Audit, Performance and Risk Committee

Thursday, 29 June 2023

Council Chambers

NOTICE IS HEREBY GIVEN that a Meeting of the **Audit, Performance and Risk Committee, Council Chambers**, **Council Office, High Street, Elgin, IV30 1BX** on **Thursday, 29 June 2023** at **14:00** to consider the business noted below.

AGENDA

MORAY INTEGRATION JOINT BOARD

SEDERUNT

Councillor Scott Lawrence (Chair)

Mr Derick Murray (Voting Member)
Mr Sandy Riddell (Voting Member)
Councillor John Divers (Voting Member)
Mr Sean Coady (Member)
Mr Graham Hilditch (Member)
Mr Simon Bokor-Ingram (Member)
Ms Sonya Duncan (Member)
Ms Deborah O'Shea (Member)

Mr Stuart Falconer (Non-Voting Member)

Clerk Name:	Tracey Sutherland
Clerk Telephone:	07971 879268
Clerk Email:	committee.services@moray.gov.uk

MINUTE OF MEETING OF THE AUDIT, PERFORMANCE AND RISK COMMITTEE

Thursday, 30 March 2023

Remote Locations via Video Conference

PRESENT

Mr Simon Bokor-Ingram, Mr Sean Coady, Councillor John Divers, Mr Graham Hilditch, Councillor Scott Lawrence, Mr Derick Murray, Ms Deborah O'Shea, Mr Sandy Riddell

APOLOGIES

Ms Sonya Duncan, Mr Stuart Falconer

IN ATTENDANCE

Also in attendance at the above meeting were the Chief Internal Auditor, Lizette Van Hal, Service Manager, Interim Strategy and Planning Lead, Angela Pieri, External Auditor Grant Thornton, Hannah McKellar, External Auditor Grant Thornton, and Lindsey Robinson, Committee Service Officer, as clerk to the meeting.

1. Chair

The meeting was chaired by Councillor Scott Lawrence.

2. Declaration of Member's Interests

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

3. Minutes

The minutes of the meetings on 24 November 2022 and 26 January 2023 were submitted and approved.

4. Action Log of Meeting of 24 November 2022

The Action Log of the meeting of 24 November 2022 was considered and updated accordingly.

5. Quarter 3 Performance Report

A report by the Corporate Manager updated the Committee on performance as at Quarter 3 (October to December 2022).

During consideration Mr Murray sought clarification as to why some targets have changed.

In response, the Chief Officer advised that he did not have the answer to hand and would need to ask the Corporate Manager and get back to the Committee.

Thereafter, the Committee agreed to note:

i. the performance of local indicators for Quarter 3 (October - December 2022) as presented in the Performance Report at Appendix 1; and

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 of the report.

6. Internal Audit Plan Report

A report by the Chief Internal Auditor provided the Committee with information on the proposed internal audit coverage for the 2023/24 financial year.

During consideration Mr Riddell sought clarification on the resources available to internal audit and if the Chief Internal Auditor was being given the space to do his job for the IJB.

In response the Chief Internal Auditor advised that he was flagging up the increased demands on internal audit and the available resources as a point of risk.

Mr Riddell was of the opinion that the Chief Officer should highlight the risks in the report to the Council Corporate Management Team.

This was agreed.

Thereafter the Committee agreed:

i. to note the report and the proposed audit coverage; and

ii. that the Chief Officer will submit a report to the Corporate Management Team to highlight the risks within the report.

7. Strategic Risk Register

A report by the Chief Officer provided the Committee with an overview of the current strategic risks, along with a summary of actions which are in place to mitigate those risks, updated March 2023.

During consideration Mr Murray asked if changes could be highlighted in bold to make it easier to see.

In response the Chief Officer advised that he could provide a copy with tracked changes and a clean copy.

Thereafter the Committee agreed to:

i. note the updated Strategic Risk Register included in Appendix 1 of the report; and

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

8. External Audit Plan for the Year Ending 2022-23

A report by the Chief Financial Officer informed the Committee of the Auditor's Annual Plan for 2022/23.

The external auditor gave an overview of the plan and any identified risks and advised that deadlines are moving to pre-Covid timescales.

Following consideration the Committee agreed to note the contents of the External Auditor's annual plan for 2022/23.

9. Internal Audit Section Completed Projects Report

A report by the Chief Internal Auditor provided the Committee on audit work completed since the last meeting of the Committee.

Following consideration the Committee agreed to note the audit update.

10. Civil Contingencies - Resilience Standards Progress

A report by the Corporate Manager informed the Committee on the progress against NHS Grampian's Resilience Improvement Plan 2019-21, and provide an overview of the work of Health and Social Care Moray's (HSCM) Civil Contingencies Group.

Following consideration the Committee agreed to:

i. note the contents of this report alongside the HSCM Civil Contingencies Group Action Plan in Appendix 1; and

ii. request an annual assurance report to this Committee from the HSCM Civil Contingencies Group.

11. External Review of Commissioned Services Update Report

A report by the Chief Social Work Officer informed the Committee of findings and action plan relating to the external review of the adult Commissioning Service.

Following consideration the Committee agreed:

i. to note the findings of the external review included in Appendix 1; and

ii. the improvement actions included in Appendix 1.

MEETING OF MORAY INTEGRATION JOINT BOARD

AUDIT, PERFORMANCE AND RISK COMMITTEE

THURSDAY 30 MARCH 2023

ACTION LOG

Item No.	Title of Report	Action Required	Due Date	Action By	Update for 29 June 2023
1.	Quarter 3 Performance Report	To get back to committee with reasons why the targets have changed. Check with Corporate Manager	ASAP	Chief Officer	The targets have not changed. This is included in the report to reflect when new targets are set as required by statutory guidance . Some of the targets are due for review.
2.	Internal Audit Plan	Inform CMT of risks highlighted within the report	June 2023	Chief Officer	Chief Officer presenting paper to CMT
3.	Strategic Risk Register	Provided a tracked change copy and clean copy to allow changes to be easily seen	June 2023	Chief Officer	completed

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 29 JUNE 2023**

SUBJECT: **QUARTER 4 (JANUARY TO MARCH 2023) PERFORMANCE REPORT**

BY: **INTERIM STRATEGY AND PLANNING LEAD**

1. REASON FOR REPORT

1.1 To update the Audit, Performance and Risk Committee on performance as at Quarter 4 (January to March 2023).

2. RECOMMENDATION

2.1 It is recommended that the Committee consider and note:

i) the performance of local indicators for Quarter 4 (January to March 2023) as presented in the Performance Report at APPENDIX 1; and

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, and 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 4 is attached in **APPENDIX 1.**

Summary

4.3 Performance within Health and Social Care Moray (HSCM) as demonstrated by the agreed indicators up to the end of quarter 4 of the financial year 2022/23 is showing as variable. Three of the indicators are presenting as green, two are amber and six are red. This represents a reduced performance compared to quarters 2 and 3 in 2022/23 and similar to quarter 1 2021/22.

4.4 Figure 1 provides a summary and the historical trends. A summary of performance for each of the 6 reporting categories is provided below. Two of these areas are presenting as green, while one is amber and the other three are red.

EMERGENCY DEPARTMENT - GREEN

4.5 There was a decrease in the rate per 1,000 this quarter from **22.6** to **20.6**, only slightly above the number presenting at the same period last year. The trend over the past 6 months has been a decrease.

