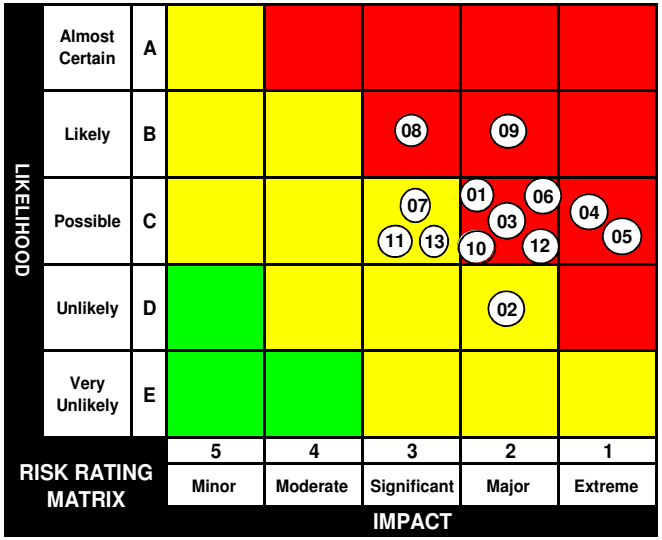
Strategic Risk Assurance Report 2018-19



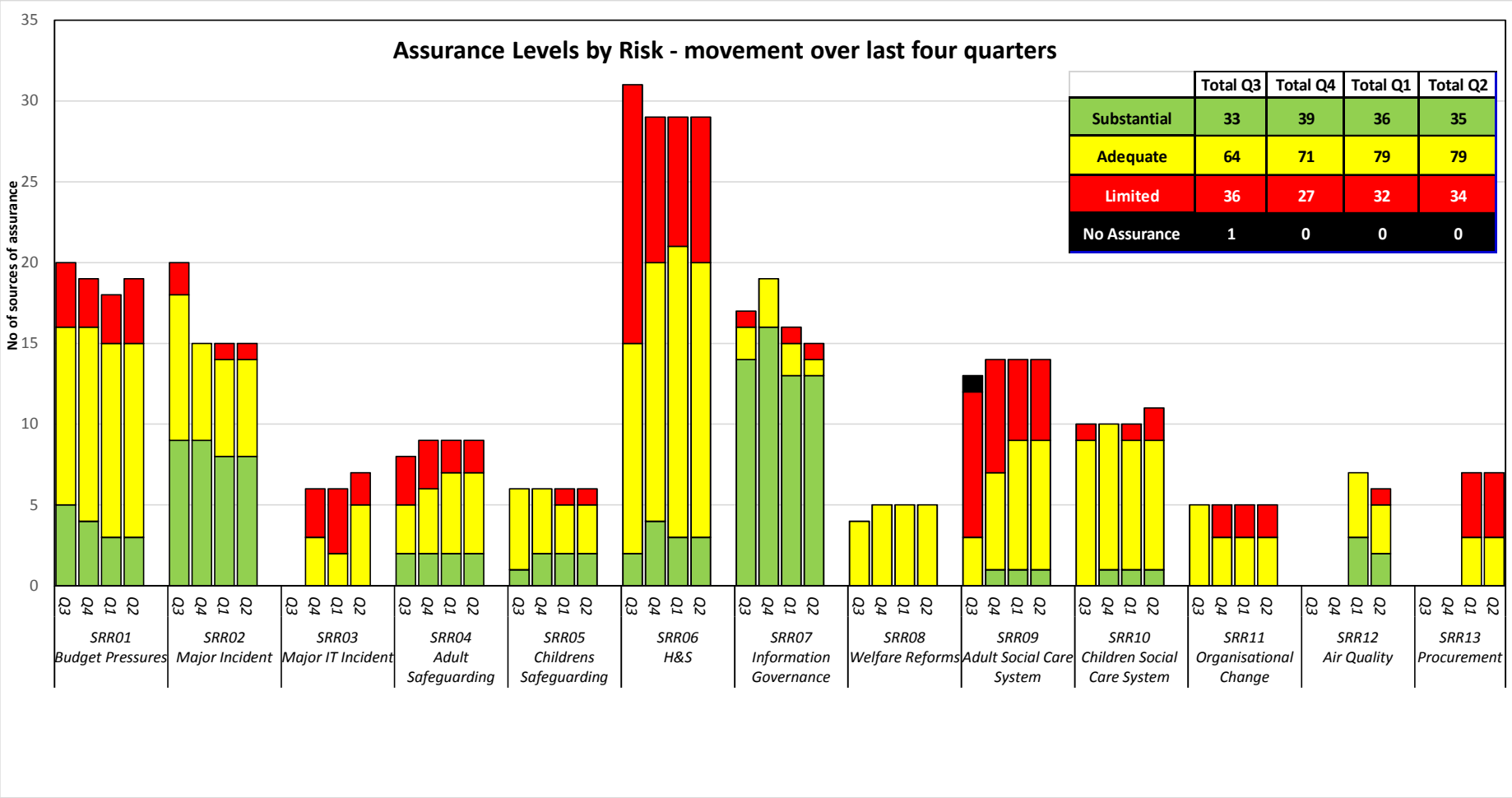
Report Version
11

Report Date
Oct-18

Period
Q2: 18-19

SOUTHAMPTON CITY COUNCIL

No	Strategic Risk - Description	Quarterly movement 2017-18 Q3	2017-18 Q4	2018-19 Q1	2018-19 Q2
01	Failure to address the significant and ongoing financial pressures in a sustainable way and to enable service provision to reflect key strategic outcomes and be aligned with the associated budget envelopes.	⇔	⇔	⇔	⇔
02	Major incident or service disruption (including serious health protection threats) leading to delivery failure that significantly impairs or prevents the Council's ability to deliver key services and/or statutory functions	⇔	⇔	⇔	⇔
03	Major IT incident or service disruption leading to delivery failure that significantly impairs or prevents the Council's ability to deliver key services and/or statutory functions	-	⇔	⇔	⇔
04	Failure to safeguard vulnerable adults resulting in a preventable incident	⇔	⇔	⇔	⇔
05	Failure to safeguard children resulting in a preventable incident	⇔	⇔	⇔	⇔
06	Failure to meet our health and safety responsibilities	↑	⇔	⇔	⇔
07	Failure to ensure the City Council's information is held and protected in line with Information Governance polices and procedures	⇔	⇔	⇔	⇔
08	The council is unable to respond appropriately or sufficient quickly to significant changes in service demand arising from changes in the welfare system	⇔	⇔	⇔	⇔
09	Failure to ensure an effective and sustainable adult social care system	⇔	⇔	⇔	⇔
10	Failure to ensure an effective and sustainable children's social care system	⇔	↓	⇔	⇔
11	The impact of organisational change and service redesign solutions, whilst delivering savings, create other unplanned for pressures and challenges	⇔	⇔	⇔	⇔
12	Failure to improve air quality to legal levels by 2020	-	NEW	⇔	⇔
13	Service areas fail to adhere to and comply on a consistent basis with with the council's 'Contract Procedure Rules'	-	-	NEW	⇔



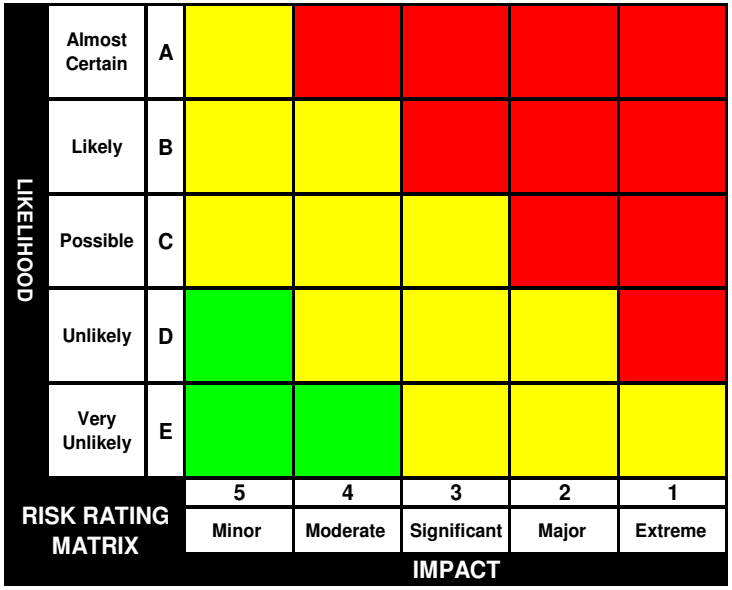
	Total Q3	Total Q4	Total Q1	Total Q2
Substantial	33	39	36	35
Adequate	64	71	79	79
Limited	36	27	32	34
No Assurance	1	0	0	0

NOTES:

SRR12 New risk added in Q4 - 17-18

SRR13 New risk added Q1 - 18-19

Risk Scoring and assessment criteria



LIKELIHOOD (Probability)	
A - Almost Certain > 95%	Highly likely to occur
B - Likely	Will probably occur
C - Possible 50%	Might occur
D - Unlikely	Could occur but unlikely
E - Very Unlikely < 5%	May only occur in exceptional circumstances

IMPACT (Consequence)			
	Service delivery (key outcomes/ priorities)	**Financial**	**Reputation**
1 - Extreme	Unable to deliver most key strategic outcomes or priorities / statutory duties not delivered	Loss or loss of income >£10m	Public Inquiry or adverse national media attention
2 - Major	Severe service disruption on a services level with many key strategic outcomes or priorities delayed or not delivered	Loss or loss of income £5m - £9.99m	Intense public, and media scrutiny
3 - Significant	Regular disruption to one or more services/ a number of key strategic outcomes or priorities would be delayed or not delivered	Loss or loss of income £500k - £4.99m	Local media interest. Scrutiny by external committee or body
4 - Moderate	Some temporary disruption to a single service area/ delay in delivery of one of the council's key strategic outcomes or priorities	Loss or loss of income £10k - £499k	Internal scrutiny required to prevent escalation
5 - Minor	No noticeable effect	Loss or loss of income < £10k	Internal review

RISK No: SRR01	Last updated: 11/10/2018

RISK DESCRIPTION
Failure to address the significant and ongoing financial pressures in a sustainable way and to enable service provision to reflect key strategic outcomes and be aligned with the associated budget envelopes.

RISK OWNER	Council Management Team
PORTFOLIO(S)	Finance and Customer Experience

OUTCOME	A sustainable council

RISK SCORE	LIKELIHOOD	IMPACT
CURRENT	C - Possible	2 - Major
Target	D - Unlikely	2 - Major

		2017-18		2018-19		
EXPECTED KEY CONTROLS	SOURCE(S) OF ASSURANCE	Q3	Q4	Q1	Q2	MITIGATING ACTIONS / COMMENTS
		ASSURANCE LEVEL				
1. Assessment of the council's overall short, medium and longer term financial position	a • 'Medium Term Financial Strategy ('MTFS') 2018/19 - 2021/22 is in place and was last approved by Cabinet and Full Council in February 2018. • The 'financial model' is subject to quarterly update and review.	1	1	1	1	*• Any in-year changes reported as part of quarterly corporate monitoring to Cabinet* *• The MTFS model has been reviewed as part of the October 2018 Budget Report and will be further updated in Feb 2019.*
2. Service budgets are profiled and aligned with agreed Council outcomes	b • Budgets are aligned with council agreed outcomes and priorities (Outcome Based Budgeting) which form a key part of the budget process. • The new operating model is explicitly aligned with Council's agreed outcomes which, in turn, reflects essential and priority services.	2	2	2	2	*• Outcome Based Plans are being further refined to ensure that they are explicitly aligned with both key priorities and outcome plans and are aligned with the administration manifesto* *• All services have completed the business academy process to help develop service business plans aligned to Outcomes and this information has fed into the budget process for 2019/20 and future years.*
3. Identification and communication of significant in year budget variances and forthcoming pressures, and identify clear actions	c • Monitoring of capital (monthly) and revenue (monthly) budgets, reported to Council Management Team (monthly) and Cabinet (Quarterly). • 'Financial Scorecards' for CMT, each Service Director and Portfolio Summary. • Capital reported to the Capital Board and CMT on a monthly basis.	1	1	1	1	*• The Financial Scorecards are now well established and are subject to ongoing review to ensure that they continue to provide relevant management information to assist in the explanation of variances and help to encourage evidence based forecasts.* *• Action plans are put in place along with mitigations. Ongoing impacts are reported as part of the budget setting process.*

	d	• Action plans to address significant in year budget variances are progressed via Intensive Support Meetings and Improvement Boards and are overseen by the Deputy Chief Executive. • The monitoring and review of significant budget variances is undertaken via the 'scorecards' which include whether an action plan to address the variance is in place and/or necessary.	2	2	2	2	• *Intensive Support Meetings, which provide a more supportive environment with greater focus on what actions are required and the impact of these actions, are now being held. The meetings are overseen by the Deputy Chief Executive.* • *Where more appropriate, services have improvement boards overseen by the relevant Service Director.*
	e	• Delivery of agreed in year budget savings reported to CMT on a monthly basis via a 'Savings Tracker'. The savings tracker is an integral part of the scorecards and incorporates a RAG status. • These are also reported as part of the Corporate Revenue Monitoring Report to Cabinet on a quarterly basis.	2	2	2	2	
4. Identification and delivery of new savings/income opportunities	f	• Process in place for all savings proposals to be captured and assessed at the earliest opportunity. • In year 'business as usual' savings are identified by service areas and are a part of the output from the new business planning process	1	1	2	2	• *Savings plans in place and, where agreed, with appropriate monitoring arrangements in place.* • *Additional savings plans have been identified to deal with in year pressures. Any residual pressures have been identified and fed into the budget setting process.*
	g	• A review of the deliverable budget savings for 2018-19 has been undertaken. Any pressures, offset by mitigations identified, have been built into the MTFS position reported to Cabinet in October 2018.	3	2	2	2	• *As part of budget setting for 2018/19 pressures from non achieved savings are being addressed and more robust challenge in place to ensure that remaining savings targets are achievable.*
	h	• 2019-20 plan in place to deliver £6.95m of savings	3	3	3	2	•*The Business Academy process has identified further savings opportunities / scope for income generation activities. This has been fed into the budget setting process along with other mitigations that have closed the budget gap for 2019/20*
	i	• Savings plans for 2020-21 (£14.10m savings) to be ramped up in terms of development.	3	3	3	3	• *Savings proposals have been put forward that ramp up in 2020/21 and future years but there is a residual gap of £4.60M to be closed.*

