

GOVERNANCE FOR JOINT SERVICES

Principles and Advice

■ August 2007 ■

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FOREWORD

Making the Connections

Joint working remains a key policy commitment that presents local partnerships with a clear and ongoing challenge to deliver better joint outcomes for local service users and their carers. *Delivering for Health* and *Changing Lives* reaffirmed the importance of joint working to enable the delivery of improvements in health and social care. With the establishment of Community Health Partnerships we are keen to ensure that partners have the information they need to move forward with confidence to consolidate and extend joint working arrangements.

I chaired a short life working group during 2006 to develop and publish advice to support partnerships in developing their governance arrangements. We believe that partnerships should feel confident that the authority and powers currently exist to enable them to achieve effective joint working. However, there are different routes that partnerships can legitimately follow to put sound governance structures, arrangements and processes in place. Therefore, this advice note seeks to describe the key principles that must underpin all governance arrangements for joint services and provides signposts to a range of references that partnerships may find useful. Though the main focus for the guidance relates to community care, the principles are also relevant to children's services. Partners may use this advice note to help to develop their local governance arrangements.



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Supporting Joint Services - Background

1. The Joint Future agenda has, over a number of years, encouraged health and local authorities to work together, and with other partners, to deliver integrated services. The focus of this has moved on from older people to include a wide range of care groups and services and to focus less on organisational structures and processes and more on improved outcomes for people.
2. There is a strong consensus, underpinned by a strong commitment from the Scottish Executive and the Convention of Scottish Local Authorities, to give renewed impetus to extending joint working that delivers tangible benefits to individuals and carers through outcome measures. At a national level work is underway to develop outcomes, measures and targets for community care underpinned by a comprehensive joint performance framework. This drive towards continual improvement is set in the context of work to prevent inappropriate hospital admissions; reduce delayed discharges, increase support for carers, and improve children's services, including better child protection.
3. Community Health Partnerships (or in some areas Community Health and Care Partnerships) provide a major opportunity to consolidate joint working across the health and social care system. Working within local authority boundaries, CHPs are pivotal in stimulating and coordinating partnership working at local level. The CHP Statutory Guidance and Regulations¹ provide scope and flexibility to enable NHS Boards and their partners to develop CHPs that reflect local circumstances. There is no "one size fits all".
4. A number of partnership arrangements has emerged that embrace community planning, integrated healthcare and joint working in different ways all set within existing legislation and guidance on governance. However, as CHPs are co-terminous with local authority boundaries, and are statutory committees of NHS Boards, they offer further scope to improve joint services planning and delivery, within a robust governance framework.
5. While it is important to have a governance framework through which stakeholders can contribute effectively, and which takes account of official roles and responsibilities, this is often not the most crucial aspect of decision-making. Establishing productive working relationships across partnerships is at least as important – key to which is the commitment shown by the 'corporate' leadership of both the NHS and Local Authority to joint working, with the practical arrangements they put in place enabling potential difficulties to be worked through. These 'relationship' issues often lie outside formal governance arrangements.

¹ <http://www.scotland.gov.uk/Publications/2004/11/20168/45831>

6. In summary:

- Community Health Partnerships offer new opportunities to further develop partnership working through community planning and integrated care; and
- Joint Future continues to set the direction of travel for joint services based on the delivery of joint outcomes and joint performance processes.

7. **Annex 1** provides a summary of legislation that enables joint working and provides signposts to literature on governance which can support the delivery of joint services.

Challenging Assumptions – Some Key Questions

1. What are the components of good governance for joint services?

There is no single overall definition or template for governance for joint services. However, the systems and processes put in place in each CHP must provide assurance to statutory bodies that functions are being properly discharged within existing legal frameworks and comply with the statutory duties placed on NHS Boards and Local Authorities.

The Good Governance Standard for Public Services defines good governance as:

- Focusing on the organisation's purpose and on outcomes for citizens and service users;
- Performing effectively in clearly defined functions and roles;
- Promoting values for the whole organisation and demonstrating the values of good governance through behaviour;
- Taking informed, transparent decisions and managing risk;
- Developing the capacity and capability of the governing body to be effective; and
- Engaging stakeholders and making accountability real.

Governance arrangements for joint services should therefore be based on the principles and information set out in:

- The Good Governance Standard for Public Services (2004) – The Independent Commission for Good Governance in Public Services¹ ;
- Delivering Good Governance in Local Government: A Framework (CIPFA, July 2007)² ;
- Governance in Community Health Partnerships - Self Assessment Tool (Audit Scotland 2006)³ ;
- Governance in Community Health Partnerships – Self Assessment Tool issues for non executive board members (Audit Scotland 2006)⁴ ;
- Joint Future Guidance in Joint Management Structures (Scottish Executive 2001)⁵ ; and
- Political/Corporate Governance Arrangements for Joint Resourcing and Management of Community Care Services (Joint Future Unit and COSLA 2006)⁶.

¹ www.opm.co.uk/ICGGPS/download_upload/Standard.pdf

² www.cipfa.drg.uk/shop

³ http://www.audit-scotland.gov.uk/publications/pdf/2006/NNHSWorks_Governance.pdf

⁴ www.audit-scotland.gov.uk/publications/pdf/2006/NNHSWorksGovernance_Non_exec.pdf

⁵ www.scotland.gov.uk/Topics/Health/care/JointFuture/Publications/ccd701

⁶ <http://www.scotland.gov.uk/Topics/Health/care/JointFuture/Publications/Governance>

CHPs should have systems in place that provide information, clarity and assurance for CHP committee members, NHS Boards and Local Authorities in relation to:

- The Strategic Partnership Agreement between the NHS and Local Authority;
- Performance management of joint outcomes linked to service plans;
- Lines of management accountability for decision making;
- Joint protocols for the management of devolved resources and budgets;
- Quality improvement systems including complaints procedures;
- Risk management including patient/client safety;
- Accountability of professionals for their practice to regulatory bodies and employers; and
- Public accountability for the delivery of agreed joint outcomes.

Annex 2 provides a current example of a checklist on Areas of Joint Governance. **Annex 3** provides a current example of a generic role specification for a CHP committee member.

2. What functions may NHS Boards delegate to CHPs and what functions may NHS Boards and Local Authorities delegate to each other?

Under the NHS Reform (Scotland) Act 2004¹ a NHS Board may delegate functions to a CHP as prescribed by CHP regulations² and as specified in the approved schemes of establishment³ or if the NHS Board decides that certain functions, which are not prescribed in regulations or in the scheme of establishment, may be best delivered through a CHP.

Section 15 of the Community Care and Health (Scotland) Act 2002⁴ allows NHS bodies and Local Authorities to delegate functions and/or powers to one another if, in their opinion, it would lead to an improvement in the way in which their functions are exercised. Any function that is delegated by the Local Authority to the NHS Board may then be delegated to the CHP.

There are some exceptions to the functions that may not be delegated by partners to each other. For NHS Boards the exceptions are anything involving surgery, radiotherapy, termination of pregnancies, endoscopy, the use of class 4 laser treatments and other treatments of an invasive nature or the provision of emergency ambulances and any functions relating to the State Hospital. These exceptions are contained in Regulations.⁵

For Local Authorities, the relevant prescribed functions and/or powers are those for which they can make payment to a NHS body and those which they may delegate to an NHS body, as respectively set out in Schedules 1 and 3 of the 2002 Regulations.

¹ www.opsi.gov.uk/legislation/scotland/acts2004/20040007.htm

² www.sehd.scot.nhs.uk/chp/guidance.htm

³ www.sehd.scot.nhs.uk/chp/Pages/CHPSchemes.htm

⁴ www.opsi.gov.uk/legislation/scotland/acts2002/20020005.htm

⁵ www.opsi.gov.uk/legislation/scotland/ssi2002/20020533.htm

3. How have partners been addressing the issue of accountability for delivery of joint services?

Different arrangements are in place to suit local circumstances. For example, in one Board area the Local Authority has delegated (via the 2002 Act) responsibility to the local Community Health and Care Partnerships (CHCP) responsibility for the delivery of social care services. This is based on a Strategic Partnership Agreement between the NHS and Local Authority. The CHCP Director is directly accountable to the NHS Board Chief Executive and to the Local Authority Director of Social Work for delivery of health and social care services. There is no overarching Joint Future Committee. Delegation by the Local Authority to officials is set within an agreed scheme of delegation.

