Aberdeen City Health & Social Care Partnership

A caring partnership

Board Assurance and Escalation Framework

Approved xxxxx. Next review 2022.

Content

Part 1: Introduction

1.1 Background

The partner organisations of Aberdeen City Health and Social Care Partnership (ACHSCP), Aberdeen City Council (ACC) and NHS Grampian (NHSG) (the "Parties"), are committed to successfully integrating health and social care services, to achieve the partnership's vision of:

"A caring partnership, working together with our communities to enable people to achieve healthier, fulfilling lives and wellbeing."

ACHSCP has established an Integration Joint Board (IJB) through the Public Bodies (Joint Working) (Scotland) Act 2014. The remit of the IJB is to prepare and implement a Strategic Plan in relation to the provision of health and social care services to adults in its area in accordance with sections 29-39 of the Public Bodies Act. The arrangements for governance of the IJB itself, including rules of membership, are set out in the Integration Scheme and Standing Orders.

While the Parties are responsible for implementing governance arrangements of services the IJB instructs them to deliver, and for the assurance of quality and safety of services commissioned from the third and independent sectors, the Parties and the IJB are accountable for ensuring appropriate clinical and professional governance arrangements for their duties under the Act. The IJB therefore needs to have clear structures and systems in place to assure itself that services are planned and delivered in line with the principles of good governance and in alignment with its strategic priorities.

The IJB must have in place a robust framework to support appropriate and transparent management and decision-making processes. This framework will enable the board to be assured of the quality of its services, the probity of its operations and of the effectiveness with which the board is alerted to risks to the achievement of its overall purpose and priorities.

1.2 Regulatory framework

The Aberdeen City Health and Social Care Integration Scheme describes the regulatory framework governing the IJB, its members and duties. In particular, the IJB is organised in line with the guidance set out in the Roles, Responsibilities and Membership of the Integration Joint Board - governments advice to supplement the Public Bodies (Joint Working) (Integration Joint Board) (Scotland) Order 2014. The principles of and codes of conduct for corporate governance in Scotland are set out in "On Board: A Guide for Members of Public Bodies in Scotland", published by the Scottish Government in July 2006. Detailed arrangements for the board's operation are set out in "Roles, Responsibilities and Membership of the Integration Joint Board" Guidance and advice to supplement the Public Bodies (Joint Working) (Integration Joint Board) (Scotland) Order 2014. The IJB also has its own standing orders .

The IJB will make recommendations or give directions where appropriate (i.e. where funding for employment is required) to the decision-making arms of ACC and NHSG as required.

1.3 Purpose of the framework

This governance framework describes the means by which the board secures assurance on its activities. It sets out the governance structure, systems and performance and outcome indicators through which the IJB receives assurance. It also describes the process for the escalation of concerns or risks which could threaten delivery of the IJB's priorities, including risks to the quality and safety of services to service users.

It is underpinned by the principles of good governance (Good Governance Institute and Health Care Quality Improvement Partnership 1, Scottish Government Risk Management Public Sector Guidance 2, and the Chartered Institute of Public Finance and Accountants and the International Federation of Accountants-International Framework :Good Governance in the Public Sector 3) , [1] [2] [3] and by awareness that ACHSCP is committed to being a leading edge organisation in the business of transforming health and social care.

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[1] Good Governance Institute (GGI) and Healthcare Quality Improvement Partnership (HQIP), *Good Governance Handbook,* January 2015,. http://www.good-governance.org.uk/good-governance-handbook-publication/

[2] The Scottish Government, Risk Management – public sector guidance, 2009. http://www.gov.scot/Topics/Government/Finance/spfm/risk

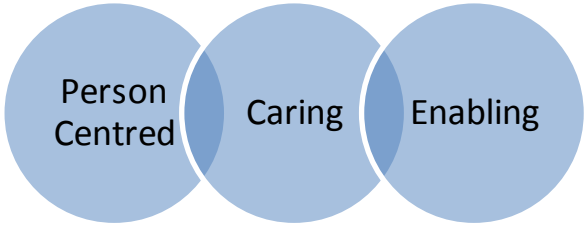
[3] Chartered Institute of Public Finance and Accountancy (CIPFA) and the International Federation of Accountants® (IFAC®). *International Framework: Good Governance in the Public Sector*, (2014) - http://www.cipfa.org/policy-and-guidance/standards/international-framework-good-governance-in-the-public-sector

This commitment requires governance systems which will encourage and enable innovation, community engagement and participation, and joint working. Systems for assurance and escalation of concerns are based on an understanding of the nature of risk to an organisation's goals, and to the appetite for risk-taking. The development of a mature understanding of risk is thus fundamental to the development of governance systems. The innovative nature of Health and Social Care Integration Schemes also requires governance systems which support complex arrangements, such as hosting of services on behalf of other IJBs, planning only of services delivered by other entities, accountability for assurance without delivery responsibility, and other models of care delivery and planning. This framework has been constructed in the light of these complexities and the likelihood that it may be important to amend and revise the systems as our understanding of the integration environment develops.

The structures and systems described are those in place from July 2021. In order to ensure that the framework can best support the IJB in its ambitions going forward, it is reviewed annually.

1.4 An integrated approach to governance for health and social care

In working towards the vision stated above, the IJB is committed to ensuring that delegated services are:



The integration principles identified by The Scottish Government [4] within the Policy – Social Care also underpin decision-making within the IJB.

In 2013, the principles of good governance for both healthcare quality and for quality social care in Scotland were described.[5] These stressed the importance of:

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[4] Integration Planning and Delivery Principles, The Scottish Government. http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Principles

[5] Governance for Quality Healthcare, The Scottish Government, 2013. http://www.gov.scot/Topics/Health/Policy/Quality-Strategy/GovernanceQualityHealthcareAgreement

- Embedding continuous improvement
- Providing robust assurance of high quality, effective and safe clinical and care services
- The identification and management of risks to and failure in services and systems
- Involvement of service users/carers and the wider public in the development of services
- Ensuring appropriate staff support and training
- Ensuring clear accountability

The rest of this document and its appendices sets out the structures and systems currently in place to support both assurance of compliance and of transformation of services within the scope of ACHSCP business. This framework can be represented graphically as follows in Table 1:

Table 1: Assurance and Compliance Framework

	ASSURANCE of COMPLIANCE	ASSURANCE of IMPROVEMENT, INNOVATION and TRANSFORMATION
FOCUS	Compliance with standards and regulation, communication and escalation of concerns and risks	Improving services, measuring and sustaining improvement Challenging work patterns, innovation, redesign and transformation
KEY COMPONENTS	People and Groups: partners; roles; committee structures Plans and Activities: engagement plan; risk management policy and system; audit system Feedback and Reporting processes: concerns and escalation process	
	Board Level	
	Corporate Level	
	Service Level	
	Individual Level	
OUTCOMES	IJB measures of success for stakeholders and assurances from internal and external sources	IJB measures of success for stakeholders and assurances from internal and external sources

Part 2: The Framework

2.1 Strategic priorities

From the nine strategic outcomes identified nationally as desired outcomes form integration, the ACHSCP has, in its current Strategic Plan[6] (approved in March 2019-work is currently underway for a refresh of the Plan) articulated five broad strategic aims, which form the basis of its governance framework and which meet the nine strategic outcomes.