	j	• Savings plans for 2021-22 (£10.94m savings) to be ramped up in terms of development.	-	NEW 3	3	3	• *Savings proposals have been put forward that ramp up in 2020/21 and future years but there is a residual gap of £3.95M to be closed.*
	k	• Savings plans for 2022-23 (£10.94m savings) to be ramped up in terms of development.	-	-	-	NEW 3	• *Savings proposals have been put forward that ramp up in 2020/21 and future years but there is a residual gap of £4.71M to be closed.*
5. Assessment of those services where increase in demand is anticipated together with identification of key risk indicators.	l	• The development of outcome based budgets focuses on initiatives and changes to the services in order to reduce demand.	2	2	2	2	• *Further work has been undertaken to fully review outcome and business plans. This has fed into the October budget report and update of the MTFS.*
6. Opportunities for additional viable and sustainable income generating activities are identified and implemented. Service charges and fees for income generating activities are set at the appropriate level and payments are collected. Payments to suppliers and other external third parties are made on time and avoid additional interest payments or charges	m	• Approach to commercialisation agreed by the Strategy and Commissioning Board. • Several services have been taken through the 'Business Academy' process which enables the service to articulate their service and work towards robust business plans.	2	2	2	2	• *Following the success of the Commercial Business Academy, the key principles of the academy have been applied to the business planning process for all services.*
	n	• There is a robust invoicing and income collection process in place.	1	1	1	2	• *Income collection £42.03M against annual target of £130M* • *Debt more than 12 months old 14.36% (against target of less than 20%).* • *0.14% written off against target of less than 5%.* *NOTE: The foregoing relates to the invoices that are raised via Agresso (43% of total) and does not take account of services invoicing through other systems. This has been taken into account for this quarter.*
	o	• Payments stats / information on overdue invoices issued by Accounts Payable and Client Monies Team to CMT through the MOP.	2	2	2	2	• *% of invoices paid within terms Q2 : 96.44%, (Q1 90.63%).* • *Average payment days: 19*

7. Dedicated, suitably experienced and sufficient resource to lead, support, facilitate and oversee ongoing change related programmes and projects	p	• Programme Management Office (PMO) is responsible for managing major strategic change projects and programmes across the council.	**2**	**2**	**2**	**2**	*• Permanent establishment of staff now complete* *• A number of fixed term contractors appointed to support specific projects and ensure that capacity and spread of skills is met.*
8. Progress and delivery of both the overall Programme and individual change projects regularly reported to a senior manager/member board with slippage or variances clearly identified and associated action plans to address.	q	• Progress and delivery of the overall programme and individual projects is in the first instance monitored via the Programme Boards and the relevant Cabinet Member. • Initiatives that are likely to call upon investment funding requirements are also subject to scrutiny at Capital Board.	**2**	**2**	**2**	**2**	*• Standardised governance, reporting and processes have been developed and are being rolled out.* *• CMT programme Board now has oversight of key projects.* *• CMT reporting process agreed.*
9. Identification and assessment of high priority and other projects that are anticipated to deliver significant cashable benefit	r	• Opportunities for savings form an integral part of the new business planning and budget setting processes. • Project prioritisation and review exercises undertaken periodically.	**1**	**2**	**2**	**2**	*• Project prioritisation exercise concluded in Q1 which has informed decisions on prioritisation and scheduling.* *• CMT Programme Board will review projects and priorities (including the addition, delay or stopping) on a 2 monthly basis.*
10. Understanding of future staffing levels and required attributes and skill set which is then reflected in individual staff development and organisational workforce planning arrangements	s	• Revised Performance Management Framework agreed which is intended to ensure that all staff are working to deliver the Council Strategy and other key strategies which are then translated into outcome plans, service based business plans and individual and/or team objectives. • Workforce Strategy and Plan, approved by Full Council in 2016, that seeks to address issues around the need for more a formal, robust and consistent approach to succession planning, for key posts and/or a spread of skills to avoid over reliance on any particular individual.	**2**	**2**	**2**	**2**	*• A streamlined APR framework is in place following feedback from staff in 2017; this includes "golden thread" links to council outcomes and behaviours. Revised paperwork for 2018/19 this simplified appraisal conversations.* *• The Workforce Strategy is implemented through a comprehensive HR and OD work plan with governance through the HR and OD Board.* *•The Org Design Board established confirmed principles for future change and this are being applied for all restructures and supported by HR Advisory service.* *• Workforce plan data collection now in place to help inform planning; apprentice programme in place.*

1 - Substantial assurance	**2 - Adequate assurance**	**3 - Limited assurance**	**4 - No assurance**

There is clear evidence of a robust and effective process, framework or activity that is operating effectively and is delivering the required outcomes.	*There is evidence of a sound process or framework in place however there are some inconsistencies or gaps. Effective delivery of required outcomes may not always be consistent and/or reliable.*	*Evidence of inconsistent application and/or critical weakness(es) within the process, framework or activity. The delivery of required outcomes is inconsistent and/or unreliable.*	*There is no, or insufficient, evidence of an appropriate policy, framework or activity. Required outcomes are not being delivered.*

RISK No: SRR02	Last updated: 09/10/2018

OUTCOME	A sustainable council

RISK DESCRIPTION
Major incident or service disruption (including serious health protection threats) leading to delivery failure that significantly impairs or prevents the Council's ability to deliver key services and/or statutory functions.

RISK OWNER	Service Director Transactions & Universal Services
PORTFOLIO(S)	Transport and Public Realm / Green City

RISK SCORE	LIKELIHOOD	IMPACT
CURRENT	D - Unlikely	2 - Major
Target	D - Unlikely	2 - Major

EXPECTED KEY CONTROLS		SOURCE(S) OF ASSURANCE	2017-18 Q3	2017-18 Q4	2018-19 Q1	2018-19 Q2	MITIGATING ACTIONS / COMMENTS
1. Business Continuity Plans are in place for key service areas that are tested and reviewed on a periodic basis.	a	• Corporate BC Plan and Service BC Plans in place • Alerting mechanism within the Corporate BC Plan was successfully used in the snow/ice response Feb/Mar 18 and the telephony outage of May 18. • 9 Service BCPs were reviewed and reissued in January 2018, next due for a review January 2019. • A full BC cycle (development, testing [exercise and incident], review and reissue) has now been undertaken for these service BC plans, annual review will now take place.	2	1	1	1	• *The Digital and Business Operations Service Business Continuity Plan will be developed alongside the development of the IT DR arrangements.* • *The Corporate BCP will be reviewed to take into account IT DR changes when complete, and will be tested in January 2019.*
	b	• Any significant learning points arising from live incidents and test exercises are reported to the Emergency Preparedness, Resilience and Response (EPRR) Board, a shared Board with Portsmouth City Council.	1	1	1	1	*First meeting of newly constituted EPRR Board on 2nd October.*

2. Range of Emergency Response plans in place to address or respond to legal or statutory obligations.	c	• Full range of emergency response plans in place [on Sharepoint] with periodic status reports to the EPRR Board. • SCC Pandemic Influenza Plan, SCC Oil and Chemical Pollution Plan, SCC Rest Centre Plan, Heatwave and Cold Weather plans and joint-SCC and PCC REPPIR plan have been reviewed and updated. • SCC's Emergency Response Plan was updated in April 2018. This is now aligned with an approach across SCC and PCC's to enable better efficiency when maintaining, training and exercising. • LRF Pandemic framework updated and STAC plan reviewed.	**1**	**1**	**1**	**1**	*• All plans are current and aligned with good practice however work is underway to align SCC and PCC's suite of plans to enable better efficiency when maintaining, training and exercising. Various joint plans are now in place and work is underway on a joint Coastal Pollution Pland and Cold Weather Plan.* *• The Hampshire and Isle of Wight Local Resilience Forum (HIOW LRF) generic emergency plan (which SCC authors) has been updated to encompass the Thames Valley LRF area and in effect from September 2018.* *• Op Parallel Bridge (death of a senior national figure) plan was issued in July 2018* *• The Reactor Emergency Plan issued in Q2 and public information leaflets due for distribution in Q3.* *• A new HIOW and TV LRF Widespread Electricity Loss plan is currently being drafted and due in draft format in Q3 with expected finalised plan available in Q4*
	d	• Joint exercises undertaken with other agencies on a periodic basis with outcome reported to the EPRR Board, Southampton Joint Health Protection Forum & HIOW LRF. • Jan 18 - Exercise FOXWATER focussing on tactical elements of REPPIR response and SCC's generic emergency plan implementation. This was successful and the Office for Nuclear Regulation has confirmed this was an appropriate test. • Exercise CRIMSON CARAVAN took place on 21/6/18. which tested the LRF Community Recovery Plan and the Recovery elements of the SCC REPPIR plan focussing on the aftermath of an off-site nuclear emergency in Southampton and Portsmouth. • Exercise SOTER took place on 25/5/18. This tested the multi-agency response to a mass casualty incident	**1**	**1**	**1**	**1**	*• Lessons identified during Exercise Crimson Caravan will be incorporated into the October 2019 review of the Reactor Emergency Plan.* *• Lessons identified during Exercise Soter will inform future mass casualties planning - EPRR team will ensure social care is adequately represented due to impacts on this sector. Currently awaiting lessons identified from Ex Soter from NHS England; also, discussion regarding resourcing to support EPRR in social care is underway- NHS EPRR Core Standards include a specific criteria for mass casualties, which will need to be considered.*

3. An adequate number of suitable officers have been trained, with arrangements to ensure that they are available, to undertake roles required during the council's response to an emergency	e	• Adequate numbers of suitable officers in place to undertake **Duty Gold** role on Emergency Duty Rota. • The LRF holds 2 Strategic Coordinating Group training sessions a year and all rota participants at this level are required to attend. • All officers employed under the Chief Officers' contract are contractually required to participate in the emergency rota and have all received 1:1 training on their role.	**1**	**1**	**1**	**1**	*• Training is up to date and numbers are adequate.*
	f	• Adequate numbers of suitable officers in place to undertake **Duty Silver** role on Emergency Duty Rota. • All have received 1:1 training on their role. • The LRF holds 2 Tactical Coordinating Group training sessions a year and all rota participants at this level are required to attend.	**1**	**1**	**1**	**1**	*• Training is up to date and numbers are adequate.*
	g	• Adequate numbers of suitable officers in place to undertake **Duty Bronze** role on Emergency Duty Rota • All officers have received suitable training and equipment to undertake the role. • These arrangements have been tested during the response to several live incidents (c.4/year).	**1**	**1**	**1**	**1**	*• There are two current, trained Duty Bronze Officers on the appropriate standby rota, and four new members of staff due to receive training in Q3*
	h	• Adequate numbers of suitable officers in place and available to undertake Emergency Planning Duty Officer role on Emergency Duty Rota • A joint Emergency Planning Duty Officer ('JEPDO') cadre of experienced EP officers from SCC and PCC is in place. • All have received suitable training and equipment to undertake the role.	**1**	**1**	**1**	**1**	*• JEPDO has successfully dealt with over 150 incident responses since its establishment in July 2017.*

4. The risk of significant flooding within the city and its potential impact is identified with appropriate physical controls and associated response plans in place that are reviewed and tested periodically.	i	• Multi-Agency Flood Response and Recovery Plan-Agency Flood Plan in place which includes Southampton-specific information. Next review date (Part 1) in May 19. • Southampton Joint Flood Management Board in place. Key stakeholders include SCC, Southern Water, Env Agency, ABP and Network Rail. • JFMB meets to plan, review and learn from issues/incidents arising during the winter months. • Planning applications for development (existing and new) are reviewed to meet a number of criteria and policy to ensure that development is appropriate and does not put people or property at unnecessary risk. • Flood incidents reported to and/or picked up by the SCC Flood RM Team and investigated where deemed necessary. • Flood risk reductions schemes in place in specific locations to reduce impact of tidal flooding to residential properties together with flood action group and flood plan. • Surface Water Hotspot document in place and updated as significant new surface water issues emerge which is then used to inform discussions with RMAs and contractors.	**2**	**2**	**3**	**3**	*• The SCC Flood Risk Management team has dealt with an unprecedented scale and frequency of flood incidents in 2018 which has had an impacted upon the capacity of this small team (2 officers). A review of how the team is structured and resourced has been undertaken and proposals presented to the Cabinet Member in August 2018. A budget pressure and restructure proposal has been included in the current business academy / budget setting process. The assurance level reflects the impacts described above.* *• SCC Part 3 multi-agency flood plan and accompanying maps expected to be be finalised in Jan 2019 - improving the response of multi-agency partners to flooding.* *• Testing of Flood Plan for St Denys delayed indefinitely due to the contractor administration and team capacity. All homeowners with flood prevention products installed will however have been shown how to deploy in order to protect their property.* *• ABP pumping station replacement project may reduce flood risk in West of the City - SCC working with ABP to find a relevant solution that will accommodate climate change to manage flood risk longer term.* *• Consultant drainage engineer currently working on modelling for one area of the city to identify whether the allotments can be utilised to manage flooding. Also working on Sustainable Drainage Systems (SuDS) opportunity mapping to identify areas that may benefit from SuDS to manage surface water.* *• Work being undertaken to identify responsibility for the management and maintenance of culverted watercourses should Southern Water successfully reclassify a currently marked public surface water sewer as a watercourse.*

