MORAY INTEGRATION JOINT BOARD

AUDIT, PERFORMANCE AND RISK COMMITTEE

Thursday, 27 August 2020

remote locations via video conference

NOTICE IS HEREBY GIVEN that a Meeting of the **Moray Integration Joint Board Audit, Performance and Risk Committee** is to be held in **remote locations via video conference**, on **Thursday, 27 August 2020** at **13:00** to consider the business noted below.

AGENDA

MORAY INTEGRATION JOINT BOARD

AUDIT, PERFORMANCE AND RISK COMMITTEE

MEMBERSHIP

Councillor Theresa Coull (Chair)	Moray Council
Councillor Tim Eagle	Moray Council
Mr Sandy Riddell	Non-Executive Board Member, NHS Grampian
Mr Dennis Robertson	Non-Executive Board Member, NHS Grampian

NON-VOTING MEMBERS

Ms Elidh Brown	tsiMORAY
Mr Steven Lindsay	NHS Grampian Staff Partnership Representative

ADVISORS

Ms Tracey Abdy	Chief Financial Officer, Moray Integration Joint Board
Ms Pamela Dudek	Chief Officer, Moray Integration Joint Board
Mr Atholl Scott	Chief Internal Auditor, Moray Integration Joint Board

Clerk Name:

Clerk Telephone: 01343 563014

Clerk Email: committee.services@moray.gov.uk

MINUTE OF MEETING OF THE MORAY INTEGRATION JOINT BOARD

AUDIT, PERFORMANCE AND RISK COMMITTEE

Thursday, 30 January 2020

Inkwell Main, Elgin Youth Café, Francis Place, Elgin, IV30 1LQ

PRESENT

Ms Tracey Abdy, Ms Elidh Brown, Councillor Theresa Coull, Mrs Pam Dudek, Councillor Tim Eagle, Mr Steven Lindsay, Mr Sandy Riddell, Mr Dennis Robertson, Mr Atholl Scott

IN ATTENDANCE

Ms Jeanette Netherwood, Corporate Manager; Mr Bruce Woodward, Senior Performance Officer; and Mrs Caroline Howie, Committee Services Officer, Moray Council, as clerk to the meeting.

1 Chair of Meeting

The meeting was Chaired by Councillor Theresa Coull.

2 Declaration of Member's Interests

There were no declarations of Members' Interests in respect of any item on the agenda.

3 Minute of Meeting dated 19 September 2019

The Minute of the meeting of the Moray Integration Joint Board Audit, Performance and Risk Committee dated 19 September 2019 was submitted and approved.

4 Action Log of Meeting dated 19 September 2019

The action log of the Moray Integration Joint Board Audit, Performance and Risk Committee dated 19 September 2019 was submitted and it was noted that all actions, other than the following, had been completed:

Item 1 ' Action Log of Meeting dated 28 March 2019' - data not forthcoming from NHS, the Chief Officer will raise this at a senior level. Due date to be updated to March 2020.

Item 2 ' Strategic Risk Register - September 2019' - there are similar issues with obtaining data in relation to staff recruitment and retention. Due date to be update to March 2020.

Item 4 ' Payment Verification Assurance Update' - a new contracts manager has been appointed; due date to be further updated to March 2020.

5 Quarter 2 (July - September 2019) Performance Report

A report by the Chief Financial Officer updated the Committee on the performance of the Moray Integration Joint Board (MIJB) as at Quarter 2 (July - September 2019/20).

Mr Woodward advised it was the intention to change the format of the report and a suggested template would be provided to the next meeting for consideration.

Discussion took place on issues with performance which were being escalated to the performance meeting; it is hoped this will see an improvement during the next reporting period.

Thereafter the Committee agreed to note:

i. the performance of local indicators for Quarter 2 (July - September 2019) as presented in the summary report at appendix 1 of the report;

ii. the analysis of the local indicators that were highlighted and actions being undertaken to address performance that is outside of acceptable target ranges as contained within Section 5 of the report; and

iii. a further report with a suggested new template will be presented to the meeting in March.

6 Strategic Risk Register - January 2020

Under reference to paragraph 13 of the Minute of the meeting of the Moray Integration Joint Board dated 28 November 2019 a report by the Chief Officer provided an overview of the current strategic risks, along with a summary of actions which are in place to mitigate those risks, updated January 2020.

During discussion of the risks being faced it was stated there would be pressure in the future as a number of senior staff are due to retire.

Thereafter the Committee agreed to note the:

i. amendments to the description of risk; and

ii. updated Strategic Risk Register and action plan included in appendices 1 and 2 of the report.

7 Internal Audit Update

Under reference to paragraph 12 of the draft Minute of the meeting dated 19 September 2019 a report by the Chief Internal auditor provided Committee with details of progress on projects contained within the Internal Audit plan for 2019/20 financial year.

Discussion took place on the progress of audit work for those areas identified in the report.

Thereafter the Committee agreed to note that:

i. while some projects have been taken forward, there is further work required to bring these to a formal conclusion; and

ii. that audit assurances informing the annual audit opinion for the Moray Integration Joint Board for the 2019/20 year will continue to be drawn from the Council and NHS respectively.

8 Public Sector Internal Audit Standards - External Quality Assessment of Internal Audit

A report by the Chief Internal Auditor provided the Committee with details of an external quality assessment undertaken on the council's internal audit service.

Following consideration the Committee agreed to note the report and the action plan prepared to address the issues raised in the external quality assessment of internal audit.

9 Civil Contingencies - Resilience Standards Progress

A report by the Corporate Manager informed Committee of Health and Social Care Moray's progress against NHS Grampian's Resilience Improvement Plan 2019-2021 and provided an overview of the work of the Health and Social Care Moray (HSCM) Civil Contingencies Group.

The Chief Officer advised she was always on call during emergency situations. The system had been tested and was found to work well.

Following discussion the Committee agreed to note the:

i. contents of the report alongside the HSCM Civil Contingencies Group Action Plan, provided at appendix 1 of the report;

ii. outcome of the Primary Care Business Continuity external audit by PricewaterhouseCoopers, shown in appendix 2 of the report; and

iii. progress to date and that an annual report will be requested from the HSCM Civil Contingencies Group.

MEETING OF MORAY INTEGRATION JOINT BOARD

AUDIT, PERFORMANCE AND RISK COMMITTEE

THURSDAY 30 JANUARY 2020

ACTION LOG

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY
1.	Action Log of Meeting dated 19 September 2019	Action Log of Meeting dated 28 March 2019 – report on NHS staff sickness absence rescheduled to March.	Mar 2020	T Abdy
2.	Action Log of Meeting dated 19 September 2019	Strategic Risk Register – September 2019 – report in relation to staff recruitment and retention rescheduled to March.	Mar 2020	J Netherwood
3.	Action Log of Meeting dated 19 September 2019	Payment Verification Assurance Update – further rescheduling of report to March 2020.	Mar 2020	Sean Coady
4.	Quarter 2 (July – September 2019) Performance Report	Possible new reporting template to be provided to the next meeting.	Mar 2020	Bruce Woodward
5.	Civil Contingencies – Resilience Standards Progress	Annual assurance report to be requested from Health and Social Care Moray Civil Contingencies Group.	Aug 2020	J Netherwood

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 27 AUGUST 2020**

SUBJECT: **QUARTER 1 (APRIL – JUNE 2020) PERFORMANCE COVER REPORT**

BY: **CHIEF FINANCIAL OFFICER**

1. REASON FOR REPORT

1.1 To update the Audit, Performance and Risk (APR) Committee on its performance as at Quarter 1 (April – June 2020).

2. RECOMMENDATION

2.1 It is recommended that the APR Committee consider and note:

i) the performance of local indicators for Quarter 1 (April – June 2020) as presented in the Performance Report at APPENDIX 1;

ii) the analysis of the local indicators that have been highlighted and actions being undertaken to address performance that is outside of acceptable target ranges as detailed in APPENDIX 1;

3. BACKGROUND

3.1 The purpose of this report is to ensure the Moray Integration Joint Board (MIJB) fulfils its ongoing responsibility to ensure effective monitoring and reporting on the delivery of services and on the programme of work as set out in its Strategic Plan.

3.2 **APPENDIX 1** identifies local indicators for the MIJB and the functions delegated by NHS Grampian and Moray Council, to allow wider scrutiny by the Board.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 Local Indicators are assessed on their performance via a common performance monitoring Red, Amber, Green (RAG) traffic light rating system.

RAG scoring based on the following criteria:	
GREEN	If Moray is performing better than target.
AMBER	If Moray is performing worse than target but within agreed tolerance.
RED	If Moray is performing worse than target by more than agreed tolerance.

4.2 The detailed performance report for quarter 1 is attached in **APPENDIX 1.**

Summary:
Performance within Health and Social Care Moray (HSCM) as demonstrated by the agreed indicators up to the end of quarter 1 of the financial year 2020/21 is showing as generally positive; however the impact of COVID-19 and the changes made to routine procedures in hospitals and care homes has had a knock on impact to HSCM services that will only become evident in future quarters.

Three indicators are new and have no target set. These indicators will be monitored throughout the year and targets will be set in Q1 2020/21. There is currently no data available for SM-01 and SM-02 due to the COVID-19 pandemic interrupting operations within the HR departments.

The impact of COVID-19, where the whole system was working to a different set of priorities, will mean that it will not be possible to draw direct comparisons with previous years. Where the acute sector ceased elective operations this will have meant a reduction in the number of admissions, readmissions and delayed discharges. New indicators are being developed to address the issues raised by the MIJB at the development session on 30 July 2020. Due to the timing of the meetings these will not be reflected in this report but will be added in the Q2 report. This will include a graphic that illustrates the measures and how their performance relates to the strategic priorities as outlined in the Strategic Plan 2019-29 ‘Moray Partners in Care’.

All indicators and trends are presented with the acknowledgement that it is likely that there will be long-term unseen implications from the pandemic and targets will likely be re-assessed and updated appropriately.

The table below (Figure 1) gives a summary and the historical trend by indicator since quarter 1 2019/20.

Figure 1 – Performance Summary

Code	Measure	Q1 19-20	Q2 19-20	Q3 19-20	Q4 19-20	Q1 20-21	Target	Deviation
DD	Delayed Discharge							
DD-01	Number of delayed discharges (including code 9, Census snapshot, at end of quarter)	27	28	33	35	10	25	
DD-02	Number of Bed Days Occupied by Delayed Discharges per quarter (inc code 9) 18+ population	768	751	971	1,208	242	781	
EA	Emergency Admissions							
EA-01	Rate of emergency occupied bed days for over 65s per 1000 population	2067	2039	2085	2,169	2,086	2,242	
EA-02	Emergency Admissions rate per 1000 population for over 65s	177	179	184	183	178.2	182	
EA-03	Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population	123	123	126	125	122	127	
AE	Accident and Emergency							
AE-01	A&E Attendance rate per day per 1000 population (All Ages)	22	22	24	17	16	22	
HR	Hospital Re-Admissions							
HR-01	% of Emergency Readmissions to hospital within 28 days - Moray Patients	7.9%	8.1%	9.9%	6.4%	10.4%	7.5%	
HR-02	% of Emergency Readmissions to hospital for within 7 days - Moray Patients	4.3%	4.2%	5.5%	3.1%	4.5%	3.5%	
UN	Unmet Need							
UN-01	Number of Long Term Home Care hours unmet at weekly Snapshot	-	-	-	-	623	Data only for first year	
UN-02	Number of People requiring Long Term homecare hours unmet at weekly Snapshot	-	-	-	-	36	Data only for first year	
OA	Outstanding Assessments							
OA-01	Number of Reviews Outstanding at end of quarter snapshot	-	-	-	-	1506	Data only for first year	
MH	Mental Health							
MH-01	Percentage of patients commencing Psychological Therapy Treatment within 18 weeks of referral	73%	78%	20%	20%	21%	90%	
SM	Staff Management							
SM-01	NHS Sickness Absence (% of Hours Lost)	4.60%	3.80%	5.30%	4.60%	N/A	4%	
SM-02	Council Sickness Absence (% of Calendar Days Lost)	7.70%	8.80%	8.00%	9.08%	N/A	4%	

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

Performance management reporting is a legislative requirement under section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014.

In addition to publishing an Annual Performance Report, the Moray Integration Scheme requires that the MIJB will "monitor the performance of the delivery of integrated services using the Strategic Plan on an ongoing basis" (para 5.2.2 of the Moray Integration Scheme refers).

(b) Policy and Legal

None directly associated with this report.

(c) Financial implications

None directly associated with this report.

(d) Risk Implications and Mitigation

There are no risk issues arising directly from this report. The long term impact of the COVID-19 on the Health and Social Care system are still

unknown and performance measurement will remain flexible to enable the service to be prepared and react to any future developments.

(e) Staffing Implications

None directly associated with this report.

(f) Property

None directly associated with this report.

(g) Equalities/Socio Economic Impact

An Equality Impact Assessment is not required for the Performance Framework because there will be no impact, as a result of the report, on people with protected characteristics.

(h) Consultations

Interim Chief Officer, MIJB; Committee Services Officer, Moray Council; Service Managers where their respective areas are relevant to this report, Health and Social Care Moray; Service Manager, Performance and Workforce; IJB Corporate Manager.

6. CONCLUSION

6.1 **This report requests the MIJB comment on performance of local indicators and actions summarised in Section 4 and expanded on in APPENDIX 1.**

Author of Report: Bruce Woodward, Senior Performance Officer
Background Papers: Available on request
Ref:

PERFORMANCE REPORT

QUARTER 1 2020/21

(1 APRIL 2020 – 30 JUNE 2020)

1. TABLE OF CONTENTS

2. PERFORMANCE SUMMARY

COMMENTARY

Performance within Health and Social Care Moray (HSCM) as demonstrated by the agreed indicators up to the end of quarter 1 of the financial year 2020/21 is showing as generally positive; however the impact of COVID-19 and the changes made to routine procedures in hospitals and care homes has had a knock on impact to HSCM services that will only become evident in future quarters.

Three indicators are new and have no target set. These indicators will be monitored throughout the year and targets will be set in Q1 2020/21. There is currently no data available for SM-01 and SM-02 due to the COVID-19 pandemic interrupting operations within the HR departments.

The impact of COVID-19, where the whole system was working to a different set of priorities, will mean that it will not be possible to draw direct comparisons with previous years. Where the acute sector ceased elective operations this will have meant a reduction in the number of admissions, readmissions and delayed discharges. New indicators are being developed to address the issues raised by the MIJB at the development session on 30 July 2020. Due to the timing of the meetings these will not be reflected in this report but will be added in the Q2 report. This will include a graphic that illustrates the measures and how their performance relates to the strategic priorities as outlined in the Strategic Plan 2019-29 'Partners in Care'.

All indicators and trends are presented with the acknowledgement that it is likely that there will be long-term unseen implications from the pandemic and targets will likely be re-assessed and updated appropriately.

DELAYED DISCHARGE - GREEN

The focus of the COVID-19 reaction in Moray was assessing and finding suitable support for those in hospital (specifically those ready for discharge) to allow for the expected influx of COVID-19 patients. This has resulted in the indicators in this measure having significant reductions in both measures with only **10 patients** being delayed at the latest survey of the quarter which amounted to **242 bed days**.

Delayed Discharges are being addressed in detail under Operation Home First where data rich story boards will be developed and used to demonstrate progress. Detail on the actions taken and progress of this will be available by the end of the year and should reflect in the continuation of delayed discharge targets being met.

EMERGENCY ADMISSIONS - GREEN

There was no significant year on year change in any of the Emergency Admission measures despite there being a reduction in the number of Emergency Department attendances.

ACCIDENT AND EMERGENCY - GREEN

Moray had a significant drop in the rate of attendances people per 1,000 population to the Emergency Department in quarter 1 (from over consistently over 20 to **16**). This was mirrored across Scotland during the first months of the COVID-19 pandemic.

HOSPITAL RE-ADMISSIONS - RED

The number of re-admissions to hospital increased significantly in the last quarter. The primary driver for this is that the total number of people entering hospital has decreased. The number of **28 day re-admissions** is reduced from consistently over **150** a month in 2019/20 to a little over **100** a month in the past quarter. Similarly, the raw number of **7 day re-admissions** reduced from consistently over **80** a month in 2019/20 to under **50** a month in the past quarter.