[6] Aberdeen City Health and Social Care Partnership Strategic Plan 2019-2022

These priorities underpin:

- Decision-making criteria for service development, planning and delivery; resource allocation etc.
- The Board Assurance Framework of key strategic risks
- Strategic risk register
- Risk registers across all departments and areas of operation
- Individual performance and appraisals
- Evaluation of achievement against objectives

2.2 Risk Management Policy

a) Risk appetite

Risk appetite can be defined as:

The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time'.
(HM Treasury - 'Orange Book' 2006)

The ACHSCP recognises that achievement of its priorities may involve balancing different types of risk and that there may be a complex relationship between different risks and opportunities. The IJB has debated its appetite for risk in pursuit of the goals of integration so that its decision-making process protects against unacceptable risk and enables those opportunities which will benefit the communities it serves.

b) Risk Appetite Statement

The IJB has consequently agreed a statement of its risk appetite. The IJB will review and agree the risk appetite statement on an annual basis.

This statement is intended to be helpful to the board in decision-making and to enable members to consider the risks to organisational goals of not taking decisions as well as of taking them. As a newly established organisation, the ACHSCP's appetite for risk will change over time, reflecting a longer-term aspiration to develop innovation in local service provision. The IJB regularly debates its appetite for risks and opportunities in the pursuit of its objectives and will ensure that the statement on risk appetite reflects these discussions.

The full risk appetite statement is outlined below:
Aberdeen City Health and Social Care Integration Joint Board (the IJB) recognises that it is both operating in, and directly shaping, a collaborative health and social care economy where safety, quality and sustainability of services are of mutual benefit to local citizens, to stakeholders and to organisational stakeholders. It also recognises that its appetite for risk will change over time, reflecting a longer-term aspiration to develop innovation in local service provision based on evidence of benefits and on a culture of continuing, planned engagement with the public and other stakeholders, including those involved in service delivery. As a result, the IJB is working towards a mature risk appetite over time.
It recognises that achievement of its priorities will involve balancing different types of risk and that there will be a complex relationship between different risks and opportunities. The risk appetite approach is intended to be helpful to the board in decision-making and to enable members to consider the risks to organisational goals of *not* taking decisions as well as of taking them.
The board has identified several broad dimensions of risk which will affect the achievement of its strategic priorities. The IJB will set a level of appetite ranging from "none" up to "significant" for these different dimensions. Higher levels of all risk types may be accepted if specific and effective controls are demonstrably in place and there are clear advantages for integration objectives. The dimensions of risk and corresponding risk appetite are:

Dimension of Risk	Corresponding Risk Appetite
Financial risk	Low to moderate. It will have zero tolerance of instances of fraud. The Board must make maximum use of resources available and also acknowledge the challenges regarding financial certainty.
Regulatory compliance risk	It will accept no or minimal risk in relation to breaches of regulatory and statutory compliance.
Risks to quality and innovation outcomes	Low to moderate (quality and innovation outcomes which predict clearly identifiable benefits and can be managed within statutory safeguards)
Risk of harm to clients and staff	Similarly, it will accept minimal risks of harm to service users or to staff. By minimal risks, the IJB means it will only accept minimal risk to services users or staff when the comparative risk of doing nothing is higher than the risk of intervention
Reputational risk	It will accept moderate to high risks to reputation where the decision being proposed has significant benefits for the organisation's strategic priorities. Such decisions will be explained clearly and transparently to the public.
Risks relating to commissioned and hosted services	The IJB recognises the complexity of planning and delivery of commissioned and hosted services. The IJB has no or minimal tolerance for risks relating to patient safety and service quality. It has moderate to high tolerance for risks relating to service redesign or improvement whereas much risk as possible has been mitigated.

The IJB has an appetite to take decisions which may expose the organisation to additional scrutiny and interest. Wherever possible, decisions will be taken following consultation/co-production with the public and other key stakeholders. Concerted efforts will be made to explain reasons for decisions taken to the public transparently in a way which is accessible and easy to understand.
This risk appetite statement will be reviewed regularly, at least as often as the IJB's strategic plan is reviewed and more often when required.

c) Risk Management Framework

The Risk Appetite statement, risk management system, strategic and operational risk registers together form the risk management framework.

The framework sets out the arrangements for the management and reporting of risks to IJB strategic priorities, across services, corporate departments and IJB partners. In line with the principles set out in the Australia/New Zealand Risk Management Standard 4360 [7],(https://itlaw.wikia.org/wiki/Australian_and_New_Zealand_Standard_for_Risk_Management)
it describes how risk is contextualised, identified, analysed for likelihood and impact, prioritised, and managed. This process is framed by the requirement for consultation and communication, and for monitoring and review.

Identified risks are measured according to the IJB risk assessment methodology described below and recorded onto risk registers. The detailed methodology for assessment of risk appears at Appendix 6. They are escalated according to the flowchart shown at Appendix 7.

d) Risk Assessment methodology

Risks are measured against two variables: the likelihood (or probability) of any particular risk occurring and the consequence or severity (impact) of that risk should it occur.

For example, there may be a risk of fire in a particular office building. If it happens, this would cause harm or damage to people, property, resources and reputation.

The ***likelihood*** of this occurring will be affected by the strength of fire safety precautions (prevention). The ***consequence*** or ***severity*** of the incident if it does occur will be affected by contingency management (containment, firefighting, evacuation procedures, emergency help, communications etc. by fire safety response and by effective Business Continuity Planning (BCP) to ensure that essential services continue to be delivered, even if at a reduced level for a period). BCP serves to reduce consequence of risk events mostly in major structural or physical risks such as fire, flood, terrorism or natural disaster.

It is important to note that in most areas of risk identified and managed by ACHSCP, the aim is to managed down the likelihood of a risk event and that in most cases, the consequence or severity of a risk event will remain the same throughout the lifetime of the risk. For example, if there is a shortage of key clinical specialists one month, the consequence for service users could be a poorer health or wellbeing outcome. If vacancies are filled in a subsequent month, the likelihood of that consequence is reduced but if the risk event nevertheless occurs, the consequence for patients or clients may still be 'major' depending on the nature of the service involved.

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[7] Standards New Zealand, AS/NZS ISO 31000:2009 Risk Management

Risk measurement tables are widely used by organisations and set out levels of both likelihood and consequence, in order to reach an overall risk assessment score. It is rare in the type of services the IJB is concerned with that this is a scientific process but it provides a practical way of comparing different types of risk issues and helping organisations to prioritise between issues so that they can be managed and the risk reduced. This measurement system is also used to decide when to escalate issues that cannot be managed locally or that are of such significance that the members of the senior team or the IJB need to be aware of them.

A key point to remember when assessing a risk for the first time is what controls are currently in place to prevent a risk event. The ACHSCP risk assessment procedure requires the identification of an **initial,** or **gross,** level of risk. This is the risk assessment where it is assumed no controls are in place. This is useful in order to determine and absolute severity of a risk but in practice, the second assessment, or current risk level, is particularly important in risk management terms. This identifies the level of risk taking into account any controls (and gaps in controls) which currently exist. The third level of risk assessment comprises the stage aspired to where the level of risk may be tolerated within the terms of the Risk Appetite once all effective actions have been completed and the controls are at optimal strength. This is the **target** level of risk.

The IJB's risk measurement table is shown below:

DESCRIPTOR	Rare	Unlikely	Possible	Likely	Almost Certain
Probability	Can't believe this event would happen - will only happen in exceptional circumstances.	Not expected to happen, but definite potential exists - unlikely to occur.	May occur occasionally, has happened before on occasions - reasonable chance of occuring.	Strong possibility that this could occure - likely to occur.	This is expected to occur frequently / in most circumstances - more likely to occur than not.