DELAYED DISCHARGES – RED

4.6 The number of delays at the June snapshot was **26**, down from the previous quarter. Although the number continues to be above the target of 10, which is influencing the RED category, it is at its lowest level since August 2021, which should be recognised as a major success for HSCM.

4.7 Bed days lost due to delayed discharges reduced from **1063** last quarter to **751** this quarter. This decrease again highlights the successful work undertaken though the Delay Discharge plan. Although this continues to be above the target of 304 it is at its lowest level since August 2021, which contributes to the RED categorisation.

EMERGENCY ADMISSIONS – AMBER

4.8 The steady monthly increase in the rate of emergency occupied bed days for over 65s, noted in previous reports, continued this quarter. Since the end of quarter 3 the rate has increased from **2,547** to **2,749**, exceeding the target of 2,037 per 1,000 population.

4.9 The emergency admission rate per 1000 population for over 65s has increased this quarter from **173.3** to **185.8** above the target of 179.9. Similarly, the number of people over 65 admitted to hospital in an emergency also increased from **117.4** to **129.2** over the same period. Both of these indicators are now **AMBER** having been **GREEN** for the previous 3 quarters in 2022/23.

HOSPITAL RE-ADMISSIONS - GREEN

4.10 The 28-day re-admissions remain on target at **7.5%**, as does the 7-day re-admissions which have reduced slightly to **3.6%**.

MENTAL HEALTH – RED

4.11 After achieving **79%** in quarter 3 there has been slight reduction in performance during this quarter with **73%** of patients being referred within 18 weeks at the end of quarter 4.

STAFF MANAGEMENT – RED

4.12 NHS employed staff sickness levels (to the end of quarter 4) have increased from to **5.1%** from **5.9%**, above the target of 4%. Council employed staff sickness was **9.7%** last quarter, more than double the 4% target.

Figure 1 – Performance Summary

Health and Social Care Moray Performance Report									
Code	Barometer (Indicator)	Q4 2122 Jan-Mar	Q1 2223 Apr-Jun	Q2 2223 Jul-Sep	Q3 2223 Oct-Dec	Q4 2223 Jan-Mar	New Target (from Q1 2122)	Previous Target from Q1 2021 or earlie	RAG
AE-01	A&E Attendance rate per 1000 population (All Ages)	20.0	24.3	24.0	22.6	20.6	no change	21.7	G
DD	Delayed Discharges								
DD-01*	Number of delayed discharges (including code 9) at census point	46	46	47	29	26	no change	10	R
DD-02	Number of bed days occupied by delayed discharges (including code 9) at census point	1294	1207	1197	1063	751	no change	304	R
EA	Emergency Admissions								
EA-01	Rate of emergency occupied bed days for over 65s per 1000 population	2140	2320	2469	2547	2749	2037	2107	R
EA-02	Emergency admission rate per 1000 population for over 65s	183.0	177.5	172.4	173.3	185.8	179.9	179.8	A
EA-03	Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population	125.2	122	118.6	117.4	129.2	123.4	124.6	A
HR	Hospital Readmissions								
HR-01	% Emergency readmissions to hospital within 7 days of discharge	3.4%	4.3%	3.0%	3.8%	3.6%	no change	4.2%	G
HR-02	% Emergency readmissions to hospital within 28 days of discharge	8.0%	8.3%	6.7%	8.0%	7.5%	no change	8.4%	G
MH	Mental Health								
MH-01	% of patients commencing Psychological Therapy Treatment within 18 weeks of referral	33%	27%	33%	79%	73.0%	no change	90%	R
SM	Staff Management								
SM-01	NHS Sickness Absence (% of hours lost)	4.2%	5.0%	5.1%	5.6%	5.9%	no change	4%	R
SM-02	Moray Council Sickness Absence (% of hours lost)	9.0%	8.9%	5.2%	8.3%	9.7%	no change	4%	R

Note: In order to match other national and local data sources indicators are showing the last month in the reporting quarter.

*From May 2022, the census figures for April 2021 onwards include delays due to infection control measures in place at hospital (delay reason codes 26X and 46X)

5. AREAS NOT MEETING TARGETS

Delayed Discharge

5.1 The number of people waiting to be discharged from hospital at census date (DD-01) has reduced again in quarter 4 to **26** delays and is the lowest since August 2021 as is the number of bed days occupied (DD-02) at **751** days, and early figures show that this looks to be continuing on that trajectory into 2023/24.

5.2 Whole system Moray Portfolio meetings, which occur daily, have been taking place with operational staff from all services to ensure system wide awareness of the pressures that might cause issues with patient flow. The meeting begins with an overview of the current status of all services and then provides a platform to support staff with problems that might interrupt flow. It is also an opportunity to deploy available resource to the most critical areas. This has resulted in improved communication, quicker placement and improved flow. In addition to this more care home beds have been made available due to an agreement to pay from offer of care home bed to ensure beds are free on discharge date.

5.3 This reduction is also in part due to the new classification of delays to discharge in the NHS system introduced across Scotland in February 2023. The new Planned Discharge Date (PDD) system changed the criterion from

'medically fit' to 'clinically fit'. When we declare a person is clinically fit it allows time for occupational therapy, physio-therapy and social work to carry out their assessments before the person is categorised as a delay, and this measure has reduced delays slightly. While this has resulted in longer stays prior to an agreed discharge date it has aligned Moray practice with the rest of Scotland.

5.4 Additionally, the Hospital Discharge Team continues to scrutinise all delays daily and ensure they are still relevant, more people have been recruited into the Care at Home team enabling more rotas to be opened and there are fewer people requiring double-up care than in recent months.

5.5 Despite still not achieving the target the improvement in both delayed discharge measures is worth noting as have the measures that have been put in place and the work that has gone into achieving the improvement to date by the teams.

Emergency Admissions

5.6 The rate of emergency occupied bed days has been consistently increasing since March 2021. This measure has seen a continual rise to **2,749** at the end of quarter 4 reflects a system still under pressure despite the gains made in other measures. The numbers of admissions in EA-02 and EA-03 have not increased along with this and would suggest people are spending more time in hospital as a whole. A number of surge beds being made available in Moray have contributed to this increase due to increased capacity.

5.7 Moray's aging population will also be a factor as patients over 65 are more likely to spend time in hospital after the point at which they are 'fit' to be transferred or discharged from an acute care setting because more support needs to be organised to facilitate a discharge home.

5.8 With the reduction in delayed discharges this figure will decrease in the coming months, as it is a rolling 12 month figure, so there is a time lag in any improvements made in the system showing in the longer term trend analysis.

Mental Health

5.9 There was a slight reduction in the percentage of patients receiving psychological therapy treatment within 18 weeks (MH-01) from 79% in quarter 3 to 73% at the end of March 2023, but this is much higher than the figure at the same point in 2021/22 (33% at the end of quarter 4) but the target of 90% is still not being achieved.

5.10 This is due to a variety of factors such as an increase in the number and complexity of referrals, long term sickness absence within the team, upcoming maternity leave and a further period of planned sick leave. The team are working hard to reduce waiting times and are addressing this through current and planned group work, allowing for more people to be seen in a timely manner. However, this is not suitable for all people referred into the service.