UNMET NEED – DATA ONLY

At the end of the quarter there were **36 people** awaiting care packages which amounted to **623 hours** of unmet need. This is the first quarter it is being reported and therefore no trend is present and no actions have been undertaken.

OUTSTANDING ASSESSMENTS – DATA ONLY

At the end of quarter 1 there **were 1,506 reviews** in Carefirst showing as outstanding. While the measure is new, historical management information suggests that this is well above normal and indicates an increased pressure on Social Work. The data from which this measure is derived is due to undergo data cleansing and it is hoped that this will help give a clearer picture in future quarters.

MENTAL HEALTH - RED

For the last three quarters only around **20%** of patients commenced Psychological Therapy Treatment within 18 weeks of referral.

Following a decline in the previous three months in the number of people commencing Psychological Therapy treatment, June 2020 showed an increase in those accessing treatment within 18 weeks.

During the COVID-19 pandemic, psychological therapies staff were redeployed to the Psychological Resilience Hub. Although they have a weekly commitment to that service it is anticipated that they will be able to offer virtual outpatient appointments to those waiting within a shorter timeframe and this is anticipated to reduce waiting times.

STAFF MANAGEMENT – NO UPDATE

Due to the increased workload within HR departments in responding to the COVID-19 pandemic, data regarding this measure has been delayed by one quarter.

INDICATOR SUMMARY

Moray currently has 14 local indicators. Of these 6 are Green and 3 are Red. There are 3 indicators that are new and have targets pending and 2 that currently have no data due to no resource available within the relevant service to collate and provide the data.

Figure 2 – Performance Summary

Code	Measure	Q1 19-20	Q2 19-20	Q3 19-20	Q4 19-20	Q1 20-21	Target	Deviation
DD	**Delayed Discharge**							
DD-01	Number of delayed discharges (including code 9, Census snapshot, at end of quarter)	27	28	33	35	10	25	
DD-02	Number of Bed Days Occupied by Delayed Discharges per quarter (inc code 9) 18+ population	768	751	971	1,208	242	781	
EA	**Emergency Admissions**							
EA-01	Rate of emergency occupied bed days for over 65s per 1000 population	2067	2039	2085	2,169	2,086	2,242	
EA-02	Emergency Admissions rate per 1000 population for over 65s	177	179	184	183	178.2	182	
EA-03	Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population	123	123	126	125	122	127	
AE	**Accident and Emergency**							
AE-01	A&E Attendance rate per day per 1000 population (All Ages)	22	22	24	17	16	22	
HR	**Hospital Re-Admissions**							
HR-01	% of Emergency Readmissions to hospital within 28 days - Moray Patients	7.9%	8.1%	9.9%	6.4%	10.4%	7.5%	
HR-02	% of Emergency Readmissions to hospital for within 7 days - Moray Patients	4.3%	4.2%	5.5%	3.1%	4.5%	3.5%	
UN	**Unmet Need**							
UN-01	Number of Long Term Home Care hours unmet at weekly Snapshot	-	-	-	-	623	Data only for first year	
UN-02	Number of People requiring Long Term homecare hours unmet at weekly Snapshot	-	-	-	-	36	Data only for first year	
OA	**Outstanding Assessments**							
OA-01	Number of Reviews Outstanding at end of quarter snapshot	-	-	-	-	1506	Data only for first year	
MH	**Mental Health**							
MH-01	Percentage of patients commencing Psychological Therapy Treatment within 18 weeks of referral	73%	78%	20%	20%	21%	90%	
SM	**Staff Management**							
SM-01	NHS Sickness Absence (% of Hours Lost)	4.60%	3.80%	5.30%	4.60%	N/A	4%	
SM-02	Council Sickness Absence (% of Calendar Days Lost)	7.70%	8.80%	8.00%	9.08%	N/A	4%	

3. DELAYED DISCHARGE

Trend Analysis

The focus of the COVID-19 reaction in Moray was assessing and finding suitable support for those in hospital (specifically those ready for discharge) to allow for the expected influx of COVID-19 patients. This has resulted in the indicators in this measure having dramatic reductions.

Comparing overall trends and seasonal data is currently not relevant.

Operational Actions and Maintenance

An Enhanced Discharge Hub was set up to centralise the operational management, administrative support and data management via co-location and a virtual team model which ensured colleagues were able to communicate and make decisions as quickly as possible while maintaining professional integrity.

Daily monitoring of the capacity within external and internal providers was implemented to ensure quick placement; in addition, formal temporary systems were put in place to ensure closer operational interaction between Care at Home, External Providers (through the Commissioning Team), Access, and the Hospital Discharge Team. This enabled the centralising of all discharge activity, vacancy monitoring (in Care Homes), Care at Home capacity, and Resource Allocation decision making. Resource Allocation occurred daily as opposed to weekly as it was up to Pre-COVID-19.

Staffing resources across all adult social care teams were co-opted to support the extra work required to set up and facilitate the above.

Action Timescales

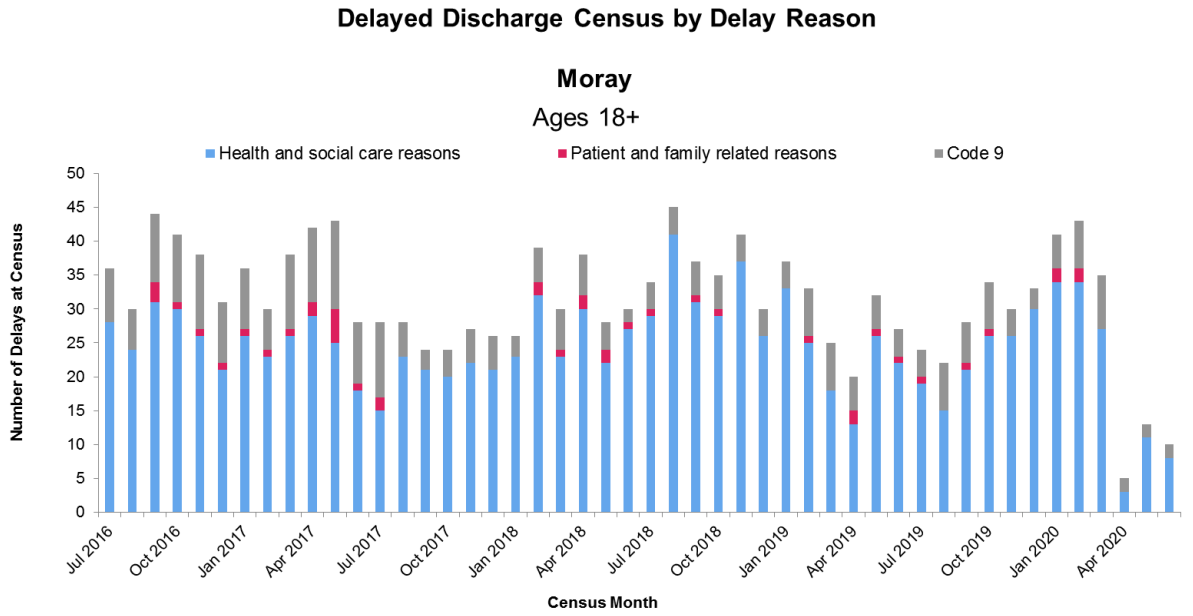
Delayed Discharges are being addressed in detail under Operation Home First where data rich story boards will be developed and used to demonstrate progress. Detail on the actions taken and progress of this will be available by the end of the year and should reflect in the continuation of delayed discharge targets being met.

DD-01: NUMBER OF DELAYED DISCHARGES (INCLUDING CODE 9, CENSUS SNAPSHOT, AT END OF QUARTER)

Purpose	Reliably achieving timely discharge from hospital is an important indicator of quality and is a marker for person centred, effective, integrated and harm free care.		
Strategic Priority	2: HOME FIRST	**Linked Indicator(s)**	DD-02
National Health & Wellbeing Outcomes	2, 3, 5, 7		

Target (+10%)	Q4 (Jan-Mar 19)	Q1 (Apr-Jun 19)	Q2 (Jul-Sep 19)	Q3 (Oct-Dec 19)	Q4 (Jan-Mar 20)	Q1 (Apr-Jun 20)
25	32	27	28	33	35	10

Figure 1



Indicator Trend

As a result, April recorded an all-time low of 5 patients in hospital and while this has increased in the following months it is now consistently under 20 people at any one time.

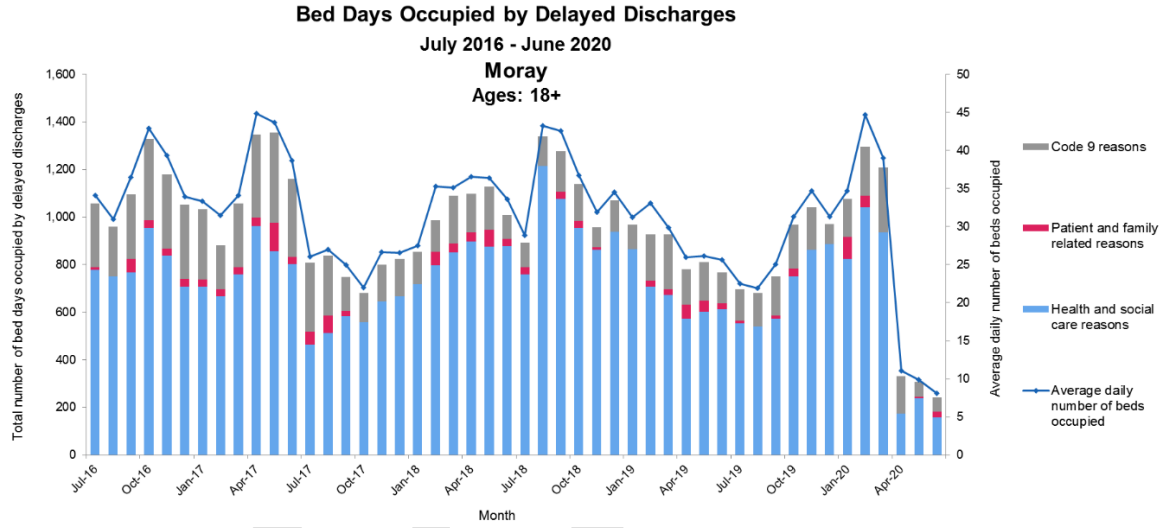
Scotland Trend	Quarter 1 Delayed Discharges reduced dramatically across Scotland this quarter with Moray having one of the larger reductions.
Peer Group	Moray reduced the numbers being delayed at discharge by almost 90% from February to April compared to 42% across its comparators.
Last Reported	August 2020 for Quarter 1 2020/21 data
Next Update Due	November 2020 for Quarter 2 data
Source	Public Health Scotland

DD-02: NUMBER OF BED DAYS OCCUPIED BY DELAYED DISCHARGES PER QUARTER (INC CODE 9) PER 1000 18+ POPULATION

Purpose	This monitors the number of people delayed in hospital once medically fit for discharge. Longer stays in hospital are associated with increased risk of infection, low mood, and reduced motivation.		
Strategic Priority	2: HOME FIRST	**Linked Indicator(s)**	DD-01
National Health & Wellbeing Outcomes	2, 3, 5, 7		

Target (+5%)	Q4 (Jan-Mar 19)	Q1 (Apr-Jun 19)	Q2 (Jul-Sep 19)	Q3 (Oct-Dec 19)	Q4 (Jan-Mar 20)	Q1 (Apr-Jun 20)
781	926	768	751	971	1,208	242

Figure 2



Indicator Trend

Due to the COVID-19 pandemic it is not possible to decipher any trend in the last quarter.

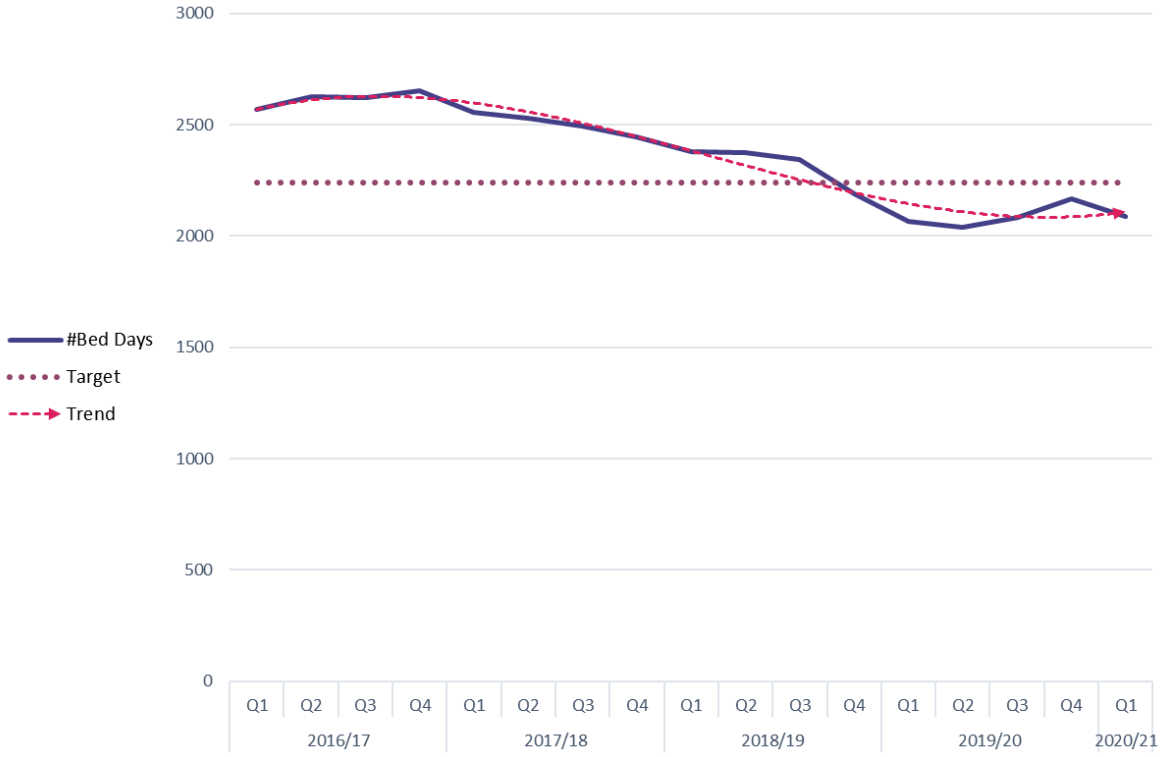
Scotland Trend	In the short-term, Scotland has had a steady increase in the three months of the quarter while Moray has decreased.
Family Group	Moray has bucked the slowly increasing comparator trend in this quarter.
Last Reported	August 2020 for Quarter 1 2020/21 data
Next Update Due	November 2020 for Quarter 2 data
Source	Public Health Scotland

4. EMERGENCY ADMISSIONS

Trend Analysis
The three indicators that fall under this measure all show generally positive quarterly figures and while there was a drop in all measures, they are still comparable to the numbers recorded in the same period in 2019/20.
Operational Actions and Maintenance
No actions have been outlined to specifically improve this measure.
Action Timescales
No timescales set currently.