Risk Matrix

Impact / Likelihood	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium	High	High	Very High	Very High
Likely	Medium	Medium	High	High	Very High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

The outputs from risk assessment are as follows:

IJB board level: The Board Strategic Risk Register (SRR)

The fundamental purpose of the SRR is to provide the organisation's Governing Body - i.e. the IJB - with assurance that it is able to deliver the organisation's ***strategic objectives and goals.*** This involves setting out those issues or risks which may threaten delivery of objectives and assure the IJB that they are being managed effectively and that opportunity to achieve goals can be taken it is the lens through which the IJB examines the assurances it requires to discharge its duties. The IJB uses this document to monitor its progress, demonstrate its attention to key accountability issues, ensure that it debates the right issue, and that it takes remedial actions to reduce risk to integration. Importantly, it identifies the assurances and assurance routes against each risk and the associated mitigating actions.

The IJB's SRR format is shown here with a real example of the kind of issue included in the document (Appendix 1). While many of the issues may be termed strategic, the key thing to remember is that these are issues which may affect the ability to deliver on strategy. It is quite possible that significant operational issues will also be incorporated, therefore. The Leadership Team consider risks classified as 'very high' for inclusion in the SRR (see Appendix 7 – risk escalation process). The Leadership Team reviews the SRR in light of their experiences and insight into key issues, including commissioning risk, and recommends the updated version to the Risk, Audit and Performance Committee (RAPC) for approval and review by the IJB.

The issues identified are measured according to the IJB risk appetite and risk assessment methodology.

The risks are identified by:

- Discussions at Leadership Team
- Review of Performance data and dashboards
- Reports from Project Management Board on review of Performance Management Office (PMO) dashboards
- Review of the Operational Risk Register (ORR) (see below) including 'deep dives' on areas of operational risk aligned to strategic risk

- Review of Chief Officer reports and reports from IJB sub committees

The Leadership Team agrees issues for inclusion on (and removal from) the SRR, and submits to the IJB or RAPC quarterly for formal review

RAPC reviews the SRR for the effectiveness of the process annually.

Corporate Level: Operational Risk Register

While the SRR is a *top-down* record of risks to objectives, the ORR is a *bottom-up* operational document which reflects the top risks that are escalated through the IJB's delegated services and gives detail on how they are being managed.

It may well contain risks that have a strategic angle, as well as those which are operational in nature, and will definitely contain risks that affect strategic objectives.

Risks from service risk registers and locality risk registers (once developed) are escalated to the ORR according to their risk assessment scores. New risks and risks proposed for escalation, will be discussed at the Clinical and Care Risk Meetings. New risks proposed for escalation can also be discussed at the Leadership Team daily huddles as well as at the 6 weekly Business Meetings of the Leadership Team.

The IJB has a standardised risk register format which is used for the ORR and all other risk registers. It is shown below with a real risk included as an example.

The ORR comprises high scoring risks or those which cannot be managed locally from a range of sources. This document is routinely reviewed by both IJB sub committees to ensure:

- the right risks are being reported and escalated
- actions are being taken to mitigate risk and improve the strength of controls
- these actions have been effective in reducing the risk level
- the IJB is aware of high-level risks affecting services and of those where actions are not being taken in a timely manner or have not been successful in reducing the risk

The issues identified are measured according to the risk assessment methodology. They are recorded using the following format:

Table 2: Risk Recording Format

ID	Strategic Priority	Description of Risk	Context/Impact	Date Last Assessed	Controls	Gaps in controls	Likelihood	Consequences	Risk Assessment	Assurances	Risk Owner/Handler	Comments

The risks are identified, using the risk assessment matrix for high scoring risks, from:

- Review of Portfolio Management dashboards
- Operational department risk registers
- Service and locality risk registers and review of reports from service governance groups
- Review of reports from IJB sub committees
- IJB Occupational Health and Safety committee reports

The Chief Officer owns the ORR, and the Clinical and Care Governance Group moderate risks escalated to ensure consistency and appropriateness of issues identified for inclusion and removal. The Clinical Care and Governance Group will meet every 2nd month and will identify any new risks. New or escalated risks are reported to the Clinical and Care Governance Committee (CCGC) so that the Committee are aware of the evolving profile of operational risks.

The Leadership Team reviews the Operational Risk Register at its 6 weekly Business Meetings and it will be reported to the CCGC in its entirety, bi-annually demonstrating the changes in the risk profile of the IJB.

Occupational health and safety risks will be reported to the Partnership's Health and Safety Committee. Some risks may be reported to both the Clinical Care and Governance Group and the Health and Safety Committee. Governance arrangements are in place to capture these risks at source and share with the other forum.

Non clinical/non occupational health and safety risks will be reported to the Risk, Audit and Performance Committee.

The risk register is shared with the NHSG and ACC through the report consultation process.

Service and locality level: Risk registers and reports from governance groups

Service and locality risk registers will use the same format as the ORR and are compiled at local level and discussed at local management and governance meetings.

Where risks cannot be satisfactorily managed locally, or where they are above scores as set out in the escalation flowchart, they will be escalated for possible entry onto the ORR. New risks and those identified for escalation will be considered at the regular Clinical Care Risk Meetings and recommendations made for the attention of the Clinical and Care Governance Group. The Leadership Team will also receive regular feedback from the Clinical Care Risk Meetings. It is critical to emphasise that the risk management system cannot rely on escalation through the risk register process alone. The Leadership Team, through the operational group management structure, has a key role in helping to manage and find solutions to risk issues at all levels of the organisation.

Arrangements have developed over the first years of operations across services, taking into account existing systems. Operational risks managed at the service and department level are monitored by the Chief Officer and Leadership Team. The Clinical and Care Governance Group (see Appendix 3) has a key role in identifying risk across services which may affect the safety and quality of services to users. The Group also has responsibility for reminding risk owners to ensure operational risks are reviewed regularly and for reporting new and escalated risks to the Group. The aims in developing risk communication between services and the IJB will be to achieve consistency in reporting the nature and scale of risks and to clarify how these are reported, escalated and actions monitored. The risk escalation flowchart at Appendix 7 shows the basis for this process.

2.3 Roles and Responsibilities for governance

a) Committee structure

This section describes the key committees and groups in relation to the IJB governance framework.

The board has established two sub-committees, as follows: **RAPC** and **CCGC These** committees have powers conferred upon them by the IJB.

In relation to governance and assurance, the **RAPC** performs the key role of reviewing and reporting on the effectiveness of the governance structures in place and on the quality of the assurances the Board receives. It has a moderation role in relation to the consistency of risk assessment. It also has oversight of information governance issues.

The **CCGC** provides assurance to the IJB in relation to the quality and safety of services planned and/or delivered by the IJB. Its key role is to ensure that there are effective structures, processes and systems of control for the achievement of the IJB's priorities, where these relate to regulatory compliance, service user experience, safety and the quality of service outcomes. To support this role, the CCGC is informed by the clinical and care governance arrangements in place across NHS and ACC (see Appendix 4 - Clinical and care governance diagram).

It also assures the IJB that services respond to requirements arising from regulation, accreditation and other inspections' recommendations. The Committee will consider and approve high value clinical and care risks, consider the adequacy of mitigation, the assurance provided for that mitigation and refer residual high risks to the Board. It has a key role in assuring the board that learning from governance systems across services, including learning arising from incidents, complaints, identified risks and Duty of Candour (DOC) investigations, is shared and embedded as widely as possible. The Committee will receive the full Operational Risk Register twice per year.