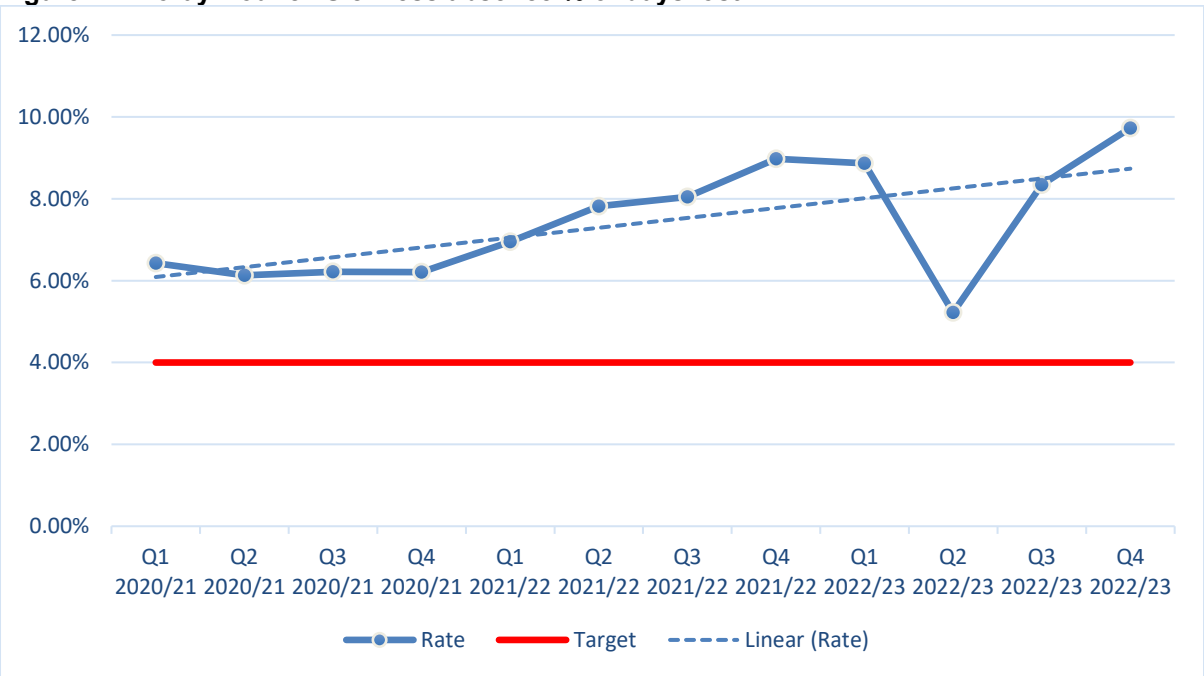
5.11 The service is also linked into the Grampian wide Psychological Therapies Improvement Board meetings looking at capacity within the service and trajectory planning.

5.12 Without recruitment to the maternity leave post and as a result of further planned sick leave, it is difficult to predict when this position may change.

Staff Management

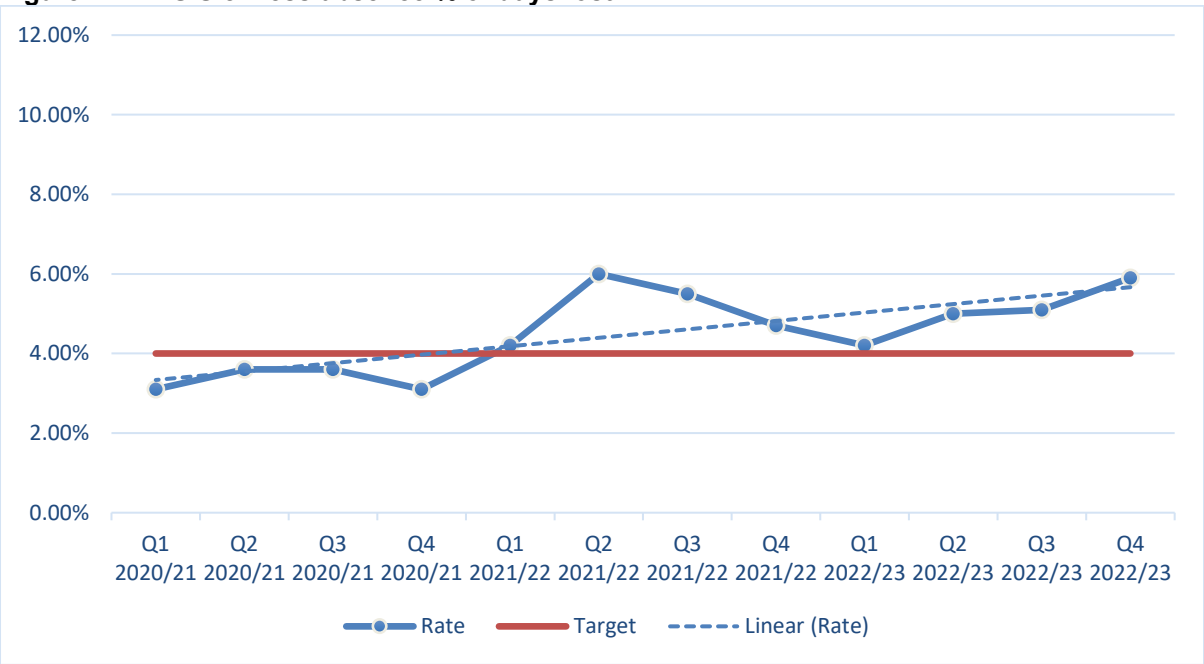
5.13 Sickness absence for Moray Council employed HSCM staff has increased from 8.3% in quarter 3 to 9.7% in quarter 4. This is the highest it has been in the two years. After a decrease in quarter 2 this is now showing an increasing trend as shown in figure 1.

Figure 1 – Moray Council Sickness absence % of days lost



5.14 NHS staff absences due to sickness are continuing to increase from 5.1% in quarter 3 to 5.9% at the end of quarter 4.

Figure 2 – NHS Sickness absence % of days lost



5.15 The recruitment cell continues to give excellent support to Provider Services working to highlight the team and their role. Recruitment has been ongoing with **21** new Social Care Assistants (SCAs) starting in quarter 4, bringing the total of new SCAs for 2022/23 to **71**. The largest proportion of these recruits **(42.3%)** coming from outside of care sector, followed by those coming from other care companies in the Moray area **(33.8%)**.