In another Board area the Local Authority and NHS Board have jointly appointed a Director who is directly accountable to both the Chief Executive of the Local Authority and the Chief Executive of the NHS Board for the planning and delivery of all health and social care services with delegated, aligned budgets. In this case there is a "Partnership Board" comprising Councillors and Non Executive Directors of the NHS Board who agree the overall strategic plan, monitor performance and act as an advisory Committee to the Local Authority within an approved scheme of delegation and budgets are aligned.

In some NHS Board areas Joint Future partnership arrangements have not changed significantly. However partners are seeking ways of streamlining committee arrangements to avoid duplication of activity whilst maintaining separate lines of accountability for joint services.

4. How is accountability preserved across different management structures e.g. shared management, single management, joint management etc?

All CHPs and Joint Future systems must have clear lines of management accountability for service specification and decision making for joint services and have systems in place for performance management. High levels of delegation and effective scrutiny enables quicker decision making. Accountability is preserved through the investment of authority in officials and/or members of partnership committees. In particular, partners should have in place:

- transparent lead arrangements where it is appropriate for one partner to take the lead;
- schemes of delegation for decision making for managers and staff;
- protocols for service delivery;
- clear operational line management for staff that satisfies the requirements of all employers; and
- effective professional leadership.

Managers are responsible for ensuring that systems are in place to enable the effective performance management of joint services. Performance management for joint services is a strategic, integrated and ongoing process that delivers sustained success to organisations by improving the performance of the people

who work within it and developing capabilities and capacity. A number of frameworks are currently used by partners such as the Balance Scorecard or Citistat and there are a number of locally evolving approaches.

However, all performance management systems should:

- demonstrate a shared vision of the partners' joint objectives
- have measurable performance targets and outcomes which relate to both operating unit(s) and wider organisational objectives;
- incorporate regular, formal reviews of progress towards these targets and outcomes;
- use the review process to identify areas of development; and
- evaluate the overall performance management process and its contribution to overall performance to allow change and improvements to be made.

Annex 4 provides a current example of integrated management roles and responsibilities.

5. What principles underpin good financial governance for aligned or pooled budgets for joint services?

The key principles of probity and best value must underpin all financial governance systems whether or not services are provided jointly. In the following areas of practice there is a need to ensure that:

- processes for planning, commissioning and budgeting for the delivery of health and social care services are aligned;
- all budgets are based on an explicit, agreed financial plan and agreement about the delivery of joint outcomes/outputs in line with the Strategic Partnership Agreement;
- all budgets are set at the level required to ensure that agreed resource inputs, activities and service outputs will deliver the expected joint outcomes;
- there is a written and explicit scheme of delegation for financial decision-making and accountability/responsibility including detailed protocols for efficiency savings, virement and management of resource variations;
- robust joint mechanisms for managing risk are in place at all stages of the financial management process;
- reporting of financial performance is clear, systematic and timely to inform management decision-making; and
- financial protocols are harmonised and enable designated managers to make decisions as close to the frontline as possible e.g. authorised signatories.

Further information can be found in "Practical Advice on Joint Resourcing and Joint Management (Scottish Executive, 2003)".¹

¹<http://www.scotland.gov.uk/Topics/Health/care/JointFuture/Publications/PracticalAdvice/Q/EditMode/on/ForceUpdate/on>

6. What principles underpin an effective complaints process for joint services?

Having an effective process for managing complaints not only benefits the complainant, but can have real benefits for the organisation by:

- providing free feedback on service delivery;
- identifying areas needing improvement;
- providing an early chance to put things right; and
- strengthening public support for the organisation.

The following principles should underpin the process of handling complaints about joint services. There must be:

- a jointly agreed process between partners for handling complaints with as few steps as possible;
- clear lines of accountability for complaints management which are integrated into quality improvement arrangements;
- defined responsibilities and protocols for dealing with complaints which will promote ownership of the complaints process; and
- senior management responsibility for the complaint management function eg CHP General Manager/Director.

The complaints process for joint services must be well publicised and readily available to all service users and staff. It should be driven by the search for improvement and reflect and enhance the culture of good service delivery.

7. Are there any specific issues in relation to the management of risk for joint services?

Risk management is the systematic identification, evaluation and management of risk. This includes both risks arising from the activities of the organisation, and those which arise from the external environment such as difficulties in recruiting staff. Each local area will have different risks according to their local circumstances. However, each partnership should have an effective risk management system in place and a register which is jointly and routinely monitored and updated. Partner risk control systems should, as far as possible, complement each other and each risk should be delegated to specific officers to manage.

Partners should pay particular attention to key risks such as the effective management of financial pressures; delivering on joint outcomes (eg delayed discharge targets); and information sharing between partners. It is crucial that partners agree risk control measures and do not take unilateral decisions which may adversely impact on the delivery of joint outcomes.

Examples of risk control assessments and control plans are in **Annex 5** together with a pro forma which may assist partnerships to manage risks more effectively.

8. How should good governance arrangements for joint working address the sharing of information between partners?

In April 2006 the National Data Sharing Forum was launched, which has overall governance for 14 local data sharing partnerships, building on the work of the previous eCare Programme.

Guidelines for the sharing of personal information need to fully comply with the Data Protection Act, Common Law of Confidentiality and, within the NHS, meet the requirements of the Caldicott Guardians.

Partnerships should develop and implement a standard set of tools to provide a framework for sharing information within their area including an overarching information - sharing protocol (ISP). Guidance and support is available to assist partnerships with the development of agreed ISPs for partnerships and includes a Gold Standard ISP which may be accessed through the link below.

In addition, partnerships should develop and implement a training programme for staff, delivered on a multi-agency basis. This training programme could be delivered as a stand-alone module, as part of training in data sharing tools, or linked to key operational initiatives such as Joint Future or *Getting it Right for Every Child*.

Clear information materials must be available for service users and the general public outlining how the partnership deals with their personal information and staff must be trained on how to use these materials. An essential requirement of sound information governance is for service users to be clearly consulted about the sharing of information and, if information is to be shared, their consent sought, unless a risk assessment or legislative imperative determines that the sharing of information should take place without consent.

Further information may be found at www.scotland.gov.uk/dss or email ecare@scotland.gsi.gov.uk.

9. What are the key issues to be addressed in order to ensure effective governance for staff delivering joint services?

Staff governance is generally defined as “a system of corporate accountability for the fair and effective management of all staff” and has equal importance to other components of organisational governance. Staff providing joint services can expect to have the highest level of people management set within the respective partner organisations’ staff/employee governance frameworks. As joint teams continue to evolve, it will be important for team leaders to have working knowledge of all relevant policies and to be clear about performance management arrangements and accounting relationships.

Staff should be clear about their line management and team leaders, who manage multi-agency teams, must be clear about their delegated authority. In addition, staff governance systems should reflect the fact that all professionals

working in health and social care services are accountable not only to their employer but also to their regulatory body. This means that CHP governance arrangements should ensure that professional advice is used to clarify levels of professional autonomy, standards and quality in general, and required staff member competences.

Existing partner HR policies should be reviewed when operating in joint services and partners should have agreed protocols to address all cross-employer grievances, harassment and other related issues or complaints which no internal policy or procedure can resolve.

NHS Staff Governance responsibilities are described at:

<http://www.sehd.scot.nhs.uk/publications/dc20020208sgss.pdf>.

A Joint Appointments Guide is available at:

www.opm.co.uk/download/papers/joint-appts-text.pdf.

Having the Authority – Legislation and Literature Summary

1. Background

This section summarises:

- the legislative basis under which NHS Boards and local authorities were created;
- the legislative basis for joint working (including any restrictions imposed on the ability of partners to engage in joint working); and
- the literature on governance which can support the delivery of joint services.

