approved by the Board from time to time, and shall advise on issues of relevance and significance such as legislation, guidance, financial implications and equality issues.

5.6 In the event that the Chief Social Work Officer or the Clinical Director requires that they be permitted access to the Board to report on matters within their professional and/or statutory roles and responsibilities then they shall be entitled to insist on a report being included on the agenda for an ordinary meeting.

5.7 The address for intimation or delivery shall be the email address notified by each member, unless a member requests that a different address, postal or electronic, is used.

5.8 Lack of or a defect in the service or intimation of the notice to any member shall not affect the validity of a meeting.

5.9 The notice and meeting papers shall be available to the public in terms of Standing Order 6 unless the Chief Officer, in consultation with the Chair, considers that consideration of an item of business may involve the disclosure of private information. The notice shall state if that is the case and state the category of private information involved.

5.10 Only the business specified in the notice shall be transacted at the meeting, unless an item of business is notified to the Chair before the meeting with a request for it to be added to the agenda, and the Chair rules to allow it to be considered on the ground of urgency. The Chair shall state the reason for such a ruling and the minute shall record the ruling and the reason given.

5.11 If the Chair rules that the matter is not urgent, it shall be included as an item for the next ordinary meeting, unless it is withdrawn or dealt with in some other way before then.

6 Public access to meetings and meeting papers

6.1 By the day after the notice calling a meeting is sent or intimated to Board members, they shall be made available to the public through the internet, except for any papers which are withheld due to the potential disclosure of private information.

6.2 Board meetings shall be held in public, unless the Board resolves to exclude the public during its consideration of an item of business due to the potential disclosure of private information.

6.3 The minute of the meeting will record the reason for any decision by the Board to exclude the public from a meeting.

6.4 The minute of the meeting shall contain a note of the outcome of the Board's consideration of an item of business for which the public was excluded which informs the public of the issues and the decision but does not disclose any private information.

7 Quorum

7.1 A meeting shall not proceed unless there are present within 30 minutes of the starting time of the meeting at least one half of the voting members.

7.2 If a quorum is not present, the meeting will stand adjourned to such date and time as may be fixed by the Chair.

7.3 Any business on the agenda for a Board meeting which is inquorate shall be carried forward to the adjourned meeting, unless it is withdrawn or dealt with in the meantime in another way. No business other than that on the agenda for the inquorate meeting shall be added to the agenda for the adjourned meeting.

7.4 Substitute voting members shall be counted for the purposes of the quorum.

7.5 A member shall be regarded as being present at a meeting if he or she is able to participate from a remote location by a secure video link or other communication link approved by the Board. A member participating in a meeting in this way will be counted for the purposes of deciding if a quorum is present.

7.6 If a member withdraws from consideration of an item of business following a declaration of interest then he or she shall not be counted for the purposes of a quorum for that item of business. If there is as a result no quorum for that item of business then the item shall not

be considered, and shall be carried forward to the next ordinary meeting, unless it is withdrawn or is dealt with in the meantime in another way.

8 Duties and responsibilities of the Chair

8.1 The Chair shall ensure that the agenda of business is properly dealt with and clear decisions are reached.

8.2 The Chair shall permit fair and responsible debate and shall ensure that the views and opinions of all those entitled to participate, including the advice of officers, are allowed to be expressed and that these contribute to the outcome of the meeting.

8.3 The Chair shall ensure the proper and timely conduct of the meeting, expediting the business on the agenda and reaching a sufficiency of debate, where appropriate.

8.4 On all points of order, relevance or competency, order of business, interpretation of these Standing Orders and in relation to urgent business, the ruling of the Chair is final and shall not be open to question or discussion.

9 Conduct of members

9.1 Members are accountable for their own individual conduct in the meeting room at all times.

9.2 Members must observe the rules of conduct stemming from the law, the Code of Conduct and any guidance from the Standards Commission, and the rules, standing orders and regulations of the Board.

9.3 Members must respect the chair, their member colleagues, Board officers and any members of the public present at meetings or other formal proceedings of the Board.

9.4 Members shall at all times conduct themselves in an orderly, courteous and respectful manner, shall comply with rulings of the Chair and shall otherwise respect the authority of the Chair.

9.5 When a member is speaking other members shall not converse or otherwise behave in a manner which is disruptive to the member speaking or to the meeting, or make any noise or disturbance which is so disruptive.

9.6 When the Chair speaks, any member who is addressing the meeting shall stop.

9.7 The Chair shall take appropriate action if he or she is of the view that a member is in breach of one or more of the foregoing standards, including requiring the withdrawal of a remark, requiring an apology, requiring the member's behaviour to cease or any other action required to allow the meeting to properly proceed.

9.8 If a member behaves obstructively or offensively or disregards the authority of the Chair, a motion may be moved and seconded to suspend the member for the rest of the meeting. The mover will explain briefly the reasons for so moving, and the member who is the subject of the motion shall have the right to make a brief reply. The motion shall then be put to a vote without amendment or discussion. If it is carried, the member shall withdraw from the meeting and take no further part in it.

9.9 The Chair has the right to adjourn a meeting in the event of disorderly conduct or other misbehaviour at the meeting.

9.10 Members of the Board are required to subscribe to and comply with the Code of Conduct adopted by the Board and approved by the Scottish Ministers.

9.11 The Clerk shall maintain the Board's Register of Interests, gifts and hospitality which shall be open for public inspection. When a member needs to update or amend his or her entry in the Register, he or she must notify the Clerk of the need to change the entry within one month after the date the matter requires to be registered.

9.12 Members must always consider the relevance of any interests they may have to any business presented to the Board and declare any interests where required by the Code of Conduct in relation to such business. When members have declared an interest they must consider whether they should withdraw from the meeting, and come to a decision which will be their own to make and their own responsibility.

10 Adjournment

10.1 If it is necessary or expedient to do so for any reason, a meeting may be adjourned by the Board to another day, time and place.

10.2 An adjournment shall be determined by a motion, which shall be moved and seconded and be put to the meeting without discussion.

10.3 If such a motion is carried, the meeting shall be adjourned to such day, time and place as may be specified in the motion, but which shall be no late than the date and time for the next ordinary meeting of the Board.

10.4 Any business not dealt with prior to the adjournment shall be carried forward to the adjourned meeting, unless it is withdrawn or dealt with in the meantime in some other way.

11 Items of business and debate

11.1 The Chair shall allow the officer responsible for an item of business to speak to it.

11.2 The Chair shall then allow all members to ask questions on the item of business, and shall allow members a reasonable opportunity to do so and to express their views.

11.3 The Board may reach consensus on an item of business without taking a formal vote.

11.4 Any voting member may move a motion or an amendment in relation to an item of business. The Chair may require the motion or amendment to be in writing. Every motion and amendment is required to be moved and seconded by a voting member. A motion or amendment shall not be recorded or discussed until a seconder has been identified.

11.5 The mover of a motion may speak, on one occasion, for five minutes.

11.6 The seconder may speak, on one occasion, for three minutes.

11.7 The mover of an amendment may speak, on one occasion, for five minutes.

11.8 The seconder may speak, on one occasion, for three minutes.

11.9 Other members, voting and non-voting, may speak, on one occasion, for three minutes.

11.10 The mover of the motion shall have a right to reply, and may speak for three minutes, but may not introduce any new material.

11.11 After the reply, the question shall be put to the Board by the Chair without further debate or discussion.

11.12 A motion to adjourn any debate on any question or for the closure of a debate may be moved and seconded before the right to reply and shall be put to the meeting without discussion. An adjournment of any debate shall be to the next meeting.

12 Voting

12.1 Where a vote is required, every question at a meeting shall be determined by a simple majority of votes of the members present and voting, or abstaining from voting, on the question.

12.2 A vote shall be taken by a show of hands, and the minute of the meeting shall record the votes cast. Except by the attendance of a substitute or in the event of a temporary vacancy, no vote may be cast by proxy for an absent voting member.

12.3 Where there is a temporary vacancy in the voting membership of the Board, the vote which otherwise would have been cast by a member of the constituent authority to be appointed to the vacancy may be exercised jointly by the other members appointed by that constituent authority.

12.4 In the case of an equality of votes, the person presiding at the meeting does not have a second or casting vote.

12.5 Where there has been an equality of votes, the Chair will bring consideration of the matter to a close for that meeting, and give direction to the Chief Officer on how the matter should be taken forward. The Chief Officer will then be obliged to review the matter, with the aim of addressing any concerns, and developing a proposal which the integration joint board can reach a decision upon at a future meeting.

12.6 Where after consideration at the future meeting the matter remains unresolved, and the Chair concludes that the equality of votes is a representation of a dispute between the two constituent parties, then the dispute resolution process which is set out in the integration scheme shall take effect. If the unresolved equality of votes is not a representation of a dispute between the two constituent parties, then the Chair and the Chief Officer must work together to arrive at an acceptable position for the integration joint board.

13 Changing a decision

13.1 A decision of the Board cannot be changed within six months unless notice has been given in the notice of meeting and:-

a) The Chair rules there has been a material change of circumstance and explains the reasons for that, or

b) The Board agrees the decision was based on incorrect or incomplete information

13.2 The minute shall record the reason for the decision being changed.

14 Minutes

14.1 The Clerk shall prepare the minutes of meetings of the Board.

14.2 The Board shall receive and review its minutes for agreement at its following ordinary meeting.

14.3 The minute shall record:-

a) The names of members present at a meeting

b) The names of any officers in attendance

c) Declarations of interest made, and whether members declaring an interest participated in the relevant item of business, or not

d) Significant legal and other advice provided by officers and professional advisers

e) Rulings by the Chair

f) A brief summary of the terms of the report and recommendations

g) Motions, amendments, voting and decisions made

h) Other matters required to be recorded by these Standing Orders

15 Matters to be determined by the Board

15.1 The Board shall approve, vary or amend these Standing Orders.

15.2 The Board shall approve the establishment of, and terms of reference of all of its committees.

15.3 The Board shall appoint all committee members, as well as the Chair and Vice-Chair of all of its committees.

15.4 The Board shall appoint its Strategic Planning Group and its members (other than the members to be nominated by each constituent party).

15.5 The Board shall approve its Strategic Plan and any other strategies that it may need to develop for all the functions which have been delegated to it.

15.6 The Board will also review the effectiveness of its Strategic Plan.

15.7 The Board shall review and approve its contribution to community planning, and shall appoint its representative(s) at the West Lothian Community Planning Partnership Board and other meetings.

15.8 The Board shall approve its Risk Management Policy.

15.9 The Board shall approve its Health & Safety Policy, if and when required by statute.

15.10 The Board shall approve its annual financial statement.

15.11 The Board shall approve Financial Regulations and a Scheme of Delegation.

15.12 The Board shall approve the content, format, and frequency of performance reporting, and its performance report for the reporting year.

15.13 The Board shall approve the total payments to the constituent bodies to implement its agreed Strategic Plan.

15.14 The Board shall agree the form and content of the Directions to be given to the constituent authorities. Where it is not practicable for the Board to agree the exact wording at its meeting it may delegate that to the Chief Officer to determine after consultation with the Chair and Vice-Chair within parameters set by the Board when delegating that authority

15.15 In relation to its annual accounts and their audit:-

- Following consideration of the findings of the review of the system of internal control and approval of the annual governance statement by the Audit Risk & Governance Committee, the Board shall consider its unaudited accounts and any recommendations from the committee

- Following its consideration by the Audit Risk & Governance Committee, the Board shall consider the external auditor's annual report and any recommendations from the committee

- Following their consideration by the Audit Risk & Governance Committee, the Board shall consider its audited annual accounts and any recommendations from the committee and shall approve the audited accounts for signature and publication

16 Other decisions and urgent business

16.1 The Board shall have the power to delegate matters other than those set out in Standing Order 15 to a committee or to the Chief Officer, subject to such conditions as it may determine, and such a delegation shall be recorded in the minute of the meeting.

16.2 The Chief Officer, in consultation with the Clerk, is authorised to take any necessary action where a matter arises of such urgency that it cannot await a decision of the Board.

16.3 Prior to using this delegated authority, the Chief Officer shall consult with the Chair and the Vice-Chair of the Board and shall not proceed until that consultation has taken place with both.

16.4 All action taken by the Chief Officer under this delegated authority shall be reported to the next meeting of the Board.

17 Committees

17.1 The Board shall appoint such committees as it thinks fit, but shall appoint a committee to deal with internal and external audit business, risk management and corporate governance.

17.2 The Board shall appoint the Chairs, Vice-Chairs and members of its committees.

17.3 The Board shall approve the terms of reference, remit, powers and meeting arrangements of such committees, which shall not include the determination of matters specified in Standing Order 15.

17.4 Each committee must include voting Board members, and must include an equal number of voting members appointed by the constituent authorities.

17.5 Any Board member, but only a Board member, may substitute at a meeting for a committee member who is also a Board member.

17.6 If a non-voting member is unable to attend a meeting of the committee, that member may arrange for a suitably experienced substitute to attend the meeting.

17.7 These Standing Orders relating to the calling and notice of Board meetings shall also be applied to committee meetings.

17.8 A member may be regarded as being present at a meeting of a committee if he or she is able to participate from a remote location by a secure video link or other communication link approved by the Board. A member participating in a meeting in this way will be counted for the purposes of deciding if a quorum is present.

APPENDIX 1

DEFINITIONS AND REFERENCES

2014 Act	The Public Bodies (Joint Working) (Scotland) Act 2014
Annual financial statement	The statement required by section 39 of the 2014 Act setting out the amount the Board intends to spend in implementation of the strategic plan
Board	The integration authority in terms of section 2 of the 2014 Act established by the Scottish Parliament on 21 September 2015
Chief Officer	The Board's Chief Officer under section 10 of the 2014 Act (formerly known locally as "Director")
Chief Social Work Officer	The Proper Officer appointed by the Council under section 3 of the Social Work (Scotland) Act 1968 for the purposes of its social work functions under that and other designated Acts and regulations
Clerk	The officer appointed by the Board to ensure the proper and lawful conduct of its proceedings and record its decisions and meetings
Code of Conduct	The code adopted by the Board and approved by the Scottish Ministers under the Ethical Standards in Public Life etc. (Scotland) Act 2000
Constituent authority	The Council or the Health Board
Council	West Lothian Council, a local authority constituted under section 2 of the Local Government etc. (Scotland) Act 1994
Direction	An instruction issued by the Board to one or both of the constituent authorities in connection with the performance of the integrated functions and related services, under section 26 or 28 of the 2014 Act
Finance Officer	The officer appointed by the Board to be responsible for the proper administration of its financial affairs, in terms of section 95 of the Local Government (Scotland) Act 1973, applied to the Board by section 13 of the 2014 Act
Financial Regulations	Regulations made by the Board as part of its regime of good governance to direct and control the financial affairs of the Board, to guide and secure the effective discharge of the statutory responsibilities of the Finance Officer, to ensure an effective internal audit and system of financial control, and to provide clarity about the financial accountabilities of all those supporting the Board
Health Board	Lothian Health Board, established under section 2 of the National Health Service (Scotland) Act 1978

Integrated functions	The health and social care functions of the constituent authorities to be delegated to the Board in terms of the Integration Scheme
Integration delivery principles	The principles in section 31 of the 2014 Act informing the strategic plan
Integration Joint Board	See "Board"
Integration planning principles	The principles in section 4 of the 2014 Act informing the integration scheme
Integration Scheme	The scheme prepared by the constituent authorities and approved by the Scottish Ministers through which the integrated functions are delegated to the Board
Item of business	A report, motion, minute or other matter in the agenda for consideration and determination at a meeting of the Board
Locality	One of the areas into which the geographical area covered by the Board is to be divided by the Board in its strategic plan, in terms of section 29(3) of the 2014 Act
National health and well-being outcomes	The statutory outcomes prescribed by the Scottish Ministers under section 5 of the 2014 Act informing the integration scheme and the strategic plan, contained in the Public Bodies (Joint Working) (National Health and Wellbeing Outcomes) (Scotland) Regulations 2014
Non-voting member	A member of the Board other than one appointed by the Council or Health Board to be its voting members, under regulation 3(1)(a) or (b) of the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014
Ordinary meeting	A meeting of the Board under Standing Order 4.1, held on a date fixed by the Board as part of its regular annual cycle of meetings
Proxy	See "substitute"
Public sector equality duty	The duties incumbent on the Board in terms of Part 11 of the Equality Act 2010 and the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012
Private information	Information which may justify a decision by the Board to exclude public access to its meetings and meeting papers, as set out in Appendix 2
Register of Interests	The record of matters required to be registered by Board members and disclosed to the public under the Ethical Standards in Public Life etc. (Scotland) Act 2000 and the Ethical Standards in Public Life etc. (Scotland) Act 2000 (Register of Interests) Regulations 2003
Scheme of Delegation	The record maintained by the Board recording the powers and responsibilities delegated to its officers on a permanent or standing basis

Special meeting	A meeting other than an ordinary meeting, called by the Chair or requisitioned by Board members under Standing Order 4.4 or 4.5
Standards Commission	The Standards Commission for Scotland, established under the Ethical Standards in Public Life etc. (Scotland) Act 2000
Strategic Plan	The plan required by section 29 of the 2014 Act setting out the arrangements for the carrying out of the integration functions, how they are intended to achieve the national health and wellbeing outcomes, and other information determined by the Board
Strategic Planning Group	The group required by section 32 of the 2014 Act to be established by the Board for the purposes of preparing, finalising and reviewing the strategic plan
Substitute	A person attending a Board meeting in place of an appointed Board member and entitled to participate and vote in place of that absent member (otherwise a "proxy") in terms of Regulation 12 of the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014
Temporary vacancy	A vacancy arising in the voting membership of the Board as a result of which the other voting members appointed by the same constituent authority may exercise the missing member's or members' vote or votes, under regulation 13 of the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014
Voting member	A member of the Board appointed by the Council or Health Board to be its voting members, under regulation 3(1)(a) or (b) of the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014

APPENDIX 2

PRIVATE INFORMATION

Category	Description
1	Information relating to a particular Board member, employee, former employee or applicant to become an employee of, or a particular office holder, former office-holder or applicant to become an office-holder under, the Board or a constituent authority, where the information relates to that person in one of those capacities.
2	Information relating to any particular applicant for, or recipient or former recipient of, any service or financial assistance provided by the Board or one or both of the constituent authorities.
3	Information relating to the financial or business affairs of any particular person or body (other than the Board or a constituent authority).
4	Information relating to anything done or to be done in respect of any particular person for the purposes of any of the integrated functions and related services.
5	The amount of any expenditure proposed to be incurred by the Board or a constituent authority under any particular contract for the acquisition of property or the supply of goods or services, provided that disclosure to the public of the amount there referred to would be likely to give an advantage to a person entering into, or seeking to enter into, a contract with the Board or the constituent authority in respect of the property, goods or services.
6	Any terms proposed or to be proposed by or to the Board or a constituent authority in the course of negotiations for a contract for the acquisition or disposal of property or the supply of goods or services, provided that disclosure to the public of the terms would prejudice the board or constituent authority in those or any other negotiations concerning the property or goods or services.
7	Any advice received, information obtained or action to be taken in connection with— (a) any legal proceedings by or against the Board or a constituent authority, or (b) the determination of any matter affecting the Board or a constituent authority, (whether, in either case, proceedings have been commenced or otherwise).
8	Any action taken or to be taken in connection with the prevention, investigation or prosecution of crime.

APPENDIX 2

SCHEME OF DELEGATIONS

OF

THE WEST LOTHIAN INTEGRATION JOINT BOARD

To be reviewed in the last meeting of every second calendar year (IJB, 29 January 2017)	
29 January 2017	Approved for immediate use
21 January 2020	Biennial reviewed concluded. Changes to 3.3(f), 5.3(k) and 6.1(l). Director re-titled as Chief Officer. Changes effective from 1 February 2020
5 October 2021	Reviewed, and, following decisions at IJB meetings, additions of entries for CIPFA FM Code and Civil Contingencies Act 2004

1 Introduction

1.1 The West Lothian Integration Joint Board is a statutory corporate body with its own legal personality. It is established under the Public Bodies (Joint Working) (Scotland) Act 2014 and has the responsibilities and powers conferred by that Act and associated statutory regulations.

1.2 The IJB only has one member of staff - the Chief Officer, formerly known locally as the Director. It has other officers who are not members of its staff but who carry out duties for it (for example, the Chief Finance Officer, the Standards Officer). It also receives support from officers and employees of the council and the health board. They are not employed by the IJB and they are managed by the Chief Officer in his complementary roles in the management structures of those two organisations.

1.3 To help ensure sound decision-making, adequate control and good governance the IJB has approved this Scheme of Delegations to its officers. The Scheme sets out the powers and responsibilities of significance to the IJB's discharge of its statutory responsibilities which it has chosen to delegate to those officers.

1.4 It does not contain any delegation of powers or duties in relation to the council or the health board or their members of staff. They are separate legal bodies with different duties, powers and interests in relation to the integration of health and social care. They will have their own internal rules and delegations of powers in relation to their own interests.

1.5 Each of the posts covered by the Scheme has its own role description used by the IJB Appointments Committee and the IJB when the posts were first filled. It is not the Scheme's purpose to replace those or duplicate them or repeat them. The Scheme is part of a governance framework for efficient, effective and accountable decision-making amongst the Board, its committees and its officers.

2 General considerations

2.1 The Scheme is not an exhaustive list of things that officers can do on behalf of the Board. It records the significant and standing delegations of powers and responsibility to officers.

2.2 It does not record temporary or one-off instructions or delegations to officers. Those are recorded in minutes of Board and committee meetings. As a general rule, delegations which will last for more than six months are included, and others are not.

2.3 Subject to the specific provisions in the Scheme and the IJB's Standing Orders and Financial Regulations, powers delegated include anything which is calculated to facilitate, or is conducive or incidental to, their discharge.

2.4 In using a delegated power, officers must have regard and comply with the following over-arching considerations:-

a) They must comply with the law

b) They must have regard to statutory guidance

c) They must act within the terms of the Integration Scheme

d) They must not depart from the terms of the Strategic Plan

e) They must comply with the IJB's Standing Orders and Financial Regulations

f) They must not act where matters are reserved to the IJB or delegated to a committee

g) They must act in accordance with IJB policies, procedures and instructions

h) They must not act in relation to issues which are politically sensitive or controversial

2.5 Officers may delegate the use of their powers to other officers or employees of the council or health board providing support to the IJB. If they do so, they must ensure adequate controls and reporting arrangements are in place. Notwithstanding any such sub-delegation, they remain accountable directly and personally to the IJB.

3 Chief Officer

3.1 As a matter of law, the Chief Officer is employed by either West Lothian Council or NHS Lothian and seconded to the IJB as its only member of staff.

3.2 The Chief Officer is accountable to the IJB as its Chief Officer and also holds positions of authority and responsibility in both council and health board. He is managed jointly by the Chief Executives of the council and the health board.

3.3 The Chief Officer has the following delegated powers and responsibilities:-

a) The statutory position of Chief Officer in terms of section 10 of the Public Bodies (Joint Working) (Scotland) Act 2014

b) Providing corporate and strategic advice and direction to the IJB

c) Liaising with the Chair and Vice-Chair in relation to the preparation of agendas and reports for meetings of the IJB and its committees

d) Implementing the Integration Scheme

e) Developing, implementing and reviewing the Strategic Plan and other policies determined by the IJB

f) Implementing decisions, instructions and directions made by the IJBIJB, and, where specifically authorised by the IJB and after consultation with the Chair and Vice-Chair, to determine the exact wording of directions within parameters set by the Board when delegating that authority

g) Establishing and supporting the Strategic Planning Group

h) Appointing a competent substitute to act in his or her absence or incapacity

i) In consultation with the IJB Chair, determining whether a matter is politically sensitive or controversial

j) In consultation with the IJB Chair, Vice-Chair and Standards Officer, taking urgent action on behalf of the IJB under Standing Order 16

k) Collecting, monitoring and periodic reporting to the IJB and the public of service performance and providing service information for the annual statutory performance report

l) Collating service and financial performance information and providing the annual statutory performance report for IJB approval

m) Issuing directions to the council and health board on the IJB's instructions and monitoring and reporting on compliance by the council and health board

n) Liaising and negotiating with the council, health board and the other NHS Lothian IJBs in relation to the efficient and economical use of premises and other assets

o) Maintaining the IJB's risk register, monitoring risk and taking mitigating action, reporting on risk to the IJB

p) Representing the IJB on the Community Planning Partnership Board and ensuring the IJB's participation in the community planning process

q) Clinical and care governance and adherence to professional standards and regulatory regimes

r) Workforce development

s) Ensuring adequate provision of professional, technical and administrative support services by the council or health board

t) Ensuring the IJB's compliance with statutory regimes such as public sector equality duties, freedom of information, data protection, climate change

u) Providing and operating a complaints handling procedure and liaising with and complying with the requirements of the SPSO

v) Implementing a public and stakeholder engagement strategy and communications and public relations arrangements (including an IJB website)

w) Business continuity planning

x) Liaising with other IJBs in the NHS Lothian area, and with the council and the health board, in relation to both integrated and non-integrated functions

y) Dealing with inspections by regulatory authorities

z) Responding to consultations on non-controversial or technical issues, subject to those responses being reported to the next IJB meeting for information

aa) Ensuring compliance, discharge and review of IJB duties under the Civil Contingencies Act 2004

3.4 The Chief Officer is a non-voting member of the IJB, and a member and chair of the Strategic Planning Group.

3.5 The role description for the post was approved by the IJB Appointments Committee on 26 January 2016 and was refreshed and used for the recruitment of the Chief Officer in 2021.

4 Chief Finance Officer

4.1 The Chief Finance Officer cannot be a member of staff of the IJB and does not have to be an officer of the council or the health board. It is for the IJB to determine the appropriate appointment and contractual arrangements in consultation with the council and the health board.

4.2 The local authority financial and accounting regime is applied as a matter of law to the IJB. The Chief Finance Officer therefore carries the duties of what in council terms is the "Section 95 Officer". That position includes ensuring compliance with relevant legislation and guidance, including Part VII of the Local Government (Scotland) Act 1973, Part I of the Local Government in Scotland Act 2003 and the Local Authority Accounts (Scotland) Regulations 2014.