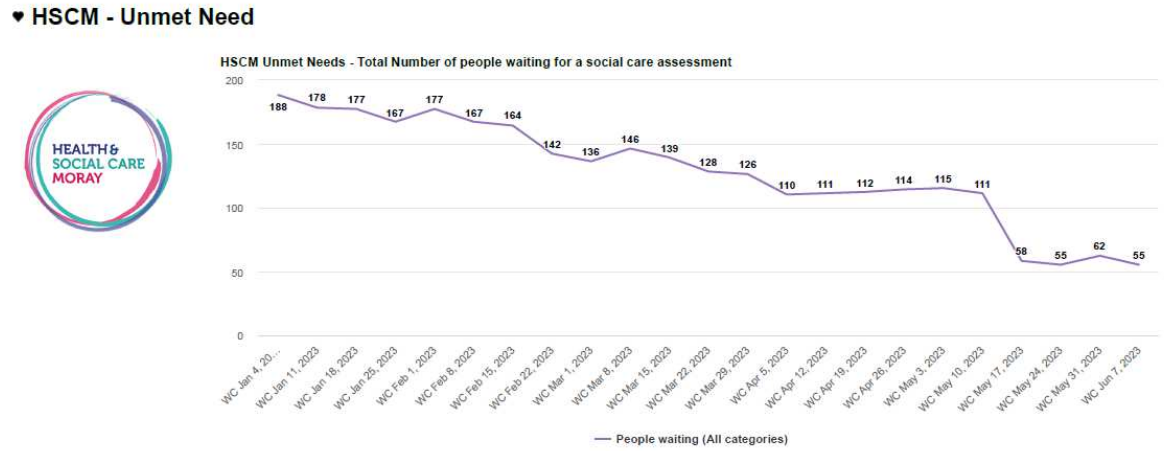
5.16 Temporary staff were employed for 12 months as Care at Home Officers to fill the gaps left by secondments and other absences and to provide support to all SCAs.

5.17 Care at Home continue to react to staffing pressures from sickness and annual leave. The average sickness rate in quarter 4 was 9.6% slightly higher than the average rate in quarter 3 of 8.5%, but lower than quarter 4 2021/22 which was 9.9%. It is expected that annual leave will now account for the highest number of staff not at work as we head into the busy holiday period.

SOCIAL CARE

5.18 The data shows people waiting for social care assessment has rapidly decreased since January 2023. There has been a test of change within the Access Teams to address the challenge of what was a very lengthy waiting list, with people then waiting considerable time for their assessment. The predominant focus of the teams is to support those with an ongoing and continued need for social work, social care, and MDT support, from the outset. In attempting to redefine the role and function of the teams and to improve social work practice one of the benefits is that collectively the teams are now in a position to undertake more assessments. The other contributing factor in the decrease in numbers of people waiting for assessment is the use of 3 care enablers, who undertake assessments where a care need is identified.

Figure 3 – Unmet Need



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 2022-2032"

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) Climate Change and Biodiversity Impacts

No climate change or biodiversity implications have been determined for this policy/activity. It should be noted that extreme weather events, such as the recent storms, are expected to occur more frequently and with greater ferocity in future years. In the longer-term there are likely to be issues with the reduction in availability and increases in costs of fossil fuels that will pose challenges for the delivery of care services to people living in rural areas.

(i) Directions

There are no directions arising from this report.

(j) Consultations
Senior Management Team, Health and Social Care, consulted as has the Democratic Services Manager, Moray Council and their comments are incorporated in the report.

6. CONCLUSION

6.1 This report provides the MIJB with an overview of the performance of specified Local and National indicators and outlines actions to be undertaken to improve performance in Section 4 and expanded on in APPENDIX 1.

Authors of Report: Aylsa Kennedy, Performance Officer
Bruce Woodward, Performance Support Officer
Background Papers: Available on request
Ref:

PERFORMANCE REPORT - SUPPORTING CHARTS

QUARTER 4 2022/23

(1 JANUARY 2023 – 31 MARCH 2023)

1. TABLE OF CONTENTS

1. PERFORMANCE SUMMARY

BAROMETER OVERVIEW

Moray currently has **11 local indicators**. Of these **3 are Green, 2 are Amber** and **6 are Red**.

Figure 1 - Performance Summary

Health and Social Care Moray Performance Report									
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2. DELAYED DISCHARGE - RED

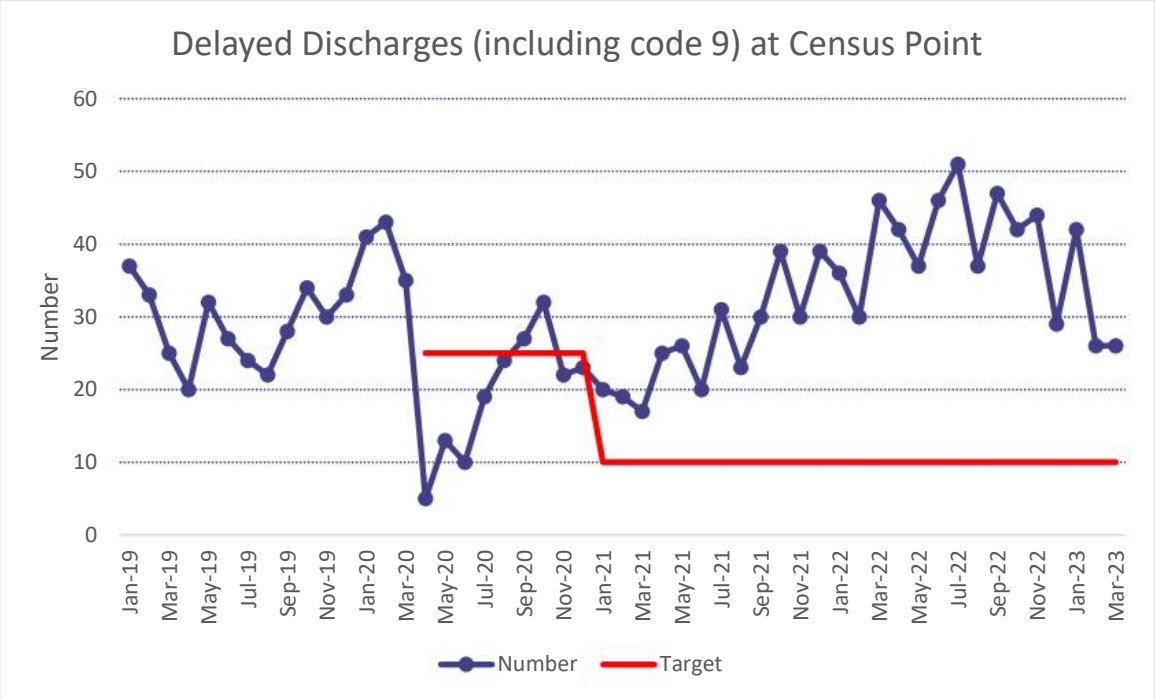
Trend Analysis

The number of delays at the June snapshot was **26**, down from the previous quarter. Although the number continues to be above the target of 10 it is at its lowest level since August 2021.
Bed days lost due to delayed discharges reduced from **1063** last quarter to **751** this quarter. Although the number continues to be above the target of 304 it is at its lowest level since August 2021.