EA-01: RATE OF EMERGENCY OCCUPIED BED DAYS FOR OVER 65S PER 1000 POPULATION						
Purpose	UC-E1, E2 and E3 are all interconnected and provide a narrative when viewed together of whether emergency admissions and bed days are within tolerance and indicate where potential risks could arise.					
Strategic Priority	1: BUILDING RESILIENCE		**Linked Indicator(s)**		EA-02, EA-03	
National Health & Wellbeing Outcomes			1, 2, 3, 5			
Target (+5%)	**Q4 (Jan-Mar 19)**	**Q1 (Apr-Jun 19)**	**Q2 (Jul-Sep 19)**	**Q3 (Oct-Dec 19)**	**Q4 (Jan-Mar 20)**	**Q1 (Apr-Jun 20)**
2,242	**2,188**	**2,067**	**2,039**	**2,085**	**2,169**	**2,086**

Figure 3 - Rate of emergency occupied bed days for over 65s per 1000 population



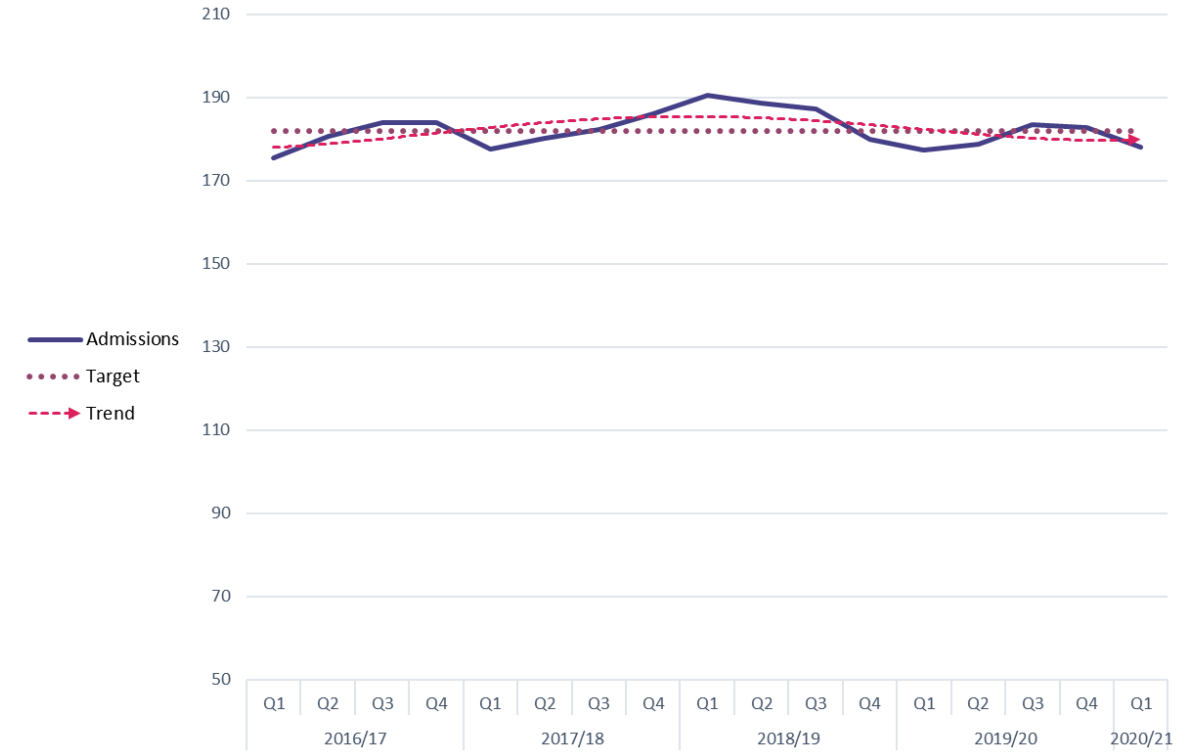
Indicator Trend

There has been a decreasing trend in this indicator over the past 4 years and despite small increases in the last two quarters the quarter 1 2010/21 figure is below any quarter prior to 2019/20 and is still below the target of 2,242.

Scotland Trend	Not Available
Peer Group	Not Available
Last Reported	August 2020 for Quarter 1 2020/21 data
Next Update Due	November 2020 for Quarter 2 data
Source	Health Intelligence

EA-02: EMERGENCY ADMISSIONS RATE PER 1000 POPULATION FOR OVER 65S						
Purpose	UC-E1, E2 and E3 are all interconnected and provide a story when viewed together of whether emergency admissions and bed days are within tolerance and indicate where potential risks could arise.					
Strategic Priority	1: BUILDING RESILIENCE		**Linked Indicator(s)**	EA-01, EA-03		
National Health & Wellbeing Outcomes			1, 2, 3, 5			
Target (+5%)	**Q4 (Jan-Mar 19)**	**Q1 (Apr-Jun 19)**	**Q2 (Jul-Sep 19)**	**Q3 (Oct-Dec 19)**	**Q4 (Jan-Mar 20)**	**Q1 (Apr-Jun 20)**
182	**180**	**177**	**179**	**184**	**183**	**178**

Figure 4 - Emergency Admissions rate per 1000 population for over 65s



Indicator Trend
This indicator has generally hovered around target for the past few years without any significant unseasonal variation.

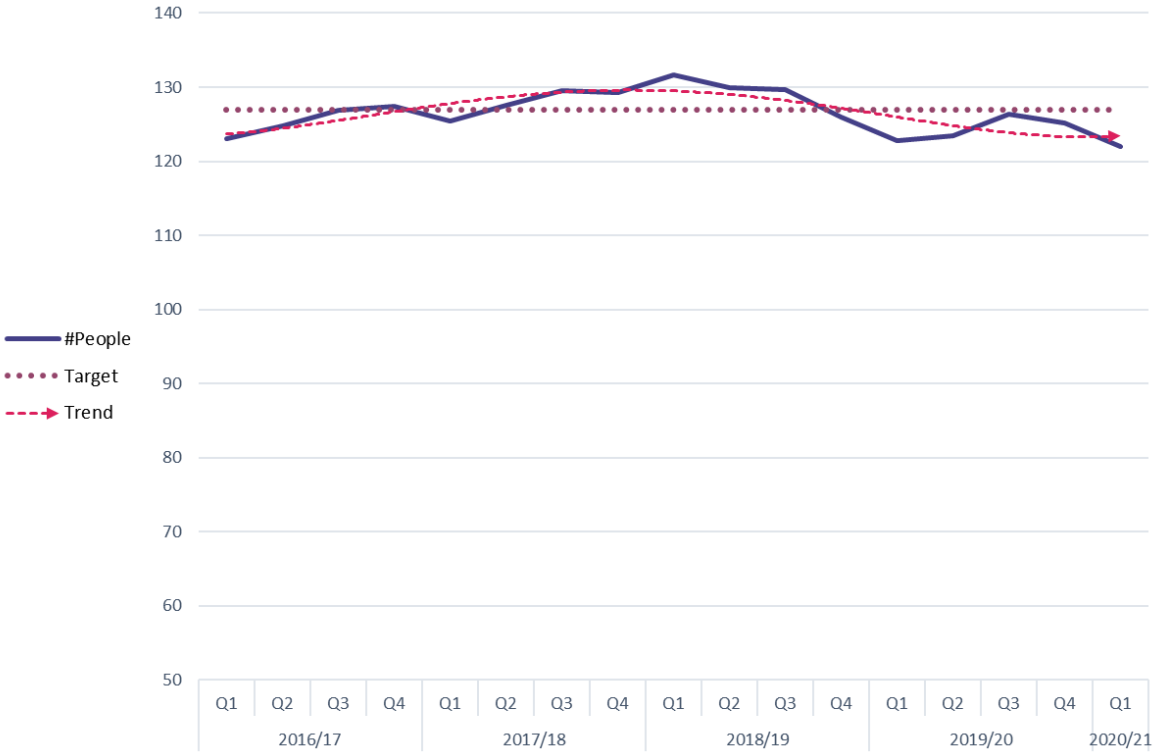
Scotland Trend	Not Available
Peer Group	Not Available
Last Reported	August 2020 for Quarter 1 2020/21 data
Next Update Due	November 2020 for Quarter 2 data
Source	Health Intelligence

EA-03: NUMBER OF PEOPLE OVER 65 YEARS ADMITTED AS AN EMERGENCY IN THE PREVIOUS 12 MONTHS PER 1000 POPULATION

Purpose	UC-E1, E2 and E3 are all interconnected and provide a story when viewed together of whether emergency admissions and bed days are within tolerance and indicate where potential risks could arise.		
Strategic Priority	1: BUILDING RESILIENCE	**Linked Indicator(s)**	EA-01, EA-02
National Health & Wellbeing Outcomes	1, 2, 3, 5		

Target (+5%)	Q4 (Jan-Mar 19)	Q1 (Apr-Jun 19)	Q2 (Jul-Sep 19)	Q3 (Oct-Dec 19)	Q4 (Jan-Mar 20)	Q1 (Apr-Jun 20)
127	126	123	123	126	125	122

Figure 5 - Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population



Indicator Trend

There had been an increase in this measure through 2018 and after a reduction in 2019/20 it would have been expected to remain at those levels.

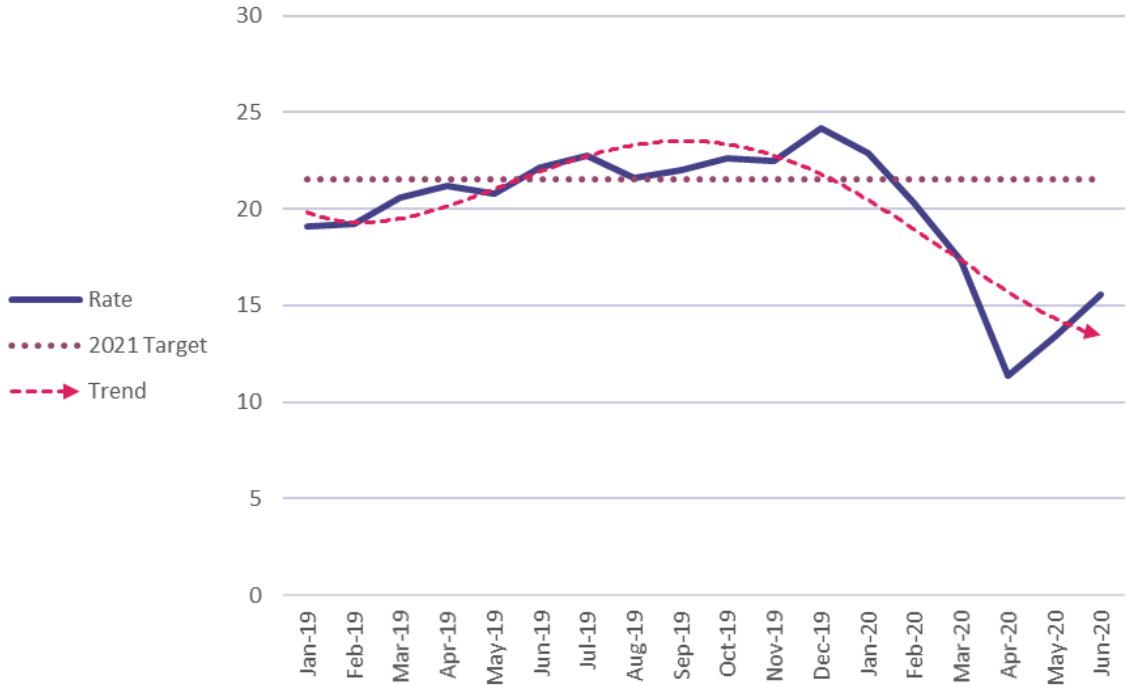
Scotland Trend	Not Available
Peer Group	Not Available
Last Reported	August 2020 for Quarter 1 2020/21 data
Next Update Due	November 2020 for Quarter 2 data
Source	Health Intelligence

5. ACCIDENT AND EMERGENCY

Trend Analysis
Moray had a significant drop in the number of attendances to the Emergency Department in quarter 1 and this was mirrored across Scotland during the first months of the COVID-19 pandemic.
Operational Actions and Maintenance
The MIJB Transformational Plan 2019-24 has Unscheduled Care as a key goal stretch goal and actions underway include shifting unnecessary unplanned hospital activity to preventative, ensuring appropriate, responsive service delivery as locally as possible and as specialist as necessary, and positive team co-ordination.
Action Timescales
No timescales set currently.

AE-01: A&E ATTENDANCE RATES PER 1000 POPULATION (ALL AGES)						
Purpose	A greater system-wide understanding of how people access emergency care, and why certain choices are made, will allow local health systems to develop intelligence about avoidable attendances at emergency departments and target their responses.					
Strategic Priority	1: BUILDING RESILIENCE		**Linked Indicator(s)**		HR-01, HR-02	
National Health & Wellbeing Outcomes			1, 2, 3, 5			
Target (+10%)	**Q4 (Jan-Mar 19)**	**Q1 (Apr-Jun 19)**	**Q2 (Jul-Sep 19)**	**Q3 (Oct-Dec 19)**	**Q4 (Jan-Mar 20)**	**Q1 (Apr-Jun 20)**
21.5	**21**	**22**	**22**	**24**	**17**	**16**

Figure 6 – Monthly A&E Attendance rates per 1000 population (All Ages)



Indicator Trend	
Prior to the pandemic there had been an increasing trend in this measure, but the pandemic resulted in the numbers attending the Emergency Department reducing significantly.	
Scotland Trend	Moray has mirrored the rest of Scotland trend.
Peer Group	Unknown
Last Reported	August 2020 for Quarter 1 2020/21 data
Next Update Due	November 2020 for Quarter 2 data
Source	Public Health Scotland

6. HOSPITAL RE-ADMISSIONS

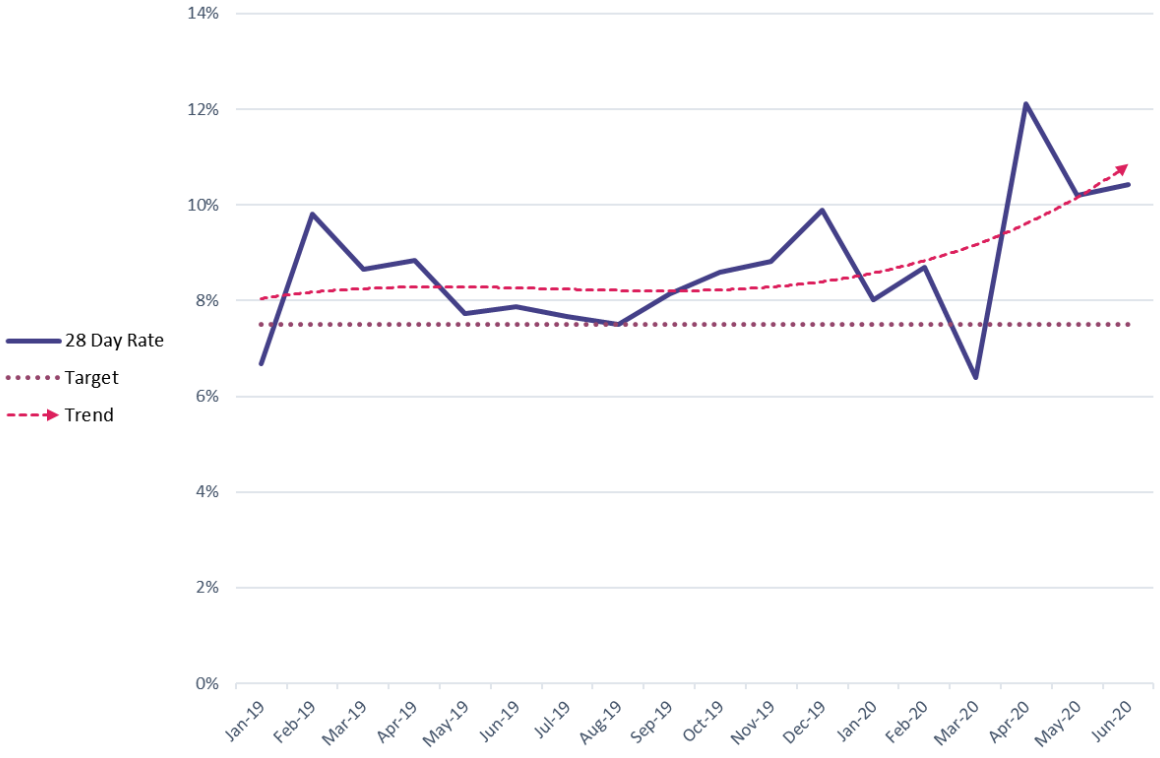
Trend Analysis
The number of re-admissions to hospital increased significantly in the last quarter. The primary driver for this is that the total number of people entering hospital has decreased. Pre-COVID-19 it was noted that the increase in the number of re-admissions was heavily influenced by the numbers of people re-admitted within 7 days while those re-admitted from 8 to 28 days remained static. This trend continues.
Operational Actions and Maintenance
Hospital re-admissions are being addressed in Operation Home First and more specifically in the Discharge to Assess stream where the intention is to analyse data on those entering hospital to better understand their journeys.
Action Timescales
It is expected there will be an update on this by the end of the year.