The IJB's **Leadership Team** is an executive group with oversight of the implementation of IJB decisions. It oversees risk registers, financial and operational delivery, the innovation and transformation programmes and assures RAPC of transformation progress. The group also assures the Board on progress towards the achievement of its strategic priorities through the Performance Management Framework.

There are existing **governance arrangements within the providers of services delegated to the IJB**. Arrangements to standardise reporting systems through the IJB's governance structures have been further progressed in 2020/21.

A diagram illustrating the structure appears at Appendix 2. A summary of the purpose, membership and reporting arrangements for these groups appears at Appendix 3.

b) Individual responsibilities

1. Board and corporate level:

The Chief Officer provides a single point of accountability for integrated health and social care services.

The Board and all its members must as a corporate body ensure good governance through the structures and systems described in this document. To ensure that the IJB is well-led and that all members are supported in this responsibility, a board development programme will be constructed to transfer knowledge and skills. To provide assurance that the Board has the capability and competence required, an annual self-assessment and periodic (minimum 3 yearly) independent assessment will be undertaken. This was last carried out in 2020.

2. Professional level:

There are existing clinical and professional leadership structures in place to support clinical and care governance. These are:

- Lead Nurse
- Chief Social Work Officer
- Lead Allied Health Professional (AHP)
- Primary Care Clinical Leads (GPs)
- Public Health Lead
- Clinical Director (GP)

3. Locality level:

The BAEF is aligned with the locality structure. This will require that there is a direct line of sight to the appropriate clinical and professional lead roles and must take into account the location of services: some are locality based and others not. The development

plan is that each of the six delivery points will have a single leader responsible for the good clinical and care governance of services within their remit.

2.4 Reporting of information to provide assurance and escalate concerns (internal & external)

The framework shown in Table 1 in section 1.4 can be populated as shown in Table 3 below. Leads and Service Managers will work with their partners in local services to develop systems for reporting from their various governance forums through to the IJB, as indicated in Table 3 below. In addressing the nature of assurance, it is important to note that the IJB, the RAPC and the CCGC operate assurance mechanisms to review *process* as well as *performance*, and in this regard the work of the RAPC is the key governance mechanism for auditing *process*. The Committee-level Good Governance Matrices and effectiveness' audits also inform assurance around process.

Table 3: Reporting of information to provide assurance and escalate concerns

FOCUS	**Assurance of compliance, performance, improvement and transformation**						
	Individuals	**Plans / activities**	**Groups / Partners**	**Reporting and feedback processes**			
				Compliance with standards	**Risk escalation and review**	**Performance monitoring**	**Improvement and Transformation reporting**
Board level	Chair Chief Officer Board members Chairs / CEOs of the Partners	Strategic plan Strategic Risk Assurance Register Operational Risk register Performance framework Audit plan Standing Orders Integration Scheme	Board Leadership Team Risk, Audit and Performance Committee Clinical and Care Governance Committee Other IJBs	Review of BAEF Review of risk scoring Review of Performance dashboard Transformation Performance Report Audit reports to Board Exception and action plan review Bi-annual review of integration scheme Bi-annual review of strategic plan			

			Scrutiny / governance arms of Parties	
Corporate level	Chief Officer Deputy Chief Officer/Chief Finance Officer Leadership Team Members	Strategic and Operational risk registers Performance dashboard Business planning Budget monitoring Joint Complaints Procedure	Leadership Team Senior Management Teams Strategic Planning Group Clinical and Care Governance Group Executive Programme Board Portfolio Programme Boards	Financial monitoring Strategic and Operational risk register review Risk moderation and review
Service level	Clinical leads and Professional leads Service managers	Engagement, Participation and Empowerment Strategy Clinical and care governance policies Risk registers and assessments	Community partners Service governance forums 'Deep Dive' activity	Risk register system Governance reports Real time feedback Response to complaints Learning from Duty of Candour events Service level dashboards
Individual level	Staff members Service users Carers	Engagement, Participation and Empowerment Strategy Complaints policy Safeguarding alerts Risk assessment Incident reporting	Staff forums IJB engagement activity Locality Empowerment Groups	Objective setting and review Supervision and line management Staff surveys Feedback mechanisms (see assurance source section) Community engagement feedback

Table 4: Reporting of information to provide assurance and escalate concerns with partner organisations

FOCUS	Assurance of compliance, performance, improvement and transformation						
	Individuals	Activities	Groups / Partners	Reporting and feedback processes			
				Compliance with standards	Risk escalation and review	Performance monitoring	Improvement and Transformation reporting
NHSG Board	NHSG Board Chair ACHSCP Chief Officer	Regular Report	NHS Board Leadership Team	Oversight of IJB activity & minutes			
ACC Full Council	ACC Chief Executive	Regular Report	ACC Full Council ACC Chief Executive Leadership Team	Oversight of IJB activity & minutes Information on financial governance, risk management, clinical & care governance etc			
Pan-Grampian IJBs	Chief Officer, ACHSCP (Aberdeen) Chief Officer, AHSCP (Aberdeenshire) Chief Officer MCHSCP (Moray) Chairs of each of the IJBs - Aberdeen City,Aberdeenshire	Regular meetings	North East Partnership Steering Group	Established regionally			

	Moray			
ACC & NHSG CEs	CE NHSG CE ACC CO ACHSCP	Quarterly Performance Review Meetings Bi-monthly 2-1 meetings	ACC NHSG ACHSCP	Performance Finance Risk Governance Directions Transformation Programme

2.5 Sources of assurance

a) Quality of services

Current providers have a range of clinical and care governance arrangements in place. Through these, the IJB has access to assurances which support the delivery of high-quality care and ensure good governance. These assurances include:

- Quality Strategies
- Policies on raising concerns
- HR Policies
- Performance Frameworks
- Safeguarding Policy (Vulnerable Adults)
- Incident reporting and investigation policies and procedures
- Information Governance policies and processes
- Board member visits to service areas ('Deep Dive' activity)
- Staff Surveys
- Joint Staff Forum
- Staff Induction Programmes
- Leadership Programmes
- Performance and Appraisal Development Process
- Compliance reports – health and social care
- Learning lessons systems

b) Engagement

The IJB regards the engagement of its partners and stakeholders in the planning and delivery of services as essential to achieving the goals of integration. The nature and level of engagement varies from group to group and the range of stakeholder with whom the IJB engages is broad, including:

- Service users
- Carers and families
- Staff
- Commissioners
- Other providers in the acute and primary care health and social care sectors
- The independent and voluntary sector
- Housing, education providers, North East Partnership (IJBs)

Engagement will include consultation; communication of information; involvement in decision-making around planning and transforming services; feedback on services and other issues of concern or interest.

ACHSCP endorsed and adopted the Community Planning Aberdeen 'Engagement, Participation and Empowerment Strategy' in order to support engagement across these groups, and to provide a source of assurance that appropriate activities have been identified and implemented. It includes consideration of how to engage with hard to reach communities.