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		

Figure 2 – Delayed Discharges

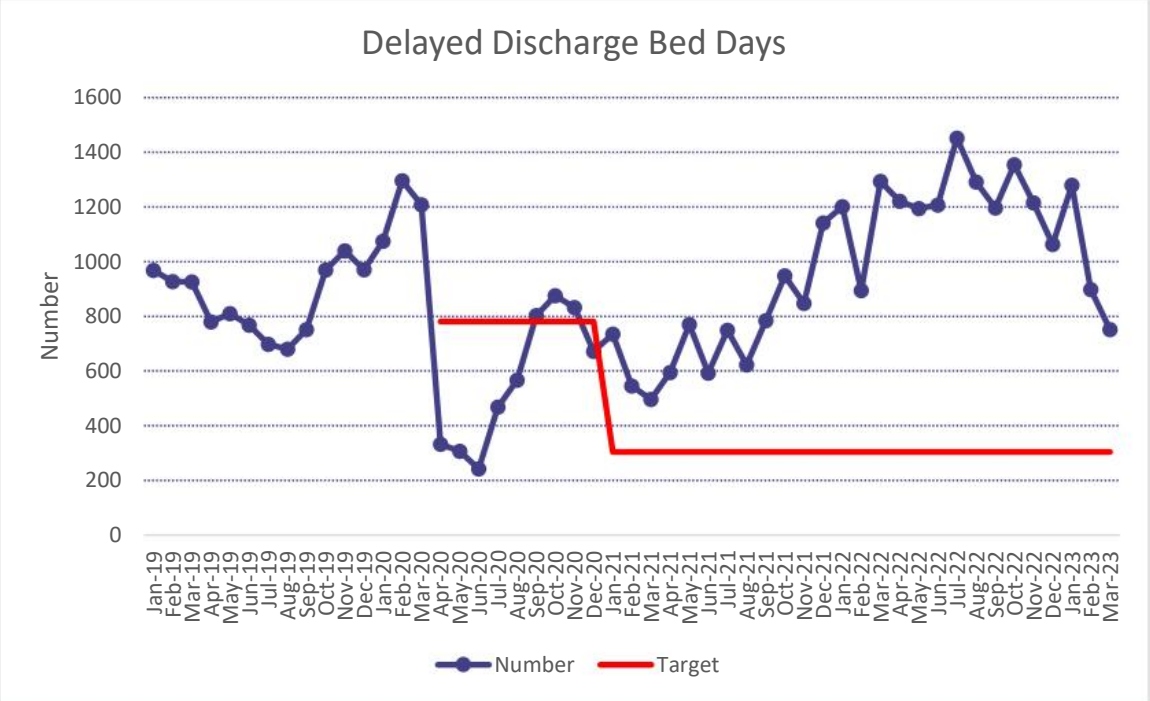


Indicator Trend – Decreasing
Despite some volatility in numbers from month to month the underlying trend for the number of people experiencing Delayed Discharge had been decreasing since the end of Quarter 2 2022/23.

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		

Figure 3 – Delayed Discharge Bed-days



Indicator Trend – Decreasing

The number of bed-days are over 2 times the target number of days but this is less than previous quarters, and similar to quarter 2 2021/22.

Source	Public Health Scotland

3. EMERGENCY ADMISSIONS - AMBER

Trend Analysis

The steady monthly increase in the rate of emergency occupied bed days for over 65s, noted in previous reports, continued this quarter. Since the end of quarter 3 the rate has increased from **2,547** to **2,749**, exceeding the target of 2,037 per 1,000 population.

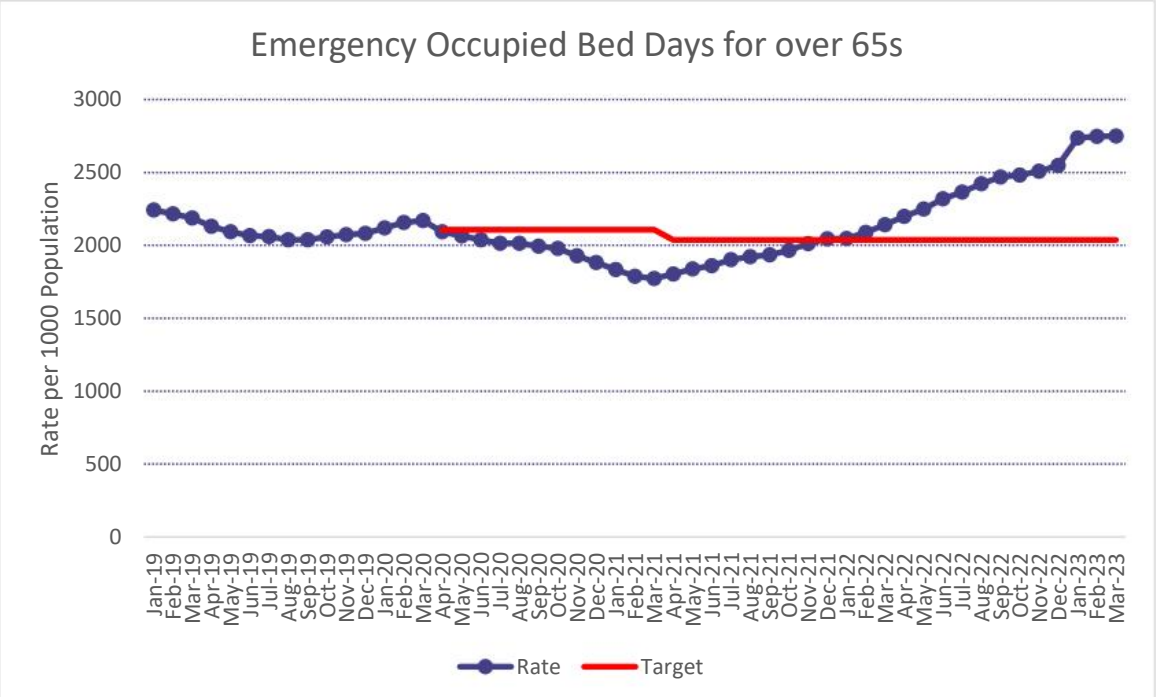
The emergency admission rate per 1000 population for over 65s has increased this quarter from **173.3** to **185.8** above the target of 179.9.

Similarly, the number of people over 65 admitted to hospital in an emergency also increased from **117.4** to **129.2** over the same period. Both of these indicators are now **AMBER** having been **GREEN** for the previous 3 quarters in 2022/23.

EA-01: RATE OF EMERGENCY OCCUPIED BED DAYS FOR OVER 65s PER 1000 POPULATION

Purpose	EA-01, EA-02, and EA-03 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		

Figure 4 – Emergency Occupied Bed-days (Over 65s)