5. A process to monitor both the performance and financial standing of key suppliers [including both significant commercial partners and other suppliers of key services e.g. joint commissioning of social care services].	j	• All key commercial contracts have Strategic Boards (involving both Members and CMT) with the more minor/less risky contracts having quarterly contract monitoring meetings.	**1**	**1**	**2**	**2**	*• All major contracts have risk registers in place which are jointly reviewed with the supplier.*
	k	• In respect of key commercial contracts a process is in place which is designed to ascertain the current financial standing of key partner organisations on a cyclical basis. This is used as a tool to assess and mitigate risks to the council. • The process, which is run on an annual basis (unless significant mid-term issues are identified), 'rates' each organisation according to the risks to the Council and will be reviewed at Strategic Board level	**1**	**2**	**2**	**2**	*• 'Special Watch' approach is in place to more closely monitor major suppliers deemed to be at risk because of their financial standing or other significant risks.* *• Reports are expected to be taken to CMT on a broadly quarterly basis and will cover the standing of 'at risk' companies, mitigation and business continuity.*
	l	• All social care contracts have a Contracts Officer assigned to manage the monitoring and review processes with commissioners taking ultimate responsibility for the overall management of contracts. • ICU contract monitoring dashboard in place which provides an overview of each contract which enables new contract monitoring processes to be consistently applied. • Where a provider holds multiple contracts for care and support services, these are normally allocated to a single commissioning lead to enable strategic oversight of key suppliers and market share-related risks • Terms of inclusion for residential and nursing homes in the city have been adopted by all local providers; • A 'provider failure protocol' is in place for ICU commissioned services and that recent experience of using this protocol to manage the impact of a provider failure has demonstrated that it is fit for purpose.	**2**	**2**	**2**	**2**	*• Residential Contract signed by all city providers, with quality monitoring processes confirmed for homes in Southampton (as required by the contract).* *• Acceptance and sign-up to the Residential Contract is required for all new care home placements in Southampton and outside the city borders.* *• GDPR changes adopted across all contracts managed by the ICU.*

6. Robust and resilient arrangements are in place to support the SCC Public Health response to a serious health protection threat	m	• SCC Public Health would provide an appropriate response in the event of a serious health protection threat. • The Science and Technical Advice Cell ("STAC") plan, managed and owned by Public Health England ("PHE") would assess the resources that might be required and how this would be provided. • The HIOW LRF STAC plan was updated June 2017 with training was provided in Sept 2017. • Procedures to support responses to vector borne diseases transmitted via non native Mosquitos are in place • Public health incident support was tested in LRF Exercises SOTER (May 2018) and CRIMSON CARAVAN (June 2018) where responders benefited from access to public health specialist advice	**2**	**2**	**2**	**2**	*• Challenges remain regarding how a protracted public health incident response would be resourced, though mutual aid protocols exist locally. Issue is unlikely to be resolved without increase in specialist resources within SCC/PCC and neighbouring authorities.*
	n	• A response plan, in the form of The Local Health Resilience Partnership "Health Protection Incident and Outbreak Plan" is in place [last reviewed June 2018]. • A local Standard Operating Procedure is in place are serves to increase SCC's resilience in response and communications by standardising distribution lists and inclusion of a 24hr Duty Officer resource.	**2**	**2**	**2**	**2**	*• Developing tools to support integrated response by event organisers, medical providers and wider health economy, linking with Public Health England and local Public Health teams on distrubtion of health promotion information. Awaiting PHE guidance.* *• Working with Dept of health on biological attack preparedness and arrangments for local antibiotic collection centres. Workshop to progress on 8/10/18.*
	o	• Local and National level public health surveillance is led by PHE. • SCC Public Health team works locally and nationally with PHE on understanding the level of threat from existing and new types of emergency.	**2**	**2**	**2**	**2**	

1 - Substantial assurance	2 - Adequate assurance	3 - Limited assurance	4 - No assurance
There is clear evidence of a robust and effective process, framework or activity that is operating effectively and is delivering the required outcomes.	*There is evidence of a sound process or framework in place however there are some inconsistencies or gaps. Effective delivery of required outcomes may not always be consistent and/or reliable.*	*Evidence of inconsistent application and/or critical weakness(es) within the process, framework or activity. The delivery of required outcomes is inconsistent and/or unreliable.*	*There is no, or insufficient, evidence of an appropriate policy, framework or activity. Required outcomes are not being delivered.*

RISK No: SRR03	Last updated: 01/10/2018

RISK DESCRIPTION
Major IT incident or service disruption leading to delivery failure that significantly impairs or prevents the Council's ability to deliver key services and/or statutory functions.

RISK OWNER	Service Director Digital and Business Operations
PORTFOLIO(S)	Finance and Customer Experience

OUTCOME	A sustainable council

RISK SCORE	LIKELIHOOD	IMPACT
CURRENT	C - Possible	2 - Major
Target	D - Unlikely	2 - Major

2017-18		2018-19	
Q3	Q4	Q1	Q2

EXPECTED KEY CONTROLS		SOURCE(S) OF ASSURANCE	ASSURANCE LEVEL				MITIGATING ACTIONS / COMMENTS
1. IT Disaster Recovery Plan, that covers IT hardware and server room resilience and applications / systems that support key services and is tested periodically, with the plan itself subject to periodic reviews to ensure that it remains aligned with business need.	a	• IT Disaster Recovery Plan in place that covers 8 key applications as agreed by the Council Management Team and subsequently with Capita on 31st August 2015. • A full technical test of DR is undertaken periodically	2	2	3	2	*• A full technical test was conducted in June 2018 however it was unsuccessful. A couple of systems were able to be restored but only using data from the data centre. The test was repeated in August and no issues arose*
	b	• The list of automatically recovered systems included in the IT Disaster Recovery Plan is being reviewed to ensure that it remains aligned with the current business need.	3	3	3	3	*• Service Lead: Digital and Strategic IT is working with an Enterprise Architect, Microsoft and Capita to develop a paper setting out the options and indicative costs to move critical software applications to the cloud and therefore increase resilience and SCCs ability to recover applications for consideration by CMT. Target End Q4.* *• In the meantime the Council is procuring applications on a cloud only basis in line with the Digital Strategy.*
	c	• Regular reports from Capita IT to the Service Lead Digital & Strategic on planning for incidents as well as feedback on learning points following major incidents.	2	2	2	2	*• The Disaster Recovery Invocation report is up to date and there are no issues outstanding. Recent issues around telephony have been closed down effectively and lessons learned. Capita prepare reports covering actions and lessons learned for all major incidents, these actions are then tracked through to delivery.*
	d	• Fault with the air conditioning system in the server room with temporary cooling in place. • The temperature is monitored manually by Capita during office hours.	-	3 NEW	3	2	*• Issue had been ongoing for several months with only temporary cooling measures in place. However this has been fixed and no further episodes have occurred since July and is therefore regarded as satisfactorily resolved.*

2. Appropriate controls are in place to manage the risk of a cyber security incident and/or to respond in an appropriate manner	e	• 'Defence in Depth' principle is used terms of minimising the risk of a cyber security attack with multi-layer firewalls and Intrusion Prevention system. • Web filtering protects users from malicious sites with malware scanning with a web firewall to protect council web applications and malware detection in end points. • Email filtering with ability to examine attachments and URLs in a sandbox environment to assess the risk. • Annual scans/assessments of both internal and external infrastructure is undertaken by a 3rd party company for the council's PSN/PCI requirements. Any issues are reported to the security team and incidents/tasks raised in Service Manager/V-Fire. Scans are completed in time for a Public Service Network (PSN) compliance submission annually each March.	**2**	**2**	**2**	**2**	*• Where possible these controls are up to date and quarterly tasks are raised within the IT Service Management Tool. Capita technical officers look at release notes for any revision and make a decision based on the compatibility matrix and operational necessity.* *• Security is tested quarterly via external Penetration (PEN) tests and any security issues highlighted will always be recorded within these scans. This is complimented by an Annual IT health check undertaken by an external 3rd party as a part of our PSN obligations.* *• The last annual scan/assessment of the internal and external infrastructure was completed and SCC has been awarded PSN's compliance valid until 25th June 2019 provided some actions are taken. There are three actions outstanding at the current time, which are underway and their completion is being monitored through the information security forum.* *• New threats are identified and assessed via the scans (at least quarterly) carried out against public-facing infrastructure. Similar scans are carried out on the internal network to identify any new threats. Capita scan and remediate on a weekly basis.* *• Currently with Payment Card Industry (PCI) compliance SCC are in a 'safe harbor' status as there are a number of sites where no Security Assessment Questionnaire has been completed, but action is being taken to resolve this with the individual services who maintain and manage their own IT equipment.*
		• Staff are required, and are periodically reminded, to report any concerns, anomalies or issues around service availablity to the IT helpdesk who will assist or investigate as appropriate.	-	-	**NEW**	**2**	*• Further reminder to be issued to all staff and members regarding the expectations / requirements and their role to play in terms of IT security.*

	f	• A cyber security incident would be managed in accordance with the procedure set out in the corporate business continuity plan. • Plan activation would be initiated by IT, who would contact the emergency planning duty officer, who would brief the duty director and chief executive and convene an extraordinary CMT meeting (plus relevant technical experts) to review the situation and direct the SCC response. • Service Business Continuity Plans are held on the Resilience Direct information platform.	2	3	3	3	*• Report was taken to CMT on 2nd July providing some background on the key cyber risks and the plans that are being put in place.* *• Cyber Response Plan Annex to the Corporate Business Continuity plan was presented to CMT for approval in July, which is to be followed up by a test.* *• Test of the Corporate BC Plan including IT disaster recovery using a cyber scenario to be undertaken. Target delivery date End Q3.* *• The feedback from this will help to feed the Local Resilience Forum exercise (planned for Q2 2019) which will partly be based on a cyber scenario.* *• Recent Denial of Service attack highlighted a need to conintue to be vigilant and remind all network users of duty to immediatly report IT incidents. Action to be taken in Q3.*

1 - Substantial assurance	2 - Adequate assurance	3 - Limited assurance	4 - No assurance
There is clear evidence of a robust and effective process, framework or activity that is operating effectively and is delivering the required outcomes.	*There is evidence of a sound process or framework in place however there are some inconsistencies or gaps. Effective delivery of required outcomes may not always be consistent and/or reliable.*	*Evidence of inconsistent application and/or critical weakness(es) within the process, framework or activity. The delivery of required outcomes is inconsistent and/or unreliable.*	*There is no, or insufficient, evidence of an appropriate policy, framework or activity. Required outcomes are not being delivered.*

RISK No: SRR04	Last updated: 11/10/2018

OUTCOME	People live safe, healthy, independent lives

RISK DESCRIPTION	
Failure to safeguarding vulnerable adults resulting in a preventable incident	
RISK OWNER	Service Director Adults, Housing & Communities
PORTFOLIO(S)	Adult Care

RISK SCORE	LIKELIHOOD	IMPACT
CURRENT	C - Possible	1- Extreme
Target	C - Possible	1- Extreme

EXPECTED KEY CONTROLS		SOURCE(S) OF ASSURANCE	2017-18 Q3	2017-18 Q4	2018-19 Q1	2018-19 Q2	MITIGATING ACTIONS / COMMENTS
			ASSURANCE LEVEL				
1. Robust Safeguarding Policy aligned with good practice and including clearly defined roles and responsibilities which is subject to regular review.	a	• Multi Agency Safeguarding Adults Policy and Guidance in place (2nd edition published in 2016). • Local Policy and Practice Guidance updated in 2016/17 and published on Intranet ('Safeguarding Adults'). • Policy, guidance and toolkit developed by the Local Safeguarding Adults Boards (4LSAB) covering Hampshire and the Isle of Wight. The policy will next be reviewed in January 2019. • Chair of Southampton LSAB also chairs Portsmouth and Hampshire LSABs, further improving coordination across the 4LSAB area. • The Local Safeguarding Adults Board (LSAB) maintains oversight of a review cycle and quality assurance.	1	1	1	1	
	b	• LSAB in place noting that the activities and functions of the board were reviewed in 2016/17 and found to be Care Act compliant. • SCC key partner in the Board's activities and meetings, and linking with partner organisations. • Designated SCC Adult Safeguarding and Service Quality Manager in place. • Southampton LSAB Strategic Plan 2016-18 was refreshed in March 2017 with actions monitored by the LSAB.	2	2	2	2	*• The annual report for 2017/18, which provides assurance regarding Care Act compliance and sets priorities and actions for 2018/19, was approved in September 2018 and will be consider by the by the council's Health Overview and Scrutiny Panel in 2019.* *• Content of SCCs Strategic Risk in respect of 'safeguarding' was an agenda item at the last meeting however it had to be deferred. Will be discussed at the next meeting in December.*

	c	• Quality Framework for Adults and Children's Social Care 2015-2018 • The Council discharges its duties for good governance through the 4LSAB Quality Assurance Group that oversees the four LSABs to achieve commonalities and develop work plans across the individual boards.	**NEW**	**3**	**2**	**2**	*• Limited assurance in Q4 was due to quality concerns around Glen Lee residential care home which was subject to a suspension of new admissions. Glen Lee is now out of suspension, and has been published as good overall from the CQC.*
2. Communication and training to ensure that all relevant staff and other key partners fully understand the Safeguarding legislation and procedures that underpin this. In addition, all staff understand what is expected of them in terms of when and how concerns should be reported.	d	• Safeguarding Training forms part of the corporate training offer both targeted and mandatory elements. All new social workers required to undertake mandatory training and assessed for competency. • The Principal Social Worker for Adults is the lead on training. • Learning and development needs picked up as part of the new Annual Performance Review process • Close working relationships with the CCG's Quality Assurance team on joint safeguarding activity with both organisations working closely with the CQC. • Adult Safeguarding Team Manager regularly attend ADASS training days to ensure that SCC remains compliant. • The ASC team have rolled out a comprehensive training programme for all social care staff in adults which covers core competencies. Also rolled2 out to our other professions including Occupational Therapy and our partners such as Solent and University Hospitals of Southampton. Approach has been adopted by the LSAB with the same approach to training sponsored for all relevant professionals with a significant adult safeguarding role in the city.	**2**	**2**	**2**	**2**	*• Adult social care are developing a detailed training matrix for safeguarding based on a national framework and supported by Bournemouth University. This is expected to be in place by End Q4 2018-19.*