4.3 The Chief Finance Officer has the following delegated powers and responsibilities:-

a) The statutory responsibility for the proper administration of the IJB's financial affairs in terms of section 95 of the Local Government (Scotland) Act 1973, as applied by section 13 of the Public Bodies (Joint Working) (Scotland) Act 2014

b) Establishing, maintaining, applying and reviewing Financial Regulations

c) Accounting record-keeping, financial management and accounting control systems

d) Ensuring that proper accounting practices are observed in the financial administration of the IJB

e) Providing strategic financial advice, planning, forecasting and direction

f) Liaising and negotiating with the council and the health board in relation to their annual budget contributions, efficiencies, budget pressures and in-year and end-of-year adjustments

g) Financial performance and budgets - monitoring, periodic reporting and providing financial information for the statutory annual performance report

h) Provision of the annual financial statement required to accompany the Strategic Plan

i) Preparing the Annual Accounts and abstract and accompanying statements, signing them and securing their submission for external audit

j) Publishing the unaudited Annual Accounts for public inspection, advertising their availability and responding to any objections made to them

k) Reporting the audited Annual Accounts and external auditor's report to the IJB for approval, arranging for their signature, submitting them to the external auditor and publishing them

l) Securing compliance with relevant statutory financial regimes, including Best Value (including the IJB Best Value Framework) and Following the Public Pound

m) Reporting to the IJB and publishing any report or special report or the findings of the Accounts Commission following any hearing on a report or special report, in terms of Part VII of the Local Government (Scotland) Act 1973

n) Liability insurance and other indemnity arrangements

o) Banking arrangements

p) Procurement and contracts, including if required Standing Orders for Contracts

q) Liaison with and supporting the IJB's Internal Auditor and the Audit Risk & Governance Committee in relation to the internal audit function

r) Liaison and cooperation with the IJB's external auditor and the Accounts Commission

s) Ensuring compliance with the CIPFA Financial Management Code

4.4 The Chief Finance Officer is a non-voting member of the IJB.

4.5 The role description for the post was approved by the IJB Appointments Committee on 26 January 2016.

5 Internal Auditor

5.1 The Internal Auditor cannot be a member of staff of the IJB and does not have to be an officer of the council or the health board. It is for the IJB to determine the appropriate appointment and contractual arrangements in consultation with the council and the health board.

5.2 The local authority financial and accounting regime is applied as a matter of law to the IJB. That requires the IJB to establish and maintain a professional and independent internal auditing service in accordance with recognised standards and practices in relation to internal auditing. The post is also governed by Part VII of the Local Government (Scotland) Act 1973, Part I of the Local Government in Scotland Act 2003 and the Local Authority Accounts (Scotland) Regulations 2014.

5.3 The Internal Auditor has the following delegated powers and responsibilities:-

a) Ensuring the provision of a professional and independent internal auditing service in accordance with recognised standards and practices in relation to internal auditing

b) Obtaining approval of the IJB Internal Audit Charter

c) Preparing, submitting for approval, implementing and reporting on an annual Internal Audit Plan

d) Supporting and advising the Audit Risk & Governance Committee in fulfilling its remit

e) Liaising with and supporting the Chair of the Audit Risk & Governance Committee in relation to that role

f) Conducting investigations and enquiries as required by the Internal Audit Plan and as directed by the Chief Officer or the Audit Risk & Governance Committee

g) Reporting to the Audit Risk & Governance Committee on investigations carried out and on other matters within its remit

h) Reviewing the IJB's system of internal control

i) Liaising and cooperating with the Internal Auditors for the council, the health board and other IJBs in the NHS Lothian area

j) Liaising and cooperating with the IJB external auditors

k) Advising the IJB and its committees and officers in relation to risk and assisting with the maintenance of the IJB's risk register

5.4 The Internal Auditor is not a member of the IJB.

5.5 The role description for the post was approved by the IJB Appointments Committee on 26 January 2016.

6 Standards Officer

6.1 The Standards Officer cannot be a member of staff of the IJB and does not have to be an officer of the council or the health board. It is for the IJB to determine the appropriate appointment and contractual arrangements in consultation with the council and the health board.

6.2 The Standards Officer is a statutory position required under regime of ethical standard in public life in Scotland. It carries statutory duties as well as additional duties contained in guidance by the Standards Commission.

6.3 The Standards Officer has the following delegated powers and responsibilities:-

a) The statutory role defined in the Ethical Standards in Public Life etc. (Scotland) Act 2000 (Register of Interests) Regulations 2003

b) Having regard to and applying the Standards Commission's Advice on the Role of a Standards Officer

c) Ensuring IJB members are eligible for membership

d) Establishing, maintaining, reviewing and publishing a Register of Interests for IJB members

e) Adoption, approval, maintenance and review of a Code of Conduct for IJB members

f) Advising and assisting IJB members in relation to the Register of Interests and the Code of Conduct

g) Ensuring IJB compliance with its other general duties under the Ethical Standards in Public Life etc. (Scotland) Act 2000 and related statutory regulations and guidance

h) Liaising with the Commissioner for Ethical Standards in Public Life and the Standards Commission

i) Clerk to the IJB and its committees

j) Making and reviewing Standing Orders for meetings of the IJB, the Strategic Planning Group and committees, to include their remits, membership and matters reserved to the IJB

k) Making, reviewing and updating a Scheme of Delegated Powers to Officers

l) Establishing, reviewing and reporting on a local Code of Corporate Governance, including adding new standards, updating and making minor changes to existing standards, but not making major changes or deleting existing standards

m) Consulting with the Chief Officer in relation to the taking of urgent action on behalf of the IJB under Standing Order 16

n) Preparation of the annual governance statement to accompany the Annual Accounts

o) Liaising with the Internal Auditor in relation to the internal audit function

6.4 The Standards Officer is not a member of the IJB.

APPENDIX 3

WEST LOTHIAN INTEGRATION JOINT BOARD

AUDIT RISK AND GOVERNANCE COMMITTEE

DOCUMENT HISTORY	
16 February 2016	Initial remit and membership arrangements considered, adjourned to future meeting
5 April 2016	Expanded remit and powers approved, membership as above
5 December 2017	Paragraph A.6 amended to reflect committee's role in relation to consideration of annual accounts and audit report
1 May 2018	Remit and powers amended to match wording of Risk Management Strategy as an action from the internal audit of risk management arrangements (paragraphs A.4, new A.12- A.15)
24 September 2018	Remit and Powers amended to reflect changes in process and responsibilities for dealing with the Board's unaudited and audited accounts
21 January 2020	Biennial review concluded. Minor changes reflected in A.4, A.5 and A.6. Director re-titled as Chief Officer. Changes effective form 1 February 2020

A REMIT AND POWERS

1 To review the effectiveness of the Board's framework of governance, risk management and internal control

2 To approve the annual risk based internal audit plan and monitor internal audit work against the plan

3 To consider the annual external audit plan

4 To approve the internal audit charter and monitor the independence and effectiveness of the internal audit function

5 To monitor the principles underpinning the working relationships between and amongst the committees of the council, NHS Lothian and the other Lothian Integrated Joint Boards dealing with audit, risk and governance, and to monitor the effectiveness of those relationships

6 To consider internal and external audit reports, reports internal control, reports on corporate governance and reports on risk management (from Board, council or health board) and to scrutinise action plans and monitor their progress and completion

7 To redirect internal audit resources as and when deemed appropriate

8 To review with officers, the adequacy of the policies and practices in operation to ensure compliance with relevant statutes, directions, standards or codes of corporate governance

9 To develop a culture of good corporate governance and to promote awareness of and compliance with the principles of good corporate governance

10 To develop a culture of risk awareness and risk management

11 To review the risk management policy and the risk management strategy.

12 To review the risks included in the risk register and consider progress in mitigating risks

13 In relation to the Board's annual accounts and their audit:-

- Consideration of the findings of the review of the system of internal control and approval of the annual governance statement, prior to the Board's consideration, with any recommendations from the committee, of its unaudited accounts

- Consideration of the external auditor's annual report prior to its consideration, with any recommendations from the committee, by the Board

- Consideration of the audited annual accounts for signature and publication prior to their consideration, with any recommendations from the committee, and approval by the Board

14 To review and monitor the Board's strategy and systems for the management of risk and relevant reporting arrangements and ensure they are adequate and cost effective

15 To make recommendations to the Board on any matters within its remit or which are otherwise referred to it by the Board

16 To require the attendance of the Chief Officer, Finance Officer and members of the Board, and the provision of information held by the Board, for the purposes of discharging its remit

B MEMBERSHIP

1 Six members of the Board comprising two voting members appointed by NHS Lothian, two voting members appointed by West Lothian Council, and two non-voting members

2 The Chair and Vice-Chair of the Committee are to be appointed by the Integration Joint Board

3 The Chair of the Integration Joint Board may not be a member of the Committee

C QUORUM AND STANDING ORDERS

1 The quorum for any meeting of the committee shall be on half of its voting members

2 The Standing Orders adopted by the Board on 20 October 2015, as amended if applicable, shall apply to the meetings of the Committee

D SUBSTITUTES

1 Substitutes are permitted from the membership of the Integration Joint Board, but a voting member may not attend as a substitute for a non-voting member

E MEETINGS

1 The committee shall meet at least four times in each financial year on dates fixed either by the Board or by the committee itself

F REPORTING ARRANGEMENTS

1 Minutes of meetings are to be reported and approved at the next meeting of the Committee

2 Minutes of meetings are also to be reported to the Integration Joint Board for noting, either in draft form or as approved, depending on the date of the Board's next available meeting

APPENDIX 4

WEST LOTHIAN
INTEGRATION JOINT BOARD

APPOINTMENTS COMMITTEE

DOCUMENT HISTORY	
8 December 2015	Committee remit established and approved
21 January 2020	Review concluded along with other elements of Standing Orders. No changes other than Chief Officer re-titled as Chief Officer. to be reviewed again by December 2021

1 Name

1.1 The committee shall be called the West Lothian Integration Joint Board Appointments Committee (Appointments Committee).

2 Role and Powers

2.1 To undertake recruitment, interview and appointment to the positions of Chief Officer (formerly known locally as "Director"), Finance Officer (Section 95 Officer), Internal Auditor and Standards Officer.

2.2 Decisions made by the Appointments Committee shall be reported to the next available meeting of the Board for ratification.

3 Membership

3.1 The voting members of the Board in place when the meeting of the Appointments Committee is called.

3.2 Arrangements shall be made by the Clerk, in consultation with the Chair and Vice-Chair, to call to each meeting, and to have in attendance at each meeting, no more than two of the voting members for each of the council and health board.

4 Chair and Vice-Chair

4.1 The positions of Chair and Vice-Chair shall be appointed by the Board, and must be held by voting members.

5 Quorum

5.1 No business shall be conducted unless there are present at least half of the voting members appointed to the committee.

6 Standing Orders

6.1 The Standing Orders of the Board shall apply to proceedings of the committee.

7 Advice and support

7.1 The committee shall be entitled to call on officers of the council and the health board for the support and advice it needs to perform its remit, and those officers may attend meetings of the committee to act as advisers.

8 Minutes and reporting

8.1 Minutes of meetings of the committee shall be reported to the next committee meeting for approval, and to the next available of the Board for information, either in draft or approved form, as the case may be.

6.5 The role description for the post was approved by the IJB Appointments Committee on 26 January 2016.

Date	1 December 2021
Agenda Item	6

INTEGRATED HEALTH AND SOCIAL CARE
WEST LOTHIAN
WORKING FOR WELLBEING

Report to West Lothian Integration Joint Board Audit, Risk and Governance Committee

Report Title: CIPFA Financial Management Code Compliance / Financial Regulations Update

Report By: Chief Finance Officer

Summary of Report and Implications	
Purpose	This report: (tick any that apply).
	- seeks a decision ✓ - is to provide assurance ✓ - is for information - is for discussion
	The purpose of this report is to provide the Committee with an update on progress towards compliance with the CIPFA Financial Management Code, the main aspect of which relates to the proposed updated Financial Regulations for review
Recommendations	It is recommended that the Committee: 1. Notes the progress on compliance with the CIPFA Financial Management Code as set out in Appendix 1 2. Considers the proposed updated Financial Regulations included as Appendix 2 to this report 3. Agrees that the Financial Regulations, taking account of any changes or recommendations by the Committee, are reported to the IJB on 13 January 2022 for approval.
Directions to NHS Lothian and/or West Lothian Council	A direction(s) is not required.
Resource/ Finance/ Staffing	The CIPFA Financial Management Code provides a series of financial management standards and supports governance in local government bodies. The financial regulations assist in securing best value in the use of resources.
Policy/Legal	Section 12 of the Local Government in Scotland Act (2003) states the requirement to observe proper accounting practices that are signed off by the auditors. The financial regulations form a key component of governance and internal control arrangements within the IJB. It is important that they incorporate the requirements of any new legislation and agreed financial

	management standards or regulations that support good practice in financial sustainability and governance.
Risk	None.
Equality, Health Inequalities, Environmental and Sustainability Issues	The report has been assessed as having little or no relevance with regard to equality or the Public Sector Equality Duty. As a result, an equality impact assessment has not been conducted.
Strategic Planning and Commissioning	None.
Locality Planning	None.
Engagement	IJB Standards Officer.

Terms of Report

1. Introduction

1.1 The IJB agreed to adopt the CIPFA Financial Management Code at its meeting of 18 March 2021 for financial year 2021/22 onwards. The Code is designed to support good practice in financial management and assist in demonstrating financial sustainability. An action plan to help ensure compliance with the Code was also agreed by the IJB. This report provides an update on progress against the action plan and taking account of the action in respect of the Financial Regulations, provides an updated set of Financial Regulations for the Committee's consideration. It is proposed that the updated Financial Regulations, taking account of any comments from the Committee, are reported to the IJB for approval it its meeting on 13 January 2022.

2. CIPFA Financial Management Code Action Plan Update

2.1 The CIPFA Financial Management Code sets out a series of financial management standards which the IJB should seek to comply with and based on this an Action Plan was presented to the IJB detailing the existing processes, procedures and documentation currently used that are relevant to assessing IJB compliance with the Code. While the Action Plan set out a strong level of compliance, a small number of areas were identified for further action including reviewing the IJB's Financial Regulations to incorporate the provisions of the new Financial Management Code.

An updated action plan setting out the compliance position as at December 2021 is appended to this report. Based on this update, including the proposed updated Financial Regulations, it is considered that the IJB is compliant with the Code and this position will be reviewed on an ongoing basis as part of annual budget reports.

3. Financial Regulations Update

3.1 A key element of financial governance is a clear set of financial regulations that will allow the IJB to conduct its business efficiently. Section 95 of the Local Government (Scotland) Act 1973 requires all Integration Joint Boards in Scotland to have adequate systems and controls in place

to ensure the proper administration of their financial affairs. The 1973 Act also requires that a proper officer is appointed to take responsibility for the administration of the IJB's financial affairs. For the IJB, this role is fulfilled by the Chief Finance Officer.

3.2 The Chief Finance Officer is also responsible for issuing procedures, guidance and advice to underpin the financial regulations, and for investigating any breach of the regulations. It should also be noted that the IJB does not directly receive or expend cash via a bank account, or employ staff. As a result the Financial Regulations are relatively high level as they are not required to cover areas such as security of assets, banking / treasury arrangements, procurement and payment procedures. The financial regulations are required to be reviewed every three years, and the last review was reported to the IJB on 21 January 2020.

4. Background to Update of Financial Regulations

4.1 The existing Financial Regulations have been reviewed to ensure they comply with the CIPFA Financial Management Code and a number of changes are proposed and these are highlighted in the updated Financial Regulations attached in Appendix 2 so the committee can clearly see the proposed changes. The Committee is asked to consider the proposed updated Financial Regulations and any changes or recommendations it may wish to make to the Board when it considers the Financial Regulations for approval on 13 January 2021.

Appendices	1. CIPFA Financial Management Code Action Plan Update 2. Financial Regulations Update
References	1. CIPFA Financial Management Code – report to IJB on 18 March 2021 2. Review of Financial Regulations – report to IJB on 21 January 2020 3. Local Government in Scotland Act 2003
Contact	Patrick Welsh, Chief Finance Officer, West Lothian Integration Joint Board Email: patrick.welsh@westlothian.gov.uk Tel. No: 01506 281320

APPENDIX 1 – CIPFA FINANCIAL MANAGEMENT CODE EVIDENCE OF CURRENT COMPLIANCE - UPDATE

The CIPFA Financial Management Code is intended to support good practice in financial management and assist in demonstrating a body's financial sustainability. The code sets out the standards of financial management for local government bodies. The table below provides an updated assessment of how West Lothian IJB currently complies with the Code including further progress with actions and continued compliance with requirements.

Section 1 – The responsibilities of the chief finance officer and leadership team

Financial Management Standard	Evidence of Compliance	Actions and Timescale	Update on Actions – December 2021
Financial Management Standard A – The leadership team is able to demonstrate that the services provided by the authority provide value for money.	The leadership team of the IJB utilise a number of frameworks and documents to ensure that the IJB provides value for money. These include: • Ensuring compliance with the IJB's Best Value Framework • Review of financial business cases for service projects • Ensuring compliance with Financial Regulations and Reserves Policy • Monthly financial monitoring and risk based monitoring providing necessary and required scrutiny and feedback.	Continue with the existing systems of internal control and the management of risk. The Financial Regulations will be reviewed to ensure that they fully reflect the requirements of the Code, and the amended regulations reported to the Board for approval.	Updated Financial Regulations reflecting requirements of the Code have been prepared for the Committee's consideration prior to being reported to the Board for approval on 13 January 2022.

Financial Management Standard	Evidence of Compliance	Actions and Timescale	Update on Actions – December 2021
Financial Management Standard B – The authority complies with the CIPFA Statement on the Role of the Chief Financial Officer in Local Government.	The role description of the Chief Financial Officer for West Lothian IJB, complies with the principles set out in the CIPFA statement; this is evidenced by the role, responsibilities and status of activities undertaken. **Principle 1** – Is a key member of the Leadership Team (at West Lothian this is as a Board member and a member of the Health and Social Care Partnership Management Team) **Principle 2** – Takes lead role in the IJB's financial strategy (the CFO reports to the Chief Officer and the Board on all financial strategy matters) **Principle 3** – Leads and promotes good financial management (the CFO encourages and emphasises sound financial management via a variety of means) **Principle 4** – Leads and directs the finance functions of the IJB which is fit for purpose (the CFO manages and is responsible for the financial management and reporting in respect of the IJB) **Principle 5** – Is professionally qualified with suitable experience (the Section 95 Officer is a qualified accountant, with significant relevant experience)	Update the Scheme of Delegation, including the section 95 officer role and responsibilities, to demonstrate compliance with the CIPFA statement, following consideration of the Code by the Board.	Scheme of Delegation has been reviewed and updated by IJB Standards Officer.

Section 2 – Governance and financial management style

Financial Management Standard	Evidence of Compliance	Actions and Timescale	Update on Actions – December 2021
Financial Management Standard C – The leadership team demonstrates in its actions and behaviours responsibility for governance and internal control.	The governance structure of the IJB demonstrates the actions and internal controls in place. This includes the IJB's Financial Regulations, Standing Orders, the Local Code of Corporate Governance and the Scheme of Delegation.	The relevant governance documents are reviewed per timescales agreed by the Board.	Governance documents continue to be reviewed in line with required timescales.
Financial Management Standard D – The authority applies the CIPFA/SOLACE Delivering Good Governance in Local Government: Framework 2016.	The IJB has a Code of Corporate Governance and a compliance process which is aligned to the CIPFA/SOLACE Delivering Good Governance in Local Government: Framework 2016. The Code of Corporate Governance is reported annually to the Audit, Risk and Governance Committee and is reviewed on a bi-annual basis.	None. The IJB fully applies the CIPFA/SOLACE Delivering Good Governance in Local Government Framework 2016.	The IJB continues to fully apply the CIPFA/SOLACE Delivering Good Governance in Local Government Framework 2016.
Financial Management Standard E – The financial management style of the authority supports financial sustainability.	The financial management style of the IJB has been recognised by external auditors Ernst and Young who are satisfied with the financial management arrangements in place although financial sustainability continues to be a risk.	Continue to work with partner bodies around financial sustainability of the IJB and further development of the medium term financial strategy.	Work ongoing with partner bodies around 2022/23 budgets and next medium term financial strategy.

Section 3 – Medium to long-term financial management

Financial Management Standard	Evidence of Compliance	Actions and Timescale	Update on Actions – December 2021
Financial Management Standard F – The authority has carried out a credible and transparent financial resilience assessment.	The IJB is presented with regular finance updates from the Chief Officer which consider key budget risks both operational and strategic. A financial assurance process is undertaken each year on budget resources provided by partner bodies to identify any funding risks to the IJB which could impact on financial resilience.	Building on existing activities, it is proposed that from 2021/22, the budget report will include a section that notes the position on financial resilience and sustainability.	The IJB's 2021/22 budget report included additional information on financial resilience and sustainability.
Financial Management Standard G – The authority understands its prospects for financial sustainability in the longer term and has reported this clearly to members.	The IJB's Strategic Plan and commissioning plans set out the vision for the delivery of the IJBs priorities, the Strategic Plan and associated commissioning plans have gone through the necessary scrutiny and approval processes and take account of MTFP budget assumptions.	The IJBs Strategic Plan is currently for the period 2018/19 to 2022/23. Although the code is not prescriptive it notes the importance of a long term strategy and strategic vision. An updated two year budget to 2022/23 will be presented to the Board in June 2021. Going forward, a five year financial strategy will be developed in conjunction with the Strategic Plan for 2023/24 to 2027/28 setting out a range of assumptions on expenditure and funding.	An updated two year budget to 2022/23 was reported to the Board in June 2021. Work is ongoing around initial development of a five year plan covering the period 2023/24 to 2027/28.

Financial Management Standard	Evidence of Compliance	Actions and Timescale	Update on Actions – December 2021
Financial Management Standard H – The authority complies with the CIPFA Prudential Code for Capital Finance in Local Authorities.	Not applicable.	Not applicable.	Not applicable
Financial Management Standard I – The authority has a rolling multi-year medium term financial plan consistent with sustainable service plans.	The IJB has a medium-term financial plan for the period 2018/19 to 2022/23 with budgets updated annually to ensure they reflect the latest circumstances and most up-to-date information. Commissioning plans are prepared that are consistent with financial resource assumptions and align with the IJB's Strategic Plan.	The IJB's MTFP financial plan covered a five year period, 2018/19 to 2022/23. A new financial plan will be prepared for the next five year period 2023/24 to 2027/28 and will take account of the new Strategic Plan and commissioning plans.	Initial work is being developed on assumptions and approach for preparation of next five year financial plan for period 2023/24 to 2027/28.

Section 4 - The annual budget

Financial Management Standard	Evidence of Compliance	Actions and Timescale	Update on Actions – December 2021
Financial Management Standard J – The authority complies with its statutory obligations in respect of the budget setting process.	The IJBs annual budget report, including issue of Directions, complies with statutory requirements included in the Public Bodies (Joint Working) (Scotland) Act 2014.	Continue to meet statutory obligations by approving Directions associated with annual budget resources agreed.	Continue to meet statutory obligations by approving Directions associated with annual budget resources agreed. The 2021/22 Directions were issued following Board agreement on 18 March 2021.

Financial Management Standard	Evidence of Compliance	Actions and Timescale	Update on Actions – December 2021
Financial Management Standard K – The budget report includes a statement by the chief finance officer on the robustness of the estimates and a statement on the adequacy of the proposed financial reserves.	The budget report undertakes financial assurance on the robustness of estimates and assumptions for the annual budget. Given the IJB has not had any uncommitted reserves the budget report has not to date included a statement on the adequacy of financial reserves.	Currently there is no specific statement from the chief finance officer on the adequacy of reserves. Therefore, the annual budget report to the IJB will be updated to include a statement in respect of IJB reserves.	The 2021/22 budget report included a section on IJB reserves and this will be part of the budget report on an annual basis going forward.

Section 5 – Stakeholder engagement and business cases

Financial Management Standard	Evidence of Compliance	Actions and Timescale	Update on Actions – December 2021
Financial Management Standard L – The authority has engaged where appropriate with key stakeholders on long-term financial strategy, medium-term financial planning and annual budget.	The IJB engages on a collaborative basis with NHS Lothian and West Lothian Council in respect of medium term financial planning and the annual budget process.	The IJB will continue to engage on financial plans and on specific elements of the financial plan. In particular, there will be engagement on new plans for 2023/24 onwards	Continue to engage on financial plans including new plans to be developed for 2023/24 onwards.

Financial Management Standard	Evidence of Compliance	Actions and Timescale	Update on Actions – December 2021
Financial Management Standard M – The authority uses an appropriate documented option appraisal methodology to demonstrate the value for money of its decisions.	The utilisation of business cases is an essential element of service delivery plans and transformation. The IJB considers key business cases related to IJB functions for agreement. (e.g. REH and St John's Hospital business cases)	The IJB will continue to review and approve relevant strategic outline business cases to prioritise resources and demonstrate value for money.	The IJB will continue to review and approve relevant strategic outline business cases to prioritise resources and demonstrate value for money.

Section 6 – Monitoring Financial Performance

Financial Management Standard	Evidence of Compliance	Actions and Timescale	Update on Actions – December 2021
Financial Management Standard N – The leadership team takes action using reports enabling it to identify and correct emerging risks to its budget strategy and financial sustainability.	The IJB has Financial Regulations and an approved Integration Scheme which includes the process for monitoring and reporting of budgets and the identification of risks which allows for mitigating actions being undertaken. This is completed in conjunction with reports being presented on the outcome of UK and Scottish Government budget announcements.	There are regular reports to the HSCP SMT and Board on the progress on the current year budget and any changes to budget assumptions for future years. These will be reviewed to identify any potential improvements.	Budget assumptions for 2021/22 reviewed as part of annual IJB budget process including monitoring reports to each Board meeting.

Financial Management Standard O – The leadership team monitors the elements of its balance sheet that pose a significant risk to its financial sustainability.	The IJB adopts a monthly approach to monitoring with budget monitoring reported to each Board meeting during the year. Any balance sheet areas posing a risk to financial sustainability, are identified through the budget monitoring process. The Audit, Risk and Governance Committee receive regular reports on high risks areas and risks relating to the delivery of the financial plan.	In addition to regular monitoring, a statement on any risks to elements of the balance sheet will be included in the covering report to the IJB's final accounts for 2020/21 which will be reported in June 2021.	Section on balance sheet included in IJB Annual Accounts. No risks required to be highlighted.

Section 7 – External financial reporting

Financial Management Standard	Evidence of Compliance	Actions and Timescale	Update on Actions – December 2021
Financial Management Standard P – The chief finance officer has personal and statutory responsibility for ensuring that the statement of accounts produced by the local authority complies with the reporting requirements of the Code of Practice on Local Authority Accounting in the United Kingdom.	The Scheme of Delegation includes the role and responsibility of the chief finance officer for ensuring that the IJB complies with relevant legislation and guidance including the Code of Practice on Local Authority Accounting. The outturn and final accounts are reported to the Audit, Risk and Governance Committee for review and any recommendations prior to being reported to the Board for approval, with the final accounts being audited and signed off by an external auditor.	This responsibility is clearly set out in the IJB's governance arrangements. Accounts will continue to be produced in accordance with the Code of Practice.	This responsibility is clearly set out in the IJB's governance arrangements. Accounts will continue to be produced in accordance with the Code of Practice.