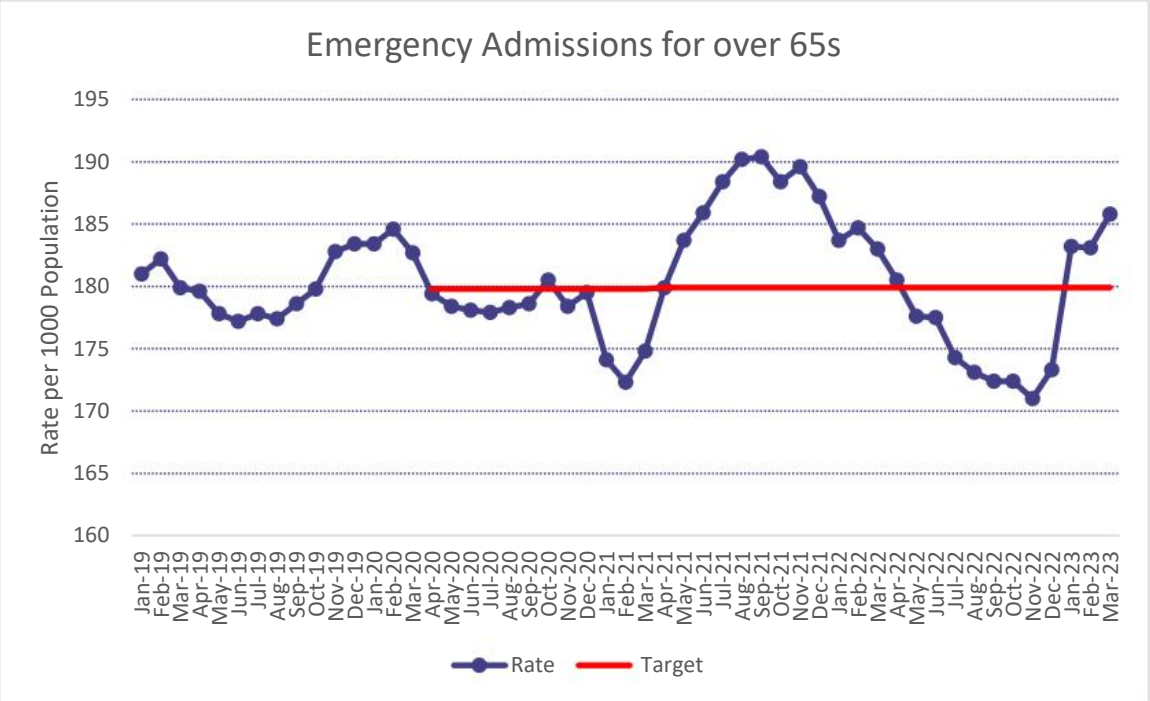
Indicator Trend – Increasing

Since the start of 2021 has been increasing and has exceeded the reduced target since quarter 3 2021/22.

Source	Health Intelligence

EA-02: EMERGENCY ADMISSIONS RATE PER 1000 POPULATION FOR OVER 65s			
Purpose	EA-01, EA-02, and EA-03 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		

Figure 5 – Emergency Admissions (Over 65s)



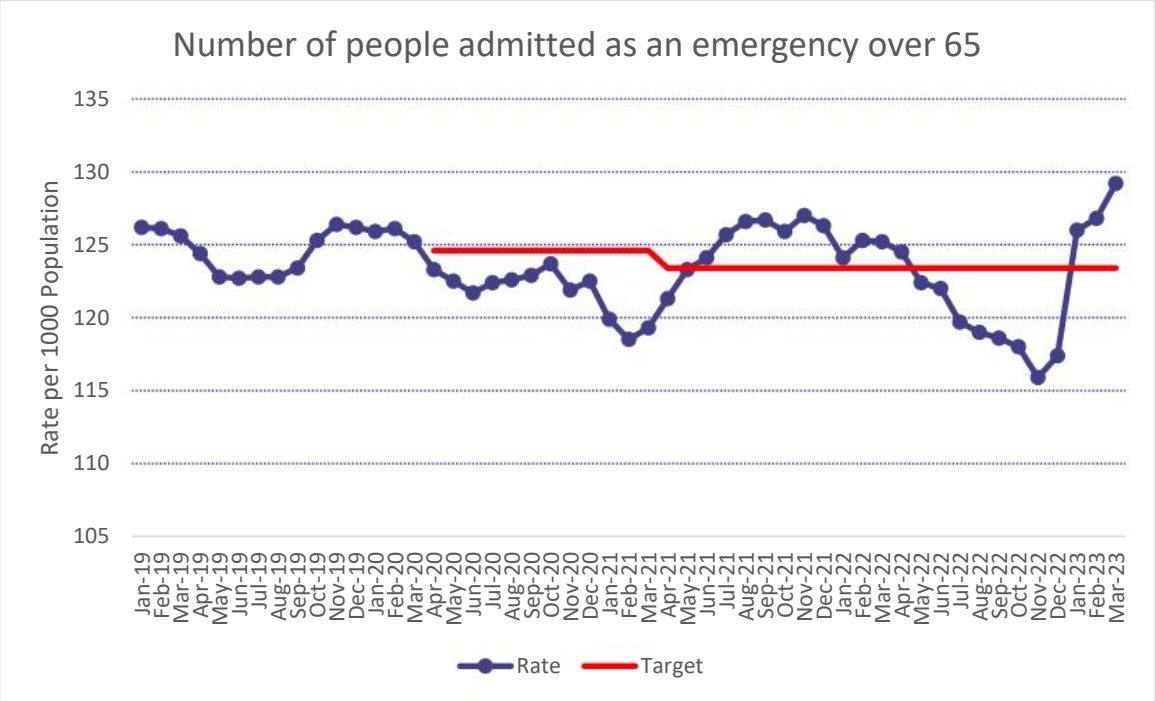
Indicator Trend – Increasing

The trend is now increasing, after a sustained reduction over the latter half of 2022, and above levels seen at the same point in 2022.

Source	Health Intelligence

EA-03: NUMBER OF PEOPLE OVER 65 YEARS ADMITTED AS AN EMERGENCY IN THE PREVIOUS 12 MONTHS PER 1000 POPULATION			
Purpose	EA-01, EA-02, and EA-03 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		

Figure 6 – Number of Over 65 People Emergency Admissions



Indicator Trend – Increasing

The trend is now increasing, after a sustained reduction over the latter half of 2022, and above levels seen at the same point in 2022.

Source	Health Intelligence

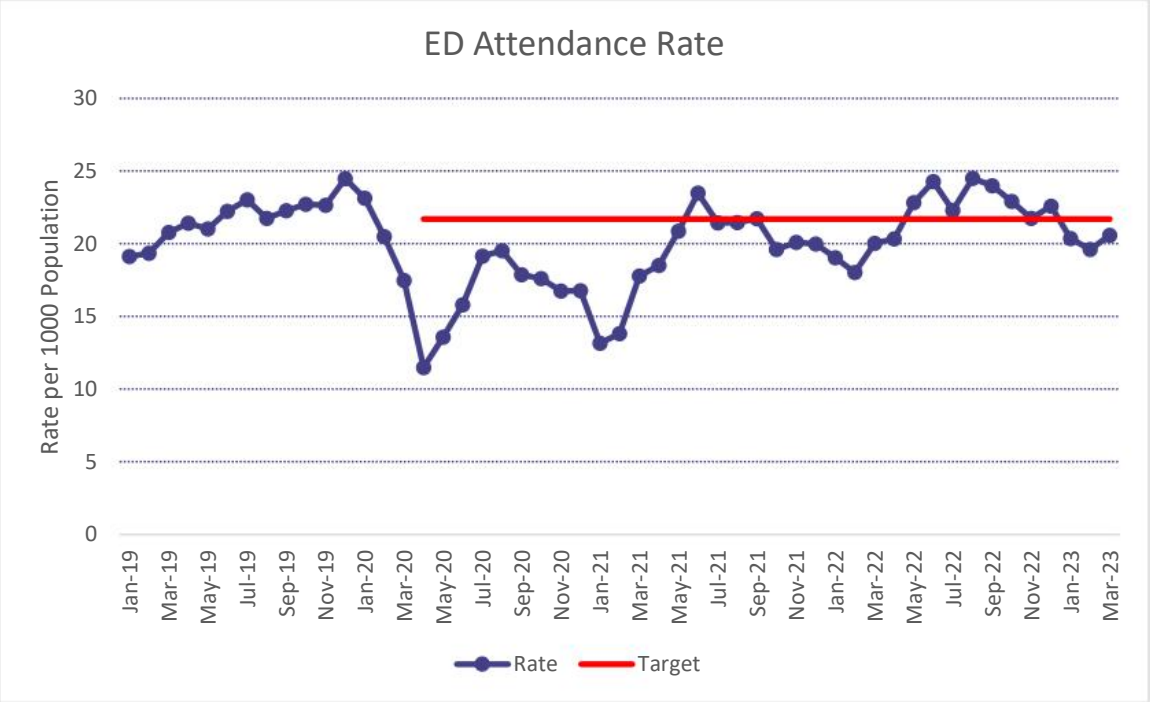
4. EMERGENCY DEPARTMENT – RED

Trend Analysis

There was a decrease in the rate per 1,000 this quarter from **22.6** to **20.6**, only slightly above the number presenting at the same period last year. The trend over the past 6 months has been a decrease.