3. Early assessment and planning in place for responding to safeguarding concerns across Adult's Social Care.	e	• Responsibility for safeguarding enquiries are devolved to service teams. This is supported by training and work with partner organisations to ensure robust process and practice. • Additional resources have been invested in Investigation officers providing greater capacity to review safeguarding issues across all sectors of the provider market place. The team has been able to retain staff with the required skills, knowledge and experience and this is effective. • Making Safeguarding Personal thematic audit undertaken at the request of the LSAB.	**2**	**2**	**2**	**2**	*• A subsequent working group arising from the Making Safeguarding Personal thematic audit has produced additional guidance for SCC and partners around risk assessment and management and safeguarding supervision standards.*
4. Safeguarding concerns identified by and reported to the Council are reviewed and communicated as appropriate both internally and with other agencies including those arising from SCC provided services.	f	• Safeguarding practice in Adult Social Care is co-ordinated by the Safeguarding and Service Quality Manager who has a lead role in working with principal partner agencies to develop and improve safeguarding practice. • Provider services Safeguarding List is maintained and available to all partner agencies. This is subject to external assessment by the 4LSAB QA group and evaluation sub group and periodic audits. • Safeguarding is a key area at joint management board for the integrated reablement service. This ensures the Community Independence Team and Urgent Response Service routinely make referrals. An Internal Audit of Adult Safeguarding completed in Q4 2017-18 and published on 25 April 2018 gave an opinion of "assurance".	**3**	**2**	**2**	**2**	*• Arrangements with Southern Health are in place but will be formally finalised by the end of October.* *• Revised safeguarding arrangements and pathways were implemented following the phase 3 restructure in April 2018.Restructing process completed.* *• Safeguarding and Service Quality Manager provided an assurance report for the LD team in Q1 2018-19 and has done similar report for the social well-being service.* *• Quality Assurance framework is at final stage of development for pilot implementation end of Nov.*

5. Robust assessment of current and future staffing requirement, for those functions that have a direct responsibility for safeguarding, with a contingency arrangement in place in respect of unforeseen pressures or staff shortages.	g	• Restructure of Adult Social Care teams as part of the phase 3 reorganisation was based on assessment of current and future need, to manage future staff reductions and to further develop partnership working with other organisations and develop broader resilience.	3	3	3	3	*• DASS is in place. Interim Principal Social Worker is in place with a service improvement role.* *• Phase 3 redesign has been completed with majority of people now in post.* *•Reduced number of locums being used within ASC. A number of waiting lists currently in ASC are being moniotored* *• Performance in carrying out planned reviews is improving due to the work of the Review Team, Integrated Teams and addtional support provided by a third party contractor*
6. Deprivation of Liberty Safeguards ('DoLS') applications are completed promptly and processed in accordance with statutory timescales including those cases needing renewal of a deprivation of liberty	h	• A risk based approach is used to prioritise DoLS applications. • The DoLS programme is delivering in accordance with the risk based plan and this is overseen by the Service Lead, Safeguarding with reports to the LSAB. • Performance is included on the Adult Social Care monthly scorecard, which is reported at CMB and AHC management team.	3	3	3	3	*• An internal audit of DOLS completed in Q4 2017-18 and published on 16 March 2018 gave an opinion of "limited assurance".* *• An Action Plan is in place that is overseen by the Quality Assurance Committee, chaired by the Integrated Commissioning Unit's Associate Director of Quality.* *• The service's response to the Internal Audit report states that the council's backlog is proportionately lower than neighbouring local authorities.*
	i	• Once allocated and assessed, the process followed for individual cases complies with the DoLS requirements. • DoLS applications are checked and monitored with service managers then checking the quality and ensuring they are compliant. • Best Interest Assessors (BIAs) receive extensive training and quality assurance mechanisms are in place.	1	1	1	1	*• Assurance confirmed on these points by an internal audit carried out during Q4 2017-18.*

1 - Substantial assurance	2 - Adequate assurance	3 - Limited assurance	4 - No assurance
There is clear evidence of a robust and effective process, framework or activity that is operating effectively and is delivering the required outcomes.	*There is evidence of a sound process or framework in place however there are some inconsistencies or gaps. Effective delivery of required outcomes may not always be consistent and/or reliable.*	*Evidence of inconsistent application and/or critical weakness(es) within the process, framework or activity. The delivery of required outcomes is inconsistent and/or unreliable.*	*There is no, or insufficient, evidence of an appropriate policy, framework or activity. Required outcomes are not being delivered.*

RISK No: SRR05	Last updated: 01/10/2018

OUTCOME	Children and young people get a good start in life

RISK DESCRIPTION
Failure to safeguard children resulting in a preventable incident

RISK OWNER	Service Director Children and Families
PORTFOLIO(S)	Children and Families

RISK SCORE	LIKELIHOOD	IMPACT
CURRENT	C - Possible	1- Extreme
Target	C - Possible	1- Extreme

EXPECTED KEY CONTROLS		SOURCE(S) OF ASSURANCE	2017-18 Q3	2017-18 Q4	2018-19 Q1	2018-19 Q2	MITIGATING ACTIONS / COMMENTS
1. Robust Safeguarding Policy aligned with good practice and including clearly defined roles and responsibilities which is subject to regular review.	a	• Safeguarding Policy for Children in place • Southampton Local Safeguarding Children Board ('LSCB') Policies & Procures Manual updated in June 2018 and subject to annual review. • SCCs Strategic Risk shared periodically with the LSCB	2	1	1	1	*• A new 'Working Together to Safeguard Children 2018' document has been adopted with the focus on moving toward a more regional multi agency safeguarding board.*
	b	• LSCB Business Plan outlines priority areas and associated actions to be taken by the LSCB for the period 2018-19 • The business plan sets out the inter agency priorities for safeguarding children and are monitored by the board of the LSCB • The status of the actions identified in the plan are reported to the LSCB	2	2	2	2	*• All actions in the LSCB Business plan are on track in terms of delivery.*
	c	• Quality Framework for Children's Social Care 2017-2020 • The Council discharges its duties for good governance through an Inspection Board with Quality Assurance Committee reporting to this	NEW	2	2	2	*• Recent Internal Audit concluded 'reasonable assurance' in respect of the Quality Framework.*

2. Communication and training to ensure that all relevant staff and other key partners fully understand the Safeguarding legislation and procedures that underpin this. In addition, all staff understand what is expected of them in terms of when and how concerns should be reported.	d	• All new social workers undertake mandatory training and are assessed for competency. • Level 3 Safeguarding Training programme is monitored and evaluated through the LSCB including attendance levels. • Level 2 Safeguarding Training is monitored and evaluated through the LSCB Training Sub Group. • Training is under the remit of the Workforce Development Manager (Practice Educator) who is able to monitor needs and take up. • Safeguarding Training forms part of the corporate training offer which includes targeted and mandatory elements. • QA oversight of the safeguarding training by the Service Manager and Principal Social Worker and the outcomes this has on service delivery.	**1**	**1**	**1**	**1**	*• Take up and quality of training is monitored and fedback into the quality assurance plan framework .*
3. Safeguarding concerns identified by, and reported to, the Council are reviewed, communicated and escalated as appropriate both internally and with other agencies.	e	• Multi-Agency Safeguarding Hub ("MASH") in place which brings together, in one location, staff from the council and a range of other key agencies to further improve the early identification and response to safeguarding concerns. • The MASH deals with a range of issues in respect of preventative and target intervention alongside managing high risk Child Protection. • The most qualified staff are used to manage the initial referrals into the MASH.	**2**	**2**	**3**	**3**	*• High level of Demand is still an issue and the lack of availability of qualified staff continues to have an impact on MASH in terms ofcompliance with the statutory timeframes. This reflects an ongoing national shortage of qualified social workers.* *• A recruitment campaign resulted in some posts being filled however there are still vacancies.*

4. The approach and arrangement in respect of 'Children's Safeguarding' is validated by external inspection agencies?	f	• Ofsted Inspections, now use a new Inspection of Local Authorities ('ILACS') framework for most inspections. • ILACS framework comprises standard inspections, short inspections, focused visits, monitoring visits and activity outside inspection. • Annual statutory review meetings ("conversations") with Ofsted	**2**	**2**	**2**	**2**	*• Ofsted inspection in June 18 in respect of 'Care Leavers Service' with a positive assessment provided* *• SCC selected by DfE as one of only three authorities to receive additional support to help accelerate its' journey from 'requires improvement' to 'good'.* *• Next conversation with Ofsted in January 2019. Outcome of most recent meetings in Feb and April 18 positive.*

1 - Substantial assurance	2 - Adequate assurance	3 - Limited assurance	4 - No assurance
There is clear evidence of a robust and effective process, framework or activity that is operating effectively and is delivering the required outcomes.	*There is evidence of a sound process or framework in place however there are some inconsistencies or gaps. Effective delivery of required outcomes may not always be consistent and/or reliable.*	*Evidence of inconsistent application and/or critical weakness(es) within the process, framework or activity. The delivery of required outcomes is inconsistent and/or unreliable.*	*There is no, or insufficient, evidence of an appropriate policy, framework or activity. Required outcomes are not being delivered.*

RISK No: SRR06	Last updated 11/09/2018

OUTCOME	A sustainable council

RISK DESCRIPTION
Failure to meet our health and safety responsibilities

RISK OWNER	Health & Safety Board
PORTFOLIO(S)	Community Wellbeing

RISK SCORE	LIKELIHOOD	IMPACT
CURRENT	C - Possible	2 - Major
Target	D - Unlikely	2 - Major

EXPECTED KEY CONTROLS		SOURCE(S) OF ASSURANCE	2017-18 Q3	2017-18 Q4	2018-19 Q1	2018-19 Q2	MITIGATING ACTIONS / COMMENTS
1. Roles, responsibilities, accountabilities and reporting arrangements are defined and understood	a	• 'H&S Policy : Statement of Intent' signed by Directors (review July 2018) together with up to date H&S policies on all other major risk areas. • Responsibilities in respect of H&S are reflected in the new Employee Performance Contracts	1	2	2	1	*• All polices are up to date, have been signed by the leader and CX and are published on the intranet.*
	b	• H&S Board comprising Service Directors, Risk & Insurance and H&SS with an agreed ToR. • H&S Board report to CMT on a quarterly basis via Strategic Risk Register and highlighting any areas of significant concern. • JCG terms of reference produced via HR&OD board.	2	1	1	1	*• Governance arrangements in terms of revised JCG's and the H&S board are now well established.*
	c	•Health & Safety Service act as the competent person regarding CLEAPSS (Consortium of Local Education Authorities for the Provision of Science Services) and RPO (Radiation Protection Officer) • All School Safety Advice notices were reviewed and reformatted in Sept 2017	3	3	3	3	*• Concern exists regarding corporate oversight of schools and the limitations of the current SLA/H&S auditing processes being limited/restricted by schools opting/buying into that process.* *• HS&EW manager has taken steps to mitigate this position including re-introducing the self-audit tool for schools from September 2018 as well as undertaking a series of ad-hoc inspections of schools sites across the summer holiday period to look at construction /maintenance works being undertaken*

	d	• Control of contractors and service providers - safe working procedure. • Control of contractors and service providers, contractor incident notification protocol (CIN). • Compliance with H&S is part of std work contracts.	3	3	3	3	• *Construction management group has now been formed which reports to the H&S board.* • *A programme of inspections utilising resource through the H&S service has been developed. Planned inspections will average 5 per month and will include construction as well as other activity across the authority.* *NOTE: There has been a delay is getting planned inspection visits implemented partly due to resource constraints; however this is now underway but is at too early a stage to*
2. H&S training needs, relevant to individual roles, are identified with appropriate and up to date guidance, training, policies and procedures in place and in an accessible format.	e	• All policies are published on the intranet and are updated at least annually or as changes come in, major changes are consulted on. • Safe working procedures are scheduled for review across two/three years - changes or amendments to the schedule are relayed to the H&S board.	1	1	2	2	• *Revised process for amending/updating safe working procedures - agreed refresh period of two/three years (sooner if legislative change), consultation and final approval via H&S board.* • *Recognised that some SWPs are out of date in terms of the last review date.* • *The schedule of reviews of SWP's is subject to governance via monthly H&S service area review meetings as well a to the H&S board. Reviews are prioritised by risk where appropriate and the schedule is fluid in terms of being able to move reviews within the two year programme where the need arises, for example where an audit identifies the SWP's*

	f	• Full suite of training courses (including e-learning) available as well as a range of bespoke courses primarily aimed at the higher risk activities (e.g. waste management, trades etc.).	**2**	**2**	**2**	**2**	*• Training courses have been put in-place including, DSE assessor, accident investigation and reporting and housing tenancy inspections.* *• Training to be developed include, stress management tool (HSE).* *• the HS&EW manager is seeking to develop training to cover health surveillance responsibilities for managers which has been*
	g	• Review of training needs, including H&S, forms part of the Annual Performance Review ("APR") process. • Monitoring of training undertaken and future training needs also reviewed at 1-2-1's or similar review meetings.	**3**	**2**	**2**	**2**	*• A revised generic training matrix has been produced which is designed to help managers develop local training needs and specific matrices through the management H&S training (Essential H&S Training for Managers) but also through the APR process.*
	h	• A self audit tool ("SAT") in is place and aimed at managers with H&S responsibilities. The outcomes of the SAT are used to inform the H&SS with regards options for the HS&W manager to plan and authorise face to face audits and further assistance where necessary.	**3**	**3**	**2**	**2**	*• The revised self-audit tool (non-schools) is now live and being used by services. Target for completion is end of September 2018.* *• Intelligence gained will be used to inform inspections and audits and/or further interventions in order to help service areas improve where necessary.* *• The level of take up of the self-audit tool and the outcomes of the assessment will be reported to the H&S Board in Q2.*