Financial Management Standard Q – The presentation of the final outturn figures and variations from budget allow the leadership team to make strategic financial decisions.	The final outturn figures are presented to the IJB annually, as part of the unaudited accounts report presented in June each year. The accounts provide information on performance against budget and identify reasons for key variances.	There is a robust process in place for reporting final outturn figures to the IJB, and this allows Board members to consider strategic financial matters.	Final outturn figures for 2020/21 reported as part of unaudited accounts presented to the Board in June 2021.

West Lothian Integration Joint Board

Financial Regulations

Version 3

Date: 1 December 2021

INTEGRATION JOINT BOARD

FINANCIAL REGULATIONS

1. Scope And Observance

1.1 The West Lothian Integration Joint Board is a legal entity in its own right created by the Public Bodies (Joint Working) (Integration Joint Board Establishment) (Scotland) Amendment (No.2) Order 2015 on 21 September 2015.

1.2 The Board is accountable for the stewardship of public funds and operates under public sector best practice governance arrangements, proportionate to its transactions and responsibilities. Stewardship is a function of management and, therefore, a responsibility placed upon the appointed members and officers of the Board. In particular:

(1) NHS (Financial Provisions) (Scotland) Regulations 1974 require NHS Directors of Finance to design, implement and supervise systems of financial control, and NHS circular 1974 (GEN) 88 requires the Director of Finance to:

- approve the financial systems
- approve the duties of officers operating these systems
- maintain a written description of such approved financial systems including a list of specific duties.

(2) Section 95 of the Local Government (Scotland) Act 1973 Act requires that every local authority shall make arrangements for the proper administration of its financial affairs and shall secure that the proper officer of the authority has responsibility for the administration of those affairs.

(3) The CIPFA Financial Management Code requires the IJB to demonstrate how its processes comply with the principles of good financial management. This approach will assist in determining whether, in applying the standards of financial management, the IJB is financially sustainable. Principles of good financial management should be proportionate to the risks to financial sustainability given the pressures on financial resources and rising demand for services.

1.3 Voting members of the Board together with non-voting members of the Board have a duty to abide by the highest standards of probity in dealing with financial issues. This is achieved by ensuring everybody is clear about the standards to which they are working and the controls in place to ensure these standards are met.

1.4 The key controls and control objectives for financial management standards are:

(1) the promotion of the highest standards of financial management by the Board

(2) a monitoring system to review compliance with the financial regulations

(3) comparisons of actual and forward projection of financial performance with planned/budgeted performance that are reported to the Board

(4) the Audit, Risk and Governance Committee of the Board fulfilling its duties under its Terms of Reference.

1.5 In all matters to do with the management and administration of the Integrated Budget by the Board and its officers exercising such delegated powers as the Board has agreed in this regard, these Financial Regulations will apply in all circumstances.

1.6 Prior to any funding being passed by one of the Parties to the Board as part of the Integrated Budget, the Financial Regulations or Standing Financial Instructions of the relevant Party will apply. Similarly, once funding has been approved from the Integrated Budget by the Board and directed by it to the Council or the NHS for the purposes of service delivery, the Standing Financial Instructions or Financial Regulations of the relevant Party will then apply to the directed sum, which will be utilised in accordance with the priorities determined by the Board in its Strategic Plan.

2. Framework For Financial Administration

2.1 Section 95 of the Local Government (Scotland) Act 1973, requires all Integration Joint Boards (IJB) in Scotland to have adequate systems and controls in place to ensure the "proper administration of their financial affairs", including the appointment of an officer with full responsibility for their governance. These Financial Regulations detail the responsibilities of the Chief Finance Officer who has been appointed as the "proper officer" along with the responsibilities of the Chief Officer and Members of the IJB. These Financial Regulations relate to the West Lothian IJB.

2.2 The CIPFA Financial Management Code supports good practice in financial management and demonstration of financial sustainability. Compliance with the Code is the collective responsibility of Board members, the Chief Finance Officer and the leadership team.

2.3 The Chief Finance Officer as the 'proper officer' for the administration of the IJB's financial affairs will oversee the operation of the Financial Regulations within the IJB.

2.4 The IJB has been delegated the responsibility for delivering a set of Health and Social Care functions by West Lothian Council and NHS Lothian. These functions are laid out in the IJB's Integration Scheme. West Lothian Council and NHS Lothian will delegate financial resources to the IJB in respect of these functions.

2.5 The IJB budget report includes a statement by the Chief Finance Officer on the sufficiency of budget resources delegated to meet Strategic Plan objectives and on the position in respect of financial reserves.

2.6 The IJB will issue directions to the Council and to the Health Board in relation to the delivery of the functions delegated to the IJB through its Strategic Plan. The Council and the Health Board in following these directions shall ensure that their own financial regulations are fully observed.

2.7 The IJB will not operationally deliver any of the functions delegated to it; all operational delivery for delegated functions will be provided by West Lothian Council or NHS Lothian as directed by the IJB.

2.8 The Chief Finance Officer will monitor and report on compliance with these regulations which apply to all members of the IJB whether voting or non-voting.

2.9 The IJB will ensure that only expenditure within the legal powers of the IJB is incurred or directed to be incurred. Where this is not clear, the IJB will consult the Chief Finance Officer prior to incurring such expenditure.

2.10 The Financial Regulations may be varied or revoked by the IJB and any variation or revocation will be effective from the first working day after the conclusion of the IJB meeting at which it was approved.

3. Integration Joint Board Responsibilities

3.1 The IJB and its Officers (Chief Officer and Chief Finance Officer) will continuously strive to secure best value and economy, efficiency, and effectiveness in their use of resources.

3.2 Chief Officer

The Chief Officer will provide a strategic leadership role as principal advisor to, and officer of, the IJB and will be a member of the senior management teams of the Parties. The Director will lead the development and delivery of the Strategic Plan for the IJB and will be accountable to the IJB for the content of the directions issued to the Parties by the IJB and for monitoring compliance by the Parties with directions issued by the IJB.

3.3 Chief Finance Officer

The Chief Finance Officer will undertake the role as laid out in S95 of the 1973 Local Government (Scotland) Act and shall make arrangements for the proper administration of the IJB's financial affairs and, as the proper officer of the IJB, has responsibility for the administration of those affairs. The Chief Finance Officer will discharge this duty by:

- establishing financial governance systems for the proper use of delegated resources
- ensuring that the Strategic Plan meets the requirement for best value in the use of the IJB's resources
- providing the IJB with appropriate financial assurance to allow the IJB to understand the assumptions and risks associated with the annual budgets allocated by West Lothian Council and NHS Lothian
- ensuring the annual financial statement is prepared for approval by the Board
- monitoring the overall financial performance of the IJB's functions and resources (as directed by either the Council or Health Board) and review the use of funding to ensure expenditure is not incurred unless it relates to agreed functions and allocations
- producing a medium term financial plan in compliance with the provisions of the CIPFA Financial Management Code

3.4 The Chief Finance Officer in consultation with the Chief Officer will advise the IJB and all its Committees on the financial implications of the IJB's activities. This will include the financial implications of the IJB Strategic Plan which will be underpinned by a Financial Plan.

3.5 The responsibilities of the IJB and its Committees in relation to the conduct of the IJB's financial affairs are defined in the IJB's Standing Orders and Integration Scheme. The IJB, on recommendations from the Chief Officer and Chief Finance Officer, and taking account of the Strategic Plan, will agree on the use of resources delegated to it and direct West Lothian Council and NHS Lothian accordingly. The IJB will also:

- consider and approve any alterations to the Financial Regulations.
- approve its annual financial statement
- approve its annual unaudited accounts and governance statement
- consider its audited accounts and report by its external auditor
- publish an Annual Performance Statement including information on financial performance

4. Financial Management And Planning

4.1 Accounting Policies and Records

The IJB's accounting policies are governed by the appropriate local government Acts as directed and amended by Scottish Ministers. The accounting records of the IJB will be held by West Lothian Council on behalf of the IJB.

4.2 Revenue Budgets

The IJB Strategic Plan will be key to influencing the corporate and financial plans developed for adult social care and health IJB functions. The Chief Officer and Chief Finance Officer will liaise closely with West Lothian Council and NHS Lothian on the development of corporate and financial strategy, taking account of the IJB Strategic Plan. In line with the requirements of the CIPFA Financial Management Code, this will include the preparation of a medium term financial plan.

Revenue budget resources delegated to the IJB by West Lothian Council and NHS Lothian will be used in accordance with the IJB Strategic Plan. The operational budget management of resources associated with IJB delegated functions will be undertaken by West Lothian Council and NHS Lothian. The IJB Chief Finance Officer will liaise with West Lothian Council and NHS Finance staff on budget monitoring matters.

The Chief Finance Officer will provide budget monitoring reports to each IJB meeting along with explanations for any significant variances from budget and the remedial action planned. The Integration Scheme lays out the arrangement for the management of variances within the IJB's operational budget – that is the resources that have been allocated to NHS Lothian and West Lothian Council to undertake the functions delegated. The Chief Officer and the Chief Finance officer will prepare and present to the IJB arrangements for the financial management of these variances.

At the end of the financial year the Chief Finance Officer is responsible for reporting the final outturn position to the IJB as part of the annual accounts process.

4.3 Capital

The IJB does not receive a capital funding allocation. Capital projects are funded by either West Lothian Council or NHS Lothian and expenditure will be controlled within their financial regulations.

The Chief Officer will consult with West Lothian Council and NHS Lothian on making best use of existing partner capital resources associated with delegated functions and on additional capital investment proposals to support delivery of the IJB Strategic Plan.

4.4 Final Accounts

The Chief Finance Officer is responsible for preparing the IJB Final Accounts in compliance with relevant legislation and accounting requirements, and liaising with External Audit on relevant matters connected to the accounts and other finance related matters.

The Chief Finance Officer will submit a copy of the Accounts to the IJB and the Controller of Audit in accordance with the agreed timescales

4.5 Reserves Policy

Legislation empowers the IJB to hold reserves, which should be accounted for in the financial accounts and records of the Board. The Chief Finance Officer is responsible for preparing a Reserves Policy to hold and manage any such reserves which will be presented to the IJB for approval.

4.6 VAT

HM Revenues and Customs have confirmed there is no requirement for a separate VAT registration for the Board. This position will continue to be kept under review by the Chief Finance Officer along with any cost implications to the IJB arising from VAT.

5. Audit And Risk

5.1 Risk

The Chief Officer is responsible for establishing the IJB's risk strategy and profile and developing the risk reporting arrangements, including a risk register. The risk management strategy will be approved by the IJB and reviewed by the IJB Audit, Risk and Governance Committee.

5.2 Insurance

The IJB is a member of the NHS CNORIS scheme which provides the IJB with the appropriate insurance cover. This insurance scheme covers the IJB, its professional advisors, and Council or NHS officers who have been requested by the IJB to provide specific advice or services to the IJB. NHS Lothian and West Lothian Council, in delivering functions as directed by the IJB, will ensure that the appropriate clinical and liability insurance is in place.

5.3 Internal Audit

The IJB Internal Auditor is responsible for reporting to the IJB Audit, Risk and Governance Committee. The internal audit service to the IJB will undertake work in compliance with the Public Sector Internal Audit Standards as defined within the Audit Charter.

The IJB Internal Auditor will, at the start of each financial year, prepare an annual risk based plan for the IJB and submit this for approval to the IJB Audit, Risk and Governance Committee.

The IJB Internal Auditor will submit an annual audit report summarising the work undertaken in relation to the IJB over the year and provide an opinion on the overall adequacy and

effectiveness of the IJB's framework of governance, risk management and control. This will be presented to the Chief Officer and the IJB Audit, Risk and Governance Committee.

All internal audit reports for the IJB will be presented to the Chief Officer and the IJB Audit, Risk and Governance Committee.

The operational delivery of services by NHS Lothian and/or West Lothian Council as directed by the IJB will be covered by the respective internal audit arrangement of these bodies.

6. Following The Public Pound

6.1 Current guidance for Local Authorities where funding is provided by one partner to another body to deliver services which would otherwise be provided by the funder, requires arrangements to be in place to maintain control and clear public accountability over the public funds. This will apply in respect of:

- the resources delegated to the Integration Joint Board by the Local Authority and Health Board
- the resources paid to the Local Authority and Health Board by the Integration Joint Board for use as directed and set out in the Strategic Plan.

Date	1 December 2021
Agenda Item	7

Report to Audit, Risk and Governance Committee

Report Title: High Risks

Report By: Chief Officer

Summary of Report and Implications	
Purpose	This report: (tick any that apply).
	- seeks a decision ☐
	- is to provide assurance ☐
	- is for information ☑
	- is for discussion ☑
	To inform the Committee of the IJB's high risks.
Recommendations	It is recommended that the Committee: • considers the high risks identified, the control measures in place, and the risk actions in progress to mitigate their impact; • makes recommendations it thinks appropriate to the Chief Officer in relation to those risks, controls and actions; • makes recommendations it thinks appropriate to the Integration Joint Board in relation to the risk register and the degree of assurance it provides.
Directions to NHS Lothian and/or West Lothian Council	A direction is not required.
Resource/ Finance/ Staffing	None.

Policy/Legal	The IJB's Policy is to effectively mitigate risks to the achievement of its objectives by implementing robust risk management strategies, policies and procedures, which enable managers to effectively identify, assess, and mitigate risk.
Risk	Directly relevant. This report sets out the IJB's high risks.
Equality, Health Inequalities, Environmental and Sustainability Issues	The report has been assessed as having little or no relevance with regard to equality or the Public Sector Equality Duty. As a result, an equality impact assessment has not been conducted.
Strategic Planning and Commissioning	Effective risk management is a pre-requisite for good performance and outcomes.
Locality Planning	None.
Engagement	IJB Senior Management Team.

Terms of Report	
1.1	The IJB's Risk Management Strategy requires the Committee to review the IJB's risk register every six months. In between, the Committee asked that the IJB's high risks be reported to its meetings, and this report fulfils that obligation.
1.2	Risks are assessed on the basis of a five by five grid of likelihood and impact, and therefore the lowest possible score is one and the highest is 25. The IJB's high risks are defined as those risks which have a current risk score of 12 or more.
1.3	The IJB currently has three high risks, one more than previously reported. Arising from the IJB meeting on 9 November a risk in relation to care at home has been added as risk IJB009.
1.4	The three high risks are as follows: • IJB009 Care at Home (score 16); • IJB007 Sustainability of Primary Care (score 12); • IJB008 Delayed Discharge (score 12). The risks are set out in detail in appendix one.

1.5	In relation to appendix one: • The traffic light icon represents the risk ranking based on the score; these are explained in the table at the start of Appendix 1; • There is a code, title and description for each risk; • The original risk score represents the uncontrolled risk, that is to say the risk without controls in place, and provides an appreciation of the potential impact if controls are absent or fail; • The current risk score represents the current risk, i.e. assuming that current controls are in place and effective; • The internal controls are those processes in place to reduce the risk from original risk score to current risk score; • The risk actions are those measures which are intended to further reduce the current risk. The report only includes those which are in progress. Once marked as complete, risk actions should be included as internal controls and taken account of when assessing the current risk score.
1.6	The standard risk assessment methodology is attached as appendix two.

Appendices	1. IJB High Risks 2. Risk Assessment Methodology
References	Report to Integration Joint Board 9 November 2021: Risk Management
Contact	Kenneth Ribbons, IJB Risk Manager Kenneth.ribbons@westlothian.gov.uk 01506 281573

Appendix 1 IJB High Risks

Report Author: Kenneth Ribbons
Generated on: 19 November 2021 10:11
Report Layout: .. 12 (previously R09d) Original Score, Current Score, Target Score, Internal Controls with linked actions (outstanding only)

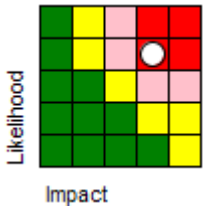
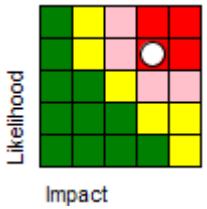
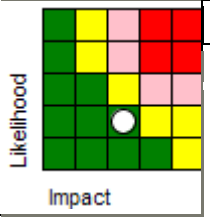
Key to Risk Scores

Icon	Score	Meaning
	16-25	High
	12-15	Medium High

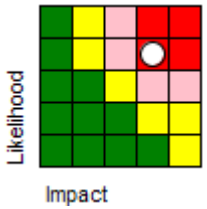
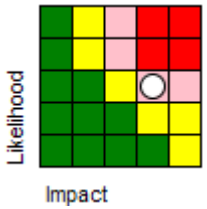
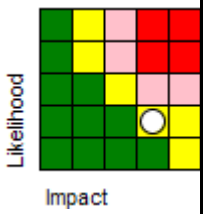
Key to Action Status

Icon	Status
	Overdue
	Approaching Due Date
	In progress

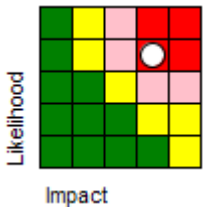
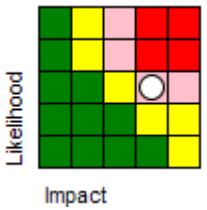
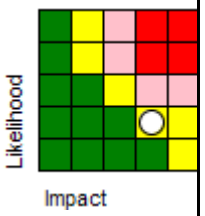
	IJB009 Care at Home	Insufficient supply of care at home to meet service demands arising from lack of availability of carers. This is a national and local issue. The challenges relate to recruitment and retention of care at home staff. This impacts on capacity to deliver care for existing and new service users. Currently this risk is highest in respect of older peoples service. These capacity issues impact on people in the community needing care at home provision and also on capacity to discharge people from hospital where a care at home service is required. (also noted as risk IJB008) The risk is closely monitored by the Care at Home Oversight Group.
	Internal Controls:	Weekly care at home oversight group comprising senior staff with analysis of unmet need and additional data to monitor trends, rising demand. Update on the position of each care at home provider in relation to staffing levels and capacity to deliver. Close working with care at home commissioned providers to explore measures to improve the situation and regular provider forums in place. Close links between integrated discharge hub, review team and commissioning team to ensure available resources are effectively managed and make best use of resources we have. Dedicated in box established for providers to allow for the geographic clustering of packages of care to enable providers to exchange packages that no longer fit their runs to create capacity and make them more efficient. Targeted recruitment of health and social care staff to support internal resilience to support external providers where required. Engagement with the Council's Access2Employment Team and arranged targeted meeting with the providers to ensure that the providers have access to national and local employment programmes and associated subsidies and support. Development of plan to utilise additional funds provided by Scottish government to increase care at home capacity, including supportive role of TEC in this. Benchmarking and connections with other local authorities, Scottish Care and Social Work Scotland to identify effective care at home capacity building elsewhere and apply learning where appropriate. Review current care at home framework arrangements to inform the future approach to the commissioning of care at home services.

Risk Score	Original Risk Matrix	Risk Score	Current Risk Matrix	Risk Score	Target Risk Matrix	Linked Risk Actions		Original Due Date	Due Date	Progress	Description
16		16		6							

	IJB007 Sustainability of Primary Care	There is a risk that GP service provision will be disrupted, restricted or unavailable because of increasing capacity and demand issues as a result of population growth and/or GP practices experiencing difficulties in recruitment, retention or absence of medical staffing leading to significant capacity issues and inadequate and insufficient service provision.
	Internal Controls:	Risk register at HSCP level of all practices identifying vulnerability rating. Programme of support measures developed and available to be tailored to each practices individual circumstances to increase their resilience and maintain service provision. Additional investment to support practices through LEGUP, primary care investment fund. Buddy practice arrangements in place across all practices. Cluster working arrangements established. Primary Care Implementation and Improvement Plan prepared and submitted to the IJB on 26/6/18.

Risk Score	Original Risk Matrix	Risk Score	Current Risk Matrix	Risk Score	Target Risk Matrix	Linked Risk Actions	Original Due Date	Due Date	Progress	Description
16		12		8		IJB18011_Ar Implementation of Primary Care Improvement Plan 2018-2021	30-Sep-2021	31-Mar-2022	95%	Phased investment and improvement plan to support implementation of the new 2018 GMS contract with focus on development of new roles and professionals within the wider Primary Health Care Team, transfer of vaccination services and development of community treatment and care centres, development of mental well-being hubs, use of technology and support of leadership development of GP and practice teams.

	IJB008 Delayed Discharge	There is a risk that patients are not being discharged in a timely manner resulting in suboptimal patient flow, impacting on poor patient and staff experience and poorer outcomes of care.
	Internal Controls:	Community health and social care teams working with discharge hub to facilitate timely discharge; daily MDT meetings Frail Elderly Programme to take forward key actions designed to improve performance Care at Home contract in respect of adequate supply and responsiveness of provision National Care Home Contract in respect of adequate supply of provision Contract monitoring procedure Regular reports to Contracts Advisory Group Regular meetings with providers and Scottish Care Review of contract rates Joint Commissioning Plans Close partnership working with St John's hospital and other NHS Lothian colleagues Strategic Commissioning Plan for Older People Quarterly performance reports to Community Care Management Group Monthly performance reports to SMT Performance reports to IJB Single point of access for acute care Integrated discharge hub now operational

Risk Score	Original Risk Matrix	Risk Score	Current Risk Matrix	Risk Score	Target Risk Matrix	Linked Risk Actions	Original Due Date	Due Date	Progress	Description
16		12		8		IJB19008_Ar Adults with Incapacity	31-Oct-2020	31-Mar-2022	80%	Whilst fewer in number the length of delay can be significant for those requiring guardianship. Review the policy and procedures for Adults with Incapacity to ensure effective decision making supporting use of least restrictive options and coordinate guardianship process where required

				IJB18014_Ar Intermediate Care	31-Dec-2020	30-Nov-2021	75%	Review intermediate care provision and determine future requirements to establish the type and capacity of intermediate care to be commissioned to meet the population needs.

APPENDIX 2

RISK ASSESSMENT METHODOLOGY

RISK MATRIX

LIKELIHOOD	Almost Certain 5	5 Low	10 Medium	15 High	20 High	25 High
	Very Likely 4	4 Low	8 Medium	12 High	16 High	20 High
	Likely 3	3 Low	6 Low	9 Medium	12 High	15 High
	Possible 2	2 Low	4 Low	6 Low	8 Medium	10 Medium
	Unlikely 1	1 Low	2 Low	3 Low	4 Low	5 Medium
		Insignificant 1	Minor 2	Significant 3	Major 4	Catastrophic 5
		IMPACT				

LIKELIHOOD TABLE

Score	Description	Estimated Percentage Chance
1	Unlikely	0-10
2	Possible	10-50
3	Likely	50-70
4	Very Likely	70-90
5	Almost Certain	90-100

Each risk is scored 1-5 for likelihood.

In assessing likelihood consider a three year time horizon and use your knowledge and experience of previous issues, both within the council and elsewhere.

IMPACT TABLE

Each risk is scored 1-5 for impact. In assessing impact each column is independent. Use the highest score.

Hazard / Impact of Risk	Personal safety	Property loss or damage	Regulatory / statutory / contractual	Financial loss or increased cost of working	Impact on service delivery	Personal privacy infringement	Community / environmental	Impact on Reputation
Insignificant 1	Minor injury or discomfort to an individual	Negligible property damage	None	<£10k	No noticeable impact	None	Inconvenience to an individual or small group	Contained within service unit
Minor 2	Minor injury or discomfort to several people	Minor damage to one property	Litigation, claim or fine up to £50k	£10k to £100k	Minor disruption to services	Non sensitive personal information for one individual revealed / lost	Impact on an individual or small group	Contained within service
Significant 3	Major injury to an individual	Significant damage to small building or minor damage to several properties from one source	Litigation, claim or fine £50k to £250k.	>£100k to £500k	Noticeable impact on service performance.	Non sensitive personal information for several individuals revealed / lost	Impact on a local community	Local public or press interested
Major 4	Major injury to several people	Major damage to critical building or serious damage to several properties from one source	Litigation, claim or fines £250k to £1m	>£500k to £2m	Serious disruption to service performance	Sensitive personal information for one individual revealed / lost	Impact on several communities	National public or press interest
Catastrophic 5	Death of an individual or several people	Total loss of critical building	Litigation, claim or fines above £1m or custodial sentence imposed	>£2m	Non achievement of key corporate objectives	Sensitive personal information for several individuals revealed / lost	Impact on the whole of West Lothian or permanent damage to site of special scientific interest	Officer(s) and/or members dismissed or forced to resign

Date	1 December 2021
Agenda Item	8

INTEGRATED HEALTH AND SOCIAL CARE
WEST LOTHIAN
WORKING FOR WELLBEING

Report to Audit Risk and Governance Committee

Report Title: Internal Audit Charter

Report By: Internal Auditor

Summary of Report and Implications	
Purpose	This report:
	- seeks a decision ☑
	- is to provide assurance ☐
	- is for information ☐
	- is for discussion ☐
	To ask the Committee to approve the internal audit charter.
Recommendations	It is recommended that the Audit, Risk and Governance Committee approves the internal audit charter.
Directions to NHS Lothian and/or West Lothian Council	A direction is not required.
Resource/ Finance/ Staffing	None.
Policy/Legal	None.
Risk	The internal audit charter contributes to the management of risk via the provision of an effective internal audit service.

West Lothian Council NHS Lothian

Equality, Health Inequalities, Environmental and Sustainability Issues	The report has been assessed as having little or no relevance with regard to equality or the Public Sector Equality Duty. As a result, an equality impact assessment has not been conducted.
Strategic Planning and Commissioning	The internal audit charter contributes to planning and commissioning via the provision of an effective internal audit service.
Locality Planning	None.
Engagement	IJB Chief Officer, Chief Finance Officer and Standards Officer.

Terms of Report	
1.1	The Public Sector Internal Audit Standards (PSIAS) is a mandatory set of standards applying to internal audit service providers in the public sector. The PSIAS requires that the purpose, authority and responsibility of internal audit is formally defined in an internal audit charter.
1.2	The existing internal audit charter was approved by the Audit, Risk and Governance Committee on 6 January 2017. It sets out internal audit's purpose, scope, responsibilities, objectives, organisational status, independence, and authority. The charter also covers arrangements for managing conflicts of interest.
1.3	The charter has been reviewed in consultation with the IJB Chief Officer, Chief Finance Officer and Standards Officer. A small number of minor presentational changes have been made and the revised charter is attached as an appendix.
1.4	The charter is important in that it clearly sets out the arrangements for securing internal audit's independence, and sets out the right of internal audit staff to receive documents, information and explanations from officers and members of the IJB.