2. Legislation

- **Social Work (Scotland) Act 1968**

This Act sets out a duty for every Local Authority to “promote social welfare” through:

- making available advice, guidance and assistance on a scale appropriate to their area; and
- providing or securing suitable and adequate facilities and assistance to persons over eighteen years.

The 1968 Act also requires Local Authorities to establish a separate social work department with a Director of Social Work. Following the Local Government etc (Scotland) Act 1994, Local Authorities are no longer required to establish social work committees or have social work departments, or appoint a Director of Social Work, although they still can.

The 1994 Act also introduced into the Social Work (Scotland) Act 1968 the requirement for a Local Authority to appoint a Chief Social Work Officer for the purposes of their statutory social work functions. Some responsibilities of the Chief Social Work Officer are defined in statute, along with a general duty to have oversight of the provision of services.

This Act has been supplemented by a wide range of Acts of Parliament (both Westminster and Scottish Parliaments) which have extended the role and responsibilities of social work into a number of service areas including mental health, community care, and adults with incapacity, criminal justice and disabled persons.

- **The Local Government (Scotland) Act 1973**

This Act abolished previous existing local government structures (namely those established by the Local Government (Scotland) Act 1947) and provided for the establishment of a two-tier system of regional and district councils.

- **National Health Service (Scotland) Act 1978**

This Act provides for the establishment of Health Boards in Scotland.

- **The Local Government etc (Scotland) Act 1994**

This Act established the 32 Local Authorities in Scotland.

- **Community Care and Health (Scotland) Act 2002¹**

Sections 13-17 refer to Joint Working arrangements between local authority and NHS bodies including:

- transfer of funds between each;
- transfer of staff; and
- Ministerial powers to require delegation between local authority and NHS bodies.

More detailed arrangements on joint working are included in the Community Care and Health (Joint Working etc) (Scotland) Regulations 2002. The functions for which partnerships can delegate responsibility are included in schedules 2 and 3 of the regulations and the exemptions are outlined in regulation 5(2) and (3). Any arrangement to delegate functions/pool budgets must be outlined in a written agreement - regulation 9 and the details to be included in the written agreement are included in regulation 11. The composition and management of a pooled fund, including audit arrangements, are included in regulation 10. There is also a requirement to consult on by arrangement - regulation 6². Guidance on the Joint Working regulations was issued in December 2002³.

- **The Local Government in Scotland Act 2003**

This Act introduced the duty for all Local Authorities to make arrangements which secure Best Value, which is continuous improvement in the performance of the Authority's functions. It also introduced the duty to initiate, maintain and facilitate Community Planning, which recognises that if the needs of individuals and communities are to be addressed successfully, they must be addressed collectively and not separately. The third key aspect of this Act is the Authority's power to advance wellbeing, which is the power to do anything which the Authority considers is likely to promote or improve the wellbeing of its area and/or persons within that area.

- **National Health Service Reform (Scotland) Act 2004**

Section 4A provides for the establishment of Community Health Partnerships (CHPs)⁴. CHPs are not independent statutory bodies, but are committees or

¹ <http://www.opsi.gov.uk/legislation/scotland/acts2002/20020005.htm>

² <http://www.opsi.gov.uk/legislation/scotland/ssi2002/20020533.htm>

³ <http://www.scotland.gov.uk/Publications/2003/01/ipjw/0/Q/Zoom/145>

⁴ www.opsi.gov.uk/legislation/scotland/acts2004/20040007.htm

sub-committees of a NHS Board. They operate within the Board's policy, planning and performance management systems.

A few CHPs have established Community Health and Social Care Partnerships that directly manage a range of community based health and social care services and are responsible for services already delivered jointly under the Joint Future agenda e.g. community services for learning disabilities, mental health and addiction.

The statutory CHP guidance enables NHS Boards to devolve authority to CHPs to progress their Joint Future agenda locally. A CHP can pool budgets and enter into joint management arrangements on a wide range of services. CHPs are developing joint approaches to governance arrangements for joint services with local authority partners including joint schemes of delegation, joint written protocols, and access to resources across agency boundaries and joint complaints procedures.

3. Literature Summary

A great deal of literature and guidance on governance already exists covering all areas of the public sector but the following references appear to have most direct relevance to the principles outlined in this document.

- **Local Government in Scotland Act 2003 (Best Value Guidance) – Scottish Executive 2004¹**

This is Scottish Executive guidance on S1(1) of the Local Government in Scotland Act 2003 – “The duty to make arrangements to secure best value continuous improvement in the performance of functions”. One of the required best value arrangements is that “...an authority which secures Best Value will be able to demonstrate a culture which encourages joint working and service provision where this will contribute to better services and customer focused outcomes”.

- **Local Government in Scotland Act 2003 - CoSLA Guide**

The COSLA Guide is described as a “brief, easy to read guide to the Act” and covers the following sections:

- Duty to secure Best Value in local government service provision;
- Community planning (see below);
- Power to advance well-being; and
- Miscellaneous other provisions relating to local government.

In addition, the development of Community Planning Partnerships is based in legislation provided in the LGIS Act. This statutory basis for Community Planning is intended to ensure long term commitment to effective partnership working with communities and between local authorities and other organisations. The Act

¹ <http://www.scotland.gov.uk/Publications/2005/01/20531>

places a duty on local authorities “to initiate, maintain and facilitate a process by which the public services provided in that area are planned by all core partners”.¹

- **Corporate Governance in the Public Sector – Improvement and Trust in Local Public Services – Audit Commission 2003**²

This study describes the strengths in current governance arrangements in the public sector and some of the areas that are most in need of attention. It explores the contribution that corporate governance makes to the quality of local services. It includes a diagnostic tool, based on the framework developed by CIPFA and SOLACE.³

There are also a range of other references on governance on the Improvement Network website which is owned by a partnership consisting of the Audit Commission, the Improvement and Development Agency, the Chartered Institute of Public Finance and Accountancy and the Leadership Centre for Local Government. Examples include the following:

- What have others done to improve governance?⁴
 - What are the main elements of governance?⁵
 - Leadership and governance⁶
- **The Good Governance Standard for Public Services**, (Independent Commission on Good Governance in Public Services, January 2005)

The Commission was established by the Office for Public Management (OPM) and the Chartered Institute of Public Finance and Accountancy (CIPFA). The Standard focuses on six core principles that are common to all public service organisations, along with supporting principles for each. It includes good practice examples and poses questions for governing bodies and managers. A pdf version of the report is available from the CIPFA website.⁷

- **Good Governance in Local Government** (CIPFA/SOLACE Joint Working Group consultation document)

In June 2006 a CIPFA/SOLACE Working Group issued a consultation paper⁸ illustrating best practice for local authorities in developing and maintaining a local code of governance and making adopted practice explicit. The consultation sought comments from local authorities and other local government organisations on revisions to governance standards which were first established in “Corporate Governance in Local Government: A Keystone for Community Governance”,

¹ <http://www.cosla.gov.uk/attachments/parliament/2003actguide.pdf>

² See Audit Commission website at: <http://www.audit-commission.gov.uk>

³ <http://www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=&ProdID=7374209E-8060-4218-B4B2-2CCF2FD490C5>

⁴ <http://www.improvementnetwork.gov.uk/imp/core/page.do?pagelid=1005876>

⁵ <http://www.improvementnetwork.gov.uk/imp/core/page.do?pagelid=1005832>

⁶ <http://www.improvementnetwork.gov.uk/imp/core/page.do?pagelid=10955>

⁷ http://www.cipfa.org.uk/pt/download/governance_standard.pdf

⁸ <http://www.cipfa.org.uk/pt/consultations.cfm>

which was published in 2001. The Framework was launched in July 2007. In response to the Framework's launch the Improvement Network is providing practical support for managers and practitioners through its web-based guide to good governance (see <http://www.improvementnetwork.gov.uk/imp/core/page.do?pagelId=1007044>).