HR-01: PERCENTAGE OF EMERGENCY RE-ADMISSIONS TO HOSPITAL WITHIN 28 DAYS - MORAY PATIENTS (DR GRAY'S)

Purpose	Re-admissions are often undesirable for patients and have also been shown to be associated with the quality of care provided to patients at several stages along the clinical pathway including during initial hospital stays, transitional care services and post-discharge support.		
Strategic Priority	1: BUILDING RESILIENCE	**Linked Indicator(s)**	HR-02, AE-01
National Health & Wellbeing Outcome	1, 2, 3, 5		

Target	Q4 (Jan-Mar 19)	Q1 (Apr-Jun 19)	Q2 (Jul-Sep 19)	Q3 (Oct-Dec 19)	Q4 (Jan-Mar 20)	Q1 (Apr-Jun 20)
7.5%	8.7%	7.9%	8.1%	9.9%	6.4%	10.4

Figure 7 - Percentage of Emergency Re-admissions to hospital within 28 days - Moray Patients



Indicator Trend

COVID-19 has shown an increase in this measure but this is accounted for in the decrease in the total number of admissions. The raw number of 28 day re-admissions in fact reduced from consistently over 150 a month in 2019/20 to a little over 100 a month in the past quarter.

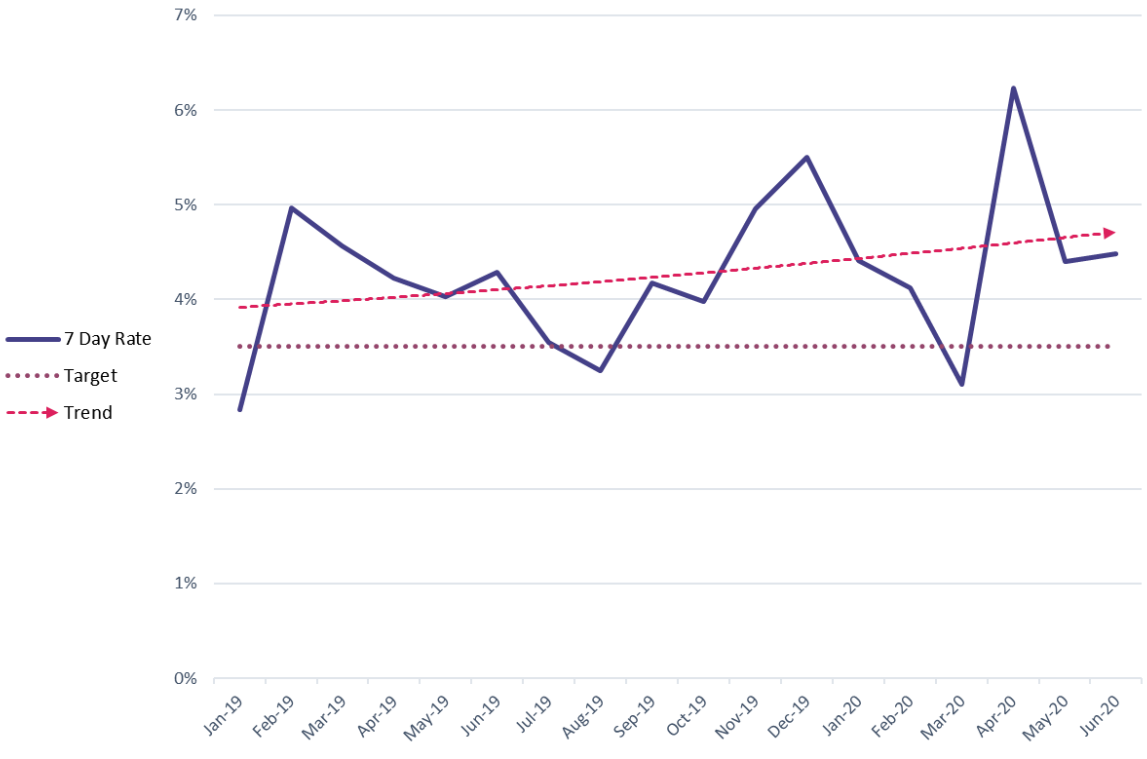
Scotland Trend	Unknown
Peer Group	Unknown
Period Last Reported	August 2020 for Quarter 1 2020/21 data
Next Update Due	November 2020 for Quarter 2 data
Source	Health Intelligence

HR-02: PERCENTAGE OF EMERGENCY RE-ADMISSIONS TO HOSPITAL WITHIN 7 DAYS - MORAY PATIENTS (DR GRAY'S)

Purpose	Re-admissions are often undesirable for patients and have also been shown to be associated with the quality of care provided to patients at several stages along the clinical pathway including during initial hospital stays, transitional care services and post-discharge support.		
Strategic Priority	1: BUILDING RESILIENCE	**Linked Indicator(s)**	HR-01, AE-01
National Health & Wellbeing Outcome		1, 2, 3, 5	

Target	Q4 (Jan-Mar 19)	Q1 (Apr-Jun 19)	Q2 (Jul-Sep 19)	Q3 (Oct-Dec 19)	Q4 (Jan-Mar 20)	Q1 (Apr-Jun 20)
3.5%	4.6%	4.3%	4.2%	5.5%	3.1%	4.5%

Figure 8 - Percentage of Emergency Re-admissions to hospital within 7 days - Moray Patients



Indicator Trend

COVID-19 has shown an increase in this measure but this is accounted for in the decrease in the total number of admissions. The raw number of 7-day re-admissions in fact reduced from consistently over 80 a month in 2019/20 to under 50 a month in the past quarter.

Scotland Trend	Unknown
Peer Group	Unknown
Last Reported	August 2020 for Quarter 1 2020/21 data
Next Update Due	November 2020 for Quarter 2 data
Source	Health Intelligence

7. UNMET NEED

Trend Analysis
This is the first quarter it is being reported and therefore no trend is present.
Operational Actions and Maintenance
As this data is currently in its first iteration and is a metric that will have been significantly impacted by COVID-19, actions for improvement are yet to be outlined (if they are required).
Action Timescales
No timescales set currently.

UN-01: NUMBER OF LONG-TERM HOME CARE HOURS UNMET AT WEEKLY SNAPSHOT

Purpose	It is important to monitor the number of people who require long-term care who are awaiting that care. The numbers of those with an unmet need is an important indicator of the health of the Health and Social Care system.					
Strategic Priority	1: BUILDING RESILIENCE		**Linked Indicator(s)**		UN-02	
National Health & Wellbeing Outcome			1, 2, 3, 5			
Target	**Q4 (Jan-Mar 19)**	**Q1 (Apr-Jun 19)**	**Q2 (Jul-Sep 19)**	**Q3 (Oct-Dec 19)**	**Q4 (Jan-Mar 20)**	**Q1 (Apr-Jun 20)**
For Info	ND	ND	ND	ND	ND	623

Indicator Trend	
No Data	
Scotland Trend	Unavailable
Peer Group	Unavailable
Last Reported	July 2020
Next Update Due	October 2020
Source	Brokerage

UN-02: NUMBER OF PEOPLE WITH LONG-TERM CARE HOURS UNMET AT WEEKLY SNAPSHOT						
Purpose	It is important to monitor the number of people who require long-term care who are awaiting that care. The numbers of those with an unmet need is an important indicator of the health of the Health and Social Care system.					
Strategic Priority	1: BUILDING RESILIENCE		**Linked Indicator(s)**	UN-01		
National Health & Wellbeing Outcome			1, 2, 3, 5			
Target	**Q4 (Jan-Mar 19)**	**Q1 (Apr-Jun 19)**	**Q2 (Jul-Sep 19)**	**Q3 (Oct-Dec 19)**	**Q4 (Jan-Mar 20)**	**Q1 (Apr-Jun 20)**
For Info	ND	ND	ND	ND	ND	36

Indicator Trend	
No Data	
Scotland Trend	Unavailable
Peer Group	Unavailable
Last Reported	July 2020
Next Update Due	October 2020
Source	Brokerage

8. OUTSTANDING ASSESSMENTS

Trend Analysis
At the end of quarter 1 there were 1,506 reviews in Carefirst showing as outstanding. While the measure is new, historical management information suggests that this is well above normal and indicates an increased pressure on Social Work. The data from which this measure is derived is due to undergo data cleansing and it is hoped that this will help give a clearer picture in future quarters.
Operational Actions and Maintenance
As this data is currently in its first iteration and is a metric that will have been significantly impacted by COVID-19 and suspension of care packages actions for improvement are yet to be outlined.
Action Timescales
No timescales set currently.

OA-01: NUMBER OF OUTSTANDING ASSESSMENTS (COMMUNITY CARE REVIEWS, SUPPORT PLANS…)

Purpose	Those awaiting assessments are at risk of not receiving the service they require in good time, and can then put pressure on other, more resource intensive primary and acute services.					
Strategic Priority	3: PARTNERS IN CARE		**Linked Indicator(s)**			
National Health & Wellbeing Outcome			1, 2, 3, 5			
Target	**Q4 (Jan-Mar 19)**	**Q1 (Apr-Jun 19)**	**Q2 (Jul-Sep 19)**	**Q3 (Oct-Dec 19)**	**Q4 (Jan-Mar 20)**	**Q1 (Apr-Jun 20)**
For Info	ND	ND	ND	ND	ND	1506

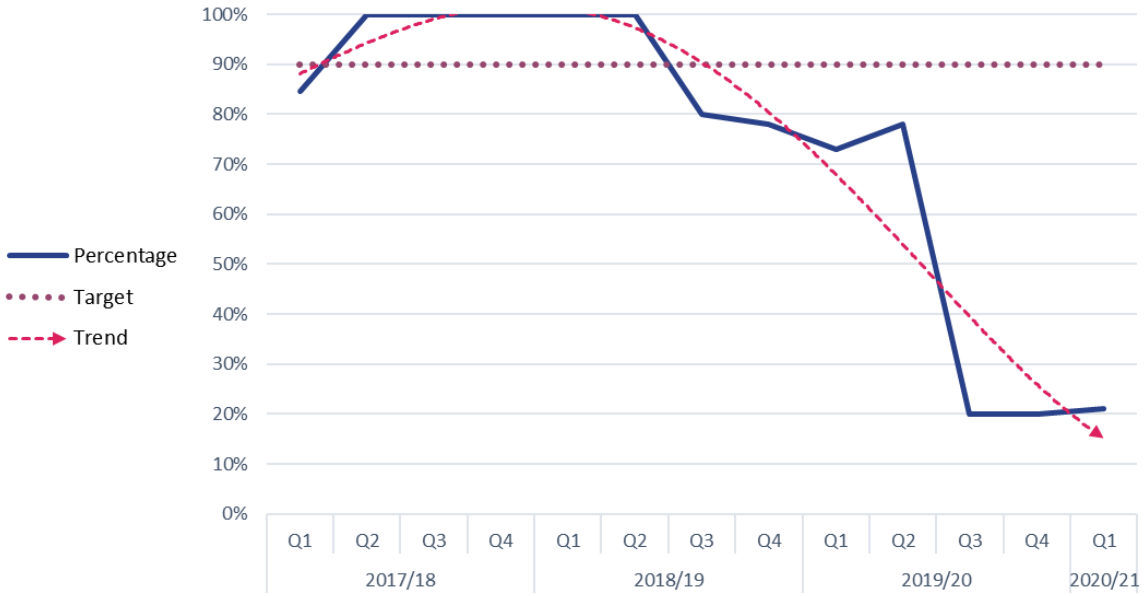
Indicator Trend	
No Data	
Scotland Trend	Not Available
Peer Group	Not Available
Last Reported	July 2020
Next Update Due	October 2020
Source	TBC

9. MENTAL HEALTH

Trend Analysis
The indicator under this measure has been decreasing rapidly over the last year and is currently at 21%.
Operational Actions and Maintenance
Following a decline in the previous three months in the number of people commencing Psychological Therapy treatment, June 2020 showed an increase in those accessing treatment within 18 weeks. During the COVID-19 pandemic, psychological therapies staff were redeployed to the Psychological Resilience Hub. Although they have a weekly commitment to that service it is anticipated that they will be able to offer virtual outpatient appointments to those waiting within a shorter timeframe and this is anticipated to reduce waiting times.
Action Timescales
We would anticipate an improvement in these figures in the quarter 3 2020/21 figures as we consider a new way of working within the service.

MH-01: PERCENTAGE OF PATIENTS COMMENCING PSYCHOLOGICAL THERAPY TREATMENT WITHIN 18 WEEKS OF REFERRAL						
Purpose	Timely access to healthcare is a key measure of quality and that applies equally in respect of access to mental health services.					
Strategic Priority	1: BUILDING RESILIENCE		**Linked Indicator(s)**			
National Health & Wellbeing Outcome			1, 2, 3, 5			
Target (-5%)	**Q4 (Jan-Mar 19)**	**Q1 (Apr-Jun 19)**	**Q2 (Jul-Sep 19)**	**Q3 (Oct-Dec 19)**	**Q4 (Jan-Mar 20)**	**Q1 (Apr-Jun 20)**
For Info	**78%**	**73%**	**78%**	**20%**	**20%**	**21%**

Figure 9 - Percentage of patients commencing Psychological Therapy Treatment within 18 weeks of referral (adults only)



Indicator Trend	
This indicator has seen a dramatic decrease in the past three quarters after hovering at 20%, well below target.	
Scotland Trend	Unavailable
Peer Group	Unavailable
Last Reported	August 2020 for Quarter 1 2020/21 data
Next Update Due	November 2020 for Quarter 2 data
Source	Health Intelligence

10. STAFF MANAGEMENT

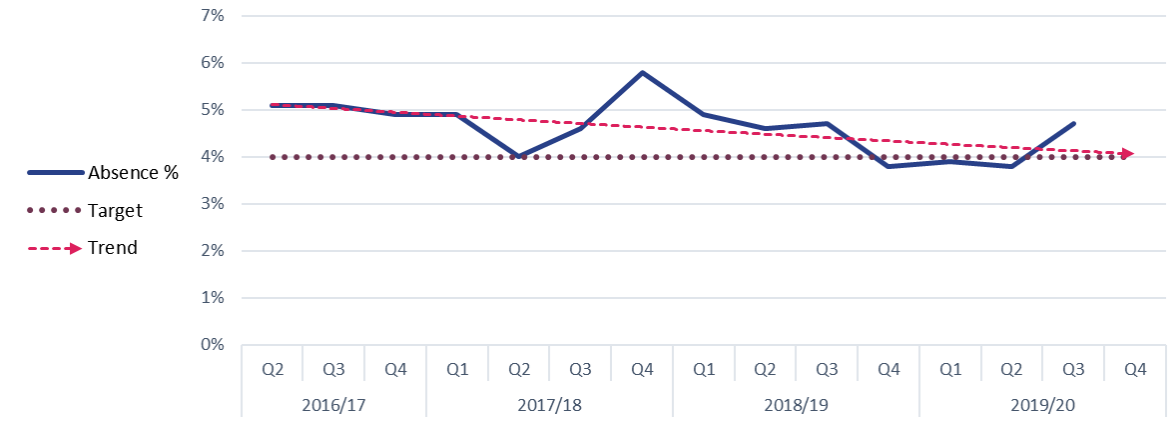
Trend Analysis
Prior to the COVID-19 pandemic absence figures within HSCM have been outside of target, particularly within the council. NHSG had hit target two quarters in a row, the most recent data has the absence rate at 4.7% against a target of 4.0%
Operational Actions and Maintenance
Currently there are no actions underway to address this.
Action Timescales
No timescales set currently.