Appendices	1. Internal Audit Charter
References	Report to Audit, Risk and Governance Committee 6 January 2017: Internal Audit Charter
Contact	Kenneth Ribbons, Internal Auditor Kenneth.ribbons@westlothian.gov.uk 01506 281573

INTEGRATED HEALTH AND SOCIAL CARE
WEST LOTHIAN
WORKING FOR WELLBEING

WEST LOTHIAN INTEGRATION JOINT BOARD

INTERNAL AUDIT CHARTER

1 December 2021

West Lothian Council
NHS Lothian

1. INTRODUCTION

1.1 The Local Authority Accounts (Scotland) Regulations 2014 require the West Lothian Integration Joint Board (IJB) to operate a professional and objective internal auditing service in accordance with recognised standards and practices in relation to internal auditing.

2. PURPOSE

2.1 In compliance with the regulations, the IJB has established an internal audit function which independently reviews the IJB's risk management, control and governance processes.

2.2 Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations.

3. STANDARDS

3.1 Internal audit operates in accordance with the Public Sector Internal Audit Standards (PSIAS).

3.2 The PSIAS has been produced by the relevant standard setters, including the Chartered Institute of Public Finance and Accountancy (CIPFA), and represents a common set of internal audit standards for all internal audit service providers in the public sector in the United Kingdom.

3.3 The PSIAS came into force on 1 April 2013 and comprise a definition of internal auditing, code of ethics and professional standards. Compliance with the PSIAS is mandatory.

3.4 The PSIAS requires that the chief audit executive periodically reviews the internal audit charter and presents it to senior management and also to the board for approval.

3.5 In this context the "chief audit executive" is the IJB Internal Auditor, "senior management" is the IJB Chief Officer and "the board" is the Audit, Risk and Governance Committee.

4. SCOPE

4.1 Internal audit's remit extends to the IJB's entire risk management, control and governance processes, both financial and non-financial.

5. RESPONSIBILITIES AND OBJECTIVES

5.1 The IJB Internal Auditor has responsibility for the IJB's internal audit function.

5.2 Internal audit provides assurance by conducting audits of the IJB's risk management, control and governance processes based on an assessment of risk.

5.3 Internal audit's objectives are to review, appraise and report on the:

- effectiveness of systems of financial and non-financial control;
- effectiveness of governance processes;
- effectiveness of risk management processes;
- extent of compliance with policies, plans and procedures;
- extent of compliance with regulations and legislation;
- degree to which assets are properly accounted for and safeguarded;
- reliability and integrity of management data and performance information;
- effectiveness of management in discharging its responsibilities for ensuring best value.

5.4 The IJB Internal Auditor prepares an annual risk based internal audit plan and reports on performance in completing the plan.

5.5 The Audit Risk and Governance Committee is responsible for overseeing the work of internal audit and monitoring its overall performance.

5.6 The IJB Internal Auditor prepares an annual report which includes an opinion on the IJB's framework of governance, risk management and control. The IJB takes this into account when reviewing the effectiveness of its system of internal control.

6. ORGANISATIONAL STATUS AND INDEPENDENCE

6.1 The IJB Internal Auditor independently and objectively reports on the IJB's risk management, control and governance processes.

6.2 The IJB Internal Auditor reports administratively to the IJB Chief Officer. The PSIAS requires the IJB Internal Auditor to report functionally to the Audit, Risk and Governance Committee. Functional reporting is defined as that which enables the IJB Internal Auditor to ensure that internal audit fulfils its responsibilities. This is achieved by the Audit Risk and Governance Committee:

- approving the internal audit charter;
- approving the risk based internal audit plan;
- receiving internal audit reports in the IJB Internal Auditor's name;
- scrutinising internal audit reports received;
- receiving reports from the IJB Internal Auditor on internal audit's performance;
- considering the efficiency and effectiveness of the internal audit function.

6.3 The IJB Internal Auditor has the right of direct access to the Chair of the Audit, Risk and Governance Committee, IJB Chief Officer and IJB Chief Finance Officer in relation to any matter pertaining to the IJB's framework of governance, risk management and control.

6.4 The IJB Internal Auditor may consult with the Standards Officer at any time about any matter pertaining to the IJB's framework of governance, risk management and control.

6.5 Audit reports are issued in the IJB Internal Auditor's name and in addition to the nominated point of contact, audit reports are circulated to:

- the IJB Chief Officer;
- the Chief Finance Officer;
- the external auditor.

6.6 The IJB Internal Auditor also has the right to send audit reports to the Standards Officer for consideration.

6.7 The IJB internal Auditor liaises with NHS Internal Audit and other Lothian IJB Internal Auditors. Information sharing protocols are developed and are authorised by the Audit, Risk and Governance Committee

7. AUTHORITY

7.1 The Local Authority Accounts (Scotland) Regulations 2014 require that any officer or member of the IJB must, as required by those undertaking internal auditing:

- make available such documents of the IJB which relate to its accounting and other records for the purpose of internal auditing; and
- supply such information and explanation as those undertaking internal auditing consider necessary for that purpose.

8. MANAGEMENT RESPONSIBILITIES

8.1 Responsibility for internal control rests with managers, who must ensure that proper internal control arrangements are in place. Internal audit's role is to evaluate the effectiveness of such internal control arrangements. Management is responsible for accepting and implementing audit recommendations, and bears any risk arising from not taking action. Internal audit is not a substitute for an effective system of internal control implemented by management.

9. RESOURCES

9.1 Responsibility for resourcing the internal audit function rests with the IJB Chief Officer.

9.2 The IJB Chief Officer ensures that resources are sufficient to enable internal audit to conduct a regular review of the IJB's risk management, control and governance processes, based on an assessment of risk. The IJB Internal Auditor is responsible for managing the resource provided and providing an effective internal audit service.

10. CONSULTING AND COUNTER FRAUD WORK

10.1 Internal audit may from time to time provide consulting services. Consulting services are generally provided at the request of senior management and are defined as advice, information or training in relation to risk management, control and governance processes.

10.2 The IJB Internal Auditor has responsibility for the IJB's counter fraud function. It may be necessary, from time to time, for the IJB Internal Auditor to undertake counter fraud

investigations, in response to referrals either from management, contractors, customers or members of the public, to establish the facts.

10.3 Counter fraud work will generally result in a report which sets out the facts of the matter, insofar as this can be determined, and include where appropriate recommendations for improvement in control.

11 CONFLICTS OF INTEREST

11.1 Internal audit staff are required to comply with all relevant codes of conduct and guidance and disclose any potential conflicts of interest which may affect their audit work, for example previous employment with Lothian Health Board or West Lothian Council.

11.2 The IJB Internal Auditor is responsible for the IJB's corporate risk management and counter fraud functions. Alternative sources of assurance are sought in relation to the effectiveness of these functions, for example by utilising the work of other council or NHS internal audit teams, or by having regard to the work of external audit.

11.3 The IJB Internal Auditor also acts as internal auditor for West Lothian Council. Any conflicts of interest arising from this will be reported to the IJB Chief Officer and, if necessary, advice will be sought from the IJB's Standards Officer.

Kenneth Ribbons
IJB Internal Auditor

Date	1 December 2021
Agenda Item	9

INTEGRATED HEALTH AND SOCIAL CARE
WEST LOTHIAN
WORKING FOR WELLBEING

Report to: Audit Risk & Governance Committee

Report Title: Governance Issues 2020/21 – Update on Progress

Report By: Standards Officer

Summary of Report and Implications	
Purpose	This report: (tick any that apply).
	- seeks a decision ☐
	- is to provide assurance x
	- is for information x
	- is for discussion ☐
	To consider an update on issues identified for attention through the annual governance statement for 2019/20 and on others matters arising since.
Recommendations	To note the update on governance issues of concern being progressed in 2020/21 and that further updated information will be included in the annual governance statement for 2020/21 and its covering report.
Directions to NHS Lothian and/or West Lothian Council	A direction is not required.
Resource/ Finance/ Staffing	N/A
Policy/Legal	Public Bodies (Joint Working) (Scotland) Act 2014; Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014; Board's Standing Orders
Risk	IJB001, Governance Failure. Good governance leads to good decision making and improved outcomes and will assist in delivering health and wellbeing outcomes
Equality, Health Inequalities, Environmental and Sustainability Issues	The report has been assessed as having no relevance with regard to equality or the Public Sector Equality Duty. As a result, an equality impact assessment has not been conducted.

Strategic Planning and Commissioning	N/A
Locality Planning	N/A
Engagement	Senior Management Team

Terms of Report

1 The Board is committed to meeting good standards of corporate governance. Compliance is the responsibility of all Board members. Providing evidence and assurance to Board members is the responsibility of officers. The Board must approve an annual governance statement each year. That is done through this committee each June. It is included in the Board's annual accounts and so is subject to public scrutiny and external audit. One of the tools used to inform the statement is a bi-annual report on progress against a schedule of governance issues identified in past statements. Items considered to have been completed after committee's consideration are removed from the schedule. Those not yet completed are carried forward. New items identified in the reporting year are added as required. A summary is included in the draft statement for approval in June each year.

2 Progress since the June meeting is shown in the appendix. It shows the status accepted by committee at that meeting, steps taken since and an assessment by officers of its current status. The information shown was considered at the Chief Officer's Senior Management Team on 21 October 2021. Progress has been good and substantial inroads have been made into the areas of concern previously identified. Ensuring full compliance with data protection legislation remains an ongoing issue. The only item on which no action is shown concerns the way in which future Board and committee meetings will be convened and made open to the public.

Appendices	None
References	Public Bodies (Joint Working) (Scotland) Act 2014, section 13 Local Government (Scotland) Act 1973, Part 7 Local Government in Scotland Act 2003, Part 1 Integration Scheme, pages 6 and 7 "Delivering Good Governance in Local Government - Framework and Guidance Notes for Scottish Authorities (CIPFA/SOLACE, 2016) Audit, Risk & Governance Committee, 17 June 2021
Contact	James Millar, Standards Officer 01506 281613, james.millar@westlothian.gov.uk

APPENDIX

PROGRESS ON GOVERNANCE ISSUES FOR 2021/22

Those accepted by committee up and including 17 June 2021 to have been completed have already been removed from the running log. New items from the annual governance statement have been added to those remaining after that meeting to form the basis for reporting in 2021/22. This version is up to date after the committee and board meetings in September 2021 and the Senior management team meeting on 21 October 2021.

ITEM	SUBJECT	STATUS JUNE 2021 ACCEPTED	PROGRESS REPORTED IN DECEMBER 2020 AND MADE SINCE	STATUS FOR DECEMBER COMMITTEE
4(17/18) AND 4(18/19)	Confirm compliance with GDPR and Data Protection Act 2018 and scheduled review (AGS)	Ongoing. Assessed as red in Code 19/20	Interim Data Protection Officer appointed. Privacy Notice implemented in localities consultation. Work ongoing with council on sharing resources and appointment of permanent Data Protection Officer and remaining compliance actions. Requires to be concluded in 2019/20 to give IJB assurance that it is and will be legally compliant. IJB, 30 June 2020 – mentioned in report on RMP as an issue still to be addressed IJB, 22 September 2020 – Chief Officer's report covered annual review of support services but made no mention of DPO or DPA compliance AR&GC, 2 December 2020 – highlighted in Internal Audit report on governance arrangements. Committee recommended urgent investigation and report back, aim is to utilise partner resources AR&GC, 24 February 2021 – report on present arrangements, compliance and risk, Chief Officer to make formal request to WLC and NHSL to provide support or shared resource. Request made to council, declined, request now made to health board AR&GC, 17 June 2021 – brief update provided on communication with health board and council seeking help	Ongoing

2(19/20)	Ensure IJB awareness of PREVENT agenda	Not started	Statutory guidance includes IJBs as public bodies with duties requiring staff engagement and awareness. In schedule of items for development sessions in 2020/21. New UK Government guidance being introduced in 2021, may affect requirement for IJB to take action. Being investigated, to be kept under review	Ongoing
22(20/21)	Implementation of recommendation in EY's annual audit report	Ongoing	IJB, 22 September 2020 – one action recommended and accepted. To be completed on an ongoing basis during 2020/21 but refreshed MTFP to be reported to IJB in first half of 2021 after budget and financial settlement AR&GC, 24 February 2021 – internal audit of financial planning found controls to be effective IJB, 18 March 2021 – in Financial Assurance report, agreed updated medium-term financial plan to be reported to IJB on 29 June 2021 IJB, 29 June 2021 - report approved to complete the action agreed from the audit report	Completed
01(21/22)	Scottish Government Guidance – Planning with People; Community engagement and participation (14 March 2021)	N/A – NEW	To be reported - impact on IJB Communication and engagement Strategy and steps required for implementation IJB, 20 April 2021 – Chief Officer report advised full report due to meeting in June 2021 IJB, 29 June 2021 – Report on implementation, review and testing against guidance. Discharged See 07(21/22), below, accidental duplication	Completed
02(21/22)	Civil Contingencies (Scotland) Act 2004 – IJBs	N/A – NEW	IJB, 29 June 2021 – Chief Officer report explained preparations and plans for compliance	Ongoing

	as first responders with effect from March 2021		IJB, 21 September 2021 – report confirming all in hand and IJB ready to respond. IJB instructed an annual update on readiness and any changes needed. Add appropriate entries to Work Plan and it can be marked as completed (not in Work Plan at IJB on 9 November 2021)	
03(21/22)	United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Act 2021 – implementation of any duties incumbent on IJB	N/A - NEW	IJB, 10 August 2021 – Chief Officer report, highlighting IJB's future responsibilities around UNCRC as they relate to delegated functions and the expectation that guidance will be received from the Scottish Government to inform local implementation 5 October 2021 – Supreme Court decision on 6 October found legislation to be outwith legislative competence, Scottish Government yet to progress an amended version	Ongoing
04(21/22)	Review and updating of FOISA Publication Scheme	N/A - NEW	IJB, 10 August 2021 – Publication Scheme reviewed, updated and republished	Completed
05(21/220	Review and approval of new Complaints Handling Procedure, per SPSO requirements	N/A – NEW	IJB, 10 August 2021 – revised procedure agreed IJB, 212 September 2021 – related Unacceptable Actions Policy approved	Completed
06(21/22)	Actions required by implementation of Feeley Report on national social care service	N/A – NEW	IJB, 21 September 2021 – after development day consideration, IJB response considered to Scottish Government consultation on National Care Service, more to be done and to return to IJB at next meeting IJB, 9 November 2021 – draft response presented and finalised	Completed
07(21/22)	Implementing "Planning with People" (Scottish Government engagement guidance of 2021)	N/A – NEW	Accidental duplication of 01(21/22), above. Discharged	Completed
08(21/22)	Monitoring and reporting progress on action plan from	N/A – NEW	IJB, 29 June 2021 – update on progress, some actions still to be concluded. Next report due in December 2021	Ongoing

	Joint Inspection of Strategic Planning			
09(21/22)	Participation in review by council and health board of Integration Scheme	N/A – NEW	30 June 2021 – Oversight and other arrangements orchestrated by NHSL first meeting, attendance by Chief Financial Officer as an interim until new Chief Officer takes over IJB, 21 September 2021 – Chief Officer report, noted ongoing review process by council and health board	Ongoing
10(21/22)	Revised Model Code of Conduct – adoption of revised IJB Code and training/implementation	N/A – NEW	August/September 2021 – SCS consultation on revised Code and draft Guidance, circulated with comments off-line to members, submitted by Standards Officer on 17 September 2021 7 November 2021 – revised Code submitted to Parliament, considered by parliamentary committee, no indication of final approval date or implementation date	Ongoing
11(21/22)	Consideration and actions from MWC Report on legality of moving patients form hospital to care homes without consent	N/A – NEW	IJB, 29 June 2021 – report on MWC findings and local aspects. Actions being developed, to report to IJB on 10 August 2021 (missed) IJB, 21 September 2021 – report confirming steps taken, confirming action plan developed and submitted to MWC. No provision made for reporting back on meeting deadlines (largely December 2021 and April 2022). Add appropriate entries to Work Plan and it can be marked as completed. (Not in Work Plan at IJB on 9 November 2021)	Ongoing
12(21/22)	Completion of action plan and then full implementation of CIPFA Financial Management Code (2019)	N/A – NEW	23 September 2021 – Chief Finance Officer to report to future AR&GC meeting on progress/completion	Ongoing
13(21/22)	Resumption of physical meetings or enabling hybrid or remote access meetings	N/A – NEW	21 October 2021 – IJB requires to determine how future meetings will be convened and made open to the public	Not started

14(21/22)	Ongoing work to track and report impacts of COVID on service delivery and governance arrangements	N/A – NEW	IJB, 29 June 2021 – COVID update in Chief Officer report. Annual performance report included impact of pandemic on achievement of PIs IJB, 21 September 2021 – Interim Performance Report provided commentary on effects of COVID on PIs	Ongoing

Date	1 December 2021
Agenda Item	10

Report to Audit Risk and Governance Committee

Report Title: Audit and Risk Committee Principles

Report By: Internal Auditor

Summary of Report and Implications	
Purpose	This report:
	- seeks a decision ☑
	- is to provide assurance ☐
	- is for information ☐
	- is for discussion ☐
	To inform the Committee of the revised audit and risk committee principles.
Recommendations	It is recommended that the Audit, Risk and Governance Committee approves the audit and risk committee principles.
Directions to NHS Lothian and/or West Lothian Council	A direction is not required.
Resource/ Finance/ Staffing	None.
Policy/Legal	None.
Risk	Effective joint working and information exchange arrangements between the audit and risk committees will contribute to the effective management of risk.

Equality, Health Inequalities, Environmental and Sustainability Issues	The report has been assessed as having little or no relevance with regard to equality or the Public Sector Equality Duty. As a result, an equality impact assessment has not been conducted.
Strategic Planning and Commissioning	Contributes to planning and commissioning via the provision of joint working and information exchange arrangements between the audit and risk committees.
Locality Planning	None.
Engagement	Vice Chair, Audit Risk and Governance Committee.

Terms of Report	
1.1	On 28 June 2017 the Audit, Risk and Governance Committee approved a set of audit and risk committee principles covering the interaction between the NHS Lothian Audit and Risk Committee and Lothian IJB Audit and Risk Committees. The principles cover communication between the committees and their chairs, communication of relevant internal audit reports, and liaison in relation to internal audit planning.
1.2	Following discussions between the NHS Lothian and IJB internal auditors it was agreed that the principles should be reviewed. Following an initial review, a meeting of the internal auditors and members of the various audit and risk committees was held on 19 October, attended by the Vice-Chair of this committee. A revised set of audit and risk committee principles was agreed which is attached as an appendix.
1.3	The main changes to the principles are: • Principle four which previously stated "The minutes of the IJB audit & risk committees and Lothian NHS Board audit & risk committee shall be accessible" has been removed. The number of principles has therefore reduced from five to four; • The current principle four now relates to the interaction between the internal audit teams and has been re-written to set out the support to be provided by NHS Lothian internal audit to the IJB internal auditors. This is an entirely new arrangement.
1.4	The Committee is invited to approve the principals.

Appendices	1. The Principles to Underpin the Working Relationships between the Lothian NHS Board Audit & Risk Committee and the Integration Joint Board Audit & Risk Committees
References	Report to Audit, Risk and Governance Committee 28 June 2017: Audit and Risk Committee Principles
Contact	Kenneth Ribbons, IJB Internal Auditor

	Kenneth.ribbons@westlothian.gov.uk 01506 281573

Appendix 1 - Principles to Underpin Working relationships between Lothian NHS and IJB Final 251021

THE PRINCIPLES TO UNDERPIN THE WORKING RELATIONSHIPS BETWEEN THE LOTHIAN NHS BOARD AUDIT & RISK COMMITTEE AND THE INTEGRATION JOINT BOARD AUDIT & RISK COMMITTEES

PRINCIPLE 1: The IJB Audit & Risk Committees and the Lothian NHS Board Audit & Risk Committee have an effective working relationship to take forward matters of common interest.

How will this work in practice?

- ✓ In addition to other specific measures, the chairs of the committees will meet every 6 months alongside the Chief Internal Auditors (broadly timing to be aligned to IA Planning and IA opinion).
- ✓ The audit & risk committees, chief internal auditors and management from the IJBs and Lothian NHS Board shall work collaboratively to resolve issues and risks, recognising that for some issues and risks there are interdependencies between the IJBs.
- ✓ The IJB Chief Officers (or delegated per IJB structures) shall lead the work required to maximise and maintain consistency in the IJBs' systems for risk management and risk registers. The aim is to create a reliable holistic view of risk from IJBs and Partner organisations.
- ✓ There will be an agreed two-way communication between the NHS Lothian ARC and the IJB. This will focus on the principles of assurance and sharing relevant information between both parties, not to duplicate the work of the respective committees.
- ✓ The IJB Audit & Risk Committees have the right to require NHS managers to attend their meetings, should they wish to discuss an internal audit report with them. However, it is agreed that this right would be exercised after due consideration and would probably be exceptional. In the normal course of events the IJB Audit & Risk Committees will in the first instance rely on the scrutiny and oversight work of Lothian NHS Board Audit & Risk Committee.

PRINCIPLE 2 : To support the efficient conduct of business, there is a clear communication process from the IJB Audit & Risk Committee to the Lothian NHS Board Audit & Risk Committee, and vice versa.

How will this work in practice?

- ✓ In the event that an IJB Audit & Risk Committee wishes to raise a matter directly with the NHS Lothian Audit & Risk Committee, the IJB relevant Officer will be tasked with communicating the request.
- ✓ The IJB Chief Finance Officer shall send the request to the secretary of the Lothian NHS Board Audit & Risk Committee (Alan Payne

Appendix 1 - Principles to Underpin Working relationships between Lothian NHS and IJB Final 251021

PRINCIPLE 2 : To support the efficient conduct of business, there is a clear communication process from the IJB Audit & Risk Committee to the Lothian NHS Board Audit & Risk Committee, and vice versa.

alan.payne@nhs.scot.uk). The secretary shall process the request accordingly.

- ✓ With regard to communication from the Lothian NHS Board Audit & Risk Committee to the IJB audit & risk committees, the secretary of the Lothian NHS Board Audit & Risk Committee shall send the information to the IJB Chief Finance Officer (or an officer that the IJB Chief Finance Officer has identified for that purpose).

PRINCIPLE 3: The reports from the Lothian NHS Board internal audit function shall be readily available to the IJB audit & risk committees. The reports from the IJB internal audit functions shall be readily available to the Lothian NHS Board audit & risk committee.

How will this work in practice?

- ✓ The Lothian NHS Board Audit & Risk Committee publishes internal audit reports once the Committee has reviewed and accepted them. The NHS Lothian Chief Internal Auditor routinely publishes internal audit reports on the Board's website following the Audit & Risk Committee meetingwww.nhslothian.scot.nhs.uk / Our Organisation / Key Documents / Audits

- ✓ Once the reports have been placed on the website, the NHS Lothian Chief Internal Auditor shall email the IJB Chief Internal Auditors to make them aware of this. This email will include reference to those reports relevant to the IJB for the Chief Internal Auditor to consider for referral.

- ✓ On a quarterly basis NHS Lothian Internal Audit present a follow up on outstanding actions to the ARC meeting. This will be shared with the IJB Chief Internal Auditors once presented to Committee.

- ✓ The IJB Audit & Risk Committees shall refer any relevant IJB internal audit reports to the Lothian NHS Board Audit & Risk Committee and reflect that referral in their minutes. The IJB Chief Internal Auditor shall liaise with the Chief Internal Auditor of NHS Lothian to share the reports.

Appendix 1 - Principles to Underpin Working relationships between Lothian NHS and IJB Final 251021

PRINCIPLE 4: NHS Lothian and the respective Council's will work together to support the IJB Internal Audit plans.

How will this work in practice?

- ✓ The IJB Chief Internal Auditors and the NHS Lothian Chief Internal Auditor will routinely during the year to share intelligence including work programmes. Both parties will aim to avoid duplication in internal audit resources. To support the IJB Internal Audit plan delivery NHS Lothian Internal Audit will provide an internal audit team member to the Chief Internal Auditors of the IJB. This will be for an agreed period of time, at a time that works for both parties.

- ✓ The NHS Lothian Internal Audit team member will be the responsibility of the Chief Internal Auditor for the IJB who will scope, direct, and review the work of the auditor. The report will be the responsibility of the IJB Chief Internal Auditor who will report the work to the IJB Audit and Risk Committee.

- ✓ The sharing of internal audit resource will be referenced in the NHS Lothian plan, but this will not form the NHS Lothian Internal Audit plan and will not be considered within the NHS Lothian annual internal audit opinion.

Date	1 December 2021
Agenda Item	11

Report to Audit Risk and Governance Committee

Report Title: NHS Lothian: Internal Audit of Risk Management at a Divisional/HSCP level

Report By: Internal Auditor

Summary of Report and Implications	
Purpose	This report: - seeks a decision ☐ - is to provide assurance ☑ - is for information ☐ - is for discussion ☑ To ask the Committee to consider the NHS Lothian internal audit report.
Recommendations	It is recommended that the Audit, Risk and Governance Committee considers the NHS Lothian internal audit report on risk management.
Directions to NHS Lothian and/or West Lothian Council	A direction is not required.
Resource/ Finance/ Staffing	None.
Policy/Legal	None.
Risk	The report is directly relevant to the management of risk within NHS Lothian at Divisional/HSCP level.

Equality, Health Inequalities, Environmental and Sustainability Issues	The report has been assessed as having little or no relevance with regard to equality or the Public Sector Equality Duty. As a result, an equality impact assessment has not been conducted.
Strategic Planning and Commissioning	Failure to effectively manage risk is likely to have a negative effect on performance.
Locality Planning	None.
Engagement	Head of Health as per the agreed action plan.

Terms of Report	
1.1	The Committee is asked to consider the recent NHS Lothian internal audit report on risk management within NHS Lothian at a Divisional / HSCP level.
1.2	The report describes three control objectives as follows: • risks at a Divisional/HSCP level are being captured and considered by the right teams on a regular basis; • risks are being addressed and are given appropriate attention to reduce their impact or likelihood, with appropriate senior management oversight; • significant risks recorded at the Divisional/HSCP level are escalated to the corporate risk register if appropriate and in a timely manner.
1.3	The report concludes that moderate assurance can be received in relation to all three control objectives. The term moderate assurance is defined in appendix four of the report and is stated to be: "In most respects the "purpose" is being achieved. There are some areas where further action is required, and the residual risk is greater than "insignificant". The controls are largely effective and in most respects achieve their purpose with a limited number of findings which require management action (for instance a mix of 'medium' findings and 'low' findings)"
1.4	It should be noted that the conclusions relate to the three stated control objectives. The report does not contain separate conclusions for each Division / HSCP. However an agreed action plan for the West Lothian HSCP is included on pages 18 and 19 of the report.