Newsletters	Groups		Other
• Partnership Matters Newsletter • Health Village newsletter • NHSG Team Brief • Scottish Care newsletter/ e-bulletin	• Care at Home Providers Group Forum • Individual Independent providers • Care and Support Providers Aberdeen • Individual Third sector providers	• Sheltered Housing Network • Joint Strategy groups • Locality Empowerment Groups • Local Community Councils • LOIP Outcome Improvement Groups	• 'Connect' – ACHSCP intranet • ACHSCP Website: https://www.aberdeencityhscp.scot/

• SHMU community newsletters • ACVO e-bulletin • VSA Carers News	• Housing providers / associations • NHS Grampian Public Forum • City Voice • Civic Forum	• Mental Health and Learning Disability forums • Joint Staff Forum • Learning Partnerships	

c) Other internal and external sources of assurance

In addition to the assurances emanating from the IJB's Clinical and Care Governance Framework, and its engagement with partners and stakeholders, there are numerous internal and external sources which relate to the delegated services. These include:

- Internal Audit
- External Audit
- External inspection agencies (Care Inspectorate and Healthcare Improvement Scotland)
- Health and Safety Executive
- Mental Welfare Commission
- Externally commissioned independent investigations e.g. Ombudsman and homicide investigations
- Clinical Audit
- Scottish Council for Voluntary Organisations (SCVO)
- Royal College reviews
- Accreditation
- Information Services Division (ISD) Scotland
- Benchmarking with other health and social care providers
- Involvement in and learning from case reviews
- Voluntary Health Scotland
- Crown Office / Procurator Fiscal Reports
- The IJB will also commission external reviews of specific services where the need for additional independent assessments and assurance are identified.

Appendices

Appendix 1 – Strategic risk register format

<table>
<tr><th colspan="3">- 1 -</th></tr>
<tr><td colspan="3">Description of Risk:</td></tr>
<tr><td colspan="2">Strategic Priority:</td><td>Lead Director:</td></tr>
<tr><td>Risk Rating: low/medium/high/very high

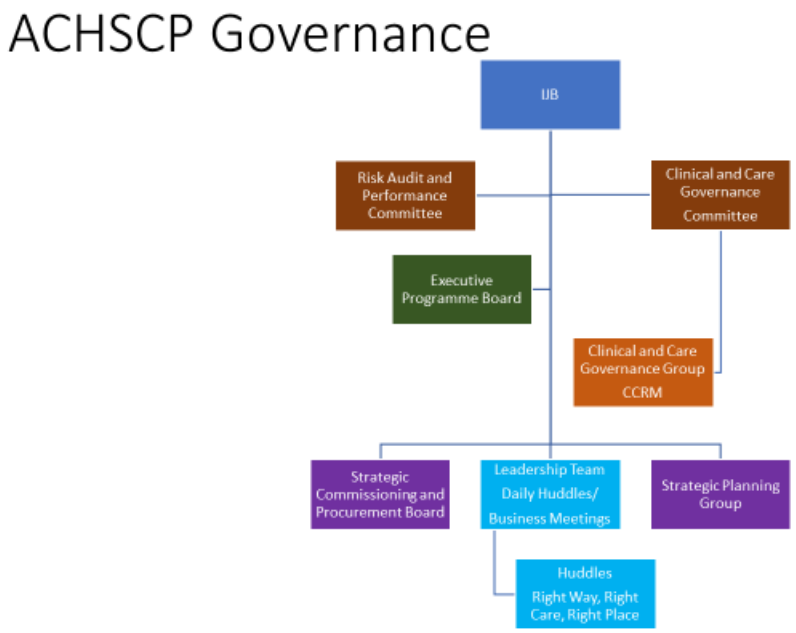
Medium</td><td rowspan="2">Rationale for Risk Rating:

Rationale for Risk Appetite:</td><td rowspan="2"></td></tr>
<tr><td>Risk Movement: increase/decrease/no change

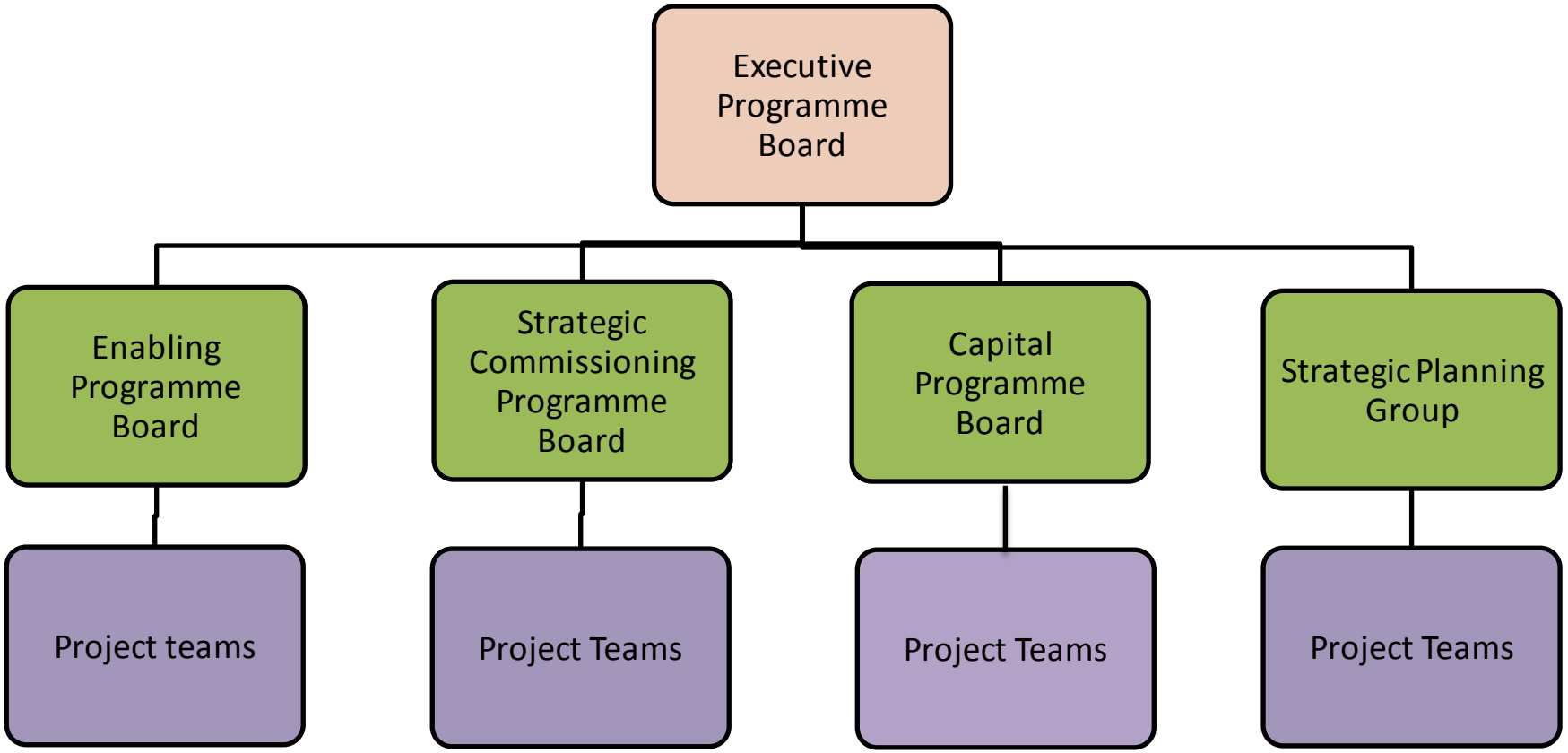
NO CHANGE</td></tr>
<tr><td colspan="2">Controls:</td><td>Mitigating Actions:</td></tr>
<tr><td colspan="2">Assurances:</td><td>Gaps in assurance:</td></tr>
</table>