SM-01: NHS SICKNESS ABSENCE % OF HOURS LOST

Purpose	Attendance at work of all employees is essential in the interests of the effective and efficient operation of services.		
Strategic Priority	1: BUILDING RESILIENCE	**Linked Indicator(s)**	SM-02
National Health & Wellbeing Outcome	8		

Target (+10%)	Q4 (Jan-Mar 19)	Q1 (Apr-Jun 19)	Q2 (Jul-Sep 19)	Q3 (Oct-Dec 19)	Q4 (Jan-Mar 20)	Q1 (Apr-Jun 20)
4%	3.8%	3.9%	3.8%	4.7%	No Data	No Data

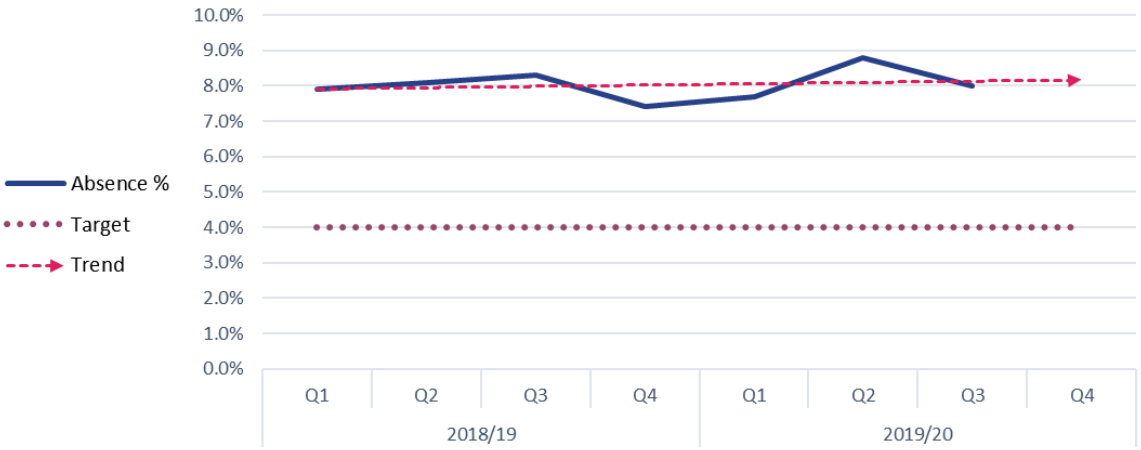
Figure 10 - NHS Sickness Absence % of Hours Lost



Indicator Trend	
Despite an increase in quarter 3 there is still a decreasing trend in this indicator.	
Scotland Trend	Unknown
Peer Group	Unknown
Last Reported	July 2020 (Quarter 4 2020/21)
Next Update Due	September 2020 for Quarter 1 and 2 data
Source	Health Intelligence

SM-02: COUNCIL SICKNESS ABSENCE (% OF CALENDAR DAYS LOST)						
Purpose	Attendance at work of all employees is essential in the interests of the effective and efficient operation of services.					
Strategic Priority	1: BUILDING RESILIENCE		**Linked Indicator(s)**		SM-01	
National Health & Wellbeing Outcome			1, 2, 3, 5			
Target	**Q4 (Jan-Mar 19)**	**Q1 (Apr-Jun 19)**	**Q2 (Jul-Sep 19)**	**Q3 (Oct-Dec 19)**	**Q4 (Jan-Mar 20)**	**Q1 (Apr-Jun 20)**
For Info	**7.4%**	**7.7%**	**8.8%**	**8.0%**	**No Data**	**No Data**

Figure 11 - Council Sickness Absence (% of Calendar Days Lost)



Indicator Trend
This indicator remains well above target and even though there was a decrease in quarter 3 the trend is still an increasing one.

Scotland Trend	Unknown
Peer Group	Unknown
Period Last Reported	July 2020 (Quarter 4 2020/21)
Next Update Due	September 2020 for Quarter 1 and 2 data
Source	Council HR

APPENDIX 1: KEY AND DATA DEFINITIONS

RAG SCORING CRITERIA

GREEN	If Moray is performing better than target.
AMBER	If Moray is performing worse than target but within specified tolerance.
RED	If Moray is performing worse than target but outside of specified tolerance.
▲ – ▼	Indicating the direction of the current trend.

PEER GROUP DEFINITION

Moray is defined as being in Peer Group 2 in the Local Government Benchmarking Framework

Family Group 1	**Family Group 2**	Family Group 3	Family Group 4
East Renfrewshire	**Moray**	Falkirk	Eilean Siar
East Dunbartonshire	**Stirling**	Dumfries & Galloway	Dundee City
Aberdeenshire	**East Lothian**	Fife	East Ayrshire
Edinburgh, City of	**Angus**	South Ayrshire	North Ayrshire
Perth & Kinross	**Scottish Borders**	West Lothian	North Lanarkshire
Aberdeen City	**Highland**	South Lanarkshire	Inverclyde
Shetland Islands	**Argyll & Bute**	Renfrewshire	West Dunbartonshire
Orkney Islands	**Midlothian**	Clackmannanshire	Glasgow City

APPENDIX 2: STRATEGIC PRIORITIES

1. THE HEALTH AND SOCIAL CARE STRATEGY AT A GLANCE

WE ARE PARTNERS IN CARE

OUR VISION: "We come together as equal and valued partners in care to achieve the best health and wellbeing possible for everyone in Moray throughout their lives."

OUR VALUES: Dignity and respect; person-centred; care and compassion; safe, effective and responsive

OUTCOMES: Lives are healthier – People live more independently – Experiences of services are positive – Quality of life is improved – Health inequalities are reduced – Carers are supported – People are safe – The workforce continually improves – Resources are used effectively and efficiently

THEME 1: BUILDING RESILIENCE - Taking greater responsibility for our health and wellbeing

THEME 2: HOME FIRST - Being supported at home or in a homely setting as far as possible

THEME 3: PARTNERS IN CARE - Making choices and taking control over decisions affecting our care and support

TRANSFORMATION (DELIVERY) PLAN supported by enablers:

- Medium Term Financial Plan
- Performance Framework
- Locality Plans
- Existing strategies
- Infrastructure Planning
- Housing Contribution
- Organisational Development and Workforce Plan
- Communication & Engagement Framework

APPENDIX 3: NATIONAL HEALTH AND WELLBEING OUTCOMES

1 - PEOPLE ARE ABLE TO LOOK AFTER AND IMPROVE THEIR OWN HEALTH AND WELLBEING AND LIVE IN GOOD HEALTH FOR LONGER.

2 - PEOPLE, INCLUDING THOSE WITH DISABILITIES OR LONG-TERM CONDITIONS, OR WHO ARE FRAIL; ARE ABLE TO LIVE, AS FAR AS REASONABLY PRACTICABLE, INDEPENDENTLY AT HOME OR IN A HOMELY SETTING IN THEIR COMMUNITY.

3 - PEOPLE WHO USE HEALTH AND SOCIAL CARE SERVICES HAVE POSITIVE EXPERIENCES OF THOSE SERVICES, AND HAVE THEIR DIGNITY RESPECTED.

4 - HEALTH AND SOCIAL CARE SERVICES ARE CENTRED ON HELPING TO MAINTAIN OR IMPROVE THE QUALITY OF LIFE OF PEOPLE WHO USE THOSE SERVICES.

5 - HEALTH AND SOCIAL CARE SERVICES CONTRIBUTE TO REDUCING HEALTH INEQUALITIES.

6 - PEOPLE WHO PROVIDE UNPAID CARE ARE SUPPORTED TO LOOK AFTER THEIR OWN HEALTH AND WELLBEING, INCLUDING TO REDUCE ANY NEGATIVE IMPACT OF THEIR CARING ROLE ON THEIR OWN HEALTH AND WELLBEING.

7 - PEOPLE USING HEALTH AND SOCIAL CARE SERVICES ARE SAFE FROM HARM.

8 - PEOPLE WHO WORK IN HEALTH AND SOCIAL CARE SERVICES FEEL ENGAGED WITH THE WORK THEY DO AND ARE SUPPORTED TO CONTINUOUSLY IMPROVE THE INFORMATION, SUPPORT, CARE, AND TREATMENT THEY PROVIDE.

9 - RESOURCES ARE USED EFFECTIVELY AND EFFICIENTLY IN THE PROVISION OF HEALTH AND SOCIAL CARE SERVICES.

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 27 AUGUST 2020**

SUBJECT: **INTERNAL AUDIT UPDATE**

BY: **CHIEF INTERNAL AUDITOR**

1. REASON FOR REPORT

1.1 To provide the Committee with a general update including details of progress on projects contained within the Internal Audit plan for 2019/20 financial year.

2. RECOMMENDATION

2.1 The Audit, Performance and Risk Committee is asked to consider and note this audit update.

3. REPORT

Context /Key Systems

3.1 It has been a challenging time since I provided my last update to this committee, no more so than for those working in the health and care sectors. But back office functions have also had to adapt, prioritise and deal with the issues that are important, and for internal audit ensuring the integrity of the main financial systems has been a key consideration. While audit resources have been directed to other areas including oversight of the provision of substantial grant support funding for businesses, a watching brief has been kept over payroll and creditor payments systems to ensure, through sample testing, that payments from public funds have been correctly made and suitably evidenced with appropriate documentation.

3.2 In terms of the system controls I am confident that these have worked as intended, albeit there will have been added complexities as a consequence of staff homeworking, and higher volumes of data to process for staff working more in the way of variable hours. Likewise, urgent need undoubtedly will have influenced purchasing decisions that potentially at times will have stretched procurement rules. But I am aware that colleagues across financial services and others have acted as effective gatekeepers to ensure probity of spend in challenging circumstances. At the appropriate time additional audit work will be completed to glean further assurances in these key areas.

Specific topics in the Audit plan

3.3 Three audit topics were included in the audit plan for last financial year and an update on each of these is as follows:

Aids and Equipment Store

3.4 This audit was completed ahead of the pandemic and the audit report and action plan containing recommendations agreed by management are attached as **Appendix 1**. Quite a number of issues were raised regarding the stores operation, it having been apparent from year-end stock taking validations that systems and procedures in place were not as effective as they might have been.

3.5 No doubt post pandemic there will be a greater focus on stores and the role they place in supporting the effective delivery of services. It will be interesting to see the approach taken to implementing the audit recommendations when the follow up of agreed actions can be undertaken.

Adaptations - Private and Council Housing

3.6 This review was substantially completed pre pandemic and the report at present is in draft with the Housing Services management for consideration of audit findings. The budget for adaptations work is an amalgam of funding from Social Care and Housing. When the review was concluded part way through the year it was noted that the budget was likely to be fully utilised, perhaps exceeded by year end, and there was a waiting list in place. With a focus now on Home First, it is possible that the work programme in this area will require to be expanded and future budget planning and staffing resource to oversee consequential increased workloads may need consideration. The audit report and agreed action plan will be brought to this Committee when completed.

Care Homes/Residential Nursing (excluding assessment criteria)

3.7 This audit was included in the plan on the recommendation of management but no clear remit was developed and no progress has been made. Internal audit's focus is on good governance and effective systems of control, therefore if there are changes required around policy intentions there would need to be clarity around the contribution audit work would make to inform that debate.

3.8 What was clear when we last reviewed this area was that 'both care and financial assessment processes for permanent care placements for the elderly were robust and consistently applied'. However, the audit report also noted the two-tier charging system depending on whether places were privately or council funded and it was also reported that 'nationally there are wider issues likely to impact on the provision and funding of elderly care in the future including public sector financial constraints, sustainability of the care provider market, demographics and an ageing population, integration and the planned adoption of a national minimum wage'

3.9 Some of these issues have now been brought to the fore as a consequence of the pandemic, and any audit work in this area going forward is likely to be informed by the assessment of the role of this type of care provision going forward.

Follow up - Learning Disabilities

3.10 It is now eighteen months since I reported to the Committee on this subject and at the time I was asked to conduct further work to assess progress being achieved. Much has happened in the interim with a clear intention to transform but progress has been and will be challenging as the reconfiguration of services takes place.

3.11 A review of recent reporting by the Chief Social Work Officer in her latest annual report and from Board papers demonstrates that there is clarity in terms of what needs to happen; the key to success in this area will be in ensuring that the pace of change is maintained through appropriate resourcing to ensure intended outcomes can be achieved within planned timescales. Audit work may be appropriate at some stage but mindful of the need to add value as well as provide assurances, it is my view for now that the Board is well sighted on what needs to happen in this area. I am not persuaded that further audit work at this time would add to what is already known and has been reported.

Self-Directed Support

3.12 A member of the internal audit team continues to provide advisory support to the working group involved in the development of the self-directed support initiative. One of the more unusual decisions reached was the purchase of a camper van type vehicle for a service user. Given the costs and circumstances pertaining, the decision was referred to and approved by senior management. The audit focus primarily was on ensuring issues around ownership, maintenance, insurance etc. of the vehicle were properly formalised to protect the interests of the service and a draft agreement between the Moray Integration Joint Board (MIJB) and service user was prepared with the assistance of Legal Services. A signed copy of the completed agreement has been requested and an update will be provided to the meeting.

Joint working

3.13 No issues to report –with separate main financial systems of the NHS and councils being used in the delivery of services directed by IJBs there is little overlap in audit inputs, and annual assurances for the IJB accounts come separately from health board and council management and auditors respectively. In practical terms, it is considered that the scope for joint auditing projects will remain limited, with liaison with internal auditors for Aberdeen City and Aberdeenshire Councils (who provide services to their respective IJBs) and with Price WaterhouseCoopers (PwC) for NHS Grampian likely to continue only on an informal basis on any matters that may be of mutual interest.

Ad hoc works

3.14 Work to follow up the recommendations made in the 'Carefirst Information Governance' audit completed last year has still to be undertaken.

4. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Moray Partners in Care 2019 – 2029"

Not directly applicable.

(b) Policy and Legal

The internal audit service is provided in terms of paragraph 7:1 of the Local Authority Accounts (Scotland) Regulations 2014, and there is a requirement to provide a service in accordance with published Public Sector Internal Audit Standards.

(c) Financial Implications

No implications directly arising from this report.

(d) Risk Implications

The pandemic has led to challenges for all services, even internal audit whose access to people as opposed to systems has been restricted as consequence of changed ways of working and recognition that certain service areas and staff have been immersed in responding to the emerging and now ongoing crisis. With the new normal as yet uncertain internal audit's focus will be to do what it can to support good governance and the integrity of systems; to learn from the experience and give consideration to how best we can continue to provide the audit assurance required in terms of Internal Auditing Standards.

(e) Staffing Implications

No implications

(**f) Property**

No implications.

(g) Equalities/ Socio Economic Impacts

Not required as no changes to policy.

(h) Consultations

The MIJB Chief Financial Officer has been consulted in respect of this report.

5. CONCLUSION

5.1 This report provides and update on progress re projects included in the audit plan and on other issues relevant to the MIJB.

Author of Report: Atholl Scott, Chief Internal Auditor
Background Papers: Internal Audit Plan
Ref: mijb/ap&rc/27082020

Moray Council

Internal Audit Section

Appendix 1

Occupational Therapy Store

Final Report

DEPARTMENT: **Education and Social Care**

SUBJECT: **Occupational Therapy Store**

REPORT REF: **20'018**

Table of Contents

1. Executive Summary

The annual Internal Audit plan for 2019/20 provided for a review to be undertaken of the Occupational Therapy (OT) Store.

Occupational Therapy stocks comprise aids and equipment issued to service users to help with various daily tasks including cooking, dressing and bathing. The individual items of equipment held can vary in value from a few pounds to upwards of £1,000 for certain type of hoists, specialised seating etc. The total stock turnover for 2018/19 amounted to just over £500,000.A particular feature of this store is that it also deals with returns of equipment that is no longer required and, where possible, this equipment is decontaminated and made available for reuse.

The audit used the Chartered Institute of Public Finance (CIPFA) System Based Control Matrices as the basis for developing the audit programme. This included looking at overall management arrangements for the store covering purchases, issues and security access arrangements. It also considered the controls around use of the stores management software system (the Equipment Loans Management System known as ELMS).

The audit noted the challenges facing the service in terms of providing timely support to individuals with a diverse range of needs, but concluded that there is further work to be done to improve the operation of the store and the stores system to ensure optimal performance is achieved.

Areas highlighted as requiring particular attention were as follows:

- details of orders processed and invoices paid are not recorded through ELMS but through another software application within the Council. For completeness it would be preferable for ELMS to be used for all stock related processes; this has not been achieved and thus management information and reporting from the system is only partial.

- from audit sample testing, there was a higher than expected number of variances between the stocks identified as held in the stores system and the actual physical stock held in the store, an illustration of the effects of operating with a less than fully functioning stores system

- while stock other than consumable items had been bar-coded, the stores layout was in need of improvement as it was difficult to locate some of the items selected; also ‘additional’ items were noted that were not part of stock and for these there needs to be a determination as to future use or disposal.

More widely, it is considered that there are opportunities to evaluate how the store functions, for example by exploring just in time deliveries for 'routine' lower value items, limiting stock held to specialist items, and developing systems and procedures to aid staff who deliver the service. In this regard, it is considered there is good practice within other stores operated within the council and there is potential for this to be exploited as a means of securing the improvements required.