AE-01: ED ATTENDANCE RATES PER 1,000 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	3: PARTNERS IN CARE	**Linked Indicator(s)**	HR-01, HR-02
National Health & Wellbeing Outcomes	1, 2, 3, 5		

Figure 7 – ED Attendance Rate



Indicator Trend – Stable

During quarter 3 the attendance rate per 1,000 population has remained stable, sitting just above the target level. However, the attendance rate has fallen below the target in the last quarter of 2022/23.

Source	Health Intelligence

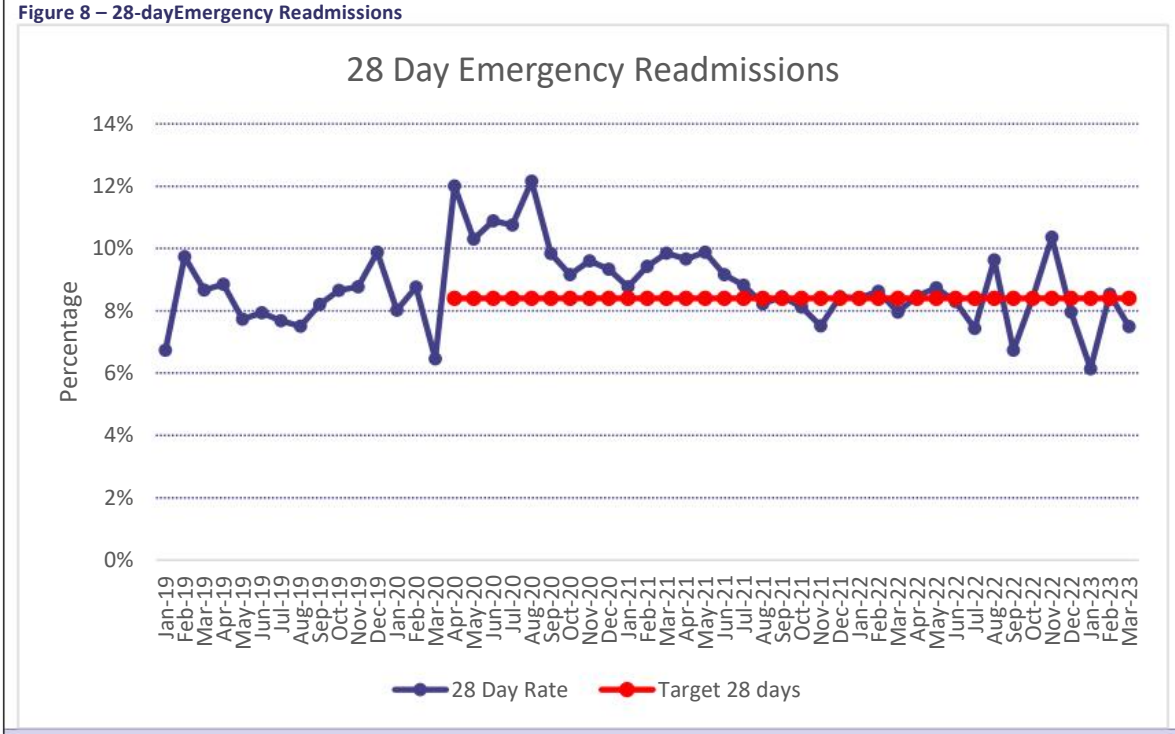
5. HOSPITAL RE-ADMISSIONS - AMBER

Trend Analysis

The 28-day re-admissions remain on target at **7.5%**, as does the 7-day re-admissions which have reduced slightly to **3.6%**.

HR-01: PERCENTAGE OF EMERGENCY RE-ADMISSIONS TO HOSPITAL WITHIN 28 DAYS - MORAY PATIENTS			
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. (This measure lags by a month due to the time required for a potential 28 day discharge to occur)		
Strategic Priority	1: BUILDING RESILIENCE	**Linked Indicator(s)**	HR-02, AE-01
National Health & Wellbeing Outcome	1, 2, 3, 5		

Figure 8 – 28-dayEmergency Readmissions

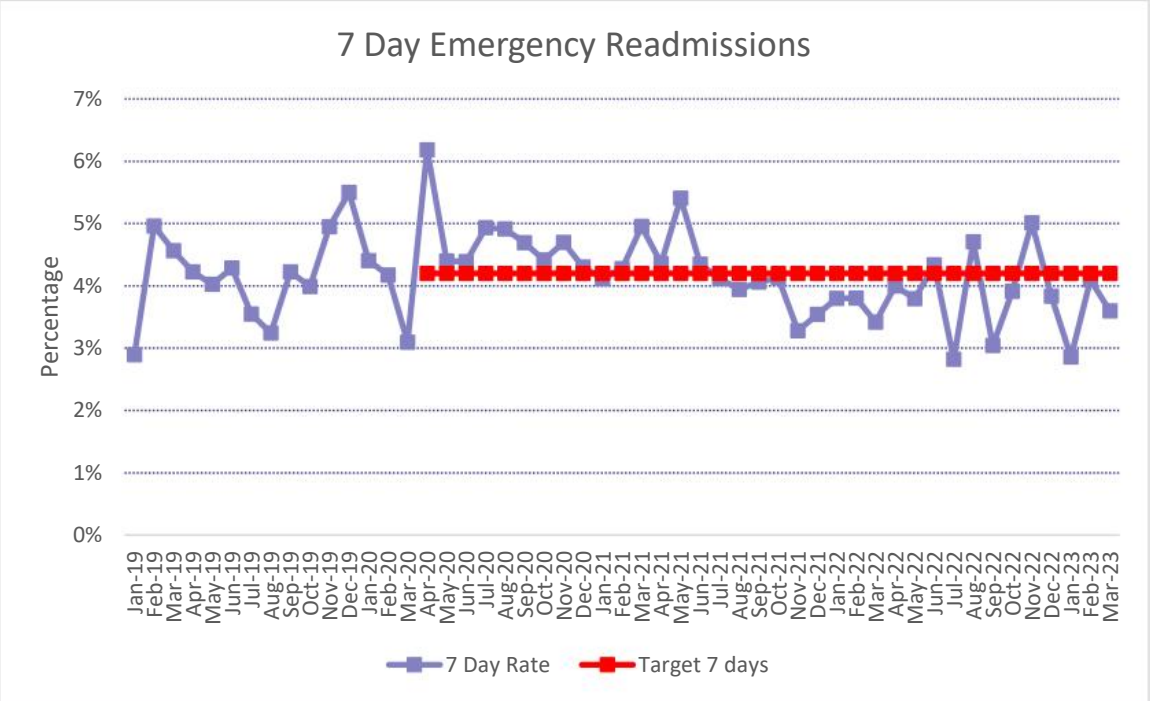


Indicator Trend – Stable
28-day Hospital Re-admissions have remained around the target of 8.4% for this quarter.