Appendices	1.	NHS Lothian internal audit report dated May 2021: Risk Management at a Divisional/HSCP level

References	None.
Contact	Kenneth Ribbons, IJB Internal Auditor Kenneth.ribbons@westlothian.gov.uk 01506 281573

Internal Audit

Risk Management at a Divisional/HSCP level

May 2021

Internal Audit Assurance assessment:

Control Objective 1	Control Objective 2	Control Objective 3
Moderate Assurance	Moderate Assurance	Moderate Assurance

Timetable

Date closing meeting held: 13th May 2021

Date draft report issued: 20th May 2021

Date management comments received: Various (all before 8th June 2021)

Date Final report issued: 8th June 2021

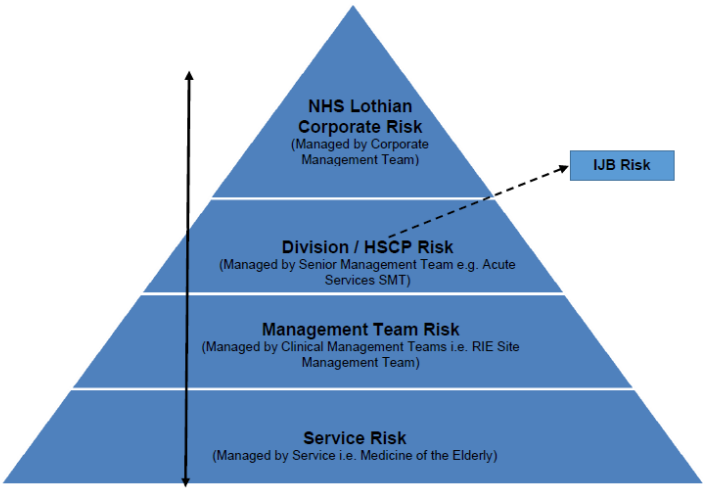
Date presented to Audit and Risk Committee: 21st June 2021

Contents

1. Introduction

1.1 Under Public Sector Internal Audit Standards (PSIAS) we are required to consider certain aspects of NHS Lothian's risk management arrangements on an annual basis. NHS Lothian have an established Risk Management Policy with a supporting Risk Management Operational Procedure to aid the implementation of the policy and ensure consistency of approach in operational risk management.

1.2 The process outlines the Risk Register Hierarchy (see diagram below), including what risks should be managed at what level. including their escalation up or down. This recognises that some risks can be managed at an operational level or lower level if they do not have an impact across the whole system.



1.3 The Quality Team has already identified areas to strengthen the risk management process at the corporate risk register level, including how risks should be accepted on to the risk register, plans to mitigate the risk, looking at risk gradings and how senior management oversight should be provided. Therefore, our review has not focused on NHS Lothian Corporate risks, but instead considered how risks are managed lower down the hierarchy, specifically at a Division/HSCP level.

Scope:

1.4 Our review has sought to support the work of the Quality Team. We have focused on the controls in place (design and operation) to ensure risks are managed at an operational level at the Division level on the hierarchy. We have considered how this is managed within each Division/HSCP. We considered the controls in place (design and operation) to ensure risks are captured, ensuring risks are not duplicated and how this links to the corporate risk register, including appropriate escalation and de-escalation of risks, focusing on how risks are escalated to a corporate risk level.

Acknowledgements

1.5 We would like to thank all staff consulted during this review, for their assistance and cooperation.

2. Executive Summary

Summary of Findings

2.1 The table below summarises our assessment of the risks and the adequacy and effectiveness of the controls in place to meet each of the risk areas agreed for this audit. Definitions of the ratings applied to each action are set out in **Appendix 4**.

No.	Control Objectives	Assurance Level	Number of Findings			
			Critical	High	Medium	Low
1	Risks at a Divisional/HSCP level are being captured and considered by the right teams on a regular basis	Moderate Assurance	-	-	2	-
2	Risks are being addressed and are given appropriate attention to reduce their impact or likelihood, with appropriate senior management oversight	Moderate Assurance	-	-	2	-
3	Significant risks recorded at the Divisional/HSCP level are escalated to the corporate risk register if appropriate and in a timely manner	Moderate Assurance	-	-	1	-
Total			-	-	5	-

Conclusion

2.2 Through discussions with the Divisions/HSCPs, each were clear on their responsibilities in relation to risk, why risk management is important and how risks should be identified and documented. This could be articulated through the management of risks during the COVID-19 pandemic, requiring services to respond quickly, and risks be managed in an agile manner. Additionally, the Divisions/HSCPs were comfortable with how they could escalate risks if they could not be managed at the Divisional level and how to do this appropriately. However, it was also recognised that DATIX (the risk management system) was not always updated to reflect the risk management processes being undertaken on a day-to-day basis and areas for improvement were required.

2.3 A good culture around risk management within the Divisions/HSCPs was noted through our discussions, with all being aware of their responsibilities in relation to risk and examples provided to demonstrate how risks have been managed during the COVID-19

pandemic. Additionally, there was a good understanding of what risks should be managed at what level and where escalation may be required. However, there is in some places a lack of formalisation of processes and documentation behind the understanding demonstrated. This has been recognised throughout the Divisions, with East Lothian HSCP implementing a quarterly Risk Management Group, Edinburgh HSCP setting up a Risk Management Forum and Committee and REAS looking to formalise processes to make risk management business as usual as we emerge from the COVID-19 pandemic.

2.4 Areas for improvement identified through our review included:

- Formalising the risk management procedures in place within each Division/HSCP to clearly articulate how risks are managed, through which groups and how often, to ensure responsibilities in relation to risk management are clearly documented.
- Performing an overall review of the risks captured in DATIX and ensuring they are updated accordingly, as the risks were outdated in a lot of cases.
- Ensuring all senior management teams at the Divisions/HSCP are considering risks as a standing agenda item and ensuring general managers and service line managers are considering risks as part of their formal meetings too.
- Considering within the Divisions/HSCP how formalised reporting of progress against actions for high and very high rated risks could be incorporated into their risk management procedures to provide assurance over the actions being taken.
- Reconsidering how Divisional/HSCP high or very high risks could be reported into NHS Lothian, given the refreshed role of the CMT. There is also an opportunity to create a more formalised escalation route for risks to NHS Lothian via this route. Any changes made to the reporting and flow of risks should be updated in NHS Lothian's Risk Management procedures.

Methodology and Approach

2.5 We conducted interviews with staff from all Divisions/HSCPs to gain an understanding of the risk management processes in place at each. In addition, we reviewed their risk registers and supporting documents to assess how risks were being captured and considered on DATIX. Where possible, we obtained evidence of senior management team meeting minutes or minutes/agendas from other groups to corroborate the processes described by management.

2.6 It should be noted that we reviewed the controls in place over the capturing and recording of risks, linked to senior management oversight and escalation, however, we have not reviewed the legitimacy or accuracy of the risks identified as part of this review.

2.7 A complete listing of staff involved, and documents reviewed can be seen at **Appendix 3**.

3. Management Action Plan

Control objective 1: Risks at a Divisional/HSCP level are being captured and considered by the right teams on a regular basis	
Finding 1.1 – Not all divisions have defined risk management procedures in place	**Medium**
There is notable variation in how risks are managed across the Divisions/HSCPs. This is expected given the differing governance structures and functions each has. The risk management processes currently used or recently implemented by each has been summarised within Appendix 1. However, not all risk management processes within the Divisions/HSCPs are formalised, either via a procedural document or flow chart. Paragraph 4.23 of the NHS Lothian Risk Management procedure states that all senior management teams should have an explicit process in place for managing risks within their own area. Whilst the processes in place for risk management could be described by all, there is a risk that without a formalised document describing these processes that all relevant parties, including service level managers, lack clarity in responsibilities in relation to risks. Additionally, there were instances where meetings relating to risks were not minuted, such as the quarterly risk management meeting at East Lothian HSCP, and there would be benefit in doing so in order to provide robust evidence of the system in control in place relating to risk and for clear documentation of how decisions have been made.	
<u>Recommendation</u> All Divisions/HSCPs should ensure they have documented procedures, aligning to the NHS Lothian risk management framework, which clearly articulate their risk management processes. Additionally, risk management meetings should be formally minuted, documenting discussion of risks and how key decisions relating to risks have been made.	
<u>Management Response, Action, Responsibility and Target Date</u> Management responses, actions and target dates have been received from each of the Divisions/HSCPs for this recommendation. These have been included at Appendix 2 for each. When writing this report, we were aware not all actions applied to each of the Divisions/HSCPs and we asked management to consider each finding in relation to their own procedures and reflect on improvements which could be made. We are satisfied where management have stated that they already comply with the recommendation that we agree and that no action is required.	

Control objective 1: Risks at a Divisional/HSCP level are being captured and considered by the right teams on a regular basis	
Finding 1.2 – Datix is not up to date for all Divisions/HSCPs with areas for improvement noted	**Medium**

Through interviews with Divisions/HSCPs it was acknowledged that DATIX (the risk management system) is not always kept up to date. This is partly reflective of the COVID-19 pandemic where risks have been managed on a much more agile basis, and the discipline of updating DATIX has not been a high priority. This has occurred to varying degrees at each Division/HSCP.

This was corroborated through review of each Divisions/HSCPs risk register where the following areas for improvement were noted:

- Review of risks are not always being performed in a timely manner, with many reviews past their due dates. Multiple occasions of this happening could be seen in each Division/HSCP risk register (with the exception of Midlothian HSCP). For example, some risks are listed on DATIX as requiring review in 2017, yet this has not been updated since. In addition, reviews were overdue where controls were deemed to be inadequate, and therefore we would expect these to be being considered in a more urgent manner.
- Poor articulation of risks and their associated action plans. This was noted throughout all risk registers where the action plan included refence to a specific group but did not always outline what that group was expected to achieve in relation to management of the risk. In addition, the adequacy of controls is not always documented beside the action plan. This occurred in REAS, Acute, East Lothian, West Lothian and Edinburgh HSCP's risk register.
- Potentially outdated risk ratings or no risk rating associated with identified risks. For example, within REAS, Acute and Edinburgh HSCP's risk register there were a number of High rated risks, where the adequacy of controls was noted as satisfactory which could indicate that the risk had been managed to a lower level and a reduction in rating required. In addition, there were 3 risks within the Acute risk register with no grading, and 4 within Edinburgh HSCP with no grading.
- Duplication of risks within risk registers. For example, within Edinburgh HSCP there were multiple risks relating to lone working/violence and aggression with very similar action plans associated. In addition, this is a risk on the corporate risk register, and should be reviewed in conjunction with this to ensure each risk register only includes actions relating to each. Additionally, REAS includes risks on self-harm and ligature, which are directly linked and could be amalgamated into one risk.
- Duplication of risks to the corporate risk registers. For example, on the REAS risk register risk 2386 relates to Traffic Management. This is not articulated as to how REAS would specifically manage the risk, and therefore, this would be more appropriate to be solely on the corporate risk register. In addition, Acute has two risks relating to Access to Treatment which are also held on the corporate risk register.

However, the differentiation of how the risk is being managed at each level is not currently clear, with actions overlapping.

Whilst examples have been pulled out from specific risk registers above, the same themes for improvement appeared across most risk registers. Additionally, it should be noted that outdated DATIX entries was a known area for improvement identified through all interviews undertaken, and work is underway within each Division/HSCP to update these.

Recommendation

Each Division/HSCP should perform a review over their senior management team risk register to ensure risks are appropriately documented on the risk management system. This should consider, but is not limited to the following:

- can risks be managed at an operational level (i.e. do they actually need to be on the divisional risk register)
- does the risk description articulate the residual risk not being managed by the service level
- who owns the risk and associated controls and do the controls set out clear lines of accountability
- is there a plan in place to manage higher level risks which will be appraised by senior management
- does the risk rating reflect the residual risk taking into account the plans in place
- is there any overlap/duplication of risk.

Going forwards, Divisions/HSCP should look to update DATIX on a more regular basis, the process for which could be documented in the procedures developed from Finding 1.1.

Management Response, Action, Responsibility and Target Date

Management responses, actions and target dates have been received from each of the Divisions/HSCPs for this recommendation. These have been included at Appendix 2 for each.

When writing this report, we were aware not all actions applied to each of the Divisions/HSCPs and we asked management to consider each finding in relation to their own procedures and reflect on improvements which could be made. We are satisfied where management have stated that they already comply with the recommendation that we agree and that no action is required.

Control Objective 2: Risks are being addressed and are given appropriate attention to reduce their impact or likelihood, with appropriate senior management oversight	
Finding 2.1 – Not all Divisional/HSCP Senior Management Teams or service delivery teams have risk as a standing agenda item at their monthly meetings.	**Medium**

It is expected that senior management teams of each Division/HSCP will have oversight of the risk management processes within their service, and that risks should be considered as part of the senior management team meetings. Additionally, risks should be considered by management teams and service level teams below their level – and evidence of this happening could not always be provided. It was noted through interviews at the time of the audit that the following practices were occurring:

- Acute risks are managed at the Clinical Management Group level, with these risks being escalated directly to NHS Lothian Executive Team via the Healthcare Governance Committee, if necessary. These risks are not going through the Acute Senior Management prior to escalation as should be the process. In addition, as the Clinical Management Group focus on clinical risks, there is currently no formal forum to consider wider risks facing the service.
- REAS risks are considered at each senior management team meeting, but not as a standing agenda point or in relation to the risk register. Additionally, it was noted that risk is not currently a standing agenda point on general managers meetings.
- East Lothian and Edinburgh HSCP have recently implemented a governance structure for the management of risks. However, these structures do not feed directly into their senior management teams to provide oversight to them. Whilst it is recognised that members of the senior management team (including the Chief Officer) will be on the risk committees, it would still be prudent to report risks or activity of the risk management groups to the senior management teams. Additionally, the frequency these groups plan to meet may not allow for timely consideration of risks. For example, very high risks should be being considered on a monthly basis – and it may be better to consider these at the senior management team meetings than wait for the quarterly risk reporting groups.
- East Lothian, West Lothian and Edinburgh HSCP noted that risks would be escalated to a senior management level via general managers if necessary. However, it was not evidenced that general managers consider risks as a standing agenda item or on a regular basis.

It should be recognised that improvements have been made since the time of the audit, with REAS, for example, including risk as a standing item on their Performance Management Agenda.

Recommendation

All Divisions/HSCPs should ensure risk is a standing agenda item on the senior management team agenda. This should be done even where risks are being managed through another committee (such as East Lothian and Edinburgh HSCP) to ensure the whole senior

management team have oversight of the risks and the process for managing risks. The review of risks should be minuted as part of the monthly meetings to document the oversight provided by the senior management teams. Additionally, each Division/HSCP should ensure that management teams and service levels below them are considering risks on a regular basis. This could be done by ensuring team meetings consider risk as a standing agenda point, or through other committees, such as at Midlothian HSCP where all general managers attend the Business Governance Group and discuss their individual risk registers. This would provide assurance to the senior management team that risks are being considered at this level.
Management Response, Action, Responsibility and Target Date Management responses, actions and target dates have been received from each of the Divisions/HSCPs for this recommendation. These have been included at Appendix 2 for each. When writing this report, we were aware not all actions applied to each of the Divisions/HSCPs and we asked management to consider each finding in relation to their own procedures and reflect on improvements which could be made. We are satisfied where management have stated that they already comply with the recommendation that we agree and that no action is required.

Control Objective 2: Risks are being addressed and are given appropriate attention to reduce their impact or likelihood, with appropriate senior management oversight	
Finding 2.2 – Formalised review of risks at a senior management team level should be introduced for higher level risks	**Medium**
NHS Lothian's Risk Management process recommends that a review of the risk register should be carried out at least every 3 months at the appropriate level, although individual risks, depending on their risk rating, may be reviewed more frequently. It is also recommended that risks should be reported to an appropriate forum/committee within the Divisions/HSCPs to consider progress against actions. For very high risks, this could be done once monthly and for high risks every three months by the senior management team. With medium and low level risks considered on a less frequent basis and can be via management teams, rather than the senior management teams. Through discussions with the Divisions/HSCPs, risks, including very high and high level risks are being managed by risk handlers on an ongoing basis and discussed with risk owners on a one-to-one basis but there is not necessarily formalised compliance reporting of progress against actions to a forum such as the senior management team. There is a risk that without formalised reporting of risks against action plans, that actions are not addressed in a timely manner or actions do not reflect the risk as it changes. Again, it is recognised that the risk rating of some risks may be higher than required, as per Finding 1.2 and reporting against all high level risks may not be required once a review of DATIX has been performed.	
<u>Recommendation</u> There is an opportunity for the Divisions/HSCPs to consider how to incorporate compliance checks of high and very high level risks to their risk management processes, reporting progress against action plans to the relevant senior management teams or risk forums at an appropriate frequency. These should go as papers to the relevant committees with discussions minuted accordingly. The agreed process should be incorporated into the formalised procedures, as per Finding 1.1. This process should be considered following a review of DATIX and the risk ratings, as per Finding 1.2 to ensure risk ratings are appropriate and do not result in over-reporting.	
<u>Management Response, Action, Responsibility and Target Date</u> Management responses, actions and target dates have been received from each of the Divisions/HSCPs for this recommendation. These have been included at Appendix 2 for each. When writing this report, we were aware not all actions applied to each of the Divisions/HSCPs and we asked management to consider each finding in relation to their own procedures and reflect on improvements which could be made. We are satisfied where management have stated that they already comply with the recommendation that we agree and that no action is required.	

Control Objective 3: Significant risks recorded at the Divisional/HSCP level are escalated to the corporate risk register if appropriate and in a timely manner	
Finding 3.1 – There is an opportunity to consider the process for reporting and escalating risks, incorporating the refreshed role of the CMT in relation to risk.	**Medium**

The NHS Lothian Risk Management procedure includes an escalation flowchart. Within this it states that where risks are unable to be managed at a Divisional/HSCP level then the Risk Owner should present the risk to an appropriate Executive Director prior to discussion at CMT to ensure all efforts to mitigate the risks are appraised.

Through interviews with the Divisions/HSCPs it was noted that known escalation routes did include discussing the risk with their relevant executive director, as well as taking the risks through the Healthcare Governance Committee. However, it was unclear what the process was once a risk had been flagged to an Executive Director or the Healthcare Governance Committee. Additionally, the Healthcare Governance Committee's role in relation to risk is around assurance over the actions taken to mitigate risks and not necessarily to escalate risks to the corporate risk register level, therefore, not an appropriate medium to escalate risks.

Additionally, as stated at paragraph 6.1 of the NHS Lothian Risk Management procedure, every 6 months Divisional High/ Very High risks are reported to the Audit and Risk Committee. On review of Audit and Risk Committee meeting minutes from April 2019 to April 2021, this has not been taking place. On reflection, however, it should be considered whether the Audit and Risk Committee is the best forum for these risks to be reported to given their focus on the corporate risk register and supporting the Board in their assurances over risk.

It is recognised, that the corporate management team (CMT) are taking a more formal role in relation to risk management, where the corporate risk register is going to be discussed every 2 months. It would be appropriate to consider how this forum can be used to formalise the process for the escalation of risks as well as the reporting of risks from the Divisional/HSCP level. It would still be appropriate to report very high or high divisional risks to provide oversight of risks which could impact NHS Lothian or which may require to be escalated on to the corporate risk register.

<u>Recommendation</u>

There is an opportunity for NHS Lothian to consider how risks from a Divisional/HSCP level should be reported going forwards, with the NHS Lothian risk management framework being updated accordingly. Now a more formalised process, the review of the corporate risk register by the CMT could include the review of Divisional high and very high risks (shifting this responsibility away from the Audit and Risk Committee). In addition, this could include consideration of any risks at a Divisional/HSCP level which have been escalated which may need to be included on the corporate risk register.

NHS Lothian's risk management procedures should be updated to incorporate the refreshed role of the CMT and reporting which will be reviewed as part of their remit. These changes should be communicated to the Divisions/HSCPs.

Management Response • The CMT will consider twice a year high and very high risks at an Acute and HSCP level to assess risks that may require escalation onto the CRR. • The CMT Risk paper will ask that the CMT consider any operational risks that require escalation for potential inclusion on the CRR. • The review of NHSL Risk Policy and Procedure (2018) will incorporate audit findings and response including the role of the CMT. Management Action • The first consideration of high and very high risk from across the system will take place in September 2021. • The CMT paper will have within it a standard section asking the CMT to consider strategic and operational risks for potential escalation on to the CRR from June 2021. • The NHSL Risk Policy and Procedure is due for review which will be completed by October 2021 and will incorporate internal audit findings and actions.

Responsibility:	Target Date:
Associate Director for Quality Improvement & Safety	As outlined above for the 3 actions to be taken (June 2021, September 2021, October 2021)

4 Internal Audit Follow-up Process

4.1 Approximately two weeks following issue of the final Internal Audit report, a member of the Audit Team will issue an ‘evidence requirements’ document for those reports where management actions have been agreed.

4.2 This document forms part of the follow up process and records what information should be provided to close off the management action.

4.3 The follow-up process is aligned with the meetings of the Board’s Audit & Risk Committee. Audit Sponsors will be contacted on a quarterly basis with a request to provide the necessary evidence for those management actions that are likely to fall due before the next meeting of the Audit and Risk Committee.

4. Appendix 1 – Risk Management Processes

Below outlines the high level processes described to us by each of the Divisions/HSCPs during the interviews undertaken. Where possible, we have corroborated these processes.

West Lothian HSCP
West Lothian HSCP Senior Management Team (SMT) meet formally once a month. Risk is on the agenda of each SMT meeting, and a formal review of the risk register is performed at SMT every quarter. Monitoring of risks will be done on a one-to-one basis between the Risk Handler and Risk Owner, and this is not currently minuted or evidenced.
East Lothian HSCP
East Lothian HSCP over the last 6 months, have implemented quarterly risk management meetings specifically for risks where a review of the risk register is performed. However, these meetings are not currently minuted. Monitoring of risks is through these meetings, however, again this review is not currently minuted or evidenced.
Midlothian HSCP
Midlothian HSCP Senior Management Team meet every 2 weeks and risk is a standing agenda item. The Senior Management Team is supported by 4 committees (Business Governance Group, Finance and Performance, Staff Governance and Clinical Care and Governance) each of which have risk as a standing agenda item. Service level risks are considered monthly via the Business Governance Group. Monitoring of risks is through these forums. This process is supported by Midlothian's HSCP Risk Reporting Structure.
Edinburgh HSCP
Edinburgh HSCP have recently introduced a Partnership Risk Committee and Partnership Risk Forum to manage risks. The Forum will meet every 2 months and feed into the Committee which will meet every quarter. Given this is a new process, minutes of these meetings could not be provided at the time of the audit. Monitoring of risks is planned to be via the forum and committee going forwards. This process is supported by Edinburgh HSCP Risk Management Guidance.
REAS
Recognising the change in the senior management team in REAS just prior to and during the COVID-19 pandemic, risk management procedures have not yet become business as usual. The senior management team meets formally once a month where pertinent and emerging risks are discussed and monitored. However, risks or the review of the risk register is currently not a standing agenda item on the senior management team meetings. Since initial discussions with internal audit, this has been improved with the risk register forming a standing item on the monthly performance meetings agenda.
Acute Services
Risks relating to service areas are discussed through the Acute Services Clinical Management Group and is a standing agenda item. Risks identified at this group are reported to the Healthcare Governance Committee. However, there is not a formal process in place to review risks at a Senior Management Team level. Monitoring of risks is currently through the Clinical Management Group.