Current performance:	Comments:

Appendix 2 - Board Committee diagram



Appendix 3 – Transformation Programme Structure



Appendix 4 – Roles of the Governance Groups

Principal function/s	Membership	Reports to	Reports received / reviewed
Leadership Team			
Robust and effective management processes are required to ensure management oversight of: • Care and Clinical Governance • Risk Management and oversight of Service and Corporate Risk Registers • Financial governance and performance oversight • Service performance • Staff governance • Health and Safety • Executive oversight of change programmes • Ensuring IJB's strategic plan is delivered • Good decision making and approval of business cases	The core membership is as follows: • Chief Officer – chair • Chief Finance Officer – financial reporting • Clinical Director (GP) – Clinical Governance reporting • Lead, Strategy and Performance • Business Management Lead • Transformation Lead • Communications Lead • People and Organisation Lead • AHP Lead • Lead Nurse • Social Work Lead • Rehabilitation Lead • Mental Health & LD Lead • Commissioning Lead • Primary Care Lead • Primary Care Lead	IJB	The following will report as required to the Leadership Team : • Leadership team members • Service Managers • Transformation Programme Managers • Chief Officers – Moray and Aberdeenshire in relation to performance of 'hosted services' • Designated service health and safety leads • Partnership representatives / trade union representatives • Service Improvement and Quality • Chief Social Work Officer • Health Intelligence • Business Managers
Strategic Planning Group			

Principal function/s	Membership	Reports to	Reports received / reviewed
The role of the Strategic Planning Group is overseeing the development of the strategic commissioning plan and in continuing to review progress, measured against the statutory outcomes for health and wellbeing, and associated indicators. The strategic commissioning plan should be revised as necessary (and at least every three years), with the involvement of the Strategic Planning Group.	Prescribed groups of persons to be represented in strategic planning group: • health professionals; • users of health care; • carers of users of health care; • commercial providers of health care; • non-commercial providers of health care; • social care professionals; • users of social care; • carers of users of social care; • commercial providers of social care; • non-commercial providers of social care; • non-commercial providers of social housing; and third sector bodies carrying out activities related to health care or social care.	Executive Programme Board	Locality Empowerment Groups Annual Performance Report Strategic Plan
Risk Audit and Performance Committee			
To review and report on the relevance and rigour of the governance structures in place and the assurances the Board receives. These will include a risk management system and a performance management system underpinned by an Assurance Framework.	The Committee will be chaired by a non-office bearing voting member of the IJB and will rotate between NHS and ACC. The Committee will consist of not less than 4 members of the IJB, excluding Professional Advisors. The Committee will include at least two voting members, one from Health and one from the Council. The Board Chair, Chief Officer, Chief Finance Officer, Chief Internal Auditor and other Professional Advisors and senior officers as required as a matter of course, external audit or other persons shall attend meetings at the invitation of the Committee. The Chief Internal Auditor should normally attend meetings and the external auditor will attend at least one meeting per annum.	IJB	Annual audit plan
Clinical & Care Governance Committee			

Principal function/s	Membership	Reports to	Reports received / reviewed
To provide assurance to the IJB on the systems for delivery of safe, effective, person-centred care in line with the IJB's statutory duty for the quality of health and care services.	The Committee shall be established by the IJB and will be chaired by a voting member of the IJB. The Committee shall comprise of: • 4 voting members of the IJB • Chief Officer • Chief Social Work Officer • Chair of the Clinical and Care Governance Group / Clinical Director (GP) • Chair of the Joint Staff Forum • Professional Lead – Nurse/AHP • Public Representative • Third Sector representatives	IJB	CCG Group report Feedback/Incidents Reporting Escalations from CCG Group
Clinical & Care Governance Group			
To oversee and provide a coordinated approach to clinical and care governance issues and risks within the Aberdeen City Health and Social Care Partnership.	• Clinical Director (GP) (Chair) • Lead Social Work Manager • Lead Nurse • Public Health Lead • Patient/Public Representative • Lead Allied Health Professional • GP Representative • Dental Clinical Lead or Dental Service Representative • Lead Optometrist • Representative from Sexual Health Service • General Practice Patient Safety Lead • Woodend Hospital and Link@ Woodend Representative • Representative from Commissioned Service • Partnership Representative	Leadership Team Clinical and Care Governance Committee NHSG Clinical Quality & Safety Group ACC Public Protection Committee	Reports from services: AHP Dentistry Optometry Pharmacy Nursing General Practice Social Work/Care Woodend Hospital and Links @ Woodend Biannual Reports Falls Pharmacy/medication Patient Safety in Primary Care New and escalated risks

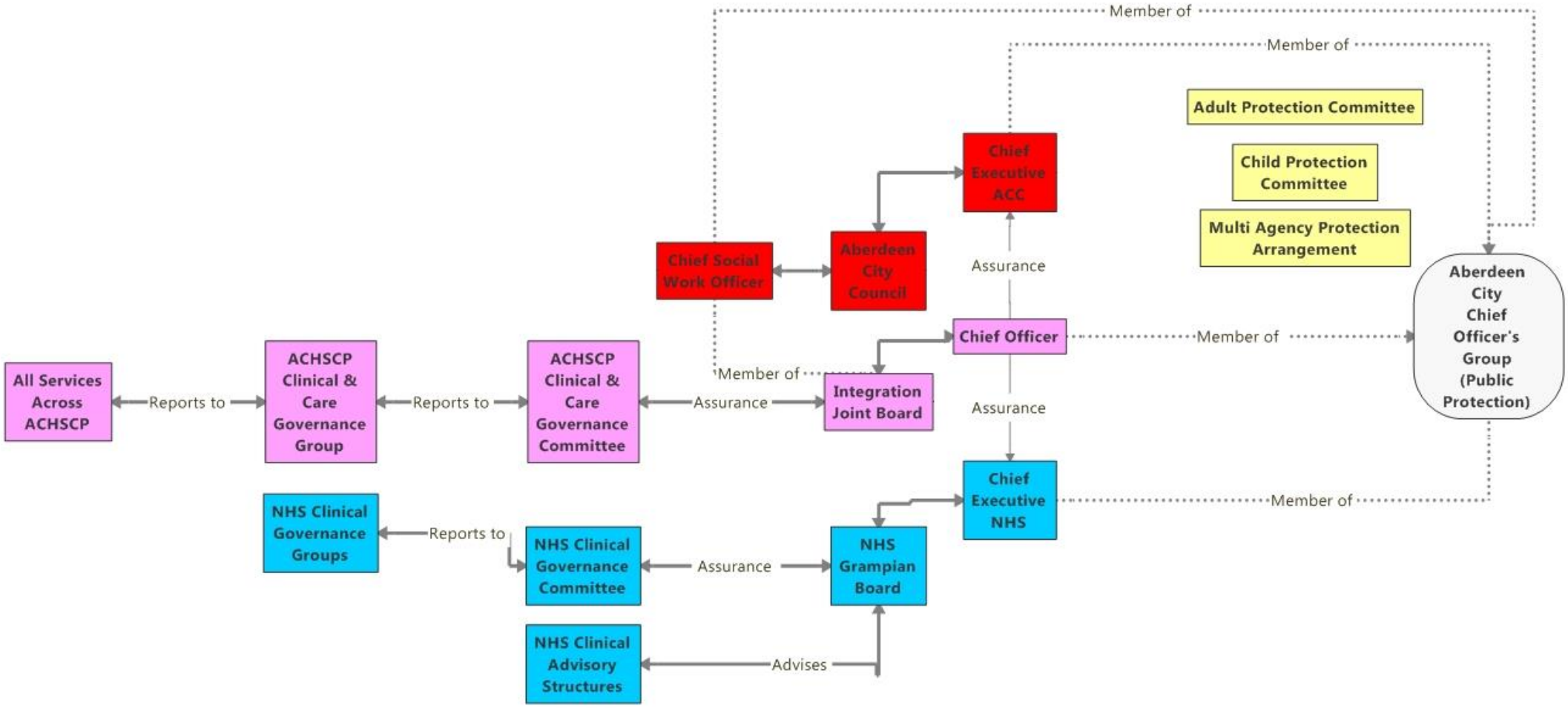
Principal function/s	Membership	Reports to	Reports received / reviewed
	• Representative from Community Mental Health and Learning Disability Services • Representative from Acute Sector • Public Partner		
Locality Empowerment Groups			
To deliver the locality planning requirements of the Public Bodies (Joint Working) (Scotland) Act 2014, in respect of the Aberdeen City Health and Social Care Partnership. The Locality Empowerment Groups play a key role in ensuring the delivery of the Aberdeen City Health and Social Care Strategic Plan, including contributing to the delivery of its associated strategic outcomes. The role of the Locality Empowerment Groups includes developing and ensuring appropriate connections and partnerships across the Locality to help to improve the health and wellbeing of the locality population and reduce the health inequalities that we know impact poorly on people's lives. The locality leadership group will influence, and be influenced by, the city's Strategic Planning Group and ultimately the Integration Joint Board.	Community Members Public Health Coordinator	Strategic Planning Group	Locality Plans Health Improvement Fund report