3. Key operational H&S risks are assessed, identified and controlled with appropriate and up to date guidance, training, policies and procedures in place and in an accessible format.	i	**ASBESTOS** **Framework** • Asbestos Management Group reporting to H&S Board • Asbestos policy and arrangements approved by H&S Board (Jan 18). • Corporate asbestos database together with Asbestos microsite, information, instruction and training • Risk assessments • Scientific Services, Regulation 4 inspections, • Asbestos procurement/framework agreement		**2**	**1**	**1**	**2**	*• Revised policy and arrangements document, replacing previously separate policy and SWP will be the model applied to other polices when reviewed. This provides a single document, signed by the CX and leader and is reviewed annually.* *• Internal Audit report identified a number of actions; a number of historic incidents on IE were not closed, these have now been. All new incidents are investigated and reported through the AMG with the HS&EW manager closing each incident when concluded. Scientific Services are investigating IT improvements to the asbestos database as recommended and have raised an IT project.*
	j	**Delivery** • Breaches in process and/or misunderstandings of requirements by service areas are often underlying causes of logged incidents.		**3**	**2**	**2**	**3**	*The internal audit raised issues which have/are being addressed including:* *•Better use of the procured framework of asbestos contractors and analysts* *•New process introduced to ensure asbestos incidents are properly investigated and closed on HSMS* *•Improvements being made to the asbestos database so that data is not lost when updating surveys, i.e. to enable an auditable history against property data.* *• Recent rise in incidents with non-licensed asbestos tasks carried out by the internal repairs teams is to be investigated via an assurance audit with findings being presented to AMG and the H&S board. Please note that non-licensed work is considered low risk and incidents are mainly procedural breaches and have not affected*

	k	**WATER QUALITY** **Framework** • Approved contractor appointed and in place to undertake risk assessments and remedial works • Safe working procedure - Control of Legionella • Water Quality Management Group established (Dec 17) with agreed ToR and accountable to the H&S Board		**2**	**2**	**2**	**2**	*• Procurement exercise led by Capital Assets is underway to appoint new approved contractor contract (existing contract expired in June 18).* *• Exception agreed to continue to use current provider (Urban) to carry out risk assessments whilst procurement continues.* *• Engaged a consultant through Capita to fill the authorised engineer role and to undertake a gap analysis report.*
		Delivery • Risk assessments (Housing) are being undertaken • Competent person on WQ (in-house) being used to oversee risk and actions identified.		**3**	**3**	**3**	**3**	*• Housing are focusing on continuing to undertake risk assessments as well as the DLO undertaking monitoring and low level remedial works.* *• Strategy managed by Capital Assets and focussed on risk profile of stock - where identified programmes of work will be produced.* *• Capital Assets have commissioned a WQ consultant through CH&SS to undertake gap analysis and provide the authorised engineer role which the authority has now lost.*
	l	**FIRE SAFETY** • Fire Safety Programme Board, to oversee all aspect of fire safety in place and chaired by the Service Director Adults and Housing. • Membership includes a representative from Hampshire Fire & Rescue Service together with officers from Capital Assets, Housing, H&S, Risk & Insurance.		**2**	**2**	**2**	**2**	*• The board is overseeing progress against fire risk assessment actions and programmes of work and agreeing an overall strategy.* *• Membership of Group to be extended to include a representative from Children's services.*

	m	**FIRE RISK ASSESSMENTS** **Framework** • 3S Fire provision of FRAs and competent persons/advice. • H&S Management system (Info Exchange) holds records of all FRAs and actions. • Capital Assets responsible for ensuring that SCC assets remain compliant, including managing actions arising from fire risk assessments and forming programmes of work where necessary. • Regular status reports are provided to the Fire Safety Programme Board and CMT.	**2**	**2**	**2**	**2**	*• Procurement process to cover provision of FRA's from end of current contract (Nov 18) is underway. Exploring options to access a procurement framework currently.* *• Arrangements are in place to review and manage the backlog of actions using a risk based approach. The Fire Safety Programme Board has been used to agree strategies for managing a number of actions* *• Strategy for future FRA's being considered so as to include more invasive surveys in some instances based on FRA types 1-4 and this will be further explored with any new contractor or emerging advice following the*
		Delivery • Work to address issues found are being managed by Capital Assets with regular status reports are provided to the fire safety programme board and CMT. • FRA information included on MOP and reported to CMT.	**3**	**3**	**3**	**3**	*• Issues include FRA's and actions from FRA's overdue. Capital Assets have developed an overall action plan and are progressing works to address and close risk actions with reports and progress reported through the FSPB.* *• Some FRAs are undertaken 'off contract' i.e.. by schools making their own arrangements. In all such cases this requires the recipient to provide Capital Assets with details of the review and the actions taken.*
	n	**FIRE DOOR INSTALLATION & MAINTENANCE - Framework** • Safe working procedure - Fire Door Protocol in place and is being applied. • Issues identified as part of Fire risk assessments and other routine or ad hoc inspections.	**2**	**1**	**1**	**1**	*• Contracts let (including the DLO) include confirmation on the required standards and competency of installations and maintenance applications.*

	Delivery • Capital Assets specify evidence of competency and standards with regards larger projects where door installation is required	**3**	**2**	**2**	**2**	*• Application of the SWP is undertaken locally and processes still relatively new* *• HS&W manager to undertake assurance review and report findings through the construction management group and H&S board.*
o	**INCIDENT / ACCIDENT REPORTING** **Framework** • Online reporting system (HSMS) • SWP accident, incident reporting and investigation • Instruction and training for accident investigators, • HSS log incidents, investigate and report (RIDDOR).	**2**	**2**	**2**	**3**	*• Internal Audit review assessment identified that a number of incidents logged on HSMS are not closed. The HS&EW manager is investigating possibilities with the system to address the historic incidents logged which may include archiving options, but is also looking at processes for managing incidents logged to ensure that they are suitably managed to conclusion.*
	Delivery - • Reporting figures are low suggesting under-reporting and issues with process or culture. • Managers slow to respond resulting in increased resource to chase and close incidents within timescales. • Accidents/Incidents left open on the Incident reporting system • The Capita H&SS are measured (KPI) on RIDDOR notification timescales.	**3**	**3**	**3**	**3**	*• (KPI) on RIDDOR notification timescales is rarely under target however general response times by managers is slow. Will be reviewed as part of the wider review of compliance data systems.* *• Internal audit report highlighted number of incidents which are not closed. HS&W manager is seeking to resolve identified issues with system including date fields which may be applied retrospectively, reporting against pending items in respect of closing entries in an appropriate and timely manner.* *• Training sessions covering both accident/incident reporting and accident investigation are available.*

p	**EMPLOYEE HEALTH (Noise/COSHH/Vibration) - Framework** • H&S policy and arrangements • Safe Working Procedures in place • Risk assessments together with information, instruction & training, • Supervision and monitoring, • Provision of personal protective equipment		**2**	**2**	**2**	**2**	*• Audit regarding operational teams health surveillance and COSHH in-progress by H&SS.* *• Review will also look at buying/hiring strategies re plant and equipment.*
	Delivery • Audits of operational teams based around health surveillance processes and COSHH will identify gaps, weaknesses and inconsistencies. across operational areas being undertaken (approved by H&S Board - 04/10/17).		**3**	**3**	**3**	**3**	*• HS&W manager is awaiting HSA reports covering the 5 operational areas identified and will feedback outcomes via H&S board. Final report received 11/09/18 and is currently being evaluated in terms of actions required and a plan to deliver those.*
q	**LONE WORKING** **Framework** • Safe working procedure - working alone in safety • Risk assessments, • Lone worker protection systems (Jontek) • Information, instruction and training, • Incident reporting and incident list.		**2**	**2**	**2**	**2**	*• The SWP does not reference any lone worker protection systems as a control measure.* *• The SWP - lone working will be updated to reflect processes to access Jontek once established and any actions noted as part of the review of lone working (see below).*
	Delivery • Jontek System originally limited to Adults, Housing and Communities teams but has been expanded out further to a wider range of teams that undertake lone working including occupational therapists, social workers (assessment, options and planning), income services, Capital Assets and Emergency Planning • Ad-hoc use of lone worker control measures.		**3**	**2**	**2**	**2**	*• HS&W manager has instigated a review of lone working arrangements and will update the SWP - lone working once complete. The review should help identify any improvements which may be made to existing arrangements (including Jontek) as well as establishing whether risk is significant and may necessitate further controls being explored.* *• An increased number of services have now accessed and are using the Jontek lone*

	r	**HOT WORKS** (includes, welding, soldering, flat roofing, vinyl flooring seam welding, paint stripping, etc.). **Framework** • Safe working procedure - permits to work • Risk assessments • Operating procedures and/or method statements • Hot works permit systems, information, instruction and training, supervision and monitoring		**2**	**2**	**2**	**2**	*• Application of SWP, risk assessments and safe systems of work.*
		Delivery • Level of compliance with SWP unknown, no evidence.		**3**	**3**	**3**	**3**	*• HS&EW manager is awaiting final reports from two assurance audits (Housing and Fleet) undertaken to establish compliance and effective management of hot works processes. Initial feedback is favourable and indicates positive assurance but will confirm outcomes to JCG's and H&S board.*
	s	**SHARED SITE (NURSLING DEPOT)** [Inclusion on time limited basis] **Framework** • Procedures for use of the shared site covering Fire, first aid, welfare, vehicle movements, materials management, use of forklift trucks, etc. in place. • Risk assessments, information, instruction and training, supervision and monitoring, management workplace inspections.		**3**	**2**	**2**	**2**	*• Health and safety assurance audit (HSA) undertaken with action plan produced.[*
		Delivery • HS&S have undertaken an audit of workplace transport following reported incident with forklift whereby insufficient documents and evidence presented immediately following the event.		**3**	**2**	**2**	**2**	*• Action plan is stated as being complete.* *• HS&W manager is awaiting H&S inspection report from 06/09/18 to confirm that new risk assessments and safe systems of work have been fully implemented and bedded-in.*

	t **FIRST AID - Framework** • SWP - First Aid in place.	2	2	2	2	*• SWP - First Aid is being amended to reflect change and also new process being introduced to manage employees with specific medical conditions* *• HS&EW manager to arrange for a communications article to advise staff of the change once the SWP is complete.*
	Delivery • Civic Buildings responsible for managing first aid arrangements for the Civic Centre. • Town Sergeants respond to first aid incidents for members of the public in the civic buildings.	3	3	3	2	*• Civic Buildings have now assumed responsibility for managing first aid arrangements for the Civic.* *• New signage has been installed, training updates being progressed, defibs have been placed at key locations throughout the buildings and first aid kit reviewed/replaced.*

1 - Substantial assurance	2 - Adequate assurance	3 - Limited assurance	4 - No assurance
There is clear evidence of a robust and effective process, framework or activity that is operating effectively and is delivering the required outcomes.	*There is evidence of a sound process or framework in place however there are some inconsistencies or gaps. Effective delivery of required outcomes may not always be consistent and/or reliable.*	*Evidence of inconsistent application and/or critical weakness(es) within the process, framework or activity. The delivery of required outcomes is inconsistent and/or unreliable.*	*There is no, or insufficient, evidence of an appropriate policy, framework or activity. Required outcomes are not being delivered.*

RISK No: SRR07	Last updated: 13/09/2018

OUTCOME	A sustainable council

RISK DESCRIPTION
Failure to ensure the City Council's information is held and protected in line with Information Governance polices and procedures.

RISK OWNER	Information Governance Board
PORTFOLIO(S)	Leader and Clean Growth and Development

RISK SCORE	LIKELIHOOD	IMPACT
CURRENT	C - Possible	3 - Significant
Target	E - Very Unlikely	3 - Significant

		2017-18		2018-19		
EXPECTED KEY CONTROLS	SOURCE(S) OF ASSURANCE	Q3	Q4	Q1	Q2	MITIGATING ACTIONS / COMMENTS
1. A Strategic Information Governance Board is in place with agreed terms of reference, appropriate membership and reporting structure into a senior management team.	a • Information Governance Board ("IGB") in place with terms of reference agreed by the Council Management Team ('CMT') in July 2016 and kept under review by the Service Director - Legal and Governance ('SDLG'). • SDLG reports annually to the Governance Committee and bi-annually to CMT on information governance, including breaches and training compliance.	1	1	1	1	• *The work of the GDPR Sub Group is now subsumed within the IGB.*
	b • IGB Chaired by the Corporate Senior Information Risk Owner "SIRO" (SDLG). • IGB meetings are held every six weeks and are chaired by the SDLG as CMT lead. Membership of the group includes the Senior Solicitor (Corporate), Services Lead Digital and IT, the Caldicott Guardian, Senior Records Officer, Information Lawyer, Service Lead - Risk, Insurance, Assurance & Audit and the Service Lead - Customer & Employee Experience and the Service Director Digital and Business	1	1	1	1	

	c	• A corporate SIRO is in place with Information Asset Owners (Service Directors) trained and in place across the Council. • IAOs are accountable to both IGB and CMT for information governance compliance within their areas and are required to submit evidence, six monthly, of compliance on a quarterly basis to the IGB. Non-compliance will be reported to CMT.	**1**	**1**	**1**	**1**	*• Checklists for Q1 and Q2 were sent out at the beginning of September to IAAs with the deadline for completion being the end of September. Once these have been analysed, we will have a better idea of risks.*
2. Information Governance ("IG") Framework is in place across the organisation which gives a structure for managing IG and ensures a level of assurance which enables the organisation to meet its regulatory requirements.	d	• IG Framework in place. • All Information Asset Owners together with Information Asset Administrators have been trained in respect of the their responsibilities. • The Data Protection Officer has met with all Information Administrators.	**1**	**1**	**1**	**1**	*• Data Protection Officer continues to meet with new IAOs and IAAs as needed.*
	e	• An overarching IG policy in place under which all relevant polices fit. • A control list is in place and all policies due for review are tabled at each IGB as a standing agenda item.	**2**	**1**	**1**	**1**	*• Policies continue to be monitored as required.*
	f	• There is an Information Asset Register ('IAR') in place with Heads of Service being the appointed 'Information Asset Owners'. • IAOs are tasked with responsibility for keeping their service area information updated and asked to account for compliance for their areas of responsibility on a quarterly basis to IGB. • An Information Asset Management system (IAMS) is in place which provides IAOs and IAAs with visibility of information in their control, and the privacy risks associated with it.	**1**	**1**	**1**	**1**	*• GDPR Champions have been completing and verifying the accuracy of the IAR, and their contracts will be terminated at the end of September. At this point, Service Areas will be responsible for providing information on the IAR via the quarterly checklists. Ultimately, they will be given direct access.*

	g	• A published Retention Schedule is in place which is comprehensive and up to date. • Compliance with the retention schedule is captured in the quarterly checklists that are required to be completed by the IAOs. • The disposal of electronic records and data is aligned with the arrangements in respect of the disposal of hard copy records and data	**1**	**1**	**1**	**1**	*• Where a need for the retention schedule to be amended or updated, the Senior Records Officer works with the service area to facilitate.* *• IAAs should regularly review thier retention schedules as part of checklists. It is their responsibility to liaise with SRO if any changes are required.*
			-	-	**NEW 3**	**3**	*• There is awareness in respect of the challenges around disposal of electronic records. The IT Lead is compiling a list of systems across the Council, and will work with the system administrators and suppliers to explore destruction / archiving solutions available in respect of electronic records.* *• The SRO has been working with the Paris Support team to cleanse date from the system, and this is progressing well however, the project has identified a large number of additional paper records and Paris records that could be cleansed. The SRO has completed the first stage of this work and will be providing advice to the support team.* *The SRO is working with the administrators of Uniform to begin data cleansing, but there is a need for resource to do the work and this has been discussed at IGB.* *One system administrators have been advised on how to select data for cleansing but are waiting for Capita IT consultants to confirm technical matters to them before this can proceed.* *• The compliance returns would indicate that although IAOs are aware of the requirement to review and dispose or retain records compliance is not consistent across all areas and further work is required to embed regular reviews into business as usual work.*