- **CIPFA – Governance Network**

CIPFA (the Chartered Institute of Public Finance and Accountability) and the IPF (Institute of Public Finance) have created a website containing news about current governance issues and details of events, publications and summaries via a “Knowledge Base” function¹. The following information is included on the site:

- CIPFA guidance on pooled budgets²
- Audit Commission guidance on governance for partnerships, 2005³
- A range of other CIPFA guidance⁴
- Information relevant to Scotland⁵
- A CIPFA discussion forum for sharing and discussing views and ideas on Governance⁶:
- A list of forthcoming Governance related events⁷:
- Links to: CIPFA Corporate Governance Panel⁸
- European Corporate Governance Institute⁹
- Independent Commission on Good Governance in Public Services¹⁰

- **NHS Integrated Governance Handbook – A handbook for executives and non-executives in healthcare organisations**, Department of Health, February 2006¹¹

This handbook helps Boards achieve good governance in line with DH requirements, including effective information management and stakeholder involvement. It seeks to provide support and best practice guidance for organisations that wish to review their governance and assurance arrangements to align and integrate quality, performance and governance. Section 2 covers the “how to”, including assurances and controls, reporting and information, Board committee structures and supports, and challenges and recommendations for future refinement of good governance.

¹ <http://www.cipfa.org.uk/pt/consultations.cfm>

² <http://www.cipfagovernance.net/>

³ <http://www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=&ProdID=1CDA0FEF-E610-463c-B3F3-220F607B1A2C>

⁴ <http://www.cipfa.org.uk/panels/audit/publications.cfm>

⁵ <http://www.cipfa.org.uk/scotland/>

⁶ <http://www.cipfagovernance.net/ipfvalidation/login/login.asp?type=OTHER&dest=www.cipfagovernance.net/discussions/default.asp?view=forum&forum=1>

⁷ http://www.cipfagovernance.net/search/default_viewresults.asp?Keyword=&btnSearch.x=25&btnSearch.y=11&library_ref=10

⁸ www.cipfa.org.uk/panels/corporate_governance/index.cfm

⁹ www.ecgi.org/

¹⁰ www.opm.co.uk/ICGGPS/

¹¹ Link below to pdf version of the report available from the Department of Health website: <http://www.dh.gov.uk/assetRoot/04/12/96/15/04129615.pdf>

- **How the NHS works: Governance in Community Health Partnerships – Self-Assessment Tool**, Audit Scotland, May 2006¹

This is the first in Audit Scotland’s new series of “How the NHS works”. This self-assessment governance checklist supports NHS Boards and CHPs in developing their governance arrangements. It sets out some high level statements about different areas of governance, against which boards and CHPs can assess themselves to consider which statement most accurately reflects their local circumstances and to create an action plan.

Audit Scotland also produced supplementary guidance covering issues for Non-Executive Board members in August 2006 which should be read in conjunction with the self-assessment tool.²

- **Social Work – implementation of Changing Lives (21st Century Review of Social Work)**³

The response to *Changing Lives*, the Report of the 21st Century Social Work Review⁴, draws attention to the need to set out new arrangements for the governance of social work practice, “which ensure a proactive, systematic approach to managing risk and promoting excellence”. New practice governance arrangements will support greater devolution of responsibility to front line staff, enabling more autonomous and accountable practice.

A summary of social work legislation was carried out as part of the review of social work services.⁵

- **Evaluation of Local Strategic Partnerships – Governance: a briefing note for LSPs** (Office of the Deputy Prime Minister, May 2004)⁶

This evaluation looks at four main types of partnership – advisory, commissioning, laboratory and community empowerment. It offers a toolkit to identify different sorts of governance behaviours prevalent in each and through this, examines how different ways of working are required in different circumstances. Each toolkit example offers a “strong” version – successful in achieving its aims and a “weak” version – a snapshot of what can go wrong. It also looks at the issues which should be involved in the design of good, effective governance arrangements – such as purpose, membership, roles, rules of engagement, accountability, monitoring and evaluation, servicing and outcomes. Good practice advice is also contained in the Appendix to this document.

¹ Link below to pdf version of the report available from the Audit Scotland website: http://www.audit-scotland.gov.uk/publications/pdf/2006/HNHSWorks_Governance.pdf

² <http://www.audit-scotland.gov.uk/index/06governance.asp>

³ <http://www.socialworkscotland.org.uk/resources/pub/ChangingLivesMainReport.pdf>

⁴ <http://www.socialworkscotland.org.uk/resources/pub/ChangingLivesScottishExecutiveResponse.pdf>

⁵ <http://www.socialworkscotland.org.uk/resources/pub/SocialWorkLegislationSummaryFullReport.pdf>

⁶ http://comunities.gov.uk/embedded_object.asp?id=1136910

- **Joint Future – Guidance on solutions to aligning Terms and Conditions of Service policies and procedures and managing staff in joint working arrangements** – Joint Future Human Resources Group, May 2004¹

This paper offers solutions to some perceived barriers in working together, including a suggested staffing framework to address the Joint Future HR agenda in local partnerships.²

- **The Care Services Improvement Partnership (CSIP) Integrated Care Network includes a number of useful discussion papers and tools such as:**

- **Integrated Care Network Discussion paper on Governance (January 2004)**³

This discussion paper focuses on corporate governance and deals with practical issues in the context of the respective roles of NHS and local government representatives; of the principles of openness and accountability; and of the roles of users and carers. Though not prescriptive in content, the paper refers to a wide range of other sources, and offers a series of perspectives, observations and suggestions on solutions to governance issues.

- **Integrated Care Network Discussion Paper on Governance of Inter-Agency partnerships: “We Have to Stop Meeting Like This” (November 2006)**⁴

Drawing on the earlier ICN Discussion paper referred to above about the concept of governance, this paper considers the wider literature about partnership working and the role of boards. It draws attention to the symbolic role of multi-agency governing boards, identifies key tensions and challenges, and summarises some key academic models and frameworks. It is intended to place recent changes and debates in a wider context and to provide a series of tools with which local services can begin to explore the kind of governance arrangements they want for their services.

- **Integrated Care Network: Integrated Teams Monitoring and Assessment (ITMA) Tool**

This is a management tool to assist those working in, and responsible for, integrated teamworking. ITMA (Integrated Teams Monitoring and Assessment) is designed to be used as a method of self assessment by established teams - or those which are newly formed - to examine several key dimensions of their partnership arrangements. ITMA is described as a relatively simple and cost-effective way of assessing the effectiveness of team working. It enables a rapid appraisal of the 'health' of a team and identifies areas of difficulty, including

¹ <http://www.scottishexecutive.gov.uk/Resource/Doc/924/0021331.pdf>

² <http://www.scottishexecutive.gov.uk/Topics/Health/care/JointFuture/hrworkplan>

³ http://www.icn.csip.org.uk/library/Resources/ICN/icn_working_governance_pdf_version_for_web_based_dist.pdf

⁴ http://www.icn.csip.org.uk/library/Resources/ICN/ICN_Governance_final_3_11_06.pdf

internal functioning and external factors and strongly focuses on further action commensurate with the significance of the problems.¹

- **Joint Future – Guidance on Scottish Executive website²**

Joint Future is the lead policy on joint working between local authorities and the NHS in community care. Its main aim is to provide faster access to better and more joined up services through improved joint working. It expects local partnerships to take holistic decisions on the management, financing and delivery of community care services for all care group. Legislation, advice, guidance and reports covering aspects of joint working are available from the Joint Future website entry link below.

- **Joint Improvement Team website³**

The Joint Improvement Team (JIT) was established in late 2004 to work directly with local health and social care partnerships across Scotland. Its main focus is to provide practical support and additional capacity to partnerships, to help address the issues and challenges they face. The ultimate goal is to deliver better health and social care services to those who need them. The JIT supports service developments in key action areas by working with a small number of partnerships on specific projects and using the outcomes to support wider developments across the country. One of these action areas is governance for joint services, and the JIT has welcomed the opportunity to contribute its expertise and resources to the Short-Life Advice Note Working Group in compiling and finalising this guidance.