2. Introduction

Occupational Therapy Stock relates to aids and adaptations equipment that is issued to service users to help with daily tasks such as cooking, dressing and bathing. The purpose of this audit was to review systems and practices operating to provide and record occupational equipment issued to Service Users.

3. Audit Scope

The annual Internal Audit plan for 2019/20 provided for a review to be undertaken of the Occupational Therapy (OT) Stores. The purpose of the audit was to compare stock records to the actual equipment held within Stores. In addition the audit also included a review of the procedures undertaken for the ordering and issue equipment to Service Users.

4. Summary Assessment

The Internal Audit Section will provide Management with an opinion on the internal control environment based on four categories of classification:

Assurance Level	System and Testing Conclusion
Full	The controls tested are being consistently applied
Substantial	There is evidence that the level of non-compliance with some of the controls may put some of the system objectives at risk.
Limited	The level of non-compliance puts the system objectives at risk.
None	Significant non-compliance with basic controls leaves the system open to error or abuse.

Our assessment in terms of the design of and compliance with, the system of internal controls for Occupational Therapy Stores as limited by the scope of the audit is set out below:

System Assessment	Testing Assessment
Limited	None

The audit was conducted in accordance with the Public Sector Internal Audit Standards (PSIAS) with our conclusions based on discussions with council officers and the information available at the time the fieldwork was performed.

5. Findings

The main issues raised for management consideration are:

5.1 A discrepancy rate of approximately 75% was noted from a check made to compare the equipment physically held within Stores to the recorded stock figure detailed within ELMS.

5.2 It was noted that equipment can be written off and disposed without supervisory authorisation. The officer responsible for cleaning of returned equipment is able to write off the item within ELMS without further authorisation requirements.

5.3 A visit to Stores found locating individual items of equipment time consuming due to where items had been stored within the building. The actual location of the equipment was found not to be clearly labelled within the building and the same type of equipment not always kept in the same place.

5.4 Access to OT equipment within the Stores Building is not restricted. CIPFA guidance recommends that some kind of barrier or restriction should be installed to control access to only authorised officers.

5.5 It was noted that the ELMS does not distinguish between new and recycled items of equipment. It had previously been agreed that items of equipment issued and then returned to Stores are revalued at 50% of the unit price.

5.6 Discussions with officers noted that sometimes items are returned to Stores without being used. Further consideration should be undertaken to define a more detailed procedure regarding the valuation of items returned to Stores for re-issue.

5.7 OT equipment is issued on loan from Stores to Service Users. There is no transfer of ownership from the Council to the Service User. In order to avoid any ambiguity, consideration should be given that Service Users sign a declaration confirming responsibility for the item and any further terms and conditions that would assist in the management of equipment.

5.8 Testing noted an example where equipment was recorded within ELMS as waiting to be delivered. However, when checked, the Service User stated that the item had already been installed. Further investigation noted approximately 150 items of equipment that were recorded within ELMS as “failed scans”. The current status and location of these items of equipment will require further investigation.

. 5.9 During the audit visit to Stores, a separate room was noted that was full of OT type equipment. Enquiries with officers noted that this equipment had not been recorded within ELMS and officers within Stores had no involvement regarding maintenance, storage etc. It is believed that the equipment may be an accumulation of various items collected from educational establishments.

5.10 It was noted there is no agreed procedure for informing Stores of a change in circumstance regarding a service user condition that results in no longer requiring an item of equipment. Currently, an informal system operates where Stores are informed if an item of equipment requires collection.

5.11 It was found that where an item of equipment is no longer required and a Service User has either disposed of or refused to return the item, there is no procedure for recovering the cost from the Service User.

5.12 It was noted that ELMS is used for the issue and management of OT equipment, while the ordering of the item is undertaken through Tranman. The completion and sending of the Tranman order to a supplying company is undertaken by an Administration Officer within the Stores office. Authorisation for the purchase may be received through an ELMS request authorised by the OT Team Manager or an OT Advanced Practitioner. However, the Storeman may also provide a list of regularly used items that require to be re-ordered.

5.13 Audit testing to verify the accuracy of the Stores records noted equipment with a unit value greater than £20 that had not been bar coded with an individual Asset Number. Agreed procedures require equipment with a unit value greater than £20 to have an individual bar code.

5.14 No review has been undertaken regarding the security measures to safeguard the equipment held within the Stores building. It was also noted that the building is not alarmed. The gross value of all the equipment held within Stores can exceed £100,000.

5.15 Investigation of ELMS and discussions with the Occupational Therapy Team Manager noted that no management or exception reports are produced to provide greater analysis of the equipment held with regard to valuation, age, turnover etc.

5.16 Enquiries with the Council Insurers noted that equipment issued to a Service User and kept within their own property is not covered by the Council's Insurance Policy. Service Users have not been informed of any requirement to have adequate insurance cover for equipment within their property.

5.17 A review of the user access profiles to ELMS noted the following points:-

- A number of generic access user accounts in operation.
- A number of accounts have been established with supervisor access.
- Examples noted of users no longer in the employment of the Council. The employment status of users employed by the NHS is unclear.

5.18 It was noted that documented procedures exist regarding the operation of ELMS. However, there is no internal procedures manual to complement the ELMS Systems Manual. An internal procedures manual would provide a point of reference to employees within stores and aid greater consistency with regard operating practices.

5.19 Currently there is no charge for the issue of equipment to Service Users. However, it was noted that a neighbouring Authority do not provide a number of everyday equipment e.g. adapted cutlery. Service Users are directed to retailers where they can personally purchase these items.

5.20 There are a number of Stores services operating independently of each other within the Council. Developing closer working relationship between the various Stores functions would encourage cross-fertilization of expertise and a source of further guidance and assistance if required.

6. Recommendations

Risk Ratings for Recommendations						
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Comments	Responsible Officer	Timescale for Implementation
Key Control: Effective systems and procedures operating to ensure accurate records are maintained to account for all Occupational Therapy Equipment held within Stores and issued to Service Users.						
5.1	A full stock check should be undertaken to ensure records correspond to the actual number of items held within Stores.	High	Yes	This will be completed as a trial in February and implemented on year end.	Assistant Manager (Comm. Services)	31/03/20
5.2	The Occupational Therapy Team Manager should authorise any items to be written off.	Medium	Yes	This has been organised and will take place	Assistant Manager (Comm. Services)/ OT Team Manager	05/02/20

Risk Ratings for Recommendations						
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Comments	Responsible Officer	Timescale for Implementation
5.3	Items of equipment should be kept wherever possible in Asset Number order within the Stores Building. Asset Numbers should be clearly recorded where possible on shelving.	Medium	Yes	Where possible this will be implemented	Assistant Manager (Comm. Services)	29/02/20
5.4	Consideration should be given to restricting access to the stores area within the building to authorised designated officers.	Medium	Yes	Segregation is now in place	Assistant Manager (Comm. Services)	Completed
5.5	Further development of ELMS is required to distinguish unit price valuation of new and re-used equipment.	High	Yes	Ethetec are struggling slightly with the development of this. However this is a Commissioning Function	Information Systems Officer	29/02/20

High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Comments	Responsible Officer	Timescale for Implementation
5.6	A review should be undertaken of the current policy of revaluing re-used items of equipment at 50% of the original unit purchase price.	Medium	Yes	Currently working with Ethetec regarding a solution – again this is a Commissioning led outcome	Information Systems Officer	29/02/20
5.7	Consideration should be given for service users to sign a declaration confirming responsibility for the equipment received.	Low	Yes	The Health and Social Care Partnership will review through the System Leadership Group and propose a course of action.	Service Manager (Provider Serv.)	31/08/20
5.8	Items classified as 'failed equipment scans' should be	High	Yes	All outstanding issues have been investigated	Assistant Manager	Completed

High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Comments	Responsible Officer	Timescale for Implementation
	investigated and their location resolved and recorded correctly within ELMS.			and process in place to control daily	(Comm. Services)	
5.9	Occupational Therapy equipment noted to have been stored separately should be included within ELMS or written off if no longer serviceable.	Medium	Yes	This has been resolved by OT Manager	OT Team Manager	Completed
5.10	A review of Departmental procedures should be undertaken to ensure Stores are informed of a change in circumstance in a service users' condition where an item of equipment may no longer be required.	Medium	Yes	The Health and Social Care Partnership will review through the System Leadership Group and propose a course of action.	Service Manager (Provider Serv.)	31/08/20
5.11	Consideration should be given to invoicing service users if equipment is not returned when requested.	Low	Yes	The Health and Social Care Partnership will	Service Manager (Provider Serv.)	31/08/20

High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Comments	Responsible Officer	Timescale for Implementation
				review through the System Leadership Group and propose a course of action.		
5.12	A review should be undertaken of the current ordering system for occupational therapy equipment. Authorisation of orders should be undertaken by the Occupational Therapy Team Manager.	High	Yes	This is now in place with the budget manager (OT) and Assistant Manager having reviewed the ordering system and all orders having the correct authorisation	Assistant Manager (Comm. Services)/ OT Team Manager	Completed
5.13	In accordance with previously agreed procedures all equipment	Medium	Yes	This is currently being processed	Assistant Manager	14/02/20

High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Comments	Responsible Officer	Timescale for Implementation
	with a unit value greater than £20 should be individually bar coded.				(Comm. Services)	
5.14	A review should be undertaken of the Stores building to check it is secure from unauthorised access.	Medium	Yes	Currently under review. This will be further explored with estates however there will be a resource issue	Assistant Manager (Comm. Services)	24/01/20
5.15	Further development should be undertaken of ELMS to enable the Occupational Therapy Team Manager to receive greater management analysis of the equipment held. A valuation report of the equipment held within stores should be	Medium	Yes	This is the responsibility of Commissioning as they are responsible for the ELMS System through the Systems Admin Team. Advised that the report can now be run	Information Systems Officer	Completed

High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Comments	Responsible Officer	Timescale for Implementation
	available when requested from ELMS.					
5.16	Service Users should be advised that any equipment received should be included within their personal property content insurance.	Low	Yes	The Health and Social Care Partnership will review through the System Leadership Group and propose a course of action.	Service Manager (Provider Serv.)	31/08/20
5.17	A review should be undertaken of the ELMS software application to ensure access levels are restricted to the requirements of the individual post. All access should be directly linked to the individual rather than a generic log in.	Medium	Yes	This is currently in place	Information Systems Officer	Completed

High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Comments	Responsible Officer	Timescale for Implementation
5.18	Current operating practices should be recorded within a Service Operating Manual.	Medium	Yes	This is under development in partnership with OT and Systems Admin and Ethetec	Assistant Manager (Comm. Services)	01/06/20
5.19	In terms of value for money, consideration should be given to the range of occupational therapy equipment currently supplied to service users and whether ready available items can in the future be purchased directly by the individual.	Medium	Yes	The Health and Social Care Partnership will review through the System Leadership Group and propose a course of action.	Service Manager (Provider Serv.)	31/08/20

High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Comments	Responsible Officer	Timescale for Implementation
5.20	Further consideration should be given to developing closer working relationships with other Stores Services operating within the Council.	Low	Yes	The Health and Social Care Partnership will review through the System Leadership Group and propose a course of action.	Service Manager (Provider Serv.)	31/08/20

REPORT TO: **MORAY INTEGRTION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 27 AUGUST 2020**

SUBJECT: **INTERNAL AUDIT – ANNUAL REPORT**

BY: **CHIEF INTERNAL AUDITOR**

1. REASON FOR REPORT

1.1 In line with Public Sector Internal Audit Standards, the Chief Internal Auditor must deliver an internal audit opinion and report that can be used to inform the annual governance statement for the Moray Integration Joint Board (MIJB) for the financial year ended 31 March 2020.

2. RECOMMENDATION

2.1 It is recommended that the Audit, Performance and Risk Committee considers the audit opinion based on work undertaken during the 2019/20 year, noting the impact the pandemic has had in the period of lockdown since March 2020.

3. BACKGROUND

3.1 The Scottish Government guidance issued through the Integrated Resources Advisory Group (IRAG) required the MIJB to establish adequate and proportionate internal audit arrangements and for internal audit to provide annual assurance on the overall adequacy and effectiveness of the framework of governance, risk management and control.

3.2 These arrangements comprise consideration and review of specific audit topics as outlined in a separate audit update provided with this agenda, along with assurances from the Health Board and Council as described below, which together inform the internal audit opinion on the MIJB's internal control framework for the financial year 2019/20.

3.3 The requirement for the Internal Audit Manager to deliver an annual internal audit opinion is contained within the Public Sector Internal Audit Standards (PSIAS), which are mandatory for use by local authorities and associated

bodies. The audit opinion informs the annual governance statement published as part of the MIJB annual accounts.

3.4 The PSIAS requires the Chief Internal Auditor to confirm the organisational independence of Internal Audit, and that there has been no limitation to the scope of internal audit work completed. This can be confirmed in relation to the review of the effectiveness of system controls, noting that the timing of certain audit projects has been challenging with the MIJB progressing change programmes across many of its service areas.

3.5 The PSIAS also requires Internal Audit to participate in an external quality assessment (EQA) at least once every five years. The most recent assessment completed in 2019 identified a number of areas of good practice and concluded that the service generally conforms to the PSIAS. The review identified a number of areas for improvement and an action plan of improvement actions was progressed during 2019/20.

3.6 The audit opinion has been drawn from a number of sources including an overview of minutes of meetings of the Board, those of two sub committees covering Clinical and Care Governance, and Audit, Performance and Risk respectively. Of particular note was the regular review and updating of a risk register outlining the principal risks identified by management. Development sessions on a wide range of topics have also been noted taking place throughout the year, and the latest annual report by the Chief Social Work Officer summarising achievements and progress was reviewed, along with other information used to inform the annual governance statement.

3.7 Assurance is also based on the wider audit work conducted by the Chief Internal Auditor in his capacity as Internal Audit Manager of Moray Council, from an annual internal audit report prepared for Grampian Health Board providing an opinion on the adequacy and effectiveness of its system of internal control, and from audit work relative to MIJB topics as outlined separately in an audit update report provided separately on this agenda.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The opinion covers the period from 1 April 2019 to 31 March 2020 during which normal operational arrangements applied for the most part, noting that since 23 March, the ‘lockdown’ occasioned by the pandemic saw major changes to service delivery and new ways of working.

4.2 These changes also impacted on the work of internal audit with reduced capacity to carry out work in the usual manner, redirection of audit staff resource to other areas of work, and workload pressures on auditee colleagues preventing business as usual.

4.3 This is likely to impact on the scope and coverage of internal audit in 2020/21 which in turn has the potential to limit the levels of audit assurance available in this current year should barriers to resuming ‘normal’ service remain.

4.4 This issue has been recognised by the Internal Audit Standards Advisory Board which acknowledges that Internal Audit teams will be challenged to comply with auditing standards given the requirement to comply with

government advice and that of their organisation regarding health and safety during the coronavirus pandemic, and that this fact should be drawn to the attention of audit committees.

4.5 Opinion

The Chief Internal Auditor has considered the audit work completed and other assurances available from council and NHS audit sources and is of the opinion that for the year to 31 March 2020, reasonable assurance can be placed on the adequacy and effectiveness of the MIJB framework of governance, risk management and internal control.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Moray Partners in Care 2019 – 2029"

Audit assurances support good governance which is integral to the delivery of strategic plans for the Moray area.

(b) Policy and Legal

No implications

(c) Financial implications

No implications

(d) Risk Implications and Mitigation

No direct implications

(e) Staffing Implications

None

(f) Property

None

(g) Equalities

An equality impact assessment is not required as there will be no impact on people with protected characteristics as a result of consideration of this report.

(h) Consultations

This report has been discussed with the Interim Chief Officer of the MIJB.

6. CONCLUSION

6.1 This report provides a summary overview of the nature and extent of audit work carried out during the year, and informs the annual internal audit opinion on the internal control environment operating within the MIJB.

Author of Report: Atholl Scott
Background Papers: Internal Audit working papers
Ref: MIJB/ap&rc/270820

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 27 AUGUST 2020**

SUBJECT: **STRATEGIC RISK REGISTER – AUGUST 2020**

BY: **INTERIM CHIEF OFFICER**

1. REASON FOR REPORT

1.1 To provide an overview of the current strategic risks, along with a summary of actions which are in place to mitigate those risks, updated August 2020.