	h	• Data Protection Impact Assessments ("DPIAs") (formerly Privacy Impact Assessments) are in place for all new projects or policies. • Consideration of the need to conduct a DPIA forms part of the decision making report template and at Gateway 1 in the project management template. • The requirement to complete DPIAs forms part of the IAO quarterly checklist.	**2**	**2**	**2**	**2**	*• The increase in DPIAs continues (up 300% on last year - 17 to 68) and reflects that.the need for DPIAs is beginning to become embedded.* *• There is currently a backlog of (40) DPIAs for the Data Protection Officer to review.*
3. The organisation ensures that its staff and those working on its' behalf are adequately trained in all aspects of IG.	i	• Training in Data Protection and Freedom of Information is mandatory for all staff and is provided through e-learning and other appropriate methods including use of training videos via You Tube in order to provide basic training for colleagues without easy access to IT.	**1**	**1**	**1**	**1**	*• The current overall compliance rate in respect of the DPA and FOI e-learning training stands at 71% overall (July 2018).* *• The reliability of the data provided by L+D is a core ongoing concern - awaiting updated stat from L+D.* *• Member compliance is currently at 12.5%.*
	j	• The Corporate Legal Team is responsible for investigation of potential breaches and for liaising with the service areas with the remediation plan post breach. • All investigations and monitoring of compliance of remediation plans is performed by the Data Protection Officer. • Relevant IAOs and IAAs receive a copy of any remediation report drafted, and details of breaches are reported to CMT on a quarterly basis. • There is an annual communications plan?? with regard to IG, which includes data breaches.	**1**	**1**	**1**	**1**	
4. Information is shared within the organisation, with partners and clients according to the Law and other statutory guidance.	k	• Information sharing protocols and operational agreements are in place, registered and reviewed. • A corporate register of Information Sharing Agreements is in place and subject to regular review • The quarterly checklist requires IAOs to ensure that all necessary agreements are in place	**1**	**1**	**1**	**1**	*• Enquiries have been made with other LAs to ensure that the register is comprehensive, and further gaps should be identified as part of the information audit undertaken by the GDPR Champions.*

5. Regulatory compliance is met.	l	• Public Sector Network compliance certificated.	1	2	1	1	• *April 2018 annual review led by Capita IT* • *The 2018/19 certificate has now been obtained*
	m	• Department of Health IG Toolkit complete and returned within the prescribed annual deadlines noting that a verified IG Toolkit is necessary in order to enable the council to access data held by partners and for partners to access SCC information.	1	1	1	1	• *17-18 Toolkit has been submitted and the compliance rating of 83% has been maintained. Exercise led by Corporate Legal Team.* • *The 18-19 Toolkit submission is currently being worked on and is on track - 50% complete*
	n	• A nominated Caldicott Guardian is in place. • The Caldicott Guardian role is with the Service Director Children & Families and the Service Director Housing Adults and Communities and registration has been lodged with the Health and Social Care Information Centre.	1	1	1	1	*Service Director Children and Families and the Service Director Adults, Communities and Housing attended an externally provided training session in April.*

1 - Substantial assurance	2 - Adequate assurance	3 - Limited assurance	4 - No assurance
There is clear evidence of a robust and effective process, framework or activity that is operating effectively and is delivering the required outcomes.	*There is evidence of a sound process or framework in place however there are some inconsistencies or gaps. Effective delivery of required outcomes may not always be consistent and/or reliable.*	*Evidence of inconsistent application and/or critical weakness(es) within the process, framework or activity. The delivery of required outcomes is inconsistent and/or unreliable.*	*There is no, or insufficient, evidence of an appropriate policy, framework or activity. Required outcomes are not being delivered.*

RISK No: SRR08	Last updated: 11/10/2018

OUTCOME	A sustainable council

RISK DESCRIPTION
The council is unable to respond appropriately or sufficient quickly to significant changes in service demand arising from changes in the welfare system

RISK OWNER	Service Director Adults, Housing & Communities / Service Director Children and Families
PORTFOLIO(S)	Community Wellbeing / Adult Care

RISK SCORE	LIKELIHOOD	IMPACT
CURRENT	B - Likely	3 - Significant
Target	C - Possible	3- Significant

EXPECTED KEY CONTROLS		SOURCE(S) OF ASSURANCE	2017-18 Q3	2017-18 Q4	2018-19 Q1	2018-19 Q2	MITIGATING ACTIONS / COMMENTS
1. Appropriate business intelligence arrangements are in place to predict, track, identify and communicate significant changes in demand.	a	• Monitoring undertaken quarterly on the number of residents affected by each of the major reforms with quarterly statistics collated where available.2 • Welfare Reform Monitoring Group in place and annual report on Local Impacts of Welfare Reforms produced. This is city-wide, multi-agency group works together to co-ordinate the local response to welfare change. • Risk mitigated by Government policy amendments - these include the 7 day waiting period for new claimants being removed; Universal Credit advances increased and the period of repayment extended from 6 to 12 months; and Housing Benefit run on (new Universal Credit claimants in receipt of Housing Benefit continue to receive it for a further 2 weeks) • Where information is available it is used to assess pressures, including local use of food banks.	2	2	2	2	

2. The impact of anticipated changes in demand is reflected in both business planning and budgeting arrangements.	b	• The potential for significant changes in demand is reflected in 'Children & Families' and the 'Housing & Adults' business plans. • Impact of changes that affect the HRA (in particular the 1% annual reduction in and Business Plan has been assessed and communicated to Councillor and CMT.	**2**	**2**	**2**	**2**	*• The HRA budget has been to the Cabinet Member responsible for Housing, and has been to CMT and is going through the process now for approval as part of the council's budget setting process).*
	c	• Exercise, with other stakeholder agencies including anti-poverty services, Supporting People providers and advice services to identify additional service demand.	**2**	**2**	**2**	**2**	*• Additional and ongoing funding of up to £185K per annum provided from 2017-18 and allocated to local welfare support. Welfare Reform Monitoring Group continues to work with agencies to identify pressure points and gaps in current provision.*
3. Resources are able to be deployed /redeployed to meet service delivery pressures	d	• Systems are in place to respond to in-year increases in demand. • There are also a range of interventions and measures in place intended to manage future demand including 'edge of care services', early help and early years. • Additional capacity is in place for the Housing Income Team in preparation for the implementation of Universal Credit in order to support tenants noting and recognising that under Universal Credit gross benefits will be paid direct to tenants (thereby requiring SCC to collect the rent).	-	**2**	**2**	**2**	*• Any increase in poverty will result in an increase of referrals noting that there is no recourse to public funds.* *• The number of Social Rented Sector notifications is twice the level predicted so to minimise the impact on available resource, some automation options are currently being explored.* *• Children's Services can redeploy resources to meet demands as necessary*
4. Impact of further legislative changes on welfare benefit system are modelled and cumulative impacts mitigated		• Systems are in place to respond to new legal duties from Homelessness Reduction Act 2017 and ensure adequate provision in place to mitigate any further or cumulative impacts on service demands	-	**2 NEW**	**2**	**2**	*• Homelessness Prevention Service is implementing legal requirements with a new IT system (HOPE), additional staff and other resources, funded by Government grant.* *• Demand for discretionary rent deposits (expected to increase) is being monitored.*

1 - Substantial assurance	2 - Adequate assurance	3 - Limited assurance	4 - No assurance
There is clear evidence of a robust and effective process, framework or activity that is operating effectively and is delivering the required outcomes.	*There is evidence of a sound process or framework in place however there are some inconsistencies or gaps. Effective delivery of required outcomes may not always be consistent and/or reliable.*	*Evidence of inconsistent application and/or critical weakness(es) within the process, framework or activity. The delivery of required outcomes is inconsistent and/or unreliable.*	*There is no, or insufficient, evidence of an appropriate policy, framework or activity. Required outcomes are not being delivered.*

RISK No: SRR09	Last updated: 12/09/2018

OUTCOME	People live safe, healthy, independent lives

RISK DESCRIPTION
Failure to ensure an effective and sustainable adult social care system

RISK OWNER	Service Director Adults, Housing & Communities
PORTFOLIO(S)	Adult Care

RISK SCORE	LIKELIHOOD	IMPACT
CURRENT	B - Likely	2 - Major
Target	D - Unlikely	2 - Major

			2017-18		2018-19		
EXPECTED KEY CONTROLS		SOURCE(S) OF ASSURANCE	Q3	Q4	Q1	Q2	MITIGATING ACTIONS / COMMENTS
1. Assessment of future service demand (and projected cost) together with an understanding of demand indicators or triggers	a	• 'Joint Strategic Needs Assessment' for the city is in place • An agreed Better Care Fund Plan (BCF) is in place which contains a detailed review and interpretation of the demographics of the city. • The demand model has been updated for home care and for other placement/care types	3	3	3	3	*• Adult Intensive support meeting that were suspended in Q1 have been restarted and are chaired by Deputy Chief Executive in Q2. Assurance is still rated as limited.* *• BCF Plan has a monthly performance and finance meeting that takes in to account demand and capacity. Further challenge and assurance around joint commissioning board.*
	b	• Regular comparisons are made with our nearest neighbours via a CIPFA Benchmarking group with any significant or unexplained variances reviewed as necessary. • The council participates in the Association of Directors of Adult Social Services in England ('ADASS') national and regional comparator groups. • National adult social care outcome framework (ASCOF) benchmarking data available.	3	3	2	2	*• ADASS senior staff participate in Principal Social Worker ('PSW') Commissioning, Continuing Health Care ('CHC'), Trusted professional and Delayed Transfer of Care ('DToC') regional groups in addition to ADASS core functions.*

2. Appropriate range of preventative / early intervention actions to seek to manage and/or reduce future demand	c	• A Better Care Fund local plan, developed by the Council and Southampton City Clinical Commissioning Group ("CCG"), is in place as a part of the Better Care Fund. The Plan focusses on prevention and early intervention and building on the role of individuals in their own health and wellbeing. • Better Care fund monthly budget review meetings between SCC and CCG at CFO level with reports on progress with each of the schemes.	**2**	**1**	**1**	**1**	*• The governance arrangements and controls are providing assurance over the use of the Better Care Fund and Improved Better Care Fund.* *• The BCF is monitored and reviewed at the performance meeting, and quarterly submissions are required to inform centrally on the targets. Each scheme is being monitored by Better Care Southampton Executive Board and Better Care Southampton Working group*
	d	• Southampton Information Directory ("SID") is in place and provides information and support for adults and those that are caring for them. The SID signposts a wide range of support and self help options that are available.	**3**	**2**	**2**	**2**	*• SID has been transferred over to Social Care Connect to be monitored, managed and updated. Further training and development will be completed with Contact Centre to ensure effective use of SID*
	e	• Integrated Health and Social Care Rehabilitation / Reablement Service for the city, designed to help people maintain or regain their ability and confidence to live at home, commenced in June 2016. • Effectiveness of this service is overseen by the Better Care Integration Board.	**2**	**2**	**2**	**2**	*• Full assurance is expected once the new governance arrangements become embedded.*

	f	• An 'integrated person centred care work programme' is in place with one of the main areas of focus being on 'prevention and early intervention' • Phase 3 restructure implemented in 16 April 2018 was intended to support prevention and early intervention.	**3**	**3**	**3**	**3**	*• There remains limited assurance as resources have been prioritised to meet immediate needs. There is however an improving picture, although market development and community resources still need to be mapped to enable a strength based approach to be fully embedded.* *• Full implementation of the new target operating model has been delayed pending recruitment to vacant posts. Final recruitment campaign was very successful and vacant posts have been offered. The new TOM will be fully operational from January 2019.* *• An interim Principal Social Worker is in place and has taken on additional responsibilities for Service Improvement.*
	g	• Dedicated post funded by Improved Better Care Fund to increase the update of care technology. • Regular intensive care meetings include monitoring of the uptake of telecare installations and use of extra care housing - measures have been added to the monthly performance scorecard.	**2**	**2**	**2**	**2**	*• Performance is improving but remains below target. Confidence in agreed action plans.*
3. Eligibility criteria that is clearly defined in terms of social care needs and health needs that is rigorously enforced	h	• The Care Act introduced a set of National Eligibility Criteria which all Local Authorities must adhere to when completing a new assessment of unmet need or a re-assessment of need. • All Care Management teams have received the necessary training with refresher courses available. • Paris assessments now enable practitioners to record their judgements against the eligibility criteria contained in the Care Act and associated guidance.	**3**	**3**	**2**	**2**	*• Interim Principal Social Worker in place and has taken on additional responsibilities for Service Improvement. Further work around training, and an Adult Social Care development plan being implemented.* *• A service development plan has been agreed and is being implemented. This will be reviewed and updated on current implementation at ASC Improvement board.*

4. Robust processes and policies to ensure that both accurate and timely bills are issued to clients and that maximum client contributions are collected /recovered.	i	• Reconciliation of Paris and Business World records now in place • Process changes have been implemented, including clarification of roles	**3**	**2**	**2**	**2**	*• Trend analysis of the number of complaints and enquiries undertaken by Paris team.* *• Anticipated that new CCM system ('Care Works') will facilitate a robust reconciliation process with Business World.*
5. Regular review and reassessment process to ensure that service provision meets clients needs	j	• A dedicated internal review team is in place. • Reviews are subject to quality assurance and the programme is overseen by the Improvement Board.	**3**	**3**	**3**	**3**	*• Review performance improved but this remains below target. Improvements have been consolidated in terms of number of reviews completed but not fully realising financial benefits so remains limited assurance and subject to additional scrutiny at Adult Social Care Improvement Board.*