5. Appendix 2 - Management Responses, Actions, Responsibility and Target Dates

	Management Response	Management Action	Responsibility &Target Date
REAS Responses			
Finding 1.1	REAS has introduced a monthly performance meeting - the first meeting was on 5th May and risk register was on agenda and will be discussed routinely going forward.	Ensure Risk register is on agenda for REAS monthly performance meetings going forwards.	Responsibility: REAS Services Director Target Date: Now complete (following initial discussions with internal audit)
Finding 1.2	Risk Registers will be reviewed through performance meeting discussions and ensure that the mitigations are appropriate to the risk and the residual risk rating is commensurate. Business Manager, when appointed, will have responsibility for updating the risk register quarterly on portfolio.	Maintain performance meeting. Appoint Business Manager.	Responsibility: REAS Services Director Target Date: 31.08.2021 to allow appointment process
Finding 2.1	New Performance meeting introduced - the first meeting was 5th May 2021. This will be monthly going forward and risk register will be a standing item	Ensure performance meetings happen	Responsibility: REAS Services Director Target Date: Now complete (following initial discussions with internal audit)
Finding 2.2	New Business Manager will have responsibility of working with senior managers to ensure action plans to mitigate risks are progressed and reported to performance meeting.	Continue performance meeting. Appoint Business Manager.	Responsibility: REAS Services Director Target Date: 20.05.2021
Midlothian HSCP Responses			
Finding 1.1	Midlothian Health and Social Care Partnership meets this recommendation. We have well documented procedures in place which align to the NHS Lothian Risk Management framework. Risk is reviewed routinely at governance meetings with minutes and action logs to ensure accurate recording of risk and allows for ongoing monitoring.	Midlothian Health and Social Care Partnership will continue our work to ensure risk is accurately recorded and well monitored. Ensuring that the importance of risk management is well communicated to all staff and those identified as risk owners/handlers are clear on their responsibilities and accountabilities.	N/A
Finding 1.2	Midlothian Health and Social Care Partnership already has strong processes in place to ensure we are complaint with this requirement. Each Service has a local risk register which is reviewed at Business Governance meetings, if escalation is required, risks are taken to HSCP		N/A

	SMT for discussion, where appropriate and agreed, they are added to HSCP SMT risk register which is maintained by the Risk Management lead (Roxanne King – Business Manager). All risks are assigned an appropriate owner and handler and have clear and effective mitigation in place to control. Minor level of overlap/duplication due to the nature of our structure but impact is kept to a minimum by having a clear structure in place. No action required	
Finding 2.1	As detailed within the recommendation, Midlothian Health and Social care ensures that risk is a standing agenda item on all governance meetings as well as a standing agenda item on the Senior Management Team two weekly meeting. No action required	N/A
Finding 2.2	Midlothian Health and Social Care Partnership carries out compliance checks of high or very high risks as part of an additional quarterly review of risk management at the Senior Management Team meeting. This is to ensure that controls in place are mitigating the risk and the risk is either stabilised or decreasing in likelihood/impact. Updates are added onto the HSCP SMT risk register on Datix with next review date added. High severity risks are monitored every 2 weeks during Senior Management team (as indicated on Datix). No action required	N/A
Acute Services Responses		
Finding 1.1	Risk management processes embedded in site and services Directorates. Signed off through Site and Service Hospital Management Groups (HMG/Directorate SMT). Acute Risk Register formally discussed and signed off at Acute Senior Management Team (SMT) 3 monthly or by risk review date:- • New risks will be identified via a proforma monthly and recorded with rationale of why added to Acute Risk Register also recorded. • Existing risks will be reviewed and risk mitigations discussed and recorded.	Responsibility: Chief Officer for Acute Services Target Date: At Acute SMT Jun 24th 2021, and monthly thereafter.
Finding 1.2	Full review of Acute Risk Register at SMT on 24 June 2021 3 monthly review of risks at SMT thereafter, or in line with risk review date. Datix updated after each SMT. • Risks for escalation or review monthly agenda item. Datix updated after each SMT. • Site and Service Directorates and Acute Division Risk Registers on DATIX.	Responsibility: Chief Officer for Acute Services Target Date: By/ at Acute SMT – 24th Jun 2021
Finding 2.1	Site and service teams have risk register as a standing agenda item on their monthly management team meetings. Risk Workshops to be supported at local site and directorate level by Acute Business Manager.	Responsibility: Triumvirate (Chief Officer for Acute Services, Medical & Nursing

	Clinical risks standing agenda item on acute Clinical Management Group (CMG). Monthly review of Clinical risks takes place at CMG. Chaired by Acute Nurse Director and Acute Medical Director. Minuted discussion. New risks and risks for review standing agenda item on Acute SMT from June 2021 incl. onwards and following discussion DATIX will be updated. Review of risks on Acute SMT Agenda 3 monthly or by risk review date. Monthly review through CMG and Acute SMT.		Directors & Acute service business manager) Target Date: SMT - Jun 24th 2021 and monthly thereafter
Finding 2.2	As above. Process already embedded for CMG Acute SMT 3 monthly or by risk review date for all including High or Very High risks - with progress against action plans recorded.		Responsibility: Triumvirate (Medical & Nursing Directors & Acute service business manager) Target Date: June 2021 – Acute SMT
West Lothian HSCP			
Finding 1.1	Whilst there are arrangements in place for identifying risks across the organisation, it is accepted that there could be clearer processes in place and documented procedures which explain the partnership's approach to risk management. Whilst risk management is discussed in a range of forums, it is again accepted that there is no written process which outlines expectations or defines responsibilities around this across the organisation. Risk management is discussed on a regular basis at the partnership's senior management team and in the NHS management senior management team meeting but we need to review how risks are escalated and put a formal arrangement in place for recording discussions and assessing risk.	A full review will be undertaken by the senior management team of the governance routes for risk management including where risks are discussed and documented having regard to the Lothian Risk Management Procedure as recommended. The review will be complete and revised processes and procedures put in place by 30th June 2021 to give time for a comprehensive review to be undertaken and revised arrangements put in place. Arrangements have already been put in place for discussion about risk to be minuted and will become a standing item on the agenda for meetings.	Responsibility: West Lothian HSCP Head of Health Target Date: 30 June 2021
Finding 1.2	A review of the risk register is already underway and with the risk register being a standing item on the agenda for management team meetings, it should give the required assurance over risks being current and subject to review.	Review of risk register to be completed by 30 June 2021.	Responsibility: West Lothian HSCP Head of Health Target Date: 30 June 2021
Finding 2.1	Discussion does take place regarding risks and risks escalated by General Managers where appropriate, but it is accepted that this is not always documented in	Risk management is now included as a standing item on the agenda for management team meetings. General managers will be expected	Responsibility: West Lothian HSCP Head of Health Target Date:

	the way it should be. Further action has been taken recently on training for Senior Managers across the Partnership to ensure that we are consistent in our assessment of risk.	to report on risk in their area as a matter of course in those meetings.	30 June 2021
Finding 2.2	A degree of consistency is required in the partnership on compliance checks details of which will be included in revised documentation.	Details of the frequency of compliance checks will be incorporated into the review of risk management and incorporated into written processes for the partnership.	Responsibility: West Lothian HSCP Head of Health Target Date: 30 June 2021
Edinburgh HSCP			
Finding 1.1	The Edinburgh Health and Social Care Partnership recognise that they are on a journey in relation to their risk management approach and have developed an integrated approach to risk management that aligned to the approaches taken my partners.	• Roll out its risk management approach across the Partnership which includes guidance on how to identify risks, monitor, escalate and review risks. • Ensure Risk Committees and Forums will be minuted.	Responsibility: Edinburgh HSCP Chief Officer and Operations Manager Target Date: June 2022
Finding 1.2	The Partnership Executive Management Team recognise that they have further work to embed their new integrated approach to risk management which includes an approach for ensuring risks are managed at the right level within the organisation and a mechanism to escalate risks whether appropriate and that the.	• Review and agree the Executive Team risk register. • Work with the Wider Leadership Team through the Risk Forum and their management teams to develop divisional and team risk registers • Embed the escalation process from team to risk forum to ensure risk is managed at the correct level • Review risks across the Partnership for any overlap / duplication or areas where a risk is consistently being raised and make recommendations to the Risk Committee. • Agree the most appropriate risk management recording tool.	Responsibility: Edinburgh HSCP Operations Manager Target Date: June 2021
Finding 2.1	The Partnership recognises that risk needs to continue to be a focus within all teams with the Partnership and as part of the rollout of the risk management guidance, teams will be involved in developing their risk registers and looking at mechanisms in place to	• Development of a process note on where risks will be discussed for each team and what frequency this will be undertaken. Risk registers should also go via the Operational and Strategic Management Teams to	Responsibility: Edinburgh HSCP Operations Manager Target Date: June 2022

	ensure risks are regular discussed through focussed discussions at management teams or team risk committees set up.	provide a divisional overview of common risks. • Scrutiny of team risk registers as a role of the Risk Forum • Risk activity report to be submitted to the risk forum and an update report from the Forum on to the Committee • Clear communication how to escalate risks to the Risk Forum	
Finding 2.2	The Partnership recognise the importance of robust risk management procedures and the rollout and embedding of the risk management guidance should ensure that there is appropriate scrutiny of very high and high risks, and these should be adequately monitored through DATIX.	• All high or very high risks (and associated actions plans) will be scrutinised at the Risk Forum on a bi-monthly basis. Where the risk rating cannot be reduced, they will be escalated to the Partnership Risk Committee.	Responsibility: Edinburgh HSCP Operations Manager Target Date: June 2022
East Lothian HSCP			
Finding 1.1	Risks are discussed and registers updated quarterly the risk register is a live document however, no minute of this meeting is kept.	Quarterly risk meeting to be minuted.	Responsibility: East Lothian HSCP Chief Officer Target Date: 30th September 2021
Finding 1.2	East Lothian consider that DATIX is updated on at least a quarterly basis however will review the commentary around responsibility for actions.	Review commentary on responsible officers and actions.	Responsibility: East Lothian HSCP Chief Officer Target Date: 30th September 2021
Finding 2.1	Risks are discussed in an individual basis and escalated to the risk management meetings but will be added to the senior manager meetings as a standing agenda item	Add Risk Management to agenda for management team meeting.	Responsibility: East Lothian HSCP Chief Officer Target Date: 30th September 2021
Finding 2.2	East Lothian Risk Register is reported to the IJB Audit and Risk Committee on a regular basis. It also is reviewed through East Lothian Council and NHS Lothian processes as required.	Continue to report to relevant governance committees.	Responsibility: East Lothian HSCP Chief Officer Target Date: 30th September 2021

6. Appendix 3 – Staff Involved and documents reviewed

Staff Involved:

- Associate Director for Quality Improvement & Safety
- Quality & Safety Assurance Lead
- Acute Hospital Services Chief Officer
- Acute Nurse Director
- Acute Service Business Manager
- REAS Services Director
- Edinburgh HSCP Director
- Edinburgh HSCP Chief Finance Officer
- Edinburgh HSCP Operations Manager
- Edinburgh HSCP Head of Operations
- East Lothian HSCP Chief Officer
- East Lothian HSCP Head of Operations
- East Lothian HSCP Emergency Planning, Risk and Resilience Officer
- West Lothian HSCP Chief Officer
- West Lothian HSCP Head of Health
- Midlothian HSCP Chief Officer
- Midlothian HSCP Business Manager
- Midlothian HSCP Integration Manager

Documents Reviewed:

- NHS Lothian Risk Management Policy
- NHS Lothian Risk Management Operational Procedure and associated documents
- Corporate Single System Services Risk – 15th March 2021
- Audit and Risk Committee minutes April 2019 - April 2021
- Audit and Risk Committee Corporate Risk Register Paper – 26th April 2021
- NHS Lothian Risk Management Architecture – July 2020
- Chief Officers Meeting (IJBs) – Risk Mapping Paper – 28th October 2019
- Edinburgh HSCP Executive Team Risk Register – 27th April 2021
- Edinburgh HSCP Risk Management Guidance v.04
- Edinburgh HSCP Partnership Risk Committee v.03
- Edinburgh HSCP Partnership Risk Forum v0.3
- Edinburgh HSCP Risk Committee Papers – 6th April 2021
- REAS Risk Register – 28th April 2021
- REAS SMT Minutes – 17th March 2021, 17th February 2021
- REAS Performance Management Agenda – 5th May 2021
- Midlothian HSCP Risk Register – 30th April 2021
- Midlothian HSCP Risk Reporting Structure
- Midlothian HSCP SMT Agenda – 28th April 2021,
- Midlothian HSCP Business Management Committee Agenda – 27th April 2021
- Midlothian HSCP example service level risk register – April 2021
- East Lothian HSCO Risk Register – 12th May 2021

7. Appendix 4 - Definition of Ratings

Findings and management actions ratings

Finding Ratings	Definition
Critical	A fundamental failure or absence in the design or operating effectiveness of controls, which requires immediate attention
High	A key control failure has been identified which could be either due to a failure in the design or operating effectiveness. There are no compensating controls in place, and management should aim to implement controls within a calendar month of the review.
Medium	A control failure has been identified which could be either due to a failure in the design or operating effectiveness. Other controls in place partially mitigate the risk to the organisation, however management should look to implement controls to fully cover the risk identified.
Low	Minor non-compliance has been identified with the operating effectiveness of a control, however the design of the control is effective

Report ratings and overall assurance provided

Report Ratings	Definition	When Internal Audit will award this level
No assurance	The Board cannot take any assurance from the audit findings. There remains a significant amount of residual risk.	The controls are not adequately designed and / or operating effectively and immediate management action is required as there remains a significant amount of residual risk (for instance one Critical finding or a number of High findings)
Limited assurance	The Board can take some assurance from the systems of control in place to achieve the control objective, but there remains a significant amount of residual risk which requires action to be taken.	This may be used when: • There are known material weaknesses in key control areas. • It is known that there will have to be changes that are relevant to the control objective (e.g. due to a change in the law) and the impact has not been assessed and planned for. The controls are deficient in some aspects and require management action (for instance one 'high' finding and a number of other lower rated findings)
Moderate assurance	The Board can take reasonable assurance that controls upon which the organisation relies to achieve the control objective are in the main suitably designed and effectively applied. There remains a moderate amount of residual risk.	In most respects the "purpose" is being achieved. There are some areas where further action is required, and the residual risk is greater than "insignificant". The controls are largely effective and in most respects achieve their purpose with a limited number of findings which require management action (for instance a mix of 'medium' findings and 'low' findings)
Significant assurance	The Board can take reasonable assurance that the system(s) of control achieves or will achieve the control objective. There may be an insignificant amount of residual risk or none at all.	There is little evidence of system failure and the system appears to be robust and sustainable. The controls adequately mitigate the risk, or weaknesses are only minor (for instance a low number of findings which are all rated as 'low' or no findings)

Date	1 December 2021
Agenda Item	12

INTEGRATED HEALTH AND SOCIAL CARE
WEST LOTHIAN
WORKING FOR WELLBEING

Report to Audit Risk and Governance Committee

Report Title: Risk Management Annual Reports 2020/21

Report By: Risk Manager

Summary of Report and Implications	
Purpose	This report:
	- seeks a decision ☐
	- is to provide assurance ☑
	- is for information ☑
	- is for discussion ☑
	To inform the Committee of the annual risk management reports for 2020/21 for NHS Lothian and West Lothian Council.
Recommendations	It is recommended that the Audit, Risk and Governance Committee considers the risk management annual reports.
Directions to NHS Lothian and/or West Lothian Council	A direction is not required.
Resource/ Finance/ Staffing	None.
Policy/Legal	None.
Risk	Directly relevant to the management of risk.

West Lothian Council NHS Lothian

Equality, Health Inequalities, Environmental and Sustainability Issues	The report has been assessed as having little or no relevance with regard to equality or the Public Sector Equality Duty. As a result, an equality impact assessment has not been conducted.
Strategic Planning and Commissioning	Effective risk management is a pre-requisite for good performance and outcomes.
Locality Planning	None.
Engagement	NHS Lothian Quality & Safety Assurance Lead

Terms of Report	
1.1	The Committee will be aware of the IJB's risk management arrangements via the submission of regular reports on the IJB's risks to this Committee. The Committee received the IJB's risk management annual report for 2020/21 on 17 June 2021 and this concluded that appropriate risk management arrangements are in place within the IJB in accordance with the IJB's approved Risk Management Policy and Strategy.
1.2	The Committee may wish to receive similar assurance in relation to the management of risk within NHS Lothian and West Lothian Council and accordingly the risk management reports for these organisations for 2020/21 are attached as appendices to this report. The Committee is therefore invited to consider the NHS Lothian and West Lothian Council risk management annual reports.

Appendices	1. NHS Lothian Risk Management Annual Report 2020/21 2. West Lothian Council Risk Management Annual Report 2020/21
References	Report to Audit, Risk and Governance Committee 17 June 2021: Risk Management Annual Report
Contact	Kenneth Ribbons, Risk Manager Kenneth.ribbons@westlothian.gov.uk 01506 281573

NHS LOTHIAN

Audit & Risk Committee
21 June 2021

Medical Director

RISK MANAGEMENT ANNUAL REPORT

1 Purpose of the Report

1.1 The purpose of this report is to set out the Risk Management Annual Report from 1 April 2020 to 31 March 2021, to provide assurance on the management of risk across NHS Lothian.

Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

2.1 Accept moderate assurance that there are systems in place to manage risk across NHS Lothian and there is an improvement programme to further strengthen the risk system.

2.2 Note Healthcare Governance Committee accepted the following in November 2020 and May 2021:

- Significant assurance that local processes are in place to identify events which require to be reported to Healthcare Improvement Scotland (HIS) to comply with the new national notification process and note number and types of events reported
- Significant assurance on progress in implementing the statutory organisational Duty of Candour
- Moderate assurance in the progress made in improving processes for management of significant adverse events (SAEs) and in addressing the backlog
- Moderate assurance on process for safety alerts and the associated reports up to March 2020.

2.3 Note the annual Internal Audit into risk management will report to the June 2021 Audit & Risk Committee and will be used to review NHS Lothian's Risk Management Policy and Procedure (October 2018)

3 Discussion of Key Issues

3.1 The focus for 2020/2021 is set out below and are key components of NHS Lothian's Adverse Event Policy and Procedure (October 2018) and the Risk Management Policy and Procedure (October 2018) both of which seek to contribute to NHS Lothians safety culture and inform improvement programmes:

- Embed the National Notification System for Health Improvement Scotland level one reviews
- Embed the Duty of Candour processes
- Maintain adverse management and risk management processes during Covid -19
- Review the Corporate Risk Register to ensure it remains fit for purpose

3.2 **Adverse Event Management**

National Notification System (Healthcare Improvement Scotland - HIS)

3.2.1 All Boards have been required to notify HIS of all full SAE reviews for major harm or death events since 1 January 2020 (termed by HIS as level 1 reviews for category 1 adverse events).

3.2.2 Processes are now embedded through PSEAGs (Patient Safety & Experience Action Group) or equivalent senior management team forums to consider all reported events with major harm or death, to:

- decide the level of review and record decision in Datix, clearly articulating rationale if not for full SAE review
- commission appropriate review, including setting clear terms of reference
- appoint review team.

The NHS Lothian Medical Director validates all decisions for full SAE review prior to reporting to HIS.

3.2.3 Quality Improvement Support Team (QIST) staff continue to support management and review teams in implementing the new process, and maintain oversight, including monitoring of timescales and tracking of improvement plans.

3.3 **Organisational Duty of Candour (DoC)**

3.3.1 Our second Duty of Candour annual report has now been published, year ending 31st March 2020. Duty of Candour incidents are unintended or unexpected events that resulted in death or one of the harms as defined in the Act, and do not relate directly to the natural course of someone's illness or underlying condition.

3.3.2 Twenty-three DoC incidents were identified since our last report. It is worth noting that it is often not evident that an `incident` has occurred at the outset, only that there has been an unexpected outcome. Further review is usually required to determine whether or not an `incident` has occurred which has directly contributed to that outcome. NHS Lothian policy and procedures require communication with patients and families about reviews, regardless of whether the threshold for the statutory organisation DoC applies. The majority of incidents fell into the category of `person`s treatment increased` (11). We followed the correct procedure in all cases although in one case the communication was dealt with via the complaints process. This means we informed the people affected, apologised to them from the organisation, and offered to meet with them. Reviews have been commissioned for each of these events, 19 of which have been completed. In each case, we reviewed what happened, what went wrong and what we could have done better and offered to feed back the outcome and learning from the events to the people affected. On five of these occasions the people affected did not wish to receive feedback on the outcome

of the review. Individual and organisational learning has been undertaken, with improvement plans developed and completed or in progress for each one.

3.4 Adverse event reviews during Covid-19 outbreak

3.4.1 Adverse event processes including governance arrangements have been maintained during the pandemic, although HIS suspended the national notification requirement in 2020 from March until May, with a restart in June.

3.4.2 Patient safety reports were considered at the HCG, acute services and REAS to assess the impact of COVID on key safety measures such as Hospital Mortality Ratio, falls etc to inform assurance and management

3.4.3 Systems are in place to identify adverse events reported as relating to COVID-19 and were developed to capture events related to the vaccination programme which commenced in December 2020. This also facilitates national reporting to Public Health Scotland. QIST staff have reviewed all and provided weekly themed reports to senior management teams up until mid-May 2021. This has now stopped, and reporting and monitoring is now embedded in routine processes.

3.4.4 A summary report has also been produced, which identifies 1,199 adverse events reported between March 2020 and March 2021 which are directly related to COVID-19. Key themes identified are:

- processes related to COVID-19
- staff related
- vaccination programme
- behaviours due to Covid restrictions – both patients and visitors/families.

3.4.5 The total number of Covid events has reduced over time, except for those related to processes which, given the nature of the pandemic, are constantly evolving. Staff related events include a variety of events such as potential exposure of staff to Covid–19, staff testing positive for Covid and skill mix/staffing level issues.

3.5 Improving processes for management of and learning from SAEs

3.5.1 Improvement work has concentrated on reliable implementation of the national notification process including improving commissioning of reviews. Process maps have been completed detailing the roles and responsibilities of management teams and reviewers, with links to toolkits on the intranet to support implementation.

3.5.2 Tailored training on the management and review of adverse events has continued although HIS suspended the national notification requirement from March until May 2020, with a restart in June 2020.

3.5.3 QIST has responded to services request, with a number of sessions delivered over Microsoft Teams in recent months and `just in time` refresher training and guidance on process for lead reviewers/review teams who have been asked to undertake full SAE reviews.

3.5.4 Face-to-face sessions on communication with patients and families which were scheduled throughout 2020 for each acute site/service, HSCPs and REAS are

currently on hold due to the pandemic. Alternative modes of delivery of this training are currently being developed, adopting a blended learning model. Pre-learning materials and filming of online material is currently being completed. A small group, face-to-face experiential learning session using role play was being tested in November 2020.

3.5.5 Processes for local senior management team approval of falls and pressure ulcer reviews are now embedded. Summary reports, including themes for improvement actions are provided to all senior management teams and to acute and Board nurse and medical directors to maintain an overview. The first falls report was considered at the Nurse Directors group in August 2020.

3.5.6 All deaths of people using our mental health and substance misuse services are recorded and reviewed. This presents a significant challenge to services in identifying sufficient capacity to undertake these reviews, particularly in HSCPs, where the majority of these deaths occur. These events account for the majority of reviews over 6 months old (105 out of 175 as at first week in April 2021). Improvement work is well advanced in testing a briefing document in Edinburgh HSCP to identify those cases where there is most opportunity for learning through a more in-depth review. This process also ensures that all cases have a proportionate and appropriate level of review and enables more meaningful involvement of the local clinical team who have cared for that person. Additional clinical resource has been identified by Edinburgh HSCP to support this work and to address the backlog. Similar work is being undertaken in REAS, though the volume of cases is much lower.

3.6 Risk Register

3.6.1 The NHS Lothian Corporate Risk Register (CRR) has been subject to change due to the Covid-19 pandemic, the 3-year Recovery Plan and capital plans. In response to these contextual changes and following discussion at the Audit and Risk committee and Board it seemed timely to review the risks on the Corporate Risk Register and the associated processes.

3.6.2 The Corporate Management Team (CMT) agreed in February 2021 based on the methodology set out below to review a number of risks on the corporate risk register in order to strengthen the risk management system.

3.6.3 **Methodology** The following have been used to inform the questions set out below and guide the review:

- NHS Lothian Risk Management Policy
- NHS Lothian Risk Management Procedure
- Diagram one below (3.7.2)

1. What is the risk that cannot be managed at an operational level and what information/data supports the escalation of this risk?
2. Does the risk description articulate the residual risk not being managed at a service level?
3. Who owns this risk and associated controls and do the controls set out clear lines of accountability?
4. Is there a plan in place to manage this risk which will be appraised at a senior management level and by a governance committee of the Board?
5. Does the risk grading reflect the plans in place to manage the risk and any remaining residual risk?

6. Is there a clear relationship between the risk grading, plans in place and level of assurance accepted by the governance committees of the Board?
7. Is there any overlap/duplication of risk across the CRR?

3.6.4 Table 1 below sets the CMT recommendations approved by the Board in April 2021 and rationale, based on meetings with executive owners. The outcome of the risks under review will be presented to the June 2021 Board.

Table 1 Risk Register recommendations and Rationale

Risk ID	Opened	Risk Title	Recommendation	Rationale
Close				
4813	**23/07/19**	Royal Hospital for Children & Young People/Dept of Clinical Neurosciences	Remove from the CRR	Services will be fully operational by the end of March 2021
4694	**04/04/19**	Waste Management	Remove from the CRR	This risk was accepted onto the CRR due to unforeseen external provider availability which resulted in additional financial risk and H&S issues. The financial risk has been addressed, a new contractor is in place and any residual service risk is being managed at an operational level with clear management oversight
3527	**26/07/13**	Medical Workforce	Remove from the CRR	Aspect of the Medical Workforce within our control are being managed at an operational level and captured on operational risk registers
Review/Amalgamate				
3454	**13/02/13**	Learning from Complaints	Review this risk	This risk requires review with a focus on performance and set within the context of the corporate objectives.
3600	**23/04/14**	Finance	Review this risk	This is a long-standing risk on the CRR and as such warrants review
3726	**11/03/15**	Timely Discharge of Inpatients (Previously Unscheduled Care:	Review the risk description with a focus on community capacity, with clear control owners across the system and measurement framework which would inpatient and community measures	Ensure clarity with respect to the focus and management of this risk and reduce duplication across other risks on the CRR such as 4 hour emergency access standard.
3829	**10/10/15**	GP Sustainability.	Review this risk	This is a longstanding risk and the GP landscape has been subject to significant change and as a result this risk merits review.
4693	**04/04/19**	Brexit/EU exit	Review this risk	This risk has been reviewed and will be downgraded to medium from high risk with regular review in place to assess potential risks

Risk ID	Opened	Risk Title	Recommendation	Rationale
				that cannot be managed at an operational and/or national level.
4820	**29/07/19**	Delivery of level 3 recovery plans	Review this risk	To reduce overlap with other risks on the CRR, associated plans and measures such as Access to Treatment. Timely discharge of inpatients etc to strengthen the management of risks across the CRR
3189	**19/10/15**	Facilities Fit for Purpose	Review this risk	There is a need to clearly articulate the risks that are not being managed at an operational level. This may lead to revised or new risks related to the RIE estate (end of the PFI contract) which has both financial and patient safety implications. The Finance Director has agreed to develop this risk.
3455	**13/02/13**	Violence & Aggression.	Review this risk	This is a long standing risk on the CRR and there is a need to articulate risks that are not being managed at an operational level supported by data as there is currently clear management oversight at a service level through the H&S operational groups and H&S Committee at the Board.
3328	**01/03/13**	Roadways/ Traffic Management	Review this risk	This Risk would benefit from a review to identify residual risk, associated mitigation plans including control owners. An initial review would suggest that the focus should be on the 4 inpatient sites where there is a mismatch between demand and capacity resulting risky behaviour plus verbal and physical aggression to traffic management staff.
1076	**11/06/07**	Healthcare Associated Infection	Review this risk	This risk would benefit from a review in the light of interrelated risks on the CRR which include Facilities fit for purpose, COVID-19 and Water Safety Risk, to clarify the focus of this risk and identify the plans in place to manage the risk including control owners
3203	**26/03/12**	4 Hours Emergency Access Standard (Organisational)	Combine the organisational and patient risk on the Corporate Risk Register.	The management oversight and plans to mitigate these two risks are the same. Having one risk will ensure clarity with respect to control owners, management oversight, mitigation plans and governance reporting

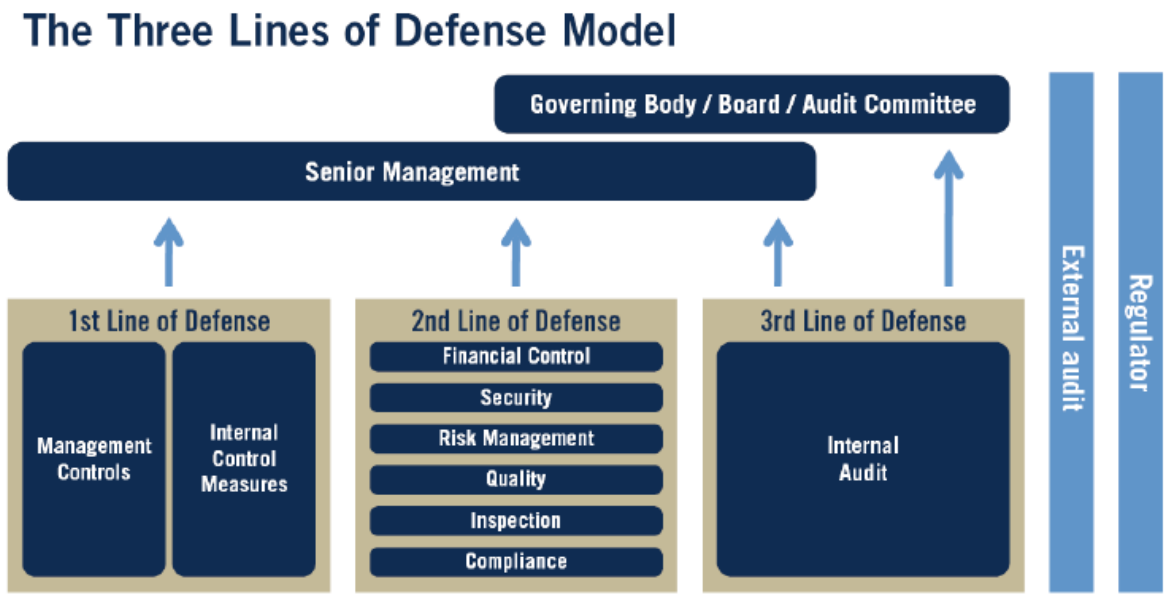
Risk ID	Opened	Risk Title	Recommendation	Rationale
4688	**21/03/19**	Patient safety in RIE ED	Combine the organisational and patient risk on the Corporate Risk Register and clearly state plans in place to mitigate the risk, control owners etc.	See above
3211	**02/04/12**	Access to Treatment (Organisation Risk)	Combine the organisational and patient risk on the Corporate Risk Register and state the key plans in place to manage this risk including control owners as there is considerable overlap between the two risks with respect to plans, measures, and oversight	The management oversight and plans to mitigate these two risks are the same. Having one risk will ensure clarity with respect to control owners, management oversight, mitigation plans and governance reporting
4191	**16/05/17**	Access to Treatment (Patient Risk)	Combine the organisational and patient risk on the Corporate Risk Register and state the key plan in place to manage this risk including accountability. .	See above
Remain				
4984	**19/03/20**	Covid-19	Remain on the CRR and include vaccine availability. Gold command to review the grading	This risk cannot be managed at an operational level, with a number of controls out with Lothian
4921	**28/10/19**	Bed Capacity in Acute Mental Health	No change to this risk on the CRR	This risk is clearly articulated and there are dedicated plans in place to mitigate the risk.
5034	**29/06/20**	Care Homes	No change to this risk on the CRR	This risk cannot be managed at an operational level. Significant infrastructure and systems for management oversight have been put in place within a tight timeframe, however, risks currently remain around providing assurance on the 4 aspects of care the Nurse Director is accountable for.
5020	**10/06/20**	Water Safety (Legionella)	No change to this risk on the CRR	This risk has been magnified as service have been reduced due to COVID. Water safety plans are being developed to support remobilisation and embed systems of control.
3828	**19/10/15**	Nursing Workforce	No change to this risk on the CRR.	Well written, clearly articulated risk, with clear plans in place to mitigate the risk

3.7 Role of the Corporate Management Team

3.7.1 It was agreed at the February 2021 CMT that the CRR would be managed through the CMT and subject to review every two months, with the risk manager in attendance to ensure proactive management, including timely feedback from assurance committees and alignment of assurance levels and risk grading.