Principal function/s	Membership	Reports to	Reports received / reviewed
The locality leadership group will also influence and be influenced by the Aberdeen City Community Planning Partnership.			
Executive Programme Board			
• Provide direction to programme board and working groups • Identify prioritised projects • Approve Business Cases • Ensure programme progress including ensuring that progress is supported to continue at pace • Approve significant changes to programmes	• Chief Officer • Chief Finance Officer • Clinical Lead • Lead Transformation Manager • Other Leadership Team Members (rotating)	Seek IJB approval to incur expenditure for projects where required under standing orders (full life costs) Report on progress and performance to IJB	Papers from Enabling / Strategic Commissioning / Capital Programme Boards & Strategic Planning Group All planned decisions All IJB papers
Programme Boards (Enabling, Strategic Commissioning, Capital)			
• Support and enable progress at pace across transformation portfolio • Review and approve Project Proposal Documents • Consider "deep dives" into working group programmes to be assured of progress	• Selected Leadership Team Members (Chair and VC) • Operational Managers • Transformation Programme Managers • Independent Sector • Third Sector • ACC Communities and Housing	Executive Programme Board	Workstreams and project groups Business Case Programme Management documentation

Principal function/s	Membership	Reports to	Reports received / reviewed
Ensure delivery of anticipated benefits and where these are no longer deliverable, redirect projects/ programmes accordingly	• Acute Sector Finance		

Appendix 5 – Clinical and care governance diagram

The diagram on the following page provides an overview of the clinical & care governance processes within ACHSCP. The processes draw upon the existing clinical & care governance within ACC and the NHS. Clinical & care governance matters relating to the ACHSCP are considered by its Clinical & Care Governance Group. The Clinical & Care Governance group has representation from all services across ACHSCP and report to the ACHSCP Leadership Team, CCGC and provide assurance to ACC and NHS clinical and safety structures.


Member of
Member of
Adult Protection Committee
Child Protection Committee
Multi Agency Protection Arrangement
Chief Executive ACC
Chief Social Work Officer
Aberdeen City Council
Assurance
Aberdeen City Chief Officer's Group (Public Protection)
Chief Officer
Member of
All Services Across ACHSCP
Reports to
ACHSCP Clinical & Care Governance Group
Reports to
ACHSCP Clinical & Care Governance Committee
Assurance
Member of
Integration Joint Board
Assurance
Chief Executive NHS
Member of
NHS Clinical Governance Groups
Reports to
NHS Clinical Governance Committee
Assurance
NHS Grampian Board
NHS Clinical Advisory Structures
Advises

NHS Scotland Core Risk Assessment Matrices

Table 1 - Impact/Consequence Definitions

Descriptor	Negligible	Minor	Moderate	Major	Extreme
Patient Experience	Reduced quality of patient experience/ clinical outcome not directly related to delivery of clinical care.	Unsatisfactory patient experience/clinical outcome directly related to care provision – readily resolvable.	Unsatisfactory patient experience/clinical outcome, short term effects – expect recovery <1wk.	Unsatisfactory patient experience/ clinical outcome long term effects –expect recovery >1wk.	Unsatisfactory patient experience/clinical outcome, continued ongoing long term effects.
Objectives/ Projects	scope, quality or schedule.	Minor reduction in scope, quality or schedule.	Reduction in scope or quality of project; project objectives or schedule.	Significant project over-run.	Inability to meet project objectives; reputation of the organisation seriously damaged.
Injury (physical and psychological) to patient/ visitor/staff	Adverse event leading to s mino injury not requiring first aid.	Minor injury or illness, first aid treatment required.	Agency reportable, e.g. Police (violent and aggressive acts). Significant injury requiring medical treatment and/or counselling.	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling.	Incident leading to death or major permanent incapacity.
Complaints/ Claims	Locally resolved verbal complaint.	Justifie written complain. Justifie complain involving lack of appropriate care.	Below excess claim. Justifie complain involving peripheral to clinical care.	Claim above excess level. Multiple justifie complaints.	Multiple claims or single major claim. Complex justifie complaint.
Service/ Business Interruption	Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service.	Short term disruption to service with minor impact on patient care.	Some disruption in service with unacceptable impact on patient care. Temporary loss of ability to provide service.	Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.	Permanent loss of core service or facility. Disruption a to significant "knock on" ef fect.
Staffing and Competence	Short term low staffing level temporarily reduces service quality (< 1 day). Short term low staffing level (>1 day), where there is no disruption to patient care.	Ongoing low staffing level reduces service quality. **Minor error** due to ineffective training/ implementation of training. Ongoing problems with staffing levels.	Late delivery of key objective/ service due to lack of staff. **Moderate error** due to ineffective training/ implementation of training.	Uncertain delivery of key objective /service due to lack of staff. **Major error** due to ineffective training/implementation of training.	Non-delivery of key objective/ service due to lack of staff. Loss of key staff. **Critical error** due to ineffective training, implementation of training.
Financial (including damage/loss/ fraud)	Negligible organisational/ personal/financial loss (£<1k).	Minor organisational/ personal/financial loss (£1-10k).	Significant organisational / personal financial loss (£10-100k).	Major organisational/personal financial loss (£100k-1m).	Severe organisational/ personal financial loss (£>1m).
Inspection/Audit	Small number of recommendations which focus on minor quality improvement issues.	Recommendations made which can be addressed by low level of management action.	Challenging recommendations that can be addressed with appropriate action plan.	Enforcement action. Low rating. Critical report.	Prosecution. Zero rating. Severely critical report.
Adverse Publicity/ Reputation	Rumours, no media coverage. Little effect on staff morale.	Local media coverage – short term. Some public embarrassment. Minor effect on staff morale public attitudes.	Local media – long-term adverse publicity. Significant effect on staff morale and public perception of the organisation.	National media/adverse publicity, less than 3days. Public confidence in the organisation undermined. Use of services affected.	National/International media adverse publicity, more than 3 days. MSP/MP concern (Questions in Parliament). Court Enforcement. Public Enquiry/FAI.