6. Direct Payments process with required controls to ensure the correct amounts are paid according to an individual's assessed social care needs and financial assessment	k	• There is an accountable CMT lead and clear process and procedures which are followed by all involved in the customer journey. • Principal Social Worker has lead role in respect of system development.	3	3	3	3	*• Internal audit report published on 14 June 2017 gave an opinion of "no assurance".* *• Management action plan being implemented to mitigate risk and provide required assurance. Programme Management Office (PMO) is supporting.* *• Adult Intensive support meeting that were suspended in Q1 have been restarted and are chaired by Deputy Chief Executive in Q2. The targets are being renegotiated for 2018/19 to ensure they are stretching but achievable. Revised targets approved by Project Board for consideration by Cabinet/CMT in Q2. Direct Payments will not be highest priority, and will be maintained at current levels. To ensure consistency and use of directly delivered services.* *• Two new Direct Payment Financial Auditors posts are to be appointed by Internal Audit to seek assurance that direct payment monies are be spent as per the clients agreed care plan. Initial post*
7. Robust and regular budget monitoring and review process including review and challenge re third party service provider costs	l	• Robust process in place across all ASC teams comprising a three stage process which runs monthly in conjunction with colleagues from the Finance and the Integrated Commissioning Unit. • A challenge and review panel meets every week and every new package of care requested is scrutinised by a Service Manager before a placement and cost are agreed.	2	2	2	2	*• Panel is providing assurance to regular intensive support budget meetings and the ASC Improvement Board.*

	m	• Delivery of savings action plan to bring budget into line	4	3	3	3	• *Current Adult Social Care in year overspend.* • *Delivery of current and future savings plans monitored through intensive support process*
8. Contingency plan in place to mitigate risk of failure of major home care provider.	n	• 'Provider failure protocol' policy in place with well rehearsed provider failure contingency arrangements including up to date reviews, options appraisal including short term TUPE of care staff into council and communications plan. • Regular meetings with Integrated Commissioning Unit and Adult Social Care operations to review and update contingency arrangements.	NEW	2	2	2	• *See SRR02(a) Item 5L which refers to ICU monitoring of key suppliers.*

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There is clear evidence of a robust and effective process, framework or activity that is operating effectively and is delivering the required outcomes.	*There is evidence of a sound process or framework in place however there are some inconsistencies or gaps. Effective delivery of required outcomes may not always be consistent and/or reliable.*	*Evidence of inconsistent application and/or critical weakness(es) within the process, framework or activity. The delivery of required outcomes is inconsistent and/or unreliable.*	*There is no, or insufficient, evidence of an appropriate policy, framework or activity. Required outcomes are not being delivered.*

RISK No: SRR10	Last updated: 24/09/2018

OUTCOME	Children and young people get a good start in life

RISK DESCRIPTION	
Failure to ensure an effective and sustainable children's social care system	
RISK OWNER	Service Director Children and Families
PORTFOLIO(S)	Children and Families

RISK SCORE	LIKELIHOOD	IMPACT
CURRENT	C - Possible	2 - Major
Target	D - Unlikely	2 - Major

		2017-18		2018-19	
EXPECTED KEY CONTROLS	SOURCE(S) OF ASSURANCE	Q3	Q4	Q1	Q2
		ASSURANCE LEVEL			
1. Assessment of current and future service demand (and projected cost) together with an understanding of the underlying demand triggers	a • Internal and external multi-agency panels look at demand in terms of both Looked After Children and the capacity and support available from the Early Help & Early Years Service.	2	2	2	2
	b • Financial plan and projections (including the spend in respect of 'looked after children') have been developed as part of the 4 year financial plan.	2	2	2	3
	c • Budget position is closely monitored recognising the challenges regarding the costs associated with Looked After Children.	-	-	NEW	3
2. Appropriate range of preventative / early intervention actions that seek to manage and/or reduce future interventions	d • Multi-agency work, co-ordinated by the Early Help & Early Years Service, with partners such as public health, housing, education including 'Early Help' and 'Sure start'.	2	2	2	2
	e • The capacity and resources to deliver a range of appropriate 'preventative/early intervention' services is in place and includes implementation of the 0-19 Offer and the 'Edge of Care' service which both support front line services.	2	2	2	2

MITIGATING ACTIONS / COMMENTS
• *Early Help and Early Years service to be redesigned in order to postively impact on demand in respect of referrals to the MASH. This follows further analysis of demand drivers.*
• *£3.5m savings target for 2019-20 and 2020-21.*
• *At end of Period 5 Financial Monitoring there is an £4.5m adverse variance in respect of Childrens and Families.*
• *Early Help and Early Years years service to be reviewed and redesigned in order to in order to postively impact on demand in respect of referrals to the MASH.*

3. Intervention criteria that is aligned with good practice, clearly defined and communicated and applied on a consistent basis.	f	• Document reviewed annually by the LSCB with threshold criteria applied to all referrals. This document is part of the LSCB multi agency guidance. • Support Guidance for Referrers - The Southampton 'Continuum of Need' which introduces four levels of intervention for the City.	**2**	**2**	**2**	**2**	
	g	• The threshold criteria is applied effectively across all children's social care in order to ensure that children and families receive the services and to enable SCC to prioritise those in greatest need. •The Quality Assurance mechanism and auditing reviews cases to identify that the threshold applied consistently and is in line with the policy.	**2**	**1**	**1**	**2**	*• Threshold criteria has been reissued with the intention of having a positive impact on reducing the number of 'Looked after children'. This is in conjuction with the redesign of the Early Help and Early Years years service.*
4. Robust assessment of current and future staffing requirement with a contingency arrangement in place in respect of unforeseen pressures or staff shortages.	h	• Children's Transformation and Improvement Plans, informed by OFSTED requirements, are in place and being overseen by workstreams reporting to the Childrens' Improvement Board. • The Board scrutinizes the improvement plans, which span a 4 year period, and acts as a critical friend.	**3**	**2**	**3**	**3**	*• Satisfactory progress was made in terms of delivery of the Year 1 actions within the improvement plans . Year 2 actions are being progressed.* *• The Phase 3 organisational restructure was implemented across all areas and, although a recruitment exercise was successful in terms of filling some posts, there are still vacancies in social worker posts across the service which is impacting on the agency budget.*
	i	• A 'Memorandum of Co-operation' in place which is a regional agreement designed to reduce the instability caused by social worker turnover and the associated costs of employing excessive numbers of agency staff. Also sets out aspirations to work more closely together to increase supply of children's social workers. • 17 of the 19 local authorities in the region have pledged their support to this approach and the MoC is now operational.	**2**	**2**	**2**	**2**	*• There is tangible evidence of the MOC making a difference in terms of less turnaround of agency staff which, in turn, has created greater stability in the workforce.* *• The number of agency workers remains static and there will be a continued pressure on the budget due to posts not being able to be filled.*

5. Compliance with statutory guidance (Working Together to Safeguard Children 2015)	j	• The Quality assurance framework, in particular the file audit process, provides evidence as to compliance with 'Working Together'. • There are also associated performance management, staff supervision and escalation arrangements in place.	**2**	**2**	**2**	**2**	*• External validation of compliance is provided by a combination of internal reviews, Ofsted inspections and Internal Audit reviews.* *• The requirements of the new 'Working Together to Safeguard Children 2018' have been adopted.*
6. The options available in respect of vulnerable children reflect both the need, range and quality of required outcomes with an associated realistic and reasonable budget provision.	j	• The Council is part of the South Central framework for Independent Foster Care which is a regional consortium of local authorities that provides a collaborative approach to managing the Independent Fostering Agency (IFA) market.	**2**	**2**	**2**	**2**	*• In respect of the outcomes available to looked after children, the limited availability of in-house foster care provision creates significant budget pressure.* *• Service is working hard to recruit in-house foster carers with some recent positive movement.* *• There is continuing pressure on the Residential Budget in terms of placements noting that 11 young people have recently been identified to leave residential care.*

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RISK No: SRR11	Last updated: 13/09/2018

OUTCOME	A sustainable council

RISK DESCRIPTION
The impact of organisational change and service redesign solutions, whilst delivering savings, create other unplanned for pressures and challenges

RISK OWNER	Strategy Hub Management Team
PORTFOLIO(S)	Leader and Clean Growth and Development

RISK SCORE	LIKELIHOOD	IMPACT
CURRENT	C - Possible	3 - Significant
Target	D - Unlikely	3 - Significant

EXPECTED KEY CONTROLS		SOURCE(S) OF ASSURANCE	2017-18 Q3	2017-18 Q4	2018-19 Q1	2018-19 Q2	MITIGATING ACTIONS / COMMENTS
1. Robust organisational and service redesign processes that includes appropriate prompts to ensure that proposals are sustainable in terms of delivery of savings whilst maintaining an appropriate level of customer service.	a	• 'Design Principles' established for future change have been agreed and are in place • Major changes require Organisational Design Board ('OD Board') overview – via Chief Financial Officer, SD HR & OD and Deputy Chief Executive and these are then recorded and notes and business case detail held. • Changes within service budgets that do not include any redundancies are agreed at Service Director ('SD') level and tracked with Finance Business partners and form part of monthly salary monitoring. • Lessons learned from restructures are used to inform further transformation; key stakeholders review each restructure with the SD and HR to determine any lessons to take forward for future plans.	2	2	2	2	*• Major change where there are possible redundancies require OD Board oversight and approval and notification through formal S188 papers; S188s are reviewed to ensure consistency of practice and HR have assigned Advisors to such change.* *• Business planning now takes account of service design as part of outcome based budget/ business plan work*
2. Organisational and service redesign solutions are approved by a senior manager group that has organisation wide oversight.	b	• OD Board in place and established with organisation design principles agreed. • Applied for all restructures that have any redundancy implications and supported by HR Advisory service • Section 188 document issued for restructure and 45 day consultation process applied • SD led changes are overseen by HR Advisors and Finance Business Partners	2	2	2	2	*• HR log all change and effect on posts / structures and review at monthly HR team meeting for consistency of approach and overall council effect. Workforce profile is mapped and tracked monthly; workforce data is managers for service review.*

3. Organisational and service redesign proposals are developed in consultation with all key internal stakeholders.	c	• 'Restructure communication and engagement plans are standard; Cabinet Members and trade union are briefed on all proposals ; face to face staff briefings; one to one meetings; end proposals published • OD Board to be satisfied that key stakeholders have been appropriately identified and that the likelihood of any potential unintended consequence is minimised. This is helped by a new standard format for S188 and summary of affected posts and by the OD Board having the overview of all proposals for approval. • Papers to the OD Board need to include a section that identifies other services that may be impacted by the proposed changes; this is communicated via Service Directors to their managers and discussed with trade unions ahead of any proposals being approved • SD led redesign - standard consultation is still required - dependent on impact on staff (10 days minimum for line management changes; 45 days if posts affected.	**2**	**2**	**2**	**2**	*• The OD Board is convened for all major change proposals to provide assured consideration of service impact, council wide issues and financial, HR and legal implications* *• OD Board chaired by Deputy CX and convened as required.*

4. The rationale for significant change is clearly communicated to all stakeholders	d	In terms of restructures: • All S188 documents are issued via face to face briefings for affected staff and trade union reps. • Documents are sent to Cabinet and Opposition Members and uploaded to intranet pages - including all presentation slides; • Affected staff are offered one to one meetings and HR Advisors support the whole process • Feedback is used to inform final proposals which are then communicated prior to implementation. In terms of broader communications: • Regular bulletins and updates are sent to staff • PULSE, the staff engagement group, meets regularly to discuss key issues • Specific communications (face to face, via email, Staff Stuff and other channels) are produced on specific change projects, such as LATCo. • SD led proposals still require face to face briefings of staff (and unions)	**2**	**3**	**3**	**3**	*• The Staff Survey 2018 is due to go live at the end of September, and we will be able to assess feedback regarding internal communications once that is complete.* *• A Senior Internal Communications Officer in is post and significant work has been undertaken to improve internal communications. For example, over 60 staff briefings have been held this year to communicate plans for LATCo to staff.* *• Communications, HR and Interim CX reviewing PULSE and overall Staff Engagement to assess and improve internal communication channels;* *• Lessons from LATCO briefings will be used to inform future approaches to significant change*

5. Proposals for digitisation or automation of aspects of service delivery are robust in terms of current and future costs and are effective in delivering the required outcomes.	e	• The need for a technical solution and the solution proposed are agreed with the Service Lead for Digital and IT and approved by the Customer and Digital Board. • Financial case including contingency provision is agreed by Finance, Service Director and Customer and Digital Board or CMT as appropriate. Funding is secured. • Project management is in place, allowing for procurement, consultation and implementation as required. • Project governance and reporting requirements are agreed by Customer and Digital Board.	2	3	3	3	*• It is proposed in the light of the termination of the contract with Capita that Service Director packs not yet approved will be discontinued and the proposals within them reviewed by the Service Lead for Digital and IT, the Customer and Digital Board and the relevant Service Leads and Directors.* *• The top 20 digital journeys are being re-worked through tactical CRM improvements agreed by Capital Board in July.* *• The Service Lead for Digital and IT is evaluating the potential of a new range of digitisation opportunities such as Artificial Intelligence for simple customer service tasks. These will be progressed via the Customer and Digital Board.*

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RISK No: SRR12	Last updated: 15/10/2018

OUTCOME	People live safe, healthy, independent lives

RISK DESCRIPTION	
Failure to improve air quality to legal levels by 2020.	
RISK OWNER	Service Director Transactions & Universal Services
PORTFOLIO(S)	Green City

RISK SCORE	LIKELIHOOD	IMPACT
CURRENT	C - Possible	2- Major
Target	D - Unlikely	4 - Moderate

2017-18		2018-19	
Q3	Q4	Q1	Q2

EXPECTED KEY CONTROLS		SOURCE(S) OF ASSURANCE	ASSURANCE LEVEL				MITIGATING ACTIONS / COMMENTS
1. Compliance with statutory duty to review and assess air quality in the city.	a	*• Air quality monitoring, review and assessment in accordance with Local Air Quality Management Technical Guidance.* *• Statutory air quality reports (primarily Annual Status Report 'ASR') completed annually summarising review and assessment process. Reports submitted by June to Department for Environment, Food and Rural Affairs ('Defra') for approval.* *• 2017 ASR completed and approved. 2018 ASR still being drafted.*	-	NEW	1	2	*• 2018 ASR overdue due to lack of capacity in service due to long term sick and vacancies plus pressures associated with Clean Air Zone ('CAZ') work. Work is now being outsourced and is due to be completed by the end of quarter 3. Arrangements to deliver the 2019 ASR through the same process being established as a contingency.* *• All statutory air quality reports to be subject to internal consultation and CMB approval prior to formal publication.*