3.7.2 The CMT would make recommendations to the Board with respect to new and/or amended risks, with a clear articulation of the risk that cannot be managed at an operational level, explicit plans to mitigate the risk along with associated measures to assess the impact of these plans. This collective oversight strengthens the NHSL risk management system including our assurance system and mirrors the diagram set out below.

Diagram 1



Graphic taken from The IIA Position Paper The Three Lines of Defense in Effective Risk Management and Control *published in 2013, adapted from ECIIA/FERMA Guidance on the 8th EU Company Law Directive, article 41*

3.8 Chairs' Risk Assurance Meeting

3.8.1 The Audit & Risk Committee approved the following Chairs' Risk Assurance meeting to take place during summer 2021:

Overall Aim
To establish a consistent and effective approach to the oversight of Risk in Board Committees

Session Objectives
Enhance understanding of:

- NHS Lothians Risk Management System at a corporate level by committee chairs:
  - Risk architecture, how are risks identified, assessed, recorded and the role of the A&R Committee
- How decisions are made to manage/treat the risk:
  - Action plans, management oversight, measuring impact
- The role of Committees and Chairs in providing oversight:
  - Key questions of management
- The linkage between risk management, levels of assurance and committee response
- Summary of discussion and next step

3.9 **Internal Audit Risk Management**

3.9.1 Every year Internal Audit conducts a review of an aspect of the NHSL risk system. The audit, which is about to complete, focuses on the controls in place (design and operation) to ensure risks are managed at an operational level at a divisional level on the hierarchy and how this is managed within Acute services and at an HSCP level. The audit will consider how at this level, risks are captured ensuring risks are not duplicated and how this links to the corporate risk register, including appropriate escalation and de-escalation of risks, focusing on how risks are escalated to a corporate risk level.

4 Key Risks

4.1 Failure to fully implement NHS Lothian's risk management policies and procedures could have an adverse effect on our current exposure to risk. The main threat is from not fully engaging with staff. This is being addressed by continued engagement with staff in the design and implementation of the actions set out in this paper.

5 Risk Register

5.1 The actions set out in this paper seek to enhance the Board's risk register assurance mechanisms.

6 Impact on Inequality, Including Health Inequalities

6.1 The findings of the Equality Diversity Impact Assessment are that although the production of this Annual Report does not have any direct impact on health inequalities, the assurance given on the component areas of risk within this document provides evidence that the elements of the processes are established to deliver NHS Lothian's corporate objectives in this area. The current Risk Management Policy and Procedure have been fully impact assessed and amended in the response to the assessment.

7 Duty to Inform, Engage and Consult People who use our Services

7.1 No strategy, policy and/or service change proposed in this paper.

8 Resource Implications

8.1 The resource implications are directly related to the actions required against each risk.

Jo Bennett
Associate Director for Quality Improvement & Safety

1 June 2021
Jo.bennett@nhslothian.scot.nhs.uk

West Lothian Council

RISK MANAGEMENT ANNUAL REPORT 2020/21

Audit, Risk and Counter Fraud Unit
14 June 2021

CONTENTS

1.0 INTRODUCTION

1.1 This report sets out the risk management work undertaken during the financial year ending 31 March 2021.

1.2 Heads of Service are responsible for ensuring that risks to their business objectives are effectively managed. The Audit, Risk and Counter Fraud Manager acts as the council's corporate risk manager and is responsible for ensuring that arrangements are in place within the council to enable managers to effectively discharge these responsibilities.

1.3 This is done by:

- preparing and maintaining corporate procedures on risk management and business continuity planning;
- administering the council's corporate risk register;
- providing advice and information to services on risk management and business continuity matters;
- monitoring services' management of risk;
- providing training as considered necessary.

1.4 The council's corporate risk register is held on Pentana, the council's performance management system, and contains 225 risks.

1.5 Performance information relevant to risk management is set out in appendix A to this report.

2.0 RISK MANAGEMENT AND BUSINESS CONTINUITY

Risk Management Policy

2.1. A revised Risk Management Policy was considered by the Partnership and Resources Policy Development and Scrutiny Panel on 7 February 2020 and the Governance and Risk Committee on 24 February 2020. Following a delay due to the Covid-19 pandemic, the Policy was approved by Council Executive on 6 October 2020.

Governance and Risk Committee

2.2. The remit of the Governance and Risk Committee requires it to maintain an overview of the council's risk management arrangements.

2.3. The Committee met four times during 2020/21. Every meeting of the Committee received reports on the council's high risks, and on the management of health and safety. At its November 2020 and March 2021 meetings the Committee received reports on the council's strategic risks.

2.4. A variety of other risk related reports were submitted to the Committee during the year including reports on:

- concurrent risks including the impact of EU exit and Covid-19;
- the council's insurance arrangements;
- the management of risk within operational properties including legionella, gas safety, fire safety, and asbestos;

- workforce planning.

2.5. On 25 January 2021 the Committee received a report on progress in relation to the council's corporate risk management strategy.

Executive Management Team

2.6. The Executive Management Team (EMT) is the council's most senior management body and comprises the Chief Executive, Depute Chief Executives, and the Head of Finance and Property Services. The EMT considers reports on the council's high and strategic risks every two months. The EMT also receives reports on outstanding audit and inspection recommendations, and considers progress in completing them.

Governance and Risk Board

2.7. The Governance and Risk Board is an officer group chaired by the Depute Chief Executive (Corporate, Operational and Housing) which meets quarterly to review risk management, business continuity, and governance matters. The Audit, Risk and Counter Fraud Manager and Senior Auditor attend the meetings and assist with the administration by preparing the agendas and action notes.

2.8. The Board approves its workplan each March and examples of risk related matters considered by the Board during 2020/21 include:

- the council's high and strategic risks;
- health and safety risks;
- information technology related risks;
- business continuity planning arrangements;
- statutory compliance (legionella, asbestos, fire safety) performance indicators;
- insurance claims statistics;
- outstanding audit and inspection recommendations.

EU Exit Working Group

2.9. The EU Exit Working Group continued to meet on a regular basis during 2020/21 to consider risks arising from EU exit and maintain an overview of the EU exit risk register. As stated previously, the Governance and Risk Committee has been updated on developments via the concurrent risks reports.

Risk Management Working Group

2.10. The Risk Management Working Group is an officer group comprised of representatives from all services ("risk champions") which meets quarterly. The council's HR Manager (Health and Safety) is a member of the group and is the risk champion for Corporate Services. The group is chaired by the Audit, Risk and Counter Fraud Manager and its purpose is to disseminate advice and information on risk management and business continuity matters, act as a forum for the discussion of risk management matters,

encourage the effective management of risk within services, and to promote effective business continuity arrangements within services.

Gallagher Bassett Risk Review

2.11. The council's risk consultant, Gallagher Bassett, provides free risk consultancy and training as part of the insurance contract. Gallagher Bassett undertook an occupational stress risk management review during 2020/21 which was reported to the Governance and Risk Committee on 25 January 2021.

2.12. The report included an agreed action plan completed by management and the agreed actions will be followed up by the internal audit team in 2021/22 to determine progress in implementing them.

Service Management Teams

2.13. The Audit Risk and Counter Fraud Manager works with all services to review and where necessary improve the quality of their risks in the corporate risk register, for example in relation to descriptions, risk scores, key controls and mitigating actions. All service management teams were visited at least twice during 2020/21.

Risk Management and Business Continuity Procedures

2.14. The council's risk management and business continuity procedures were reviewed and updated during the year. These are resident on the Audit Risk and Counter Fraud Unit's intranet site and are accessible to all services.

Corporate Business Continuity Plan

2.15. The council's corporate business continuity plan is reviewed annually. The revised plan was submitted to the Governance and Risk Board on 30 November 2020. The Board asked for further consideration to be given to the council's response to the Covid-19 pandemic and a further revised plan was submitted to the Board on 17 May 2021. The plan is held on Pentana, which is externally hosted, and the plan would therefore be available in the event of a loss of the council's IT network.

Desktop Test

2.16. The risk management plan 2020/21 included provision for conducting a desktop test of the business continuity arrangements for an operational building. This had to be postponed due to the impact of the Covid-19 pandemic. A desktop test was therefore included in the 2021/22 risk management plan and a test of the arrangements at Whitehill service Centre is planned for August 2021.

3.0 CONCLUSION

3.1. The Audit, Risk and Counter Fraud Manager works with the Executive Management Team, Governance and Risk Board, service management teams and risk champions to ensure that effective risk management arrangements are in place within the council which enable services to identify, assess and manage risks to their objectives.

Kenneth Ribbons
Audit, Risk and Counter Fraud Manager

APPENDIX A

Risk Management - Performance Information

Status	Reference	Performance Indicator	Comment	Current Target	2020/21 Value	2019/20 Value	2018/19 Value	2017/18 Value
	P:IA020	Percentage of customers who rated the overall quality of risk management advice as good or excellent.	Based on the annual survey of customers.	100%	100%	95%	100%	100%
	P:IA021	Percentage of risks subject to annual documented risk assessment in Pentana.	Based on the position at 31 March of the financial year.	100%	100%	95%	100%	95%
	P:IA022	Percentage of risk actions outstanding after their original due date.	In relation to all risk actions due for completion in the previous four years.	2%	8% (see note)	8%	6%	8%
	IA024	Percentage of customers who rated the overall quality of business continuity advice as good or excellent.	Based on the annual survey of customers.	100%	100%	100%	94%	100%
	P:IA025	Percentage of WLC1 activities with an up to date Business Continuity Plan.	Based on responses received from heads of service.	100%	100%	100%	100%	N/A

Note

P:IA022 Percentage of risk actions outstanding after their original due date: progress will be more closely monitored during 2021/22 and there will be greater engagement with services with a view to encouraging timeous completion.

Date	1 December 2021
Agenda Item	13

INTEGRATED HEALTH AND SOCIAL CARE
WEST LOTHIAN
WORKING FOR WELLBEING

Report to West Lothian Integration Joint Board Audit Risk and Governance Committee

Report Title: Self-Assessment Survey - Results

Report By: Project Officer

Summary of Report and Implications	
Purpose	This report: (tick any that apply).
	- seeks a decision ☐
	- is to provide assurance ☐
	- is for information ☑
	- is for discussion ☑
	The purpose of this report is to inform the Committee of the results of the self-assessment survey of the Committee's administrative arrangements and activity. The Committee is invited to discuss the results and identify any action required.
Recommendations	It is recommended that the Committee: 1. Notes the results of the self-assessment survey; and 2. Discuss if any actions should arise from the results.
Directions to NHS Lothian and/or West Lothian Council	A direction(s) is not required.
Resource/ Finance/ Staffing	None
Policy/Legal	Self-assessment is not a statutory requirement but is considered good practice.
Risk	No new risks identified.
Equality, Health Inequalities, Environmental and	The report has been assessed as having little or no relevance with regard to equality or the Public Sector Equality Duty. As a result, an equality impact assessment has not been conducted.

Sustainability Issues	No environmental impacts have been identified.
Strategic Planning and Commissioning	There is no direct relevance to the Strategic Plan, but good governance leads ultimately to good outcomes.
Locality Planning	N/A
Engagement	The survey questionnaire was agreed by the Committee at its meeting of 8 September and was issued to all members.

Terms of Report	
	Self-assessment survey results
1	The CIPFA Framework under which the Board's Code of Corporate Governance is being developed suggests that committees involved in scrutiny and internal control should periodically conduct a self-assessment of their effectiveness and operation. The aim is to involve members in close consideration of the role of the Committee and its members, its administrative arrangements and the context in which it operates.
2	The questionnaire was agreed at the Committee's meeting of 8 September 2021 and is the same question set as the self-assessment conducted in 2020. The survey was issued on Tuesday 16 November and members were asked to complete the survey by Tuesday 23 November.
3	New arrangements for setting up the online survey were put in place this year and this contributed to having a shorter period of time in which to complete the survey than usual.
4	Four out of a possible six members completed the survey. The results are anonymous and are appended to this report as Appendix 1.
5	The vast majority of responses were positive and no respondent indicated they disagreed or strongly disagreed with any statement – consistent with the 2020 survey results. The Committee is asked to consider the results in full and highlight any area where action should be taken.

Appendices	1. Self-Assessment Survey Results
References	Audit, Risk & Governance Committee meetings of 27 June, 12 September 2018 "Delivering Good Governance in Local Government - Framework (CIPFA/SOLACE, 2016) "Delivering Good Governance in Local Government - Guidance Notes for Scottish Authorities (CIPFA/SOLACE, 2016)
Contact	Lorna Kemp, Project Officer lorna.kemp@westlothian.gov.uk 01506 283519

Integration Joint Board Audit Risk And Governance Committee - Self-Assessment Survey 2021

1. 1) I am aware that the Committee's role and powers are set out in Standing Orders *

   Number of participants: 4

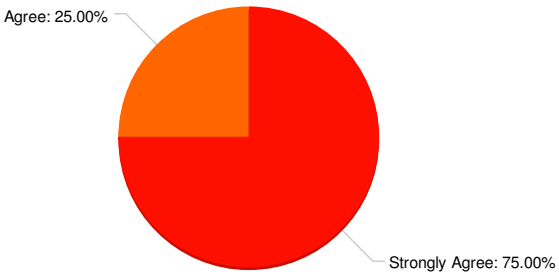
   3 (75.0%): Strongly Agree

   1 (25.0%): Agree

   - (0.0%): Neither Agree or Disagree

   - (0.0%): Disagree

   - (0.0%): Strongly Disagree



2. Comments

   Number of participants: 0

3. 2) I consider that the Committee's role and powers are clear and understood *

   Number of participants: 4

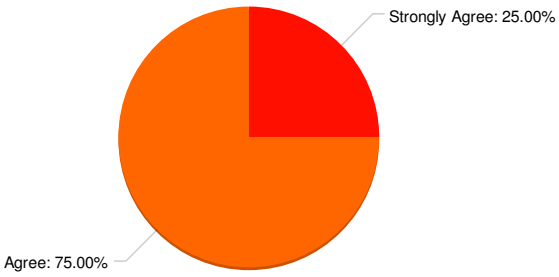
   1 (25.0%): Strongly Agree

   3 (75.0%): Agree

   - (0.0%): Neither Agree or Disagree

   - (0.0%): Disagree

   - (0.0%): Strongly Disagree



4. Comments

   Number of participants: 0

5. 3) I consider that the Committee is regarded by stakeholders as a positive influence *

Number of participants: 4

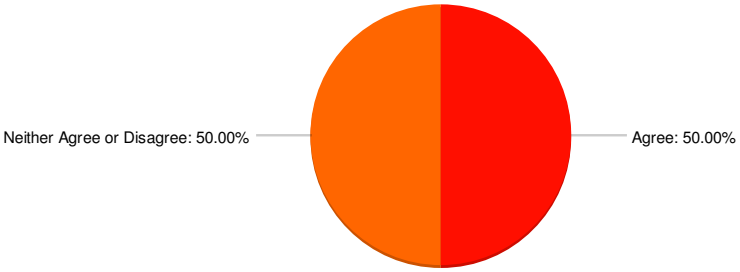
- (0.0%): Strongly Agree

2 (50.0%): Agree

2 (50.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



6. Comments

Number of participants: 1

- As a new member of the committee don't feel i can comment on stakeholders opinions at this time.

7. 4) I consider that the Committee's decisions are respected and acted upon by the partners *

Number of participants: 4

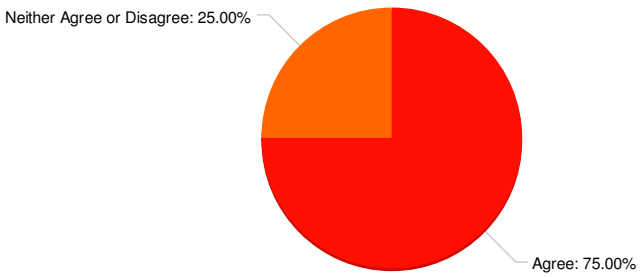
- (0.0%): Strongly Agree

3 (75.0%): Agree

1 (25.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



8. Comments

Number of participants: 1

- As above

9. 5) I consider that there is adequate communication amongst officers and Committee members *

Number of participants: 4

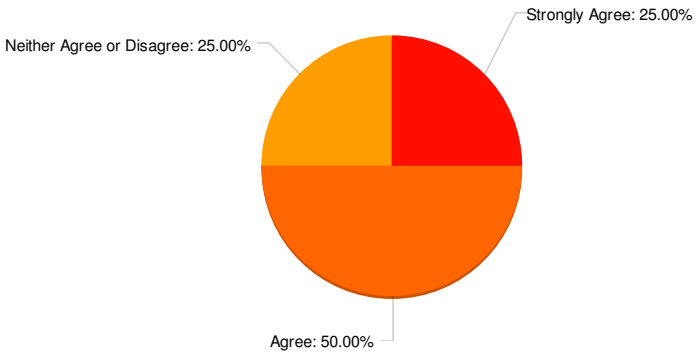
1 (25.0%): Strongly Agree

2 (50.0%): Agree

1 (25.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



10. Comments

Number of participants: 0

11. 1) I consider that the Committee is of an appropriate size and composition *

Number of participants: 4

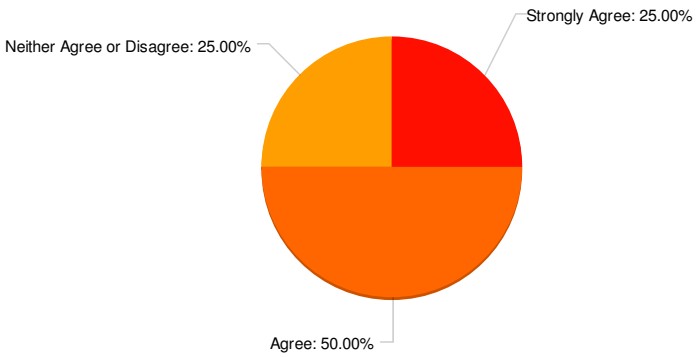
1 (25.0%): Strongly Agree

2 (50.0%): Agree

1 (25.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



12. Comments

Number of participants: 0

13. 2) I consider that the Committee is provided with adequate officer support (professional and administrative) *

Number of participants: 4

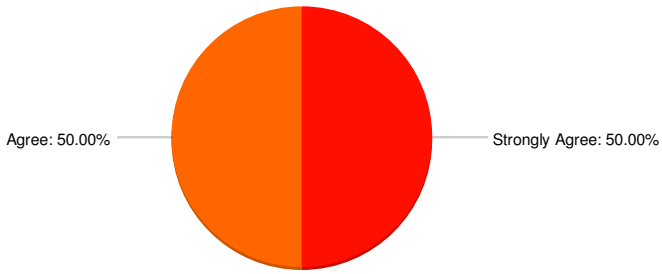
2 (50.0%): Strongly Agree

2 (50.0%): Agree

- (0.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



14. Comments

Number of participants: 0

15. 3) I consider that meetings are sufficiently frequent and at appropriate times of the year *

Number of participants: 4

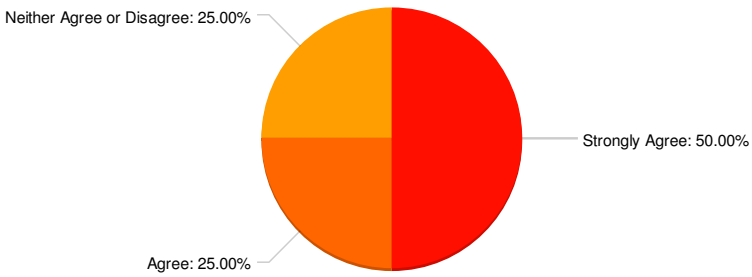
2 (50.0%): Strongly Agree

1 (25.0%): Agree

1 (25.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



16. Comments

Number of participants: 0

17. 4) I consider that the Committee maintains a work plan balancing forward planning with flexibility for reactive work *

Number of participants: 4

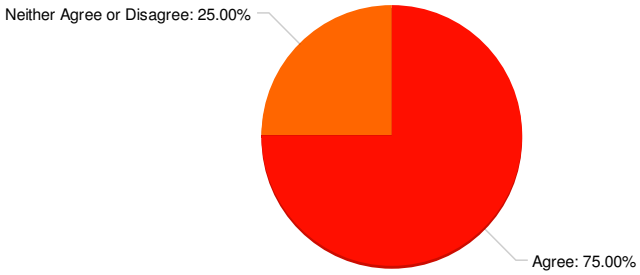
- (0.0%): Strongly Agree

3 (75.0%): Agree

1 (25.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



18. Comments

Number of participants: 0

19. 5) I consider that meeting papers are distributed appropriately (timeliness and format) to enable me to properly prepare *

Number of participants: 4

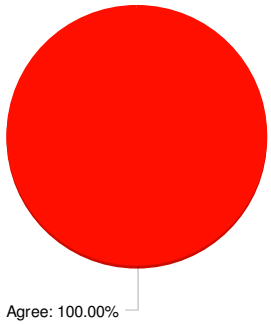
- (0.0%): Strongly Agree

4 (100.0%): Agree

- (0.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



20. Comments

Number of participants: 0

21. 6) I consider that reports and minutes provide relevant, appropriate and sufficient information *

Number of participants: 4

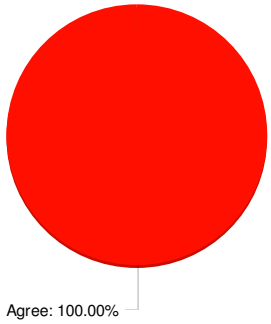
- (0.0%): Strongly Agree

4 (100.0%): Agree

- (0.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



22. Comments

Number of participants: 0

23. 7) I consider that start times and time allowed for meetings provide sufficient time for business to be done *

Number of participants: 4

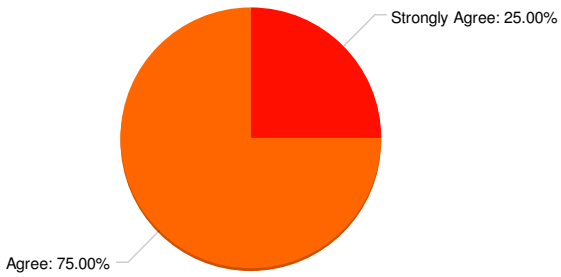
1 (25.0%): Strongly Agree

3 (75.0%): Agree

- (0.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



24. Comments

Number of participants: 0

25. 8)I consider that public access to reports and meetings is maximised and excluded only where legally justified *

Number of participants: 4

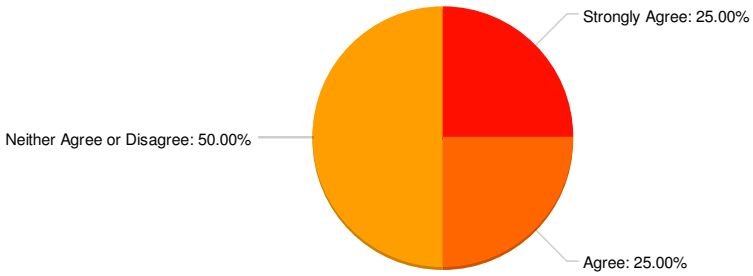
1 (25.0%): Strongly Agree

1 (25.0%): Agree

2 (50.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



26. Comments

Number of participants: 0

27. 9) I consider that the Committee is able to secure the attendance and assistance of appropriate senior officers *

Number of participants: 4

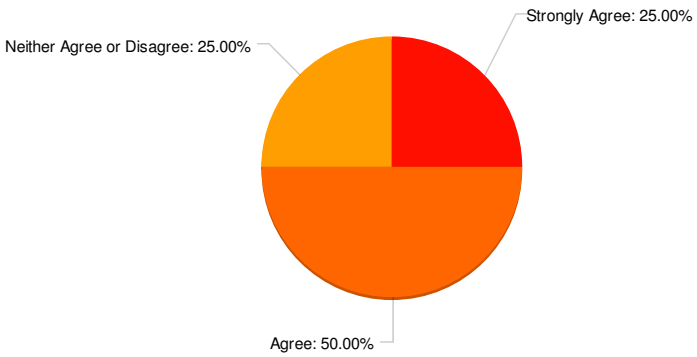
1 (25.0%): Strongly Agree

2 (50.0%): Agree

1 (25.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



28. Comments

Number of participants: 0

29. 10) I consider that the Committee is able to secure appropriate professional advice when required *