¹ <http://www.icn.csip.org.uk/index.cfm?pid=505>

² <http://www.scotland.gov.uk/Topics/Health/care/JointFuture>

³ <http://www.jitscotland.org.uk/action-areas/themes/governance.html>

Areas of Joint Governance (Checklist)

1. Partnership Governance

This defines the nature of the partnership and the legal, regulatory or other basis under which the partnership has been formulated. This clarifies if the partnership involves the transfer of functions or responsibilities under the 2002 Act and if it is a lead agency arrangement, joint or single management arrangement, etc. It also states specifically the powers under which the partners have entered into the agreement, including the general powers under core legislation, additional powers under the 2002 Act, Power of wellbeing, Community Planning, NHS (Reform) Scotland Act 2004 etc. The precise nature and type of services covered by the partnership would be defined including the range of staff and resources governed within the partnership.

Ref FAQ 1 & 2

2. Corporate Governance / Democratic Accountability

This includes joint governance standards & codes, guiding principles, decision-making processes, levels of authority, delegation, terms of reference and financial regulations. Such areas would generally be incorporated within each of the partners' Code of Corporate Governance (Standing Orders & Financial Regulations). Any joint partnership agreements should reflect precisely how these will be met and compliance achieved within the workings of the partnership. Partners should be able to demonstrate democratic accountability through the local authority partner and to comply with the Monitoring Officer / Proper Officer arrangements for each of the partners. Democratic accountability will be evidenced by appropriate representation within the partnership and effective reporting arrangements.

3. Financial Governance

This should be reflected within the partnership agreement or separately as a set of jointly agreed partnership standing financial instructions. The financial governance agreements would include: the resources to be invested by each partner; the budget setting process and parameters; definition of budgets which are pooled or aligned; reporting arrangements within the partnership and to the partner bodies; levels of virement within budgets and across the partners' budgets; how budget savings are dealt with; management of cost pressures; budget flexibilities; financial year-end procedures; accounting within partner agencies' accounts; and provisions for accounting support, costing for service developments/changes and for performance indicators, returns etc.

Ref FAQ 3&5

4. Clinical Governance / Quality

There are well established quality standards and clinical governance requirements that impact across the partnership services, which need to be

addressed. These include: identification of national and locally agreed standards; guidelines etc which impact on the services; jointly agreed quality improvement/continuous improvement objectives; arrangements for monitoring and securing these standards and improvement objectives; physical capacity and resources (including organisational design and development/modernisation (change and innovation); training/learning and development; use of national improvement agencies); dealing with joint and separate inspections and relationships with inspection agencies (expectations on how partnership will co-operate with, contribute to, or lead on these); internal improvement methodologies (i.e. best value, service redesign, PDSA - Plan, Do, Study, Act, Collaborative methodology etc.); and reporting arrangements, accountabilities and definitions.

Ref FAQ 3,4,6,7&8

5. Staff Governance

This area identifies the employment status of staff working within the partnership, the staff governance procedures to be followed and should detail how joint staffing and HR issues would be dealt with. It would need to address the core aspect of how staff governance and staff partnership would be managed and specify the nature of any joint staff forums and how these would operate. The key issue would be the application of the partner agencies' own core staff policies and procedures as they relate to the different employment arrangements for staff, the need for and nature of any arrangements to cover jointly appointed staff (including any salary scales and grades and how they relate to the core terms and conditions/ contracts of employment).

There will be a need to consider such key aspects as to how such matters as grievances, appeals, grading reviews, staff complaints, would be addressed within the partnership and the requirement for joint protocols. In particular, there may need to be a joint premises protocol where staff are co-located in shared premises or where staff may operate from a joint base from time to time or deliver certain services from a partner's premises.

Ref FAQ 9

6. Performance and Scrutiny

The partnership will require to demonstrate compliance with the Joint Performance Information and Assessment Framework (JPIAF), national outcomes, Local Improvement Targets and new joint performance reporting frameworks, including the need to jointly collate, report on and publish joint performance indicators and improvement targets. It may also need to satisfy the scrutiny and associated reporting arrangement for the host partners. Such arrangements, responsibilities and accountabilities should be clearly outlined within the partnership agreement.

Ref FAQ 4

7. Risk Management

The partners will need to agree the appropriate risk management procedures, processes and system to be used for risk management. The agreements should cover identification of high level risks (for the partnership – particularly those risks which are increased as a result of joint working), high level risk control plans, identification and recording of operational risks and reporting. Where possible, a senior officer within the partnership should have overall responsibility for co-ordination risk strategy and risk management across the joint services. This will also include emergency planning, business continuity and contingencies.

Ref FAQ 7

8. Patient Safety

More specifically a concern for the NHS partner, patient safety is nevertheless a core issue for the partnership and the agreement should cover how the patient safety agenda will be secured and delivered and will cover aspects such as managing and monitoring HAI (Hospital Acquired Infection), knowledge management around patient safety issues, standards applying to all staff in contact with patients, entering and exiting NHS premises, de-contamination of joint equipment etc. Also included may be the extension of such initiatives as cleanliness champions to non-NHS partner staff.

9. Health and Safety

Partnership arrangements will need to address the separate legal responsibilities and specific accountabilities of partner organisations and their Chief Officers, designated Health and Safety Lead Officers and H&S Advisors / Officers. This will require a management protocol detailing how the partnership will address H&S responsibilities, H&S standards, mandatory training, local joint H&S strategy and policies, HSE inspections etc.

10. Confidentiality / Caldicott / Data Protection etc

This will set out an internal partnership standard on confidentiality by reference to existing regulations and guidance covering the use and handling of sensitive data in accordance with local agreements on single shared assessment. It should include standards for sharing of information, underscored by Caldicott and Data Protection regulations and guidelines.

11. Freedom of Information/ Complaints/ Equality and Diversity etc

This element would define how freedom of information requests would be dealt with in the partnership and agree how information storage, archiving and retrieval would operate.

Similarly, joint protocols and procedures would be required to handle complaints, ensure that arrangements for involvement of citizens/patient/ public are complied with and to evidence how the standards and compliance across common requirements on equality and diversity are to be achieved.

Ref FAQ 6&8

12. Proper Officer / Monitoring Officer etc.

Partnerships may have to have regard to how these arrangements are governed within the partnership.

13. Patient/User and Carer Engagement

Partners will need to ensure that effective mechanisms are in place to engage with local communities and respond to patients, service users and carers as the key drivers for service improvements. In particular, it will be important for every Public Partnership Forum to have a fully developed working agreement with their CHP and for the CHP committee to ensure that any current or future national guidance or standards for public engagement underpin joint service planning and delivery.

Generic Role Specification for Community Health Partnership Committee Members

Summary: The member's role is to represent the views of their profession/sector/organisation/staff on how to improve health and services and to work corporately within the CHP Committee to contribute to the achievement of the CHP's aims and objectives. Members will be expected to consider primarily the work of the CHP, while mandated to represent the interests of their profession/sector/organisation/staff.

1. Role Of The CHP Committee

The Committee's main responsibilities will be to:

- plan for the development, delivery and redesign of services and health improvement, working as part of integrated health and social care systems;
- ensure that resources are directed to meet the needs of people in the CHP area as outlined in the CHP Plan;
- ensure that services are supported and delivered in a fair and equitable manner and achieve the objectives of the service;
- support clinical governance arrangements in accordance with the duty of care;
- ensure financial management of the delegated budgets to deliver on financial targets;
- ensure staff governance arrangements are in line with the Staff Governance standard;
- promote an integrated approach to involving staff, patients and the public in its work; and
- ensure that the benefits of effective partnership working are fully explored and developed with all partner agencies.

2. Remit Of The CHP Committee

Each CHP committee will engage with their local communities to improve health, deliver more integrated health and social care and tackle health inequalities. Clinicians, professionals and other disciplines involved in health and care will work together to deliver tangible benefits to their communities. This will be done in partnership with all parts of the NHS Board, Local Authority, Community Planning partners, and members of staff, the public, and the voluntary sector. The CHP Committee will also give consideration as to how it engages with the private sector.

3. Core Duties Of Each Member

Representation

Each member of the CHP Committee will be formally appointed by the NHS Board to:

- represent the views and perspectives of their profession/sector/organisation/ staff;
- work corporately within the Committee to support the agreed objectives of the CHP; and
- have robust communication channels with the profession/sector/organisation/ staff which it represents.