2. Programme of measures to reduce emissions of nitrogen dioxide, particulates and other pollutant together with an assessment of their effectiveness and an appropriate reporting process.	b	*• Air Quality Action Plan ('AQAP') details programme of measures to reduce nitrogen dioxide and other pollutants. This is reviewed and published annually with the ASR (see above).* *• Statutory reports require assessment of effectiveness by monitoring against baselines and updating progress against key performance indicators (KPIs) and is reviewed by Defra.* *• Grant funding received from Defra or Department for Transport (DfT) for air quality requires specific grant returns that includes progress updates against KPIs.* *• Ministerial direction to assess the need for a CAZ has generated a feasibility study to identify mechanism that will ensure compliance with EU Directive in shortest possible time. This is being monitored by government's Joint Air Quality Unit (JAQU) and a Plan (with a scheme of evaluation) is to submitted for approval by the Secretary of State by the end of November 2018.*	-	**NEW**	**1**	**3**	*• Future AQAP to include a performance indicator for each measure to evaluate effectiveness and delivery and a dashboard to ensure effective management review and assessment against funding/grant objectives and returns.* *• Consultation on CAZ closed on 13th September 2018. Progress report submitted to JAQU on September 15th indicating that November deadline for Full Business Case could not be achieved if a charging scheme were still in consideration following the assessment of the consultation.* *• Negotiations with JAQU are underway regarding deadlines imposed by Ministerial Direction. Reporting delays are not anticipated to impact on delivery and implementation of subsequent scheme meaning EU Ambient Air Quality Directive annual mean nitrogen dioxide limit can still be met as quickly as possible. FBC will include evaluation and monitoring plan. FBC will be reviewed by independent panel of experts for deliverability and will subsequently be approved by Secretary of State*

3. Assessment of the programme of measures to ensure that any unintended consequences, that could have a significant adverse impact on the local economy, are identified and minimised.	c	*• All significant Air Quality projects screened for unintended consequences and mitigations implemented where necessary.* *• Grant funding from Defra or DfT requires assessment of unintended consequences and only approved where risks are mitigated (demonstrated through risk registers and monitoring and evaluation plans).* *• CAZ business case includes a city wide economic appraisal of options. A distributional impact assessment will identify adverse impacts and the Governments Clean Air Fund is available to fund mitigations for adverse impacts. Equality and Safety Impact Assessment included to identify impacts for protected groups.*	**-**	**NEW**	**1**	**2**	*• Future AQAP to provide dashboards reporting outcome of impact screening assessment* *• Economic Assessment and Equality Impact Assessment both included in the CAZ consultation package and being reviewed as part of that process.* *• Further impact assessment on port operations underway and the need for specific assessments for other key stakeholders being evaluated in response to consultation.*
4. Monitoring and reporting arrangements in respect of the progress toward /achievement of the required clean air targets with appropriate interventions	d	*• Air quality monitoring, review and assessment in accordance with Local Air Quality Management Technical Guidance.* *• Statutory air quality reports completed annually summarising review and assessment. Reports reviewed and approved by Department for Environment, Food and Rural Affairs (Defra).* *• Air quality monitoring data from automatic monitoring sites undergo external and independent quality controlled and assurance.* *• Laboratory analysing nitrogen dioxide diffusion tubes externally assessed through national quality regime and holds UKAS accreditation.* *• AQAP measures progress on delivery of measures*	**-**	**NEW**	**1**	**1**	*• Independent audit of NO2 diffusion tube monitoring network being commissioned.* *• All existing quality assurance procedures for monitoring data being maintained and no issues identified.* *• 2018 ASR & AQAP to include improved transparency regarding success of individual measures.* *• Modelling methodologies used for CAZ assessment successfully passed JAQU's quality assurance process.* *• Monitoring and evaluation scheme to support CAZ Plan in development.*

5. The financial, reputational and public health consequences of not meeting the required targets are understood and articulated.	*• Air Quality Communications Plan maintained and presented to monthly CMB.* *• Specific Communications Plan for CAZ project overseen by CAZ Implementation board.* *• Communication and Marketing Plan accompanied delivery* *• Strategic and financial businesses cases included within CAZ Full Business Case in development.*	**-**	**NEW**	**2**	**2**	*• Communication and Marketing Plan accompanied delivery of CAZ consultation exercise.* *• Financial model for CAZ now in development.* *• Counsel appointed to provide legal opinion on implication of CAZ delivery to inform direction of Plan and supporting business case.*
6. Work with communities, individuals, businesses and organisations to educate and promote the uptake of low emission technology and change travel behaviours including the Council being an exemplar of sustainable working practices	e *• Electric Vehicle Action Plan with budget in place. This plan outlines £1m spend on recharge infrastructure, fleet upgrades, and promotional activity for low emission vehicles.* *• The Access Fund programme is a 3 year behaviour change programme targeting key schools, workplaces and community groups to encourage modal shift towards walking and cycling. Quarterly Board meetings monitor progress of initiatives.* *• Clean Air Network introduced by SCC to provide a platform to encourage and inform them other to deliver change, share good practice amongst themselves, understand the benefits and identify how to overcome obstacles. Being delivered in collaboration with Southampton's Environment Centre (tEC)*	**-**	**NEW**	**2**	**1**	*• SCC has secured funding to deliver an electric vehicle upgrade within its own fleet and ensure waste vehicles are CAZ compliant.* *• Air Quality Board established to oversee EVAP, CAN and associated campaigns e.g. the No-Idling campaign delivered in Q1.* *• August Access Fund Board reported all initiatives on target and within budget.* *• CAN membership reached 150. Platform used to promote CAZ consultation. Second CAN workshop being developed to promote EV's in the business fleet and work place EV charging.*

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RISK No: SRR13	Last updated: 08/10/2018

OUTCOME	A sustainable council

RISK DESCRIPTION	
Service areas fail to adhere to and comply on a consistent basis with the council's 'Contract Procedure Rules'	
RISK OWNER	Service Director Digital and Business Operations
PORTFOLIO(S)	Finance and Customer Experience

RISK SCORE	LIKELIHOOD	IMPACT
CURRENT	Possible	Significant
Target	Unlikely	Significant

EXPECTED KEY CONTROLS		SOURCE(S) OF ASSURANCE	2017-18 Q3	2017-18 Q4	2018-19 Q1	2018-19 Q2	MITIGATING ACTIONS / COMMENTS
1. Clear and concise guidance documents, that reflect both legislation and good practice, are readily accessible to officers and are subject to periodic review.	a	• Contract Procedure Rules (CPRs) reviewed annually and available via the Procurement Service intranet pages (and via the constitution) • New, succinct Procurement Strategy approved by Cabinet in January 2018. • Over the past 12 months the Supplier Management team has updated the procurement processes, guidance and forms available on the intranet to ensure a simple and user friendly process with one route to spending council money. • As part of the introduction of requisitioning, user guides (including "Business World Requisitions User Guide") have been developed.	-	-	2	2	*• Further review of benefits of current thresholds for procurement involvement undertaken in Sept 2018.Proposals will be brought forward for approval at the Council's AGM in May 2019.* *• Project to digitalise procurement forms is being undertaken. This is in progress, but has been hampered by the termination of the Capita contract.* *• Six monthly review of procurement guidance in process. The next review will be completed no later than 31/12/18* *• Review of Ethical and Sustainable procurement policies due to be undertaken in Q3-Q4 of 2018/19 and preparatory work is in progress.* *• The use of 'Feeder Systems' to create financial commitments and the associated processes is to be reviewed. CMT have agreed that this work will commence from October*

	b	• Joint SCC/Capita governance will oversee operational improvements to the Procurement Service and monitor compliance.	-	-	-	2	• *Reporting mechanisms are being refined and developed and investigations are being undertaken and prioritised on a risk basis.*
2. The type and scope of advice and support available to service areas is clearly signposted with capacity aligned to demand.	c	• The procurement section of the intranet sets out where and how advice can be obtained and escalation channels. The procurement service will transfer to the Council from Capita no later than 22/07/18.	-	-	3	3	• *The procurement service will transfer to the Council from Capita no later than 22/07/18.* • *Work continuing to refine and digitalise forms and updates to reflect requisitioning and P2P (see Key Control 1)*
3. Communication and training to ensure that all relevant staff are aware of, and fully understand the need to comply with the council's 'Contract Procedure Rules'.	d	• *Workshops with users of Procurement Service held in 2017 and surveys conducted to better understand and address user issues with procurement processes and remind of processes to follow; the updates to information and training are being driven in part by the findings of these workshops* • *April 2018 - Mandatory e-learning developed and rolled out to those involved in spending/processing council spend. E-learning module "Buying for the Council" informs when and how council money can be spent.* • *Sub-100k meetings held with Service Directors 2017/18 to investigate instances of non-compliance, identify why it had occurred and to remind officers of compliant process. Resulted in a better understanding of process by Service Directors and allowed for more positive cascading of message; this is now beginning to drive the change in culture required to help the Council move to consistent*	-	-	3	3	• *Regular reports of staff who have undertaken the training are produced by the L&D service. The Supplier Management team reviews and contacts services areas who have not undertaken the training.* • *Target of 31st July 2018 for completion of the mandatory e-learning by relevant staff. CMT have agreed a number of steps to try to ensure that those staff who have not yet undertaken the training do so no later than the end of November 2018* • *Hold procurement workshops and surveys in 2019 to assess changes in perception of the service. (not yet due)*

4. An assessment of the level of compliance with 'Contract Procedure Rules' undertaken on a periodic basis and reported to senior management	e	*• Quarterly monitoring of compliance levels with the sub £100k process when compared to previous years by comparing utilisation levels* *• This will be reviewed through the governance mechanisms for the procurement service*	-	-	3	3	*• Compliance rates are improving* *• Reporting of spend all council spend to be further developed to flag annual values spent with each supplier and support Service Directors in identifying when CPRs are not being followed. These reports are being refined and the new versions will be in place no later than 30/11/18.* *• More detailed compliance reporting to be developed through implementation of P2P from April 2019 onwards* *• Dedicated business analyst role has been created in the Procurement Service to focus on data and compliance reporting; this post has now been filled and is leading on compliance reporting*
5. Sanctions applied in the event of persistent or deliberate non-compliance with 'Contract Procedure Rules'	f	*• Non compliance with CPRs will be reported to the appropriate Service Director to review the appropriate course of action.* *• Section 2 of the CPRs states that "Officers who do not follow these Rules and/or fail to enter into a contract on behalf of the Council in accordance with them may be subject to disciplinary proceedings".*	-	-	3	3	*• Reporting information will be made available to Service Directors to allow them to investigate non-compliance and consider the appropriate course of action.* *• Continue to investigate instances of non-compliance to identify why these are occurring and to remind officers of compliant process. This will be the responsibility of the procurement team.*

6. IT Software systems support compliant procurement processes	g	*• Recent introduction of requisitioning and the introduction of P2P from April 2019 should ensure all spend is processed through the requisition workflow (to mandate that CPR processes are followed and procurement are involved in all spend as specified in CPRs).* *[**Note** : this is already in place apart from for the Feeder systems which are subject to separate actions]*	-	-	2	2	*• Through P2P process improvements from April 2019 onwards, mandate the requisitioning process by introducing system controls (where possible) which provide no alternative route to processing orders and/or allowing suppliers to be paid including:* *- Empowering the Procurement Service to reject non-compliant orders.* *- Control of supplier set up and usage – Regulating who can set suppliers up and managing when and how they can be used.* *- Requiring officers to state contract name on requisition when wishing to use a specific supplier because a contract is believed to exist.* *- Linking products (including services) to Contracted Suppliers in Business World to ensure that contracts are only used for the purpose they were set up for (i.e. a user will not be able to use supplier to purchase an item for which it does not have a contractually linked product).*

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Version Control

VERSION HISTORY					
Version No	Reviewed by	Review date	Version No	Reviewed by	Review date
01	Council Management Team	30/06/15	07	Council Mgmt Team (virtual)	23/10/17
02	Council Management Team	22/09/15	07	Governance Committee	13/11/17
03	Council Management Team	13/10/15	08	Strategy Hub Management Team	26/02/17
03	Cabinet / CMT	09/11/15	08	Operations Hub Management Team	29/01/17
03	Governance Committee	09/11/15	08	Council Mgmt Team (virtual)	02/03/17
04	Council Management Team	26/01/16	09	Council Management Team	14/05/18
05	Council Mgmt Team (virtual)	28/02/17	10	Council Mgmt Team (virtual)	26/07/18
06	Council Management Team	25/07/17	11	Council Management Team	15/10/18
07	Strategy Hub Management	22/08/17	11	Governance Committee	12/11/18
07	Operations Hub Management	09/10/17			

Version	NEW & EMERGING RISKS INCLUDING ANY SIGNIFICANT CHANGES	ACTION
08	**SRR05** - Significantly revised to incorporate the status of operational H&S issues as requested by the H&S Board	AMEND
	SRR11 - 'Failure to undertake reasonable actions and /or to provide timely and appropriate communications to key stakeholders following the Grenfell Tower Fire' Closed : H&S Board recognised that this was a specfic and time limited risk and it was appropriate for residual fire safety issues to be incorporated into the reformatted H&S Strategic Risk.	**CLOSED**
	SRR12 - renamed as SRR11	AMEND
	New Summary 2 page added	
09	**SRR02b** - New risk created to separately reflect IT risks	**NEW**
	SRR08 - Risk Description revised	AMEND
	SRR12 - New risk agreed - Air Quality	**NEW**
10	**SRR13** - New risk added - Compliance with Contract Procedure Rules	**NEW**
11	**SRR08** - Closed "Those services delivered via an 'alternative service delivery model' fail to deliver the council's required outcomes in terms of sustainability and cost effectiveness". In view of decision to pause LATCo this was no longer considered to be a strategic risk noting that SRR01 (Item 6) refers to income generation activities.	**CLOSED**
	Risk numbering amended following closed risk	AMEND