Number of participants: 4

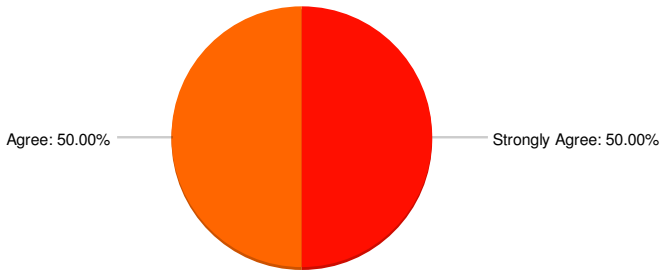
2 (50.0%): Strongly Agree

2 (50.0%): Agree

- (0.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



30. Comments

Number of participants: 0

31. 1) I consider that my role on the Committee is clear *

Number of participants: 4

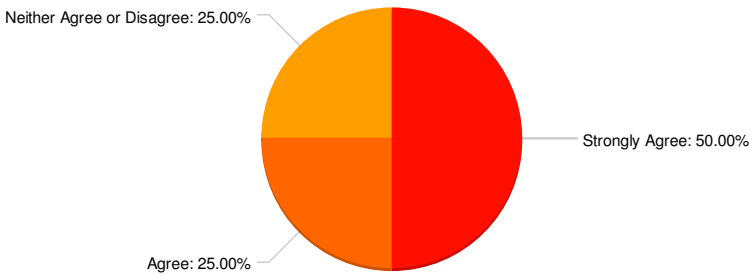
2 (50.0%): Strongly Agree

1 (25.0%): Agree

1 (25.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



32. Comments

Number of participants: 1

- I need to attend more meetings before I can comment

33. 2) I consider that the Committee has an appropriate mix of knowledge, expertise, experience and skills *

Number of participants: 4

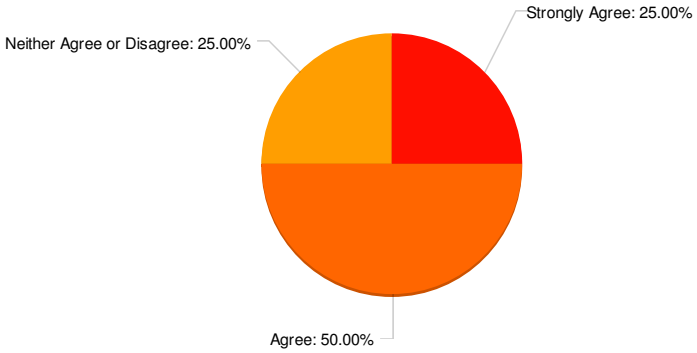
1 (25.0%): Strongly Agree

2 (50.0%): Agree

1 (25.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



34. Comments

Number of participants: 0

35. 3) I receive sufficient and appropriate training and briefings to be effective in my role as a Committee member *

Number of participants: 4

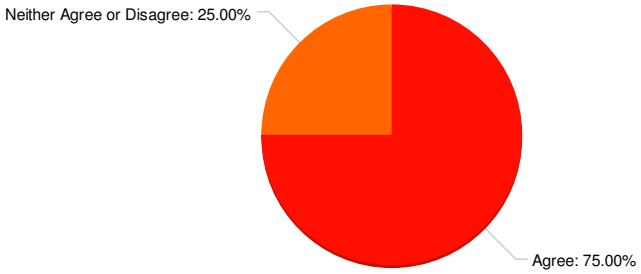
- (0.0%): Strongly Agree

3 (75.0%): Agree

1 (25.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



36. Comments

Number of participants: 0

37. 4) I undertake personal development relevant to my role and responsibilities as a Committee member *

Number of participants: 4

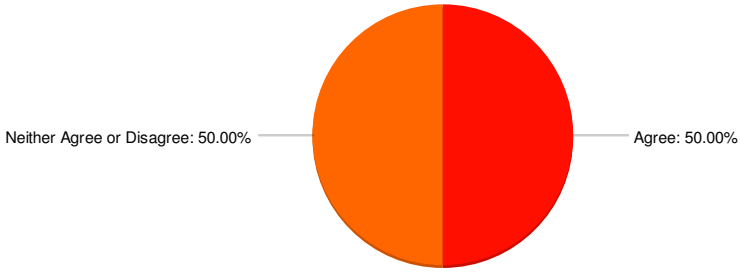
- (0.0%): Strongly Agree

2 (50.0%): Agree

2 (50.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



38. Comments

Number of participants: 0

39. 5) I consider that the Chair promotes and encourages effective and efficient meetings including input from officers and members *

Number of participants: 4

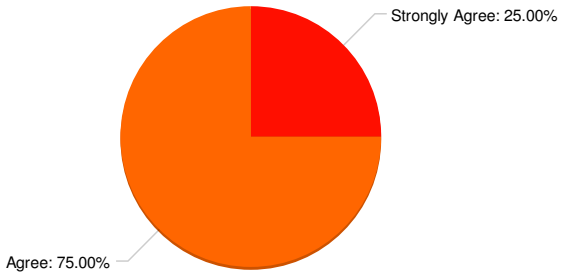
1 (25.0%): Strongly Agree

3 (75.0%): Agree

- (0.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



40. Comments

Number of participants: 0

41. 6) I consider that members prepare, attend meetings and actively contribute *

Number of participants: 4

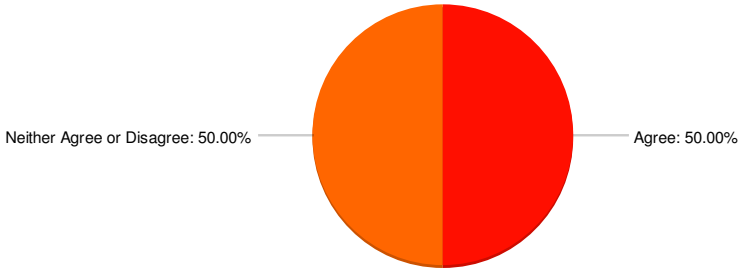
- (0.0%): Strongly Agree

2 (50.0%): Agree

2 (50.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



42. Comments

Number of participants: 0

43. 1) I consider that the Committee functions in a positive and constructive manner, including interaction amongst members and with officers *

Number of participants: 4

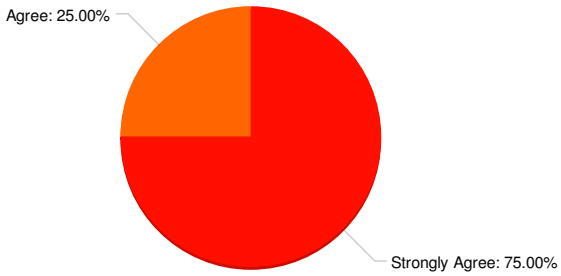
3 (75.0%): Strongly Agree

1 (25.0%): Agree

- (0.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



44. Comments

Number of participants: 0

45. 2) I consider that scrutiny is encouraged and accepted as a means to improve *

Number of participants: 4

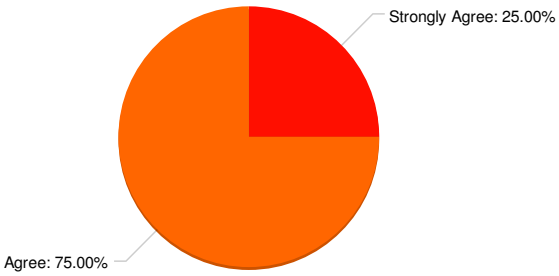
1 (25.0%): Strongly Agree

3 (75.0%): Agree

- (0.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



46. Comments

Number of participants: 0

47. 3) I consider that the Committee provides constructive challenge to officers *

Number of participants: 4

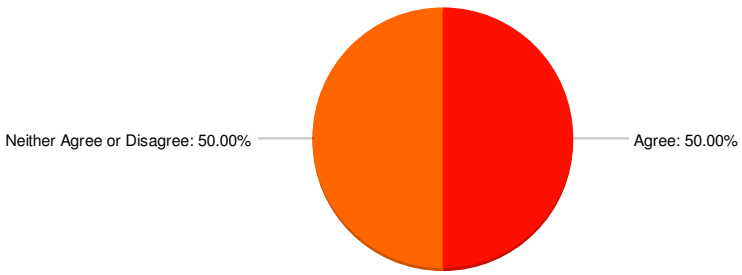
- (0.0%): Strongly Agree

2 (50.0%): Agree

2 (50.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



48. Comments

Number of participants: 0

49. 4) I consider that the Committee receives adequate responses from officers to questions *

Number of participants: 4

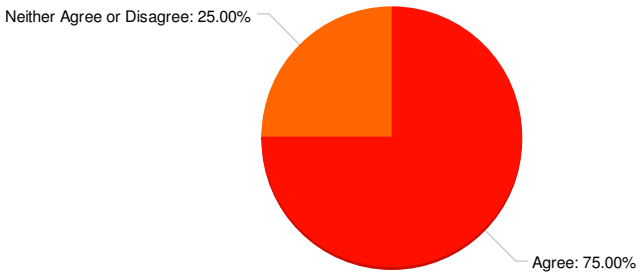
- (0.0%): Strongly Agree

3 (75.0%): Agree

1 (25.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



50. Comments

Number of participants: 0

51. 5) I feel comfortable asking candid questions and pursuing full answers *

Number of participants: 4

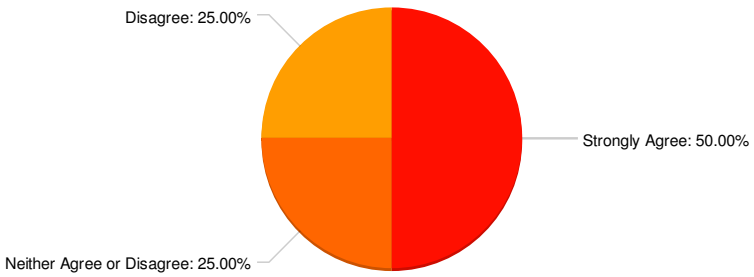
2 (50.0%): Strongly Agree

- (0.0%): Agree

1 (25.0%): Neither Agree or Disagree

1 (25.0%): Disagree

- (0.0%): Strongly Disagree



52. Comments

Number of participants: 1

- New into role so confidence an issue for me at the moment

53. 6) I consider that decisions and recommendations are captured to enable them to be recorded accurately *

Number of participants: 4

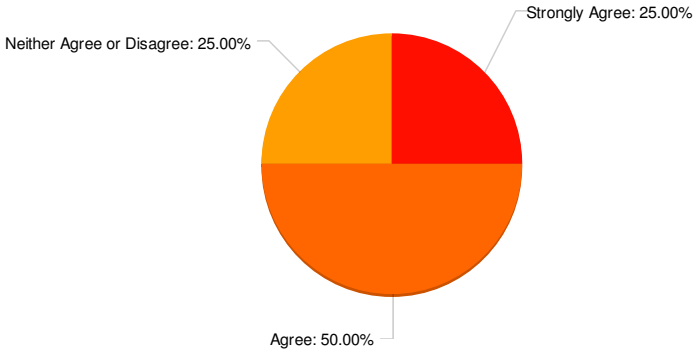
1 (25.0%): Strongly Agree

2 (50.0%): Agree

1 (25.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



54. Comments

Number of participants: 0

55. 7) I consider that decisions are executed properly and in a timely manner and are followed up by Committee *

Number of participants: 4

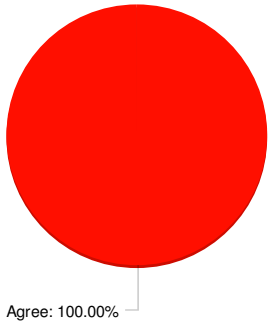
- (0.0%): Strongly Agree

4 (100.0%): Agree

- (0.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



56. Comments

Number of participants: 0

57. 8) I consider that there is evidence from meeting papers and minutes of impacts or improvements from Committee activity *

Number of participants: 4

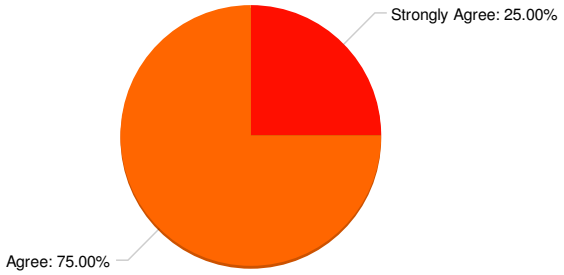
1 (25.0%): Strongly Agree

3 (75.0%): Agree

- (0.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



58. Comments

Number of participants: 0

59. 9) I consider that the Committee has good working relations with key officers, members and organisations *

Number of participants: 4

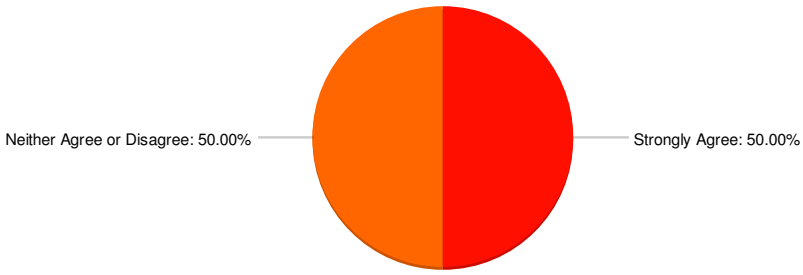
2 (50.0%): Strongly Agree

- (0.0%): Agree

2 (50.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



60. Comments

Number of participants: 0

61. 10) I consider that stakeholders (including other members and the public) are engaged with the Committee's activity and are encouraged to participate in the Committee's activity *

Number of participants: 4

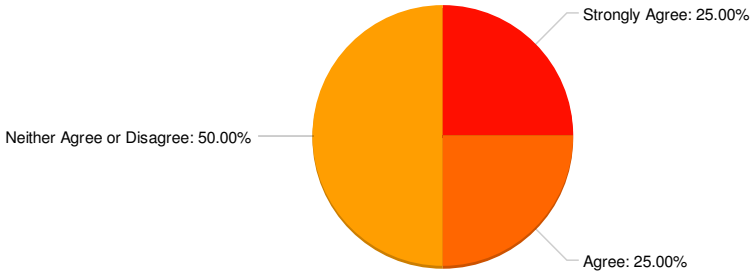
1 (25.0%): Strongly Agree

1 (25.0%): Agree

2 (50.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



62. Comments

Number of participants: 0

63. 1) I consider that interaction with the Board is defined and understood *

Number of participants: 4

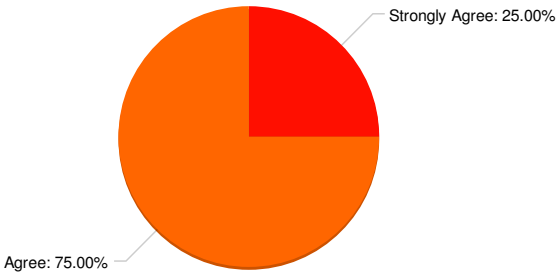
1 (25.0%): Strongly Agree

3 (75.0%): Agree

- (0.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



64. Comments

Number of participants: 0

65. 2. I consider that meetings are attended by external auditor representatives where appropriate *

Number of participants: 4

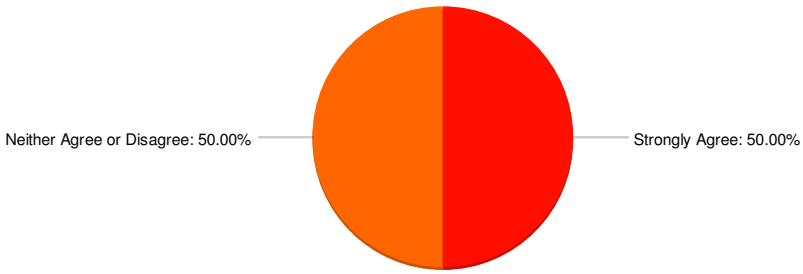
2 (50.0%): Strongly Agree

- (0.0%): Agree

2 (50.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



66. Comments

Number of participants: 0

67. 3. I consider that Committee's role in relation to the Board's annual accounts is defined and understood *

Number of participants: 4

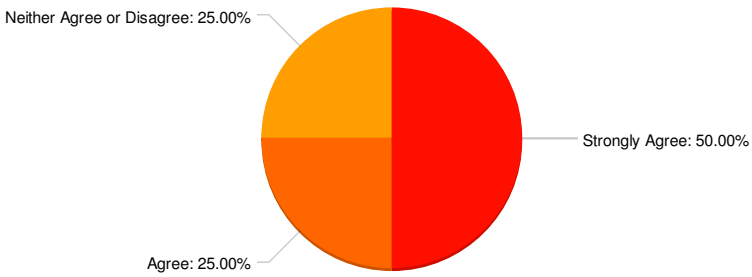
2 (50.0%): Strongly Agree

1 (25.0%): Agree

1 (25.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



68. Comments

Number of participants: 0

69. 4) I consider that members consider fully the contents and conclusions of the Annual Governance Statement before its approval *

Number of participants: 4

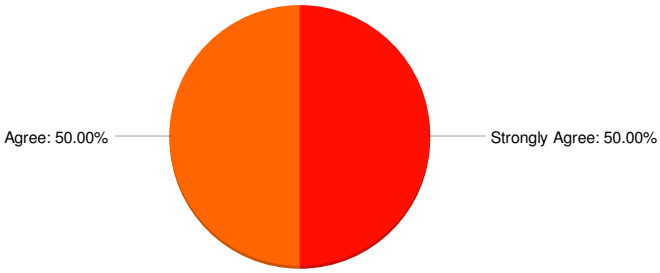
2 (50.0%): Strongly Agree

2 (50.0%): Agree

- (0.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



70. Comments

Number of participants: 0

71. 5) I consider that Committee provides effective review and challenge of risk and governance arrangements and controls *

Number of participants: 4

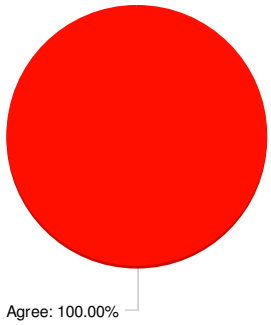
- (0.0%): Strongly Agree

4 (100.0%): Agree

- (0.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



72. Comments

Number of participants: 0

73. 6) I consider that Committee contributes to effective accountability to the public through challenge of governance, risk and control *

Number of participants: 4

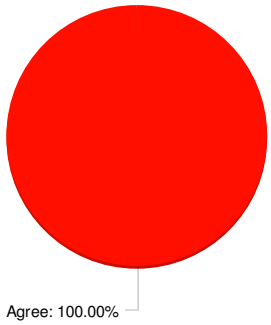
- (0.0%): Strongly Agree

4 (100.0%): Agree

- (0.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



74. Comments

Number of participants: 0

75. 7) I consider that Committee contributes effectively to the Board's control environment *

Number of participants: 4

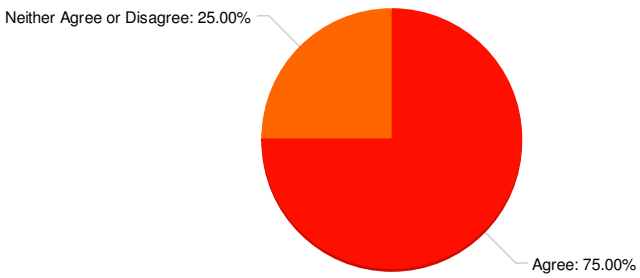
- (0.0%): Strongly Agree

3 (75.0%): Agree

1 (25.0%): Neither Agree or Disagree

- (0.0%): Disagree

- (0.0%): Strongly Disagree



76. Comments

Number of participants: 0

West Lothian Integration Joint Board - Audit Risk and Governance Committee
Action Tracker

	Item of business	Date agreed	Details	Owner	Due	Update to Committee	Status
1	007 - Data Protection Compliance	24/02/2021	Chief Officer to formally write to both the council and the health board to request that a Data Protection Officer is appointed to the IJB as necessary support service	Alison White/ Yvonne Lawton	17/06/2021	Approaches have been made to WLC and NHSL teams to ask for support in fulfilling the DPO role. Given reliance on the council's systems for holding IJB information, WLC was approached but indicated that it is unable to support the IJB to meet requirements. A subsequent approach was made to NHSL when it was suggested a meeting be set up between NHSL, WLC and staff representing the IJB to discuss further. Arrangements are being made for this to be done. A further update will be provided when available.	Ongoing

2	010 - IJB Internal Audit Plan	24/02/2021	Chief Officer seek clarity from fellow Chief Officers/Chief Finance Officers in the Lothian area to discuss the offer from NHS Lothian about assisting IJB's with internal audits and to report back to the June meeting with a recommendation	Alison White/ Kenneth Ribbons	17/06/2021	Covered in agenda under Audit and Risk Committee Principles.	Complete
3	005 - Annual Governance Statement 2020/21	17/06/2021	To agree that the Standards Officer update paragraph 3.5 to reflect the current situation	James Millar	30/06/2021	The annual governance statement was updated accordingly and included in the Board's unaudited annual accounts, which were considered by the Board prior to their submission for audit on or before 30 June.	Complete

4	009 - Internal Audit Annual Report 2020/21	17/06/2021	To request that the IJB Internal Auditor ascertain if continuing to use Falkirk Council for independent validation was an arrangement that could and should be reviewed and whether an alternative arrangement would be more suitable.	Kenneth Ribbons	08/09/2021	Falkirk Council have appointed a new head of internal audit and initial discussions have indicated that they wish to continue our joint working arrangements. Since there has now been a change in personnel at Falkirk, it is not thought necessary to explore options with other councils at this time, although the IJB Internal Auditor will keep the matter under review.	Complete
5	016 - Workplan	17/06/2021	Officers to review the dates contained in the "Next" column in the reporting cycle document	Lorna Kemp	08/09/2021	Workplan updated	Complete
6	006 - IJB Risks	08/09/2021	Officers to consider how recommendations on future reports were framed	Alison White/ Kenneth Ribbons	01/12/2021	Wording of recommendations in risks reports has been updated	Complete

7	006 - IJB Risks	08/09/2021	Officers to review the information in the following areas of the risk register: - Page 2 – review the date the revised strategic plan was approved by the IJB Page 3 - IJB19014 – consider and update the following wording "Revised cycle of reports to be submitted to IJB in January 2020; Consider the inclusion of a risk relating to social care; and Consider the issues of staff being moved in/out St Michaels Hospital	Alison White/ Kenneth Ribbons	01/12/2021	New risk on Care at Home added and included in the high risks report; Chief Officer agreed that no IJB risk is required on St Michaels Hospital	Complete

Date of Meeting: 1 December 2021

Agenda Item: 15

WORKPLAN FOR WEST LOTHIAN INTEGRATION JOINT BOARD AUDIT RISK AND GOVERNANCE COMMITTEE

Date of Meeting	Agenda Setting	Title of Report	Lead Officer	Notes
1 Dec 2021	**4 Nov 2021**			**Microsoft TEAMS**
		IJB High Risks	K Ribbons	
		Review of IJB internal audit charter	K Ribbons	
		Review of Standing Orders, Scheme of Delegation and Committee Remits	J Millar	
		Update on Governance Issues	J Millar	
		Compliance with CIPFA FM Code / Review of Financial Regulations	P Welsh	
		IJB Audit Principles	K Ribbons	Outlining the communication arrangements between the various IJB Audit Committees and internal auditors and NHS Lothian
		NHS Lothian Internal Audit Report "Risk Management at a Divisional/HSCP level"	K Ribbons	
		NHS Lothian Risk Management Annual Report 2020/21	K Ribbons	
		External audit/scrutiny report(s) - TBC	A White	
		Self-Assessment Questionnaire (Results)	L Kemp	
		Running Log of Actions	L Kemp	

23 Feb 2022	**27 Jan 2022**			**Venue TBC**
		External Audit Annual Plan	P Welsh/EY	
		Internal Audit Annual Plan	K Ribbons	
		Internal Audit report(s) – Budget Monitoring	K Ribbons	
		External assessment of conformance with PSIAS	K Ribbons	
		Review of Best Value Protocol	P Welsh	
		IJB Risk Register	K Ribbons	
		Meetings Timetable	Clerk	
		External audit/scrutiny report(s) - TBC	A White	
		Running Log of Actions	L Kemp	

REPORTING CYCLE FOR WEST LOTHIAN INTEGRATION JOINT BOARD AUDIT RISK AND GOVERNANCE COMMITTEE

WHAT	WHEN	WHY	LAST	NEXT
AUDIT				
External Audit Annual Plan	Annual	Audit Scotland guidance	Feb 21	Feb 22
Internal Audit Annual Plan	Annual	PSIAS and Internal Audit Charter	Feb 21	Feb 22
Internal Audit Annual Report including review of system of internal control	Annual	Accounts Regulations; PSIAS; Internal Audit Charter; IJB, 24 September 2018	Jun 21	Jun 22
Review the internal audit charter	Quinquennial	Accounts Regulations 2014; PSIAS; IJB ARGC, 6 January 2017	Jan 17	Dec 21
External assessment of conformance with PSIAS	Quinquennial	PSIAS; Internal Audit Charter; IJB, 6 January 2017	Mar 17	Feb 22
RISK				
IJB Risk Register	Biannual	Risk Management Strategy; IJB, 26 June 2018	Sept 21	Feb 22
IJB High Risks	Biannual	Risk Management Strategy; IJB, 26 June 2018	Jun 21	Dec 21
Risk Management Annual Report	Annual	Risk Management Strategy; IJB, 26 June 2018	Jun 21	Jun 22
Review of Risk Management Strategy and Policy	Quadrennial	Risk Management Strategy; IJB, 26 June 2018	Jun 18	Jun 22
FINANCE				
Audited Accounts, including external audit report	Annual	IJB, 24 September 2018	Sept 21	Sept 22
Review of Best Value Protocol	Biennial	IJB, 24 September 2018	Mar 21	Feb 22
Best Value Protocol Compliance Statement	Annual	IJB, 24 September 2018	Jun 21	Jun 22

WHAT	WHEN	WHY	LAST	NEXT
GOVERNANCE				
Corporate Governance Annual Report	Annual	CIPFA/SOLACE Framework; IJB Code of Corporate Governance; IJB, 1 May 2018	Jun 21	Jun 22
Update on Governance Issues	Biannual	IJB, 10 September 2019	Jun 21	Dec 21
Review of Standing Orders, Scheme of Delegation and Committee Remits	Biennial	IJB, 21 January 2020	Jan 20	Dec 21
Annual Governance Statement	Annual	IJB, 24 September 2018	Jun 21	Jun 22
Review of Code of Corporate Governance	Biannual	IJB, 10 September 2019	Sept 21	Sept 22
OTHERS				
Meetings Timetable	Annual	IJB and AR&GC practice	Feb 21	Feb 22
Self-Assessment Questionnaire (Issue)	Annual	AR&GC, 12 September 2018	Sept 21	Sept 22
Self-Assessment Questionnaire (Results)	Annual	AR&GC, 12 September 2018	Dec 20	Dec 21