2. RECOMMENDATION

2.1 It is recommended that the Audit, Performance and Risk Committee (APR) agree to:

i) consider and note the updated Strategic Risk Register included in APPENDIX 1;

ii) note the Strategic Risk Register will be further refined to align with the transformation plans as they evolve.

3. BACKGROUND

3.1 The strategic risk register is reviewed regularly by the Senior Management Team as part of a robust risk monitoring framework, to identify, assess and prioritise risks related to the delivery of services in relation to delegated functions, particularly any which are likely to affect the delivery of the Strategic Plan.

3.2 The Moray Integration Joint Board (MIJB) Strategic Risk Register is attached to this report at **APPENDIX 1** and sets out the inherent risks being faced by the MIJB, together with a current assessment on the level of the risks and mitigating actions being taken to reduce the impact of the risks.

3.3 Risk scores are weighted, based on assessment according to their likelihood and corresponding impact, as per Section 5 of the MIJB Risk Policy.

3.4 The Strategic Risks received an initial review to ensure they align to the Moray Partners in Care 2019 – 2029 strategic plan which was agreed at MIJB on 28 November 2019 (para 13 of the minute refers).

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The Risk Management Framework review is nearing completion and the output from the development workshop for MIJB members in February 2020 was approved by the Board on 25 June 2020 (para 9of the minute refers). The approved Risk Appetite Statements have been included in **APPENDIX 1**.

4.2 The impact of COVID-19 has delayed the development of transformation plans. The work to develop change plans has accelerated with the North East Partnership Group giving priority to the embedding of a Home First approach, in line with our Strategic Plan, as we prepare for potential further waves of COVID-19 and winter pressures. Home First involves a whole system approach, and the work includes the acute sector to make the change enduring. As plans evolve, the Strategic Risk Register will be updated to ensure that it reflects any barriers to realising the ambitions we are not enacting to achieve the vision set out in our Strategic Plan.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Moray Partners in Care 2019-2029"

The MIJB requires effective governance arrangements for those services and functions delegated to it and Risk Management systems are integral to this.

(b) Policy and Legal

As set out in the terms of reference, the Board has responsibility to provide assurance of the adequacy of the risk management framework.

There are no legal implications arising from this report.

(c) Financial implications

There are no direct financial implications arising from this report however the Board should note the failure to manage risks effectively could have a financial impact for the MIJB.

(d) Risk Implications and Mitigation

This report forms part of the governance arrangements for identifying and managing strategic risks of the MIJB.

(e) Staffing Implications

There are no additional staffing implications arising from this report. Senior Management Team have considered areas of high risk and are seeking to redeploy staff to address these as a matter of urgency.

(f) Property

There are no property implications arising from this report.

(g) Equalities/Socio Economic Impact

An Equalities Impact Assessment is not required because there are no service, policy or organisational changes being proposed.

(h) Consultations

Consultations have been undertaken with the Senior Management Team and Chief Internal Auditor and comments have been incorporated in this report.

6. CONCLUSION

6.1 This report and appendices contains proposed risk appetite statements that, when approved, will underpin the MIJB approach to strategic decision making.

6.2 The report also outlines the current position in relation to the impact of COVID-19 on progress with transformation plans, and recommends the Board note the revised and updated version of the Strategic Risk Register.

Author of Report: Jeanette Netherwood, Corporate Manager
Background Papers: held by author
Ref:

HEALTH AND SOCIAL CARE MORAY STRATEGIC RISK REGISTER

AS AT 17 AUGUST 2020

RISK SUMMARY

1. The Moray Integration Joint Board (MIJB) does not function as set out within the Integration Scheme, Strategic Plan and in-line with Standing Orders and fails to deliver its objectives or expected outcomes.
2. There is a risk of MIJB financial failure in that the demand for services outstripping available financial resources. Financial pressures being experienced by the funding Partners will directly impact on decision making and prioritisation of MIJB.
3. Inability to recruit and retain qualified and experienced staff to provide safe care whilst ensuring staff are fully able to manage changes resulting from integration.
4. Inability to demonstrate effective governance and effective communication and engagement with stakeholders.
5. Inability to cope with unforeseen external emergencies or incidents as a result of inadequate emergency and resilience planning.
6. Risk to MIJB decisions resulting in litigation/judicial review. Expectations from external inspections are not met.
7. Inability to achieve progress in relation to national Health and Wellbeing Outcomes. Performance falls below acceptable level.
8. Inability to progress with delivery of Strategic Objectives and Transformation projects as a result of inability to resolve data sharing and data security requirements.
9. Requirements for support services are not prioritised by NHS Grampian and Moray Council.

RISK RATING	**LOW**	**MEDIUM**	**HIGH**	**VERY HIGH**
RISK MOVEMENT	**DECREASE**	**NO CHANGE**	**INCREASE**	

The process for managing risk is documented out with the MIJB Risk Policy.

1		
Description of Risk: *Regulatory*	The Integration Joint Board (IJB) does not function as set out within the Integration Scheme, Strategic Plan and Scheme of Administration and fails to deliver its objectives or expected outcomes.	
Lead:	Chief Officer	
Risk Rating:	Low/ medium/ high/ very high	**MEDIUM**
Risk Movement:	Increase/ decrease/ no change	**NO CHANGE**
Rationale for Risk Rating:	The strategic plan has been reviewed and new plan launched in December 2019. Membership of IJB committees has been stable and the majority of members have attended several cycles of meetings. **Due to the ongoing Covid 19 response, normal business has suspended and emergency arrangements have been implemented for IJB with weekly meetings of Chair/Vice Chair and Chief Officer. Interim arrangements have been implemented for briefings to Clinical & Care Governance Chair and Audit, Performance and Risk items are considered at the IJB meetings. Progress is being made with the development of the cross system focus on "Home First" and these actions will be incorporated into the Transformation plan that underpins "Partners in Care"**	
Rationale for Risk Appetite:	The Board, staff and providers across Moray are all committed to ensuring high standards of clinical care & governance through operational policies. Innovation and new ways of working may mean traditional regulations do not exist, or are contradictory. We will only take regulatory risks knowingly, following consultation with the relevant regulatory body and where we have clear risk mitigation in place.	
Controls:	• Integration Scheme. • Strategic Plan ""Partners in Care" 2019 to 2029 • Governance arrangements formally documented and approved. • Agreed risk appetite statement. • Performance reporting mechanisms. • Consultation with legal representative for all reports to committees and attendance at committee for key reports.	
Mitigating Actions:	Induction sessions are held for new IJB members. IJB voting member briefings are held regularly. Conduct and Standards training held for IJB Members July 18 with updates provided by Legal Services as appropriate.	

	SMT regular meetings and directing managers and teams to focus on priorities. Regular development sessions held with IJB and System Leadership Group Strategic Plan has been developed. New management structure is in place and wider system re-design and transformation governance structures being developed for implementation at the same time. The work that has been progressed through need arising from the Covid19 response has escalated developments in some areas as a matter of priority. This has been done through collaborative working with partner organisations and the third sector.
Assurances:	• Audit, Performance and Risk Committee oversight and scrutiny. • Internal Audit function and Reporting • Reporting to Board.
Gaps in assurance:	The Covid 19 Response has caused a delay in producing the Transformation Plans which in turn has impacted on communication and engagement with staff and partners in respect of the intended outcomes. Work will progress over the next quarter to address this gap.
Current performance:	Scheme of administration is reported when any changes are required. An initial meeting has been held with legal advisors to establish the governance requirements for the review of the integration scheme in relation to the proposed delegation of Children's and Criminal Justice Services. Report presenting the Strategic Plan, Communication Strategy, Organisational Development and Workforce Plans, Performance Framework and the draft Transformational Plan were presented and approved at MIJB on 28 November 2019 Report on Standards Officer agreed by IJB March 2019 Members Handbook is being updated and will be circulated to all members.
Comments:	Strategic Planning and Commissioning Group approved the generic Terms of Reference and Chairs of the transformation boards at the meeting on 19 December 2019. It was intended that these boards would be established by April 2020 however this work has been on hold due to Covid19 and is being restarted but will incorporate the changes Covid is causing on ways of working.

2		
Description of Risk: *Financial*	There is a risk of MIJB financial failure in that the demand for services outstrips available financial resources. Financial pressures being experienced both by the funding Partners and Community Planning Partners will directly impact on decision making and prioritisation of MIJB.	
Lead:	Chief Officer/Chief Financial Officer	
Risk Rating:	Low/ medium/ high/ very high	**VERY HIGH**

Risk Movement:	Increase/ decrease/ no change	**NO CHANGE**
Rationale for Risk Rating:	Previous funding cuts from Moray Council have been significant 2017/18 (£1.3m) and 2018/19 (£1.759m Gross). Both the 2019/20 and 2020/21 settlement saw additional investment for health and social care. Although this was passed through to the MIJB there remains a significant funding gap as much of the new investment related to new commitments. Financial settlements are set to continue on a one year only basis, which does not support sound financial planning Demand on services continues to rise and the IJB has no remaining reserves to be utilised other than a reserve of £0.187M as at 1 April 2020, earmarked for the Primary Care Improvement Fund as directed by Scottish Government. The draft annual accounts have been produced and were presented to the IJB on 30 July 2020 prior to audit inspection. The reported deficit as at 31.3.20 is an overspend of £2.073M, The IJB have now out turned a deficit position for the 2nd consecutive year, NHSG and Moray Council are required to meet this deficit, for 19/20 the amounts are £1.306M and £0.767M respectively. In addition to existing financial challenges, the Covid-19 pandemic brings with it additional financial burden, which as yet is not quantifiable. The Chief Financial Officer has introduced processes for recording the costs of Covid -19 which are being monitored on an ongoing basis. Regular discussions are taking place with Scottish Government and financial returns in support of Mobilisation Plan are being made at regular intervals. The IJB approved a balanced revenue budget in March 2020 which included a recovery and transformation plan. It should be noted that a balanced budget position was achieved through a Recovery and Transformation plan of £1.944m. There is now a significant risk to the delivery of the MIJB 20/21 recovery plan – this has been highlighted to Government, the IJB and the Senior management team are working to address through other actions.	
Rationale for Risk Appetite:	The Board recognises the financial constraints all partners are working within. While we are cautious to open about accepting financial risks this will be done: • Where a clear business case or rationale exists for exposing ourselves to the financial risk • Where we can protect the long term sustainability of health & social care in Moray Covid-19 places additional risk on the MIJB finances	
Controls:	Chief Finance Officer appointed - this role is crucial in ensuring sound financial management and supporting financial decision making, budget reporting and escalation. Corrective action has been implemented through correspondence with budget holders and increased scrutiny at senior management level. Recovery Plan agreed and being monitored regularly. In October 2019, the MIJB approved the Medium Term Financial Framework that aims to support delivery of the Strategic Plan. The CFO and Senior Management Team are working to address the budget shortfall. A revised Financial Framework will be developed to support the emerging situation	
Mitigating Actions:	Risk remains of the challenge that the MIJB can deliver transformation and efficiencies at the pace required. Financial information is reported regularly to both the MIJB, Senior Management Team and System Leadership Group.	

	The Chief Officer and Chief Financial Officer (CFO) continue to engage in finance discussions with key personnel of both NHS Grampian and Moray Council. These conversations continue following the 2019/20 outturn position and as we respond to the Covid-19 pandemic. Chief Officer and CFO will continue to engage with the partner organisations in respect of the financial position throughout the year with a focus on the savings plan. Cross partnership finance meetings have been put in place on a quarterly basis with partner CEOs, Finance Directors and the Chair/Vice Chair of the IJB. The MIJB is acutely aware of the recurring overspend on its core services and continues to work to address this underlying issue. Measures to ensure only essential expenditure is being incurred have been communicated to all officers with budget manager responsibility.
Assurances:	MIJB oversight and scrutiny of budget. Reporting through MIJB, NHS Grampian Board and Moray Council.
Gaps in assurance:	None known
Current performance:	Budget Outturn for 2019/20 has seen an overspend after consideration of strategic funds of £2.073m. This was met by NHSG and MC in the agreed proportions of 63% / 37% respectively as per the Integration Scheme. Plans are being progressed in relation to service planning and financial review during 2020/21. The recovery plan is being monitored regularly by the Senior management team
Comments:	Senior managers to work with Chief Officer and Chief Financial Officer to address the continuing financial challenge and forecast overspend as we progress through the current pandemic. Through reporting, regular updates will be provided to the MIJB, Moray Council and NHS Grampian as part of the risk sharing arrangement in place.

3		
Description of Risk: *Human Resources (People):*	Inability to recruit and retain qualified and experienced staff to provide safe care, whilst ensuring staff are fully able to manage change resulting from Integration	
Lead:	Chief Officer	
Risk Rating:	Low/ medium/ high/ very high	**HIGH**
Risk Movement:	Increase/ decrease/ no change	**NO CHANGE**
Rationale for Risk Rating:	There continues to be issues with recruitment to some front line services that require specific skills and experience. This has been the case for some time now and continues to place pressure on existing staff. In particular there is a significant	

	issue around attracting people to work in Care at home teams. Workshops have been held in all localities but to date there has not been the increase in applications that is needed. The decision as a result of Covid19 to change the eligibility criteria to critical has reduced pressure on Care at home as there are less clients being provided a service. The difficulty with recruitment and retention of staff to caring roles is experienced by Care Homes and this can lead to an impact on HSCM teams where additional support may be required by the contractors. Covid 19 has the potential to cause severe disruption to staffing as Test, Trace and Isolate is implemented and managers are working as far as possible to mitigate any potential impact of a positive test result. There are also difficulties in recruitment to key clinical positions in Dr Grays and the impact of these are felt across the whole system. The impact of budgetary decisions by the Council in relation to reducing staffing levels has reduced levels of support provided in some key areas for Health and Social Care Moray (HSCM), such as ICT, HR, Legal and design. This has been further impacted due to Covid 19 and Committee Officer support will not be available for APR and CCG committees until the new year.
Rationale for Risk Appetite:	Safety risks that could result in harm to service users, staff or the public are inherent in Health & Social Care services. The safety of individuals is paramount therefore standards of safety management and clinical care have to be high, and the Board will continue to seek assurances this is the case. The Board's ambition is for health & social care to be people centred. This means supporting people in decision making about their own health & care, which may expose individuals to higher risk where they make an informed decision. The Board will also seek to balance individual safety risks with collective safety risks to the community.
Controls:	Management structure in place with updates reported to the MIJB. Organisational Development plan in place and Workforce Plans are being updated to align to the new strategic plan. Continued activity to address specific recruitment and retention issues. The chief social worker reviewed the situation with managers and employed a Consultant Practitioner to develop options for addressing some of the particular issues affecting social work services in Moray and to provide support to managers and staff. Management competencies continue to be developed through Kings Fund training although this is suspended due to Covid19. Communications & Engagement Strategy was approved in November 2019 and is being implemented. Council and NHS performance systems in operation with HSCM reporting being further developed and information relating to vacancies, turnover and staff absences is integral to this. This has been expanded to collate details of staff shielding or isolating so arrangements can be made to utilise staff resources as effectively as possible. SMT review vacancies and approve for recruitment

Mitigating Actions:	System re-design and transformation. Organisational Development Plan and Workforce plan has been updated and was approved by MIJB in November 2019. This will be further updated following the work carried out by the NSHG Recovery Cell on Supporting Staff and the revised NHSG Organisational Development plan. All Locality Managers are now in post with effect from January 2020. Joint Workforce Planning is being undertaken albeit it suspended at present and the joint workforce forum recommenced meeting in July 2020. Lead Managers are involved in regional and national initiatives to ensure all learning is adopted to improve this position. Lead Managers and Professional Leads are linked to University Planning for intakes and programmes for future workforce development.
Assurances:	Normally there is operational oversight by Moray Workforce Forum and reported to MIJB. Currently the HSCM Response Group is overseeing matters arising as a result of Covid19 response. Organisational Steering Group oversees any potential organisational change
Gaps in assurance:	Joint or single system not yet agreed for incident reporting.
Current performance:	iMatter survey undertaken during July 2019 across all operational areas showed improvement in response rate although there are still some teams that require to engage. Managers have worked with teams and developed action plans with 64% completed by the deadline in comparison to 50% in previous year. The Systems Leadership Group will be taking forward the implementation of the Organisational Development. An IMatter pulse survey will be undertaken in September 2020 to get a snap shot of what staff are feeling.
Comments:	Staffing issues are owned by the Systems Leadership Group who will work collaboratively across the system to seek opportunities to make jobs more attractive where it has proved difficult to recruit. There has been considerable efforts by both NHS Grampian and Moray Council to provide staff for redeployment to frontline services in HSCM and we continue to be supported by some of these staff in key areas such as PPE Stores.