The role is therefore one requiring an important balance of representing one's own profession/sector/organisation perspective but maintaining the broad view of the full aims and objectives of the CHP. Agreement will be reached on any CHP group that members will be invited to be part of.

Organisational Development

CHPs will have a challenging agenda to align services for people at local level, and to work jointly to respond to the needs of the local community. Members are required to support the Organisational Development work of the CHP committee in helping to fulfil its role effectively and to reach its agreed goals and objectives.

Role of Non-NHS Representatives (Local Authority, Voluntary Sector, Public)

Representatives of non-NHS organisations will have a joint allegiance to the CHP and to their own organisation/sector. They will work within the decision making frameworks of the organisations/sectors to which they belong, as well as complying with the governance framework within which the CHP operates.

The role of non-NHS representatives on the CHP, i.e. Local Authorities, (whether elected members or officers of the Council), voluntary sector, or the public, is to:

- bring their expertise and knowledge of the local community;
- represent the views of their organisation (where applicable), and if necessary, point out where the proposals of the CHP conflict with those of their organisation/sector; and
- help influence and shape the development of the CHP.

Public Partnership Forum (PPF) Representation

While being part of the CHP decision making process, this must not compromise the voice of the members of the PPF. For example, where the CHP or the NHS Board considers all the facts and then makes a decision which does not reflect the views of the PPF, then the PPF will be able to make their views known on this. In this situation the CHP, working through the PPF members of the CHP

committee, should ensure that the reasons why such decisions were taken are shared openly.

Role of Independent Contractor Representatives

The principles to which the representatives of the independent contractors are similar to those of non-NHS organisations. They are there to:

- bring their expertise and knowledge of the local community;
- represent the views of all branches of their profession; and
- help influence and shape the development of the CHP.

4. Core Competencies And Qualities

- Enthusiasm and commitment.
- Knowledge of the local community.
- Recognised as a leader from the organisation, sector or profession which they represent.
- Communication skills.
- Critical evaluation skills.
- The ability to encourage the commitment and ownership of the direction of travel described by the CHP from colleagues within the profession/sector that they represent.

5. Governance and Accountability

A fine balance needs to be struck to provide a confidence and accountability that each CHP will also be able to demonstrate that it is consistently applying national and local health strategy and policy for the equal benefit of all communities and individuals and is able to meet the corporate, financial, clinical and staff governance standards laid down.

Key accountability relationships are as follows:

- As a Committee of the NHS Board, the CHP Committee is accountable to the Board in discharging its functions.
- The CHP chair is accountable to the chair of the NHS Board.
- The CHP General Manager is accountable to the Chief Executive of the NHS Board.
- The CHP Lead Clinician is accountable operationally to the CHP General Manager and will have a professional line of accountability to the relevant NHS Board Director. This will be clarified as the role of the Lead Clinician and clinical leadership arrangements are developed further.
- Each member will work within the governance framework with the Code of Corporate Governance, Code of Conduct, and Local Scheme of Delegation. They must acknowledge the joint decision making forums which have the remit to take forward joint future issues.
- Members of non-NHS organisations must also work within the governance and decision making frameworks of their own organisations.

Community Health and Care Partnerships: Integrated Management and Governance Arrangements Extract (Relates to FAQ no 4)

Line Management Arrangements

1. The nature of integrated services requires individuals to be able and willing to work flexibly. The management proposals for CHCP Services will include some staff being operationally managed by a manager from a different employer. This will generally involve agreeing work objectives and day-to-day management tasks such as the implementation of service standards, allocation of work, authorisation of leave and expenses.
2. In doing this operational managers will be responsible for seeking advice from the appropriate professional leads on issues such as risk management, clarifying staff competency and autonomy levels, and Continuing Professional Development/Knowledge and Skills Framework and professional registration matters. Where formal-stage absence management and conduct issues arise, they will be dealt with through a manager within the CHCP from the parent organisation and according to agreed conditions of service within that organisation.
3. Operational management tasks will include agreeing annual work objectives and personal development plans. This will be supported by regular supervision / update meetings between the manager and staff member and will also include implementation of any formal performance review process.
4. Operational management tasks will include handling early informal stage absence and conduct issues. In doing this operational managers will be responsible for seeking advice from their designated NHS HR Adviser or Social Work Services Personnel Officer. In addition, training and guidance will be provided to managers on the early stage informal practices and policies of each agency.
5. Examples of early / informal stage issues are doing return to work interviews following absence; raising staff welfare concerns with an employee; listening to employee concerns or complaints about operational / team issues and where possible resolving these to prevent formal grievance procedure; being the person to whom incidents are reported in the first instance; seeking advice from HR / Personnel where a member of staff may need to be suspended; conduct and document initial fact-finding where an incident or complaint may require a formal investigation; provide witness statements to formal discipline or grievance processes; and appear at formal discipline or grievance hearings for questioning or to present such statements.
6. The roles, relationships and responsibilities of staff, operational managers, and HR/Personnel staff need to be clear for the above arrangements to work fairly, consistently and effectively. Initial guidance is as follows:

6.1 Working relationship between staff member and line manager

The management/employee relationship is founded on mutual trust. The building blocks of this trust are an understanding and fulfilling of respective responsibilities and expectations.

- **Responsibilities**

- **Staff member**

Staff are responsible to the line manager for carrying out their role as per agreed work objectives and contract of employment; for appropriate reporting of concerns and incidents; for reporting sickness absence; for complying with team protocols and organisational policies and procedures; and for enacting his/her own learning and personal and professional development.

- **Line Manager**

The line manager is responsible to staff for listening to and acting appropriately on any concerns or incidents reported by staff; for providing safe and suitable facilities and equipment to enable staff to fulfil their roles; for ensuring team cohesion, good communication and local operational protocols, including standards and quality; and to facilitate the smooth running of the team.

- **Expectations**

- **Staff**

Staff have the expectation of a fair and open relationship with their line manager. This includes being given the scope to deliver the role according to their competency and professional autonomy levels; receiving constructive and timeous feedback on performance; having an agreed personal /professional development plan; having expenses and annual leave / TOIL / flexi requests processed timeously; and the right to time off for personal emergencies in accordance with the parent organisation's procedures.

- **Line Manager**

The manager has the expectation that staff will carry out the agreed role with the appropriate level of supervision; will cooperate and communicate openly with other team members; honour team protocols and local agreements; report sickness absence in accordance with employing agency policy and procedure; and make timeous requests for annual leave / TOIL / flexitime.

6.2 Working relationship between line manager and HR / Personnel Function

The line manager and designated HR Adviser / Personnel Officer need to build and maintain a positive working relationship based on mutual trust and a clear understanding of each others' responsibilities with clear channels of communication being agreed at the outset.

- **HR / Personnel Function**

HR / Personnel staff are responsible for advising line managers in two main areas:

- on policy and procedural issues relating to payroll processing, procedures for authorizing leave, flexi, TOIL, and ensuring the line manager is informed of any changes to these. Responsibilities also include advising line managers on personnel policy and terms and conditions such as overtime payments, special leave, sickness absence, and processing referrals to the employing agency's occupational health service, and maternity leave requests.
- on handling of conduct, capability and employee complaints (i.e. grievance and harassment). It is essential that any formal handling of the above should be dealt with by the parent organization, and HR / Personnel staff would have the responsibility for coordinating this. However, it is equally important that line managers are appropriately advised on the handling of such issues at the early / informal stage.

- **Line Manager**

The line manager is responsible for seeking advice from HR / Personnel at the appropriate stage - this would be immediately, for any conduct, capability or employee complaints issues.

6.3 Working relationship between line manager and professional

Professional leads and line managers need to build and maintain a positive working relationship based on mutual trust and respect. Regular communication, ideally via face-to-face meetings is recommended.