Table 2 - Likelihood Definitions

Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Probability	• Can't believe this event would happen • Will only happen in exceptional circumstances	• Not expected to happen, but definite potential exists • Unlikely to occur.	• May occur occasionally • Has happened before on occasions • Reasonable chance of occurring.	• Strong possibility that this could occur • Likely to occur.	This is expected to occur frequently/in most circumstances more likely to occur than not.

Table 3 - Risk Matrix

Likelihood	Consequences/Impact				
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Almost Certain	Medium	High	High	V. High	V. High
Likely	Medium	Medium	High	High	V. High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

References: AS/NZS 4360:2004 'Making It Work' (2004)

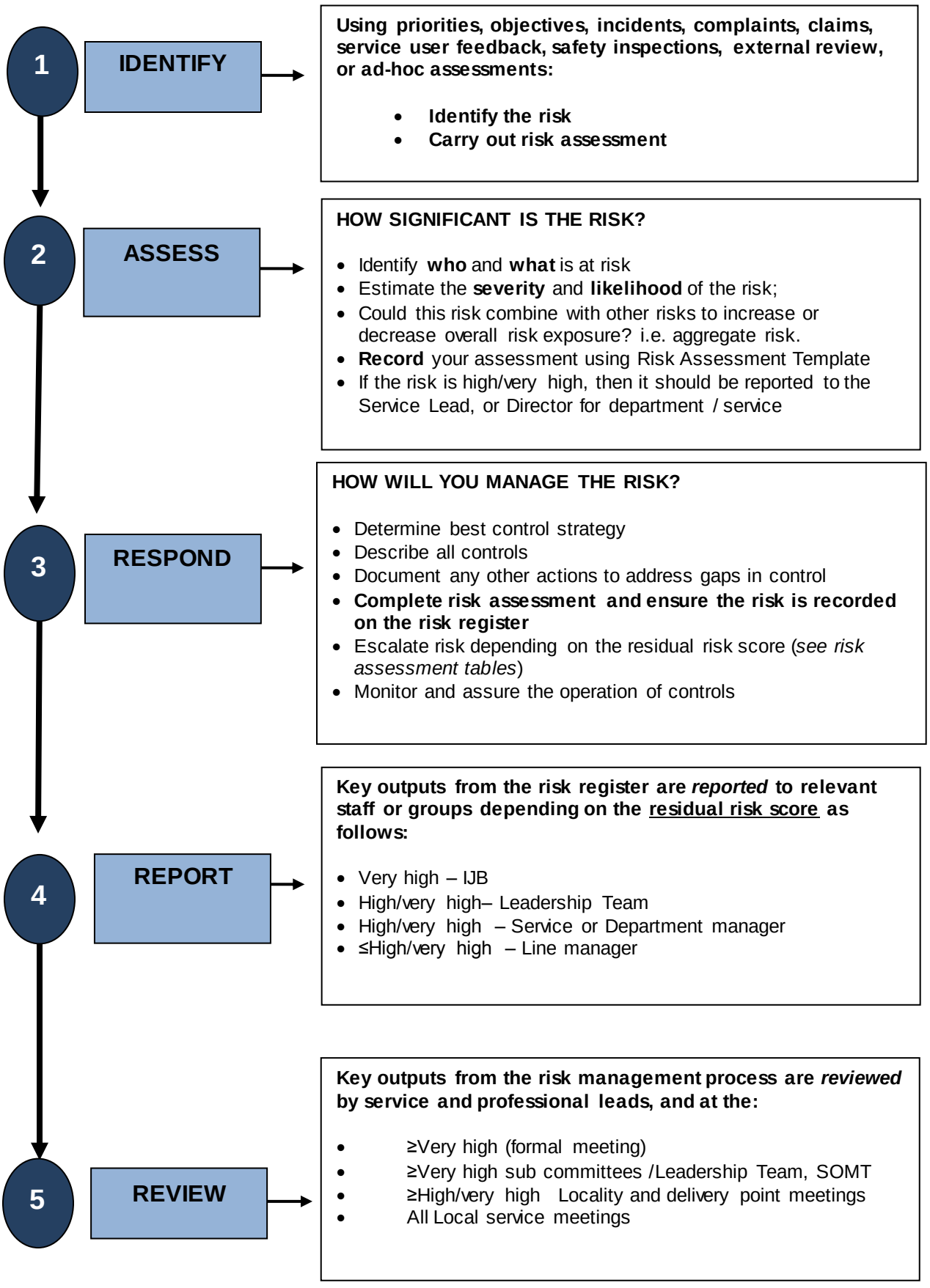
Table 4 - NHSG Response to Risk

Describes what NHSG considers each level of risk to represent and spells out the extent of response expected for each.

Level of Risk	Response to Risk
Low	Acceptable level of risk. No additional controls are required but any existing risk controls or contingency plans should be documented. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective.
Medium	Acceptable level of risk exposure subject to regular active monitoring measures by Managers/Risk Owners. Where appropriate further action shall be taken to reduce the risk but the cost of control will probably be modest. Managers/Risk Owners shall document that the risk controls or contingency plans are effective. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. Relevant Managers/Directors/Assurance Committees will periodically seek assurance that these continue to be effective.
High	Further action should be taken to mitigate/reduce/control the risk, possibly urgently and possibly requiring significant resources. Managers/Risk Owners must document that the risk controls or contingency plans are effective. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. Relevant Managers/Directors/Executive and Assurance Committees will periodically seek assurance that these controls to be effective and control that it is not reasonably practicable to do more. The Board may wish to seek assurance that risks of this level are being effectively managed. However NHSG may wish to accept high risks that may result in reputation damage, financial loss or exposure, major breakdown in information systems or information integrity, significant incidents(s) of regulatory non-compliance, potential risk of injury to staff and public.
Very High	Unacceptable level of risk exposure that requires urgent and potentially immediate corrective action to be taken. Relevant Managers/Directors/Executive and Assurance Committees should be informed explicitly by the relevant Managers/Risk Owners. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. The Board will seek assurance that risks of this level are being effectively managed. However NHSG may wish to accept opportunities that have an inherent very high risk that may result in reputation damage, financial loss or exposure, major breakdown in information systems or information integrity, significant incidents(s) of regulatory non-compliance, potential risk of injury to staff and public.

Version March 2013

Appendix 7 – Risk escalation process



Appendix 8: Ownership & Version Control

Ownership:

The BAEF Framework is owned by the Leadership Team and is regularly reviewed by the team.

Version Control

1. Version Control/Document Revision History (begun 24.11.2017)			
Version	Reason	By	Date
1.	Revisions to the BAEF requested by the Audit & Performance Committee at its meeting on the 21st of November 2017	Sarah Gibbon, Executive Assistant	24.11.2017
2.	Additional revisions to BAEF pending submission to IJB	Sarah Gibbon, Executive Assistant	22.01.2018
3.	Acceptance of changes	Sarah Gibbon, Executive Assistant	31.01.2018
4.	Annual Review	Sarah Gibbon Executive Assistant	18.01.2019
5.	Annual Review	Neil Buck Support Manager	22.04.2020
6.	Annual Review	Martin Allan Business Manager	September 2021