4	
Description of Risk: *Reputation:*	Inability to demonstrate effective governance and effective communication and engagement with stakeholders.
Lead:	Chief Officer

Risk Rating:	low/medium/high/very high	**MEDIUM**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Locality planning assessed as medium in relation to ability to work at the pace required and current workforce capacity. Performance framework to be further developed from a planning perspective to show the links through operational service delivery to strategic objectives.	
Rationale for Risk Appetite:	The Board is cautious to open about risks that could damage relationships with different stakeholders. It recognises many of our aspirations depend on effective collaboration, coproduction and partnership working with a range of stakeholders. The appetite also recognises that while the aspiration is to be a co-operative partner, some partners will not be able to move at the same pace as us all the time. We will seek to protect relationships in the long term and will not set out to antagonise stakeholders deliberately. For example, we must not be seen to exclude or prevent participation in the design of services where there is an appetite to do this. We must be mindful that repairing relationships is easier when there is already a well of goodwill to draw on, and that further damage to an already damaged relationship will not be conducive to good long term outcomes	
Controls:	Communication and Engagement Strategy approved November 2019 Annual Governance statement produced as part of the Annual Accounts 2019/20 and submitted to External Audit. Annual Performance Report for 2019/20 was published in August 2020 Performance reporting mechanisms in place and being further developed through performance support team, home first group and system leadership team. Community engagement in place for key projects areas such as Forres and Keith with information being made available to stakeholders and the wider public via HSCM website.	
Mitigating Actions:	Schedule of Committee meetings and development days in place and implemented. Good working relationship established with Audit Scotland, the MIJB's appointed external auditors since 16/17. Annual Performance Report for 2018/19 published in August 2019. Social media is actively used as a method of engaging with the public, with short videos focussing on particular services being trialled.	
Assurances:	Oversight and scrutiny by Clinical and Care Governance Committee, Audit Performance and Risk Committee and MIJB. Summary reports of minutes of MIJB meetings are submitted to Council committee and NHS Board.	

Gaps in assurance:	Progress on implementation of the Communication and Engagement Strategy has been impacted by the Covid 19. Emergency governance structure is in place so this does not provide the normal levels of engagement. Governance Framework for MIJB is being documented and will be presented for discussion at the meeting in September.
Current performance:	Communications Strategy was reviewed approved by IJB November 2019. Annual Performance Report 2018/19 published August 2019. Audited Accounts for 2018/19 were publicised by deadline 30 September 2019 Due to Covid19 there have been increased levels of briefings to staff, the public and Chair/Vice Chair of MIJB with a focus on the key elements of the response. Staff have been involved in co-ordinating services for and communicating with shielded and vulnerable people.
Comments:	A communication cell was established as part of the Local Resilience Partnership response with representation from Councils, HSCP and NHSG. This is being led by Aberdeen City Council and is an example of the collaborative working that has been taking place. This forum provides assurance that messages to all stakeholders are consistent. It also ensures that there is support for our Communications Officer and resilience provided with the access to other communication officers.

5		
Description of Risk: *Environmental:*	Inability to cope with unforeseen external emergencies or incidents as a result of inadequate emergency and resilience planning.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**HIGH**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Due to the response requirements for Covid 19 progress has been made in a number of areas. SMOC information is updated, control room guidance updated and expanded, control centre protocols were implemented and remain in place and management teams have responded in an agile, responsive and collaborative way under very challenging conditions. HSCM did not have a collectively approved list of critical functions at the start of the response however this was quickly completed and used to prioritise allocation of resources to the response. This list will be further developed to ensure it is robust for any type of disruptive event.	

	EU Exit plans are being reviewed.
Rationale for Risk Appetite:	The MIJB understand the requirement to meet the statutory obligations set out within the Civil Contingencies Act and work with partner organisations to meet these obligations.
Controls:	Winter/Surge Plan updated and has been tested alongside NHSG plans for winter and officers have participated in exercises. HSCM Civil Contingencies group established and meeting regularly to address priority subjects. NHS Grampian Resilience Standards Action Plan approved (3 year). Business Continuity Plans in place for most services although overdue a review in some areas.
Mitigating Actions:	Information from the updated BIA/BCP has informed elements of the Winter Plan (Surge plan). A Friday huddle is in place which gathers the status of services across the whole system to provide information and contact details to the Senior Manager on Call (SMOC) over the weekend. NHS Grampian have amended their approach to Pandemic preparation so HSCM Pandemic plan requires redrafting and testing Lesson learnt from the response to Covid will be incorporated into the Surge (Winter) Plan and training needs identified will be addressed. Practitioner group established for Moray with representation from HSCM, Dr Grays, Moray Council and NHSG to discuss matters arising from the Local Resilience Forum and within our respective organisations. In addition it will provide a forum for discussion of the linkages between organisational response plans to ensure there are no gaps or over reliance on particular local resources.
Assurances:	Audit, Performance and Risk Committee and NHS Grampian Civil Contingencies Group oversight and scrutiny.
Gaps in assurance:	Recent experience has highlighted the need for additional staff to be trained to be control centre managers, loggists and general awareness of response structures and meeting protocols. This will be incorporated into training schedules going forward. Some table top exercises have been completed but the intended programme for 2020 will require to be rescheduled once we are out of response phase.

	Progress has been made however further work is required to address the targets in the implementation plan that have not been met and the Resilience standards as identified by the NHSG Civil Contingencies Group. Pandemic flu plans will require to be updated with the learning from this incident
Current performance:	Many services have business continuity arrangements and some are overdue for an update. Work has progressed in identification of a critical functions list for agreement by System Leadership Group that will inform planning arrangements going forward. There will need to be changes made to business continuity plans following the implementation of additional ICT resources in services which have provided a greater deal of resilience for some services and functions – albeit reliant on electricity supply. Annual report on progress against NHS resilience standards was reviewed by APR committee in January 2020.
Comments:	Once the response phase is complete the HSCM Civil Contingencies group will schedule and review progress in achieving the NHSG resilience standards, reporting updates to System Leadership Group.

6		
Description of Risk: *Regulatory*	Risk to MIJB decisions resulting in litigation/judicial review. Expectations from external inspections are not met.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**MEDIUM**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Considered medium risk due to the reporting arrangements being relatively new	
Rationale for Risk Appetite:	The Board, staff and providers across Moray are all committed to ensuring high standards of clinical care & governance through operational policies. Innovation and new ways of working may mean traditional regulations do not exist, or are contradictory. We will only take regulatory risks knowingly, following consultation with the relevant regulatory body and where we have clear risk mitigation in place.	
Controls:	Clinical and Care Governance (CCG) Committee established and future reporting requirements identified High and Very High operational risks are reviewed by System Leadership Group monthly and a review of all risks will be undertaken as part of the risk management framework. Complaints and compliments procedures in place and monitored. Clinical incidents and risks are being reviewed on a weekly basis to ensure processes are followed appropriately and consistently and responses are recorded in a timely manner. Adverse events and duty of candour procedures in place and being actioned where appropriate and summary reports submitted to CCG committee. Reports from external inspections reported to appropriate operational groups and by exception to SMT for subsequent reporting to CCG or Audit Performance and Risk Committee as appropriate. Care Home Oversight Group is meeting daily to oversee and manage risks in care homes. Children and Adult Protection services are being delivered and reported to their respective committee on a regular basis.	
Mitigating Actions:	This risk is discussed regularly by the three North East Chief Officers. Additional resource has been allocated to support the analysis of information for presentation to CCG committee Process for sign off and monitoring actions arising from Internal and External audits has been agreed	

Assurances:	Audit, Performance and Risk and Clinical and Care Governance Sub-Committees oversight and scrutiny.
Gaps in assurance:	Process for highlighting recurring themes or strategic expectations from external inspections requires further development to ensure Committee has sight of significant issues.
Current performance:	External inspection reports are reviewed and actions arising are allocated to officers for taking forward. A summary of inspections was included in the Annual Performance report for 2018/19
Comments:	No major concerns have been identified for HSCM services in any audits or inspections this year.

7		
Description of Risk: *Operational Continuity and Performance:*	Inability to achieve progress in relation to national Health and Wellbeing Outcomes. Performance of services falls below acceptable level.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**HIGH**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Potential impacts to the wide range of services in NHS Grampian and Moray Council commissioned by the MIJB arising from reductions in available staff resources as budgetary constraints impact. Unplanned admissions or delayed discharges place additional cost and capacity burdens on the service. As a result of a number of actions taken to respond to Covid19 including the opening of Duffus Wing and the interim change for Care at Home services to only be delivered to those people assessed with eligibility criteria as critical, the level of delayed discharges have decreased significantly.	
Rationale for Risk Appetite:	The Board is cautious to open about risks that could affect outcomes that are priorities to people in Moray. There is a slightly higher appetite to risks that may mean nationally set outcomes – that are not a high priority in Moray - are not met.	

	This will only be accepted where there is a clear rationale, and preferably also a way of demonstrating what the IJB is doing to meet the aspiration the outcome was created for.
Controls:	Performance Management reporting framework. 2019 to 2029 "Partners in Care" Strategic Plan approved and Transformation Plan being developed. Performance regularly reported to MIJB. Revised Scorecard being developed to align to the new strategic priorities. Best practice elements from each body brought together to mitigate risks to MIJB's objectives and outcomes. Chief Officer and SMT managing workload pressures as part of budget process.
Mitigating Actions:	Service managers monitor performance regularly with their teams and escalate any issues to the Performance Management Group for further discussion to provide wider support, developing shared ownership and a greater understanding across the whole system. Key performance data is being circulated daily to all managers in a "Performance Flow" dashboard to ensure any potential issues are identified quickly so action can be taken.
Assurances:	Audit, Performance and Risk Committee oversight. Operationally managed by service managers, receiving reports from Performance management group (which has a specific focus on performance). Strategic direction provided by Systems Leadership Group. HSCM Response Group was established and meets regularly to review the key performance information and actions that are required to deliver the priority services.
Gaps in assurance:	Development work in performance to establish clear links to describe the changes proposed by actions identified in the new Strategic Plan is on hold, but will re-commence shortly as plans for recovery are developed.
Current performance:	Covid19 has impacted on all areas of the service and work is underway to take the learning and experience gained during the response to collate performance information in dashboards to support mangers interpret the impact of Covid19 on their services, now and going forward. There are likely to be changes to ways of working and this may also have impact on the performance information required.
Comments:	Work has progressed with development of performance monitoring and reporting of key performance indicators for locality managers.

8		
Description of Risk: *Transformation*	Inability to progress with delivery of Strategic Objectives and Transformation projects.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**MEDIUM**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	There are many issues that will impact on the ability to deliver Strategic Objectives. The transformation plan is being developed and will be presented to the Board for approval and will form the basis for monitoring progress on delivery of the objectives. One key aspect to facilitate transformation is the need for progress in relation to ICT infrastructure, data sharing and data security across the whole system. Work was undertaken by NHS GRAMPIAN and partners to address the needs for information during the response to Covid and it is hoped that this progress can be built on	
Rationale for Risk Appetite:	The Board has a high appetite for risks associated with delivery of the Transformation plan. The following should be considered when accepting these risks: • We understand and can mitigate other risk types that may arise, e.g. safety or financial within appetite • Service users are consulted and informed of changes in an open & transparent way • We will monitor the outcome and change course if necessary	
Controls:	Home First strategic theme is being progressed across the whole system and a local Home First Group is meeting weekly. The Home First Transformation Board has also been established – the output of these meetings will go through appropriate governance frameworks. A newsletter is being produced to keep staff and partners informed. Computer Use Policies and HR policies in place for NHS and Moray Council and staff are required (through and automated process) to confirm they have read these every 6 months PSN accreditation secured by Moray Council	

Mitigating Actions:	Integrated Infrastructure Group established, with ICT representation from NHSG and Moray Council, to consider and provide solutions to data sharing issues and ICT infrastructure matters. Linkages to Infrastructure board and Information sharing groups have been established albeit these meetings are not taking place regularly. Data sharing groups for Grampian and Health and Social Care Moray have been established and meetings were held regularly but have not taken place for several months due to Covid. These meetings have oversight of any issues arising from Data protection and GDPR matters from either Council or NHS systems.
Assurances:	Strict ICT and data sharing policies and protocols in place with NHS Grampian and Moray Council.
Gaps in assurance:	Transformation Plan is being developed that will detail the outcomes. Protocol for access to systems by employees of partner bodies to be documented. Information Management arrangements to be developed and endorsed by MIJB. Process of identification of issue and submission to data sharing group requires to be reinforced to ensure matters are progressed. Meetings have not been taking place due to Covid. They will commence in the next quarter.
Current performance:	Training programme to be developed on records management, data protection and related issues for staff working across and between partners.
Comments:	Where national systems are involved it may not be possible to identify a solution however the issues will be able to be raised at the appropriate level via the Grampian Data Sharing Group where all three partnerships are represented.

9		
Description of Risk: *Infrastructure*	Requirements for support services are not prioritised by NHS Grampian and Moray Council.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**HIGH**
Risk Movement:	increase/decrease/no change	**INCREASING**
Rationale for Risk Rating:	Changes to processes and necessary stakeholder buy-in still bedding in. Moray Council is undertaking a Property review of office and depot accommodation and the potential impact for HSCM services requires consideration. The output was anticipated in October 2019 however due to changes with roles and responsibilities within the Council it is not yet clear when the outcomes will be available for consultation. The changes required to places of work as a result of Covid19 will restrict the number of people that can use an office. These decisions are being made by NHSG and Moray Council and we await their assessment of what facilities we will have available. ICT infrastructure service plans in NHS Grampian and Moray Council are not yet visible to HSCM and development of communication and engagement process is required. The impact of Covid has resulted in a change in ICT strategy for Moray Council. They have moved away from staff using desktops to providing laptops which will provide more resilience and allow people to work at home. This is a necessity where the number of desks available in offices has been reduced due to implementation of social distancing guidance. There has been an issue with availability of kit (national shortage), however stock has started to be delivered and will be rolled out to priority staff over the next couple of weeks.	
Rationale for Risk Appetite:	Low tolerance in relation to not meeting requirements.	
Controls:	Chief Officer has regular meetings with partners Infrastructure Programme Board established with Chief Officer as Senior Responsible Officer/Chief Officer member of CMT. Process for submission of projects to the infrastructure board has approved and implemented to ensure appropriate oversight of all projects underway in HSCM.	

Mitigating Actions:	Dedicated project Manager in place – monitoring/managing risks of the Programme Membership of the Board reviewed and revised to ensure representation of all existing infrastructure processes and funding opportunities. Process for ensuring infrastructure change/investment requests developed Infrastructure Manager post is vacant but other officers are linking into other Infrastructure groups within NHSG & Moray Council to ensure level of 'gatekeeping'. Dr Grays site development plan is being produced collaboratively with input from NHSG and HSCM management.
Assurances:	Infrastructure Programme Board functions to provide robust governance and assurance that proposed projects have a robust business case and meets requirements of the respective partner organisations. This board reports to Strategic Planning and Commissioning Group.
Gaps in assurance:	Further work is required on developing the process for approval for projects so that they are progressed timeously. Need to review all existing processes in relation to infrastructure changes/projects/investments and streamline to avoid duplication of effort. Attendance at Infrastructure Board by NHS Grampian officers has reduced resulting in discussions at meetings being incomplete. Premises, Infrastructure and Digital Manager post that provides additional leadership in relation to major infrastructure projects is currently vacant.
Current performance:	The Infrastructure Board is currently suspended. Its purpose is for highlights/exceptions to be taken to SLG for communication and information purposes. Attendance at the Infrastructure Board meetings has reduced and the purpose and scope of this meeting is being reviewed as part of the governance arrangements relating to the developing Transformation Boards.
Comments:	Existing projects will be reviewed as part of the development of the transformation plans for the Strategic Plan to ensure resources are being dedicated appropriately and aligned to the emerging Strategic priorities. Contact has been made with Council ICT and discussions are underway regarding scoping specific support requirements of HSCM.