- **Professional Leads**

The role of the professional leads is to advise and inform line managers in making and implementing decisions which may impact on the role of staff members, to advise on risk management issues, to clarify levels of professional autonomy, standards and quality in general and staff member competencies specifically. Also to advise on CPD and registration, and any changes to policy and legislation which may impact on professional practice.

- **Line Managers**

Line managers are responsible for seeking this advice before making any decisions that may have a significant impact on staff roles, to keep professional leads informed of the progress of the work and service objectives of the team, and any future developments under consideration.

A commitment to work together to resolve areas of disagreement between line managers and professional leads is crucial to ensure clarity of staff roles and professional practice. Where a line manager and professional lead require further advice or a final decision, this will rest with the CHCP Director who will seek advice from the appropriate corporate professional lead of the parent organisation. This is notwithstanding the staff member's right to pursue the formal grievance policy of their employing organization.

Risk Management and Risk Control for the Governance of Joint Services (links to FAQ no 7)

Context

1. Effective joint working arrangements have the potential to produce substantial benefits for users, carers and organisations by reducing duplication, increasing flexibility and making best use of shared resources for the benefit of end users. However, it is recognised that close arrangements for working together also bring with them potential risks which need to be identified and effectively managed, especially in the areas of financial management, performance management, staffing and governance arrangements.
2. It is therefore important that partnerships have clear arrangements in place for them to identify risks, put in place controls and agree contingency arrangements to manage these risks. In this way Councils, Health Boards and their stakeholders can be reassured that joint arrangements will be managed effectively. Within each organisation in the partnership, risk management arrangements will be in place and it is important for each partner to own the joint risk register and ensure appropriate action is taken to manage risk in partnership.
3. It should be noted that there are a number of different forms of risk which need to be considered and the NHS has developed clinical governance frameworks to manage this. Financial risk is also a key consideration as well as risks relating to joint working and social care issues.
4. It is therefore recommended that each partnership produces a risk register which is routinely monitored and regularly updated. Each risk should be delegated to identified officers to manage. This will help ensure that risks are managed. Attached to this document is an example of a template for completion with worked examples. This can of course be used and adapted by local partnerships if that is useful or partnerships may be able to draw on existing practices.

Principles of Risk Management and Risk Control

5. Effective risk management processes are important to ensure that any risks that are a potential threat to the desired objective of any system or programme are effectively managed. An effective risk management system is an integral part of good governance and should be a key part of any partnership's internal control environment. The role of internal audit is also important in this process. This therefore gives an assurance to any governance body that risks are managed. Partnerships must ensure that an effective risk management system is in operation which provides a planned and systematic approach to identifying, evaluating and responding to risks and providing assurance that responses are effective.
6. Effective risk management systems are important because they can:
 - support the partnership's governance responsibilities;

- improve results through more informed decision-making;
- strengthen accountability;
- enhance stewardship; and
- lead to shared responsibility for managing risk.

Completing a Risk Control Plan

7. The papers attached should be considered in the context of a risk assurance framework which includes:

Key Stages

a) Identify the key objectives for the partnership. These should include objectives for financial management, service redesign and key performance targets.

b) Identify the key risks for the partnership associated with each principal objective and highest risks. This would be best done as a strategic partnership group so all views can be taken into account.

c) Prioritise each risk based on a combination of impact of the risk were it to materialise and the likelihood of the risk occurring.

c) Identify the risk owner this is the person who will ensure that the risk is dealt with and managed and who will report back on progress.

d) Identify any existing controls in place and where needed agree additional actions that will ensure the risk is minimised.

e) Agree review timescale for the risk to be formally reviewed – an annual review for the whole plan is recommended but high-risk actions may need more regular discussion. Exception reporting may be a useful way of monitoring this at strategic board level.

f) Risk Assurance is the degree to which the risk is being managed and the actions implemented. A traffic light system can be used which uses the following code:

Red – High risk – no action being taken but monitoring may be in place

Amber – Some action being taken and some control of risk in place

Green – Risk controlled and actions in place

g) Formal mechanisms need to be established to highlight areas of significant concern to the partnership, to each partner's governing body (e.g. Health Board, appropriate Council Committee).

PARTNERSHIP RISK CONTROL PLAN

Overleaf are 3 examples of a format which may be helpful to complete when considering the key risks in your Partnership area.

The following issues may be helpful for you to consider as key risk areas of partnership working

- Financial Pressures/Joint Resourcing
- Monitoring and Evaluating outcomes for Care
- Information Sharing/SSA
- Managing high risk cases
- Health and safety/staff issues
- Performance Management – meeting targets – JPIAF
- Improving Quality of Services
- Joint Planning/Service Redesign

Annex 5

Risk Assessment Form

Organisation/Department/Function/Project: **Any Partnership – worked examples**

Objective **Working in partnership to increase wellbeing and reduce inequalities across all communities**

Business Process

Completed by: _____ Date Completed: _____

Risk (Threat to achievement of business objective)	Assessment of Risk (Assume CURRENT controls in place)			Risk Control Measures	Assigned To	Target Date (Priority)	Assessment of Residual Risk (With controls in place)		
	Impact (Severity)	Likelihood (Probability)	Risk Rating				Impact (Severity)	Likelihood (Probability)	Residual Risk Rating
1. Risk of financial overspend in any partner (or both)	High	Possible	High	<ul style="list-style-type: none"> Effective mechanisms in place to control budgets by all partners and by the partnership Regular reporting of financial position to partnerships board/committee If concerns arise clear remedial actions are taken at an early stage agreed by all partners 	Chief officer NHS/ LA or joint post	Ongoing	High	Possible	Medium

Annex 5

Risk Assessment Form

Organisation/Department/Function/Project: **Any Partnership – worked examples**

Objective **Working in partnership to increase wellbeing and reduce inequalities across all communities**

Business Process Information Sharing

Completed by: _____ Date Completed: _____

Risk (Threat to achievement of business objective)	Assessment of Risk (Assume CURRENT controls in place)			Risk Control Measures	Assigned To	Target Date (Priority)	Assessment of Residual Risk (With controls in place)		
	Impact (Severity)	Likelihood (Probability)	Risk Rating				Impact (Severity)	Likelihood (Probability)	Residual Risk Rating
2. Failure to comply with data protection requirements for information sharing	Medium	Possible	Medium	<ul style="list-style-type: none"> Partnership to ensure effective agreed protocols and systems are in place for information sharing checked by the legal department All relevant staff are fully trained in the protocol Regular audits of policy and procedures to be undertaken and remedial action taken if required. 	Community Care/IT Manager	March 06 October 06	Medium	Possible	Low

Annex 5

Risk Assessment Form

Organisation/Department/Function/Project: **Any Partnership – worked examples**

Objective **Working in partnership to increase wellbeing and reduce inequalities across all communities**

Business Process

Completed by: _____ Date Completed: _____

Risk (Threat to achievement of business objective)	Assessment of Risk (Assume CURRENT controls in place)			Risk Control Measures	Assigned To	Target Date (Priority)	Assessment of Residual Risk (With controls in place)		
	Impact (Severity)	Likelihood (Probability)	Risk Rating				Impact (Severity)	Likelihood (Probability)	Residual Risk Rating
3. Failure to meet partnerships joint performance targets	High	Possible	High	<ul style="list-style-type: none"> Ensure accurate baseline data is available and appropriate data collected Regular reporting of each agreed target to partnerships board/committee and each governing body Ongoing monitoring. If target is slipping agree partnership action to address issues and implement 	Head of Performance Management	March 07 3 monthly	Medium	Possible	Medium

SELF ASSESSMENT REVIEW OF LOCAL JOINT RISK MANAGEMENT

ARRANGEMENTS

This short 8-question self-assessment is a tool to help identify future developmental and support priorities for risk management in your partnership area and can be used by senior management groups or staff in joint services.

Using information readily available in the normal course of work, use each indicator in Table A to identify broad strengths and weaknesses and come to a professional judgement on the performance level achieved locally:

- ** Very Good - Evidenced widespread good practice within a highly robust system
- * Good - Reasonably effective systems in place, with good practice being evidenced on a relatively widespread basis
- ❖ Weak - Practice is generally ineffective and such good practice as does exist is neither particularly widespread nor systematic
- ♦ Not satisfactory - Little or no evidence of good practice or simply don't know state of current practice

To help identify which of these levels your area best fits, table B provides illustrations for 'Very Good' and 'Weak'. If your practice has several of the features of very good and some weaknesses, performance is likely to be 'good'.

This is to be expected and should not be a source of disappointment but rather a means of identifying future developmental and support priorities for risk management in your area of responsibility.

To achieve greater understanding and share best practice, take a closer look at aspects of your service considered particularly good or particularly weak from the point of view of:

- Leadership and direction
- Operational management and implementation of key processes
- Availability of necessary competency, resources and support

The important outcome from self-assessment is the identification of strengths and areas for development because attention to these will help your partnership of joint service improve.

Table A: Self-assessment Indicators					
Department or Service: Partnership Area:	** Very Good	* Good	❖ Weak	◆ Not satisfactory	Summary of key local strengths, weaknesses and support needs:
1. Committees(s) or defined individual(s) actively lead the risk management agenda.					
2. Suitably competent people follow a systematic programme of ongoing risk assessment.					
3. A Risk Control Plan is maintained and used to prioritise action and provide assurance.					
4. Adverse events and near misses are recorded, investigated as necessary and analysed accordingly with lessons implemented and shared.					
5. Staff have the competencies necessary to manage key risks allied with their job.					
6. Risk management is embedded into key business processes.					
7. Formal action plans are implemented to address identified key risk concerns.					
8. Progress with risk management is considered during performance review.					

The following three risks are the most significant threatening the objectives of my area:

	Risk	Level of Risk
1.		
2.		
3.		

Table B: Illustrations			
		** 'Very Good'	❖'Weak'
1.	Committees(s) or defined individual(s) actively lead the risk management agenda.	Local managers can draw on the support of a group with formal terms of reference reporting to the management team. It meets regularly, works in partnership, involves patients and co-operates and co-ordinates with other agencies to set clear local risk objectives and priorities, monitor implementation, provide support, approve local policy and drive the achievement of best standards across the full range of OH&S, patient safety and other key risk areas.	A group of enthusiastic volunteers meet intermittently to discuss risk issues that have recently arisen. The Risk Management Strategy does not guide their activities. Patient safety is not discussed. Without a clear agreed agenda and management authority, most staff are unaware of its existence or role. Managers are unclear where to escalate risk and are doubtful of obtaining support or guidance for pressing local issues.
2.	Suitably competent people follow a systematic programme of ongoing risk assessment.	Skilled staff, with relevant training, have time planned to facilitate local assessment against a prioritised list of topics using the NHSG universal criterion. RMSU risk templates & checklists reduce effort and OR & complaints data is reviewed. Potential sources of harm, local system weaknesses and threats to objectives are thoroughly assessed even when intangible, involve other agencies and are out with premises. Controls are proportionate to risk. A range of control options is evaluated according to the hierarchy of control and responsibility for action is allocated to those best able to implement. Assessments are reviewed annually or when circumstances change.	Those conducting assessments may not have had any formal training. Risk assessments of limited quality are periodically drafted on an ad-hoc basis for no other purpose than to support specific bids for resource. Investment in control is unlikely to be proportionate to the risk identified. Other control options are not considered. No one is defined as responsible for implementation and review of the assessment probably won't occur. Key and obvious risks remain unassessed. Most staff are unaware of those risks that have been identified. Responsibility for action remains at a local level irrespective of their ability to manage. Assessments are not shared.

Annex 5

3.	A Risk Control Plan is maintained and used to prioritise action and provide assurance.	Validated risk assessments are summarised in a spreadsheet. Confidence is high that these accurately reflect the full risk profile of the area given widespread involvement of staff. All risk controls and contingency plans considered necessary to reduce risk and improve resilience are implemented (or in the process of being) and for significant risk there is evidence of this. Monitoring ensures additional controls are implemented as planned. The database is used to inform service development and investment priorities.	A list of risk assessments is collated at the end of each year to satisfy regulatory requirements. It is unlikely to be representative of the risk profile and plays little role in influencing priorities or objectives. It is not used to assist ongoing management of the service. Many required controls will not be in place and little monitoring of their introduction occurs. For significant risk, little evidence is available that controls are in place and effective. Few are aware of the existence of the RCP.
4.	Adverse events and near misses are recorded, investigated as necessary and analysed accordingly with lessons implemented and shared.	Staff freely report adverse events and near misses recognising that this leads to system improvements. Trends are analysed regularly and any investigations focused on identifying underlying causes. Lessons from national and local events used to improve practice. A rigorous Risk Notice distribution and action system is in place, with relevant feedback to a single point for review.	Only serious adverse events are recorded for various reasons. Few near misses are recorded. Little local review of data occurs and investigations conducted mainly identify fallibility in people rather than opportunities to improve systems. Lessons are not shared out with the area and little occurs to ensure that lessons are implemented.
5.	Staff have the competencies necessary to manage key risks allied with their job.	A Training Needs Analysis (via risk assessment & understanding of policy and statutory requirements) has helped identify the range of competencies required to control risk in each area. Having documented existing competencies, managers and staff developed a prioritised action plan to address any gaps found and incorporated this into individual KSF (Knowledge and Skills Framework) plans. Learning plans and records of training are regularly reviewed for progress against set competency targets with findings incorporated into the performance cycle. A systematic approach to refresher training where appropriate is in place and working.	Staff attend a variety of risk related training programmes, often as a result of an incident, on an ad-hoc rather than planned and prioritised basis. Management have not documented the range of competencies necessary for their area and are unaware whether these are in place. Attendance at refresher training is not seen as a service priority and there are no other mechanisms in place for keeping staff up to date. Record keeping is poor and with few prioritised training plans, progress is not monitored.

Annex 5

6.	Risk management is embedded into key business processes.	<p>Healthcare risk is seen as inevitable and its management an important integral component of day-to-day patient care, strategic planning and decision-making.</p> <p>Patient and staff safety, the analysis of other prevailing and future risks and their controls & contingency plans are seen as core principles underpinning objective setting & prioritisation, the health plan, service development plans, training plans, workforce plans, resource allocation and performance management at a local and corporate level.</p>	<p>Risk management is seen and implemented as a 'necessary evil' bolt on extra, disconnected from other aspects of health service business.</p> <p>Superficial or token reference is made to risk management during planning, decision making and performance review.</p> <p>Management and governance papers seldom have any risk analysis drawn from the Risk Control Plan, and where they do, this is not incorporated into the RCP.</p>
7.	Formal action plans are implemented to address identified key risk concerns.	<p>Manageable plans led by named individuals have been established in priority order from the local and corporate information collected on incidents & near misses, risk assessments, complaints and claims. The action plans include the redesign of systems & processes and adaptations to staff training and practice. Impact is measured as part of performance improvement activity. (e.g. HAI, violence, musculoskeletal disorder, medication safety, slips & falls, hazardous substances, patient identification etc)</p>	<p>Some but not all key risk areas have been identified and tend to be reactive in response to a serious incident. There is limited involvement of staff in drawing up action plans, which means there is little ownership and action plans are not progressed.</p> <p>Any plans that do exist are not based on an evaluation and understanding of local priorities.</p>
8.	Progress with risk management is considered during performance review.	<p>Indicators reflecting the local programme of risk management have been agreed and progress against them regularly reviewed. These often include safety of services, effectiveness of risk management arrangements, progress with risk assessment or training, implementation of risk notices as well as specifics from the local risk management plan. The information leads to the generation of further action planning in line with the performance review cycle and progress reports are generated accordingly. Progress or lack of progress is fed back to the services and modifications made as necessary.</p>	<p>There is limited consideration other than discussion of corporate items that may have limited local significance. Neither the usefulness of the initiatives nor their relevance to a prioritised action plan has been considered. Significant quantitative indicators and trends around training, incidents and ill health are excluded. Line managers performing well in risk management are not rewarded to the same extent as performance in other areas. Similarly, poor progress generates little response.</p>

Governance for Joint Services Short Life Advice Note Working Group

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