Source	Health Intelligence

HR-02: PERCENTAGE OF EMERGENCY RE-ADMISSIONS TO HOSPITAL WITHIN 7 DAYS - MORAY PATIENTS			
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	

Figure 9 – 7-day Emergency Readmissions



Indicator Trend – Stable

7-day Hospital Re-admissions have remained around the target of 4.2% for this quarter.

Source	Health Intelligence

6. MENTAL HEALTH – RED

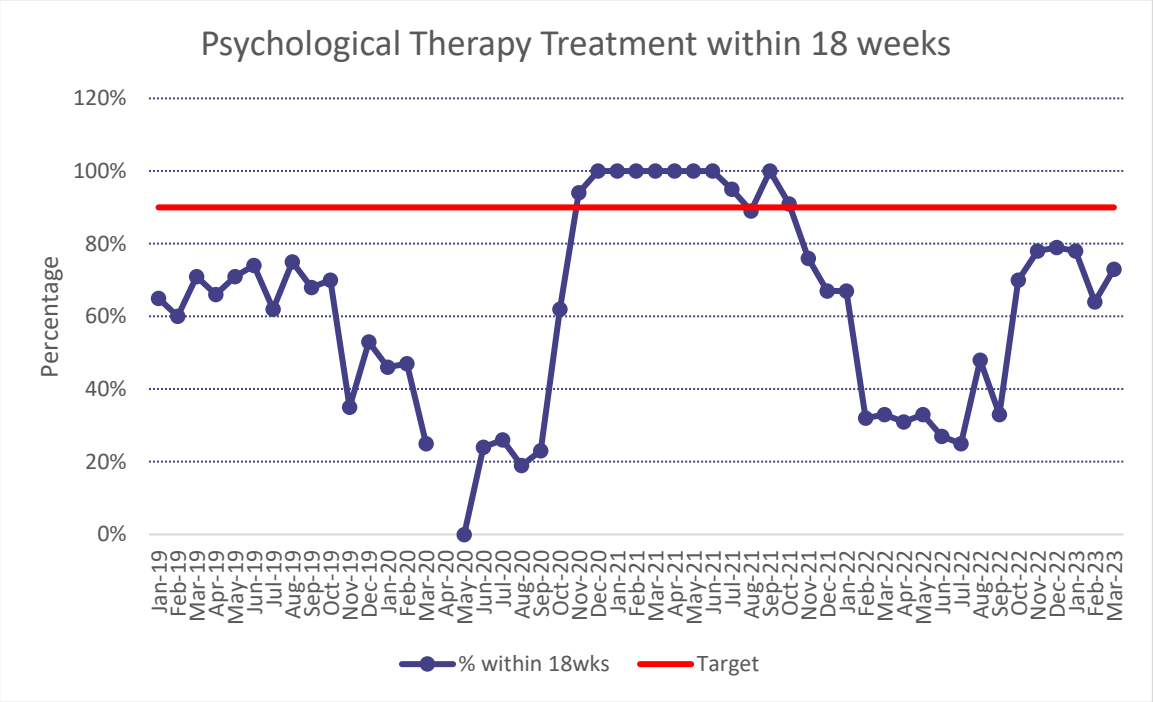
Trend Analysis

After achieving **79%** in quarter 3 there has been slight reduction in performance during this quarter with **73%** of patients being referred within 18 weeks at the end of quarter 4.

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	3: PARTNERS IN CARE	**Linked Indicator(s)**	
National Health & Wellbeing Outcome		1, 2, 3, 5	

Figure 10 – Psychological Therapy Treatment within 18 Weeks



Indicator Trend – Increasing

After being consistently low for 4 quarters the rate has started to return to pre pandemic levels.

Source	Health Intelligence

7. STAFF MANAGEMENT - RED

Trend Analysis

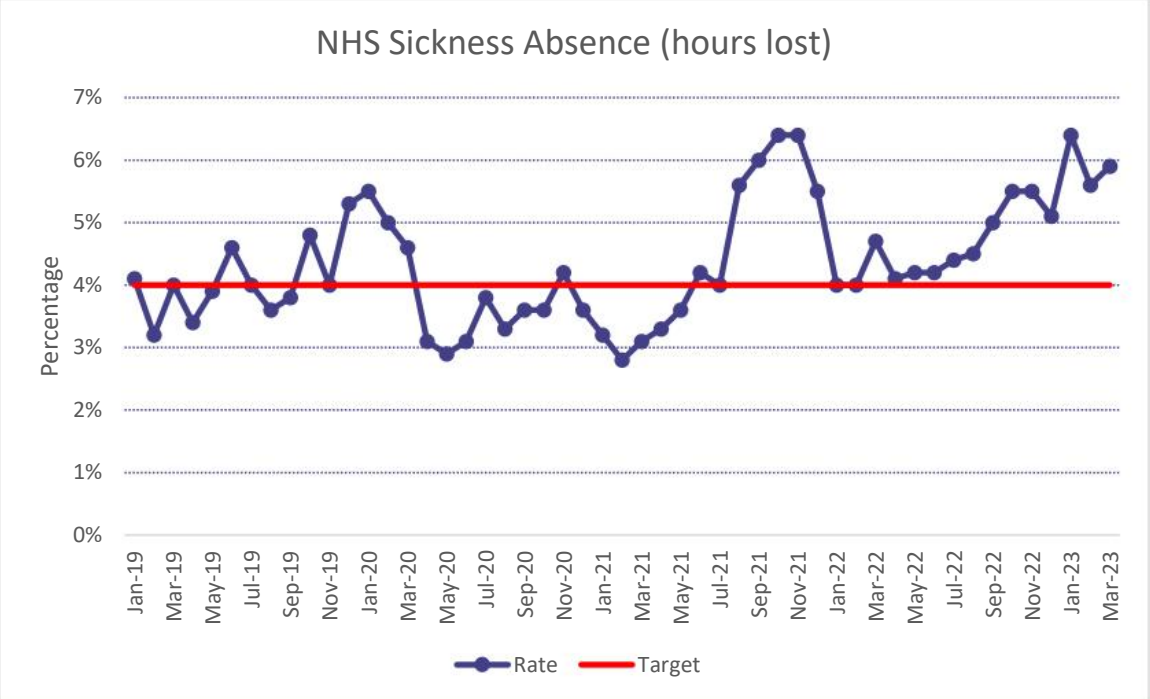
Sickness absence for NHS employed staff rose to 6.4 during quarter 3, but has since reduced and for the first 2 months of quarter 1 is at 4.2%. This may indicate that staffing absence is back to pre-pandemic levels for NHS employed staff. However, Council employed staff sickness has remained high with a minimal reduction from 8.98% to 8.87%, which is above the figure for the same period in the previous 2 years.

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%)	Q3 21/22	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
4%	5.5%	4.7%	4.2%	5.0%	5.1%	5.9%

Figure 11 – NHS Sickness Absence



Indicator Trend – Increasing
This indicator had been increasing over 2022/23 and continues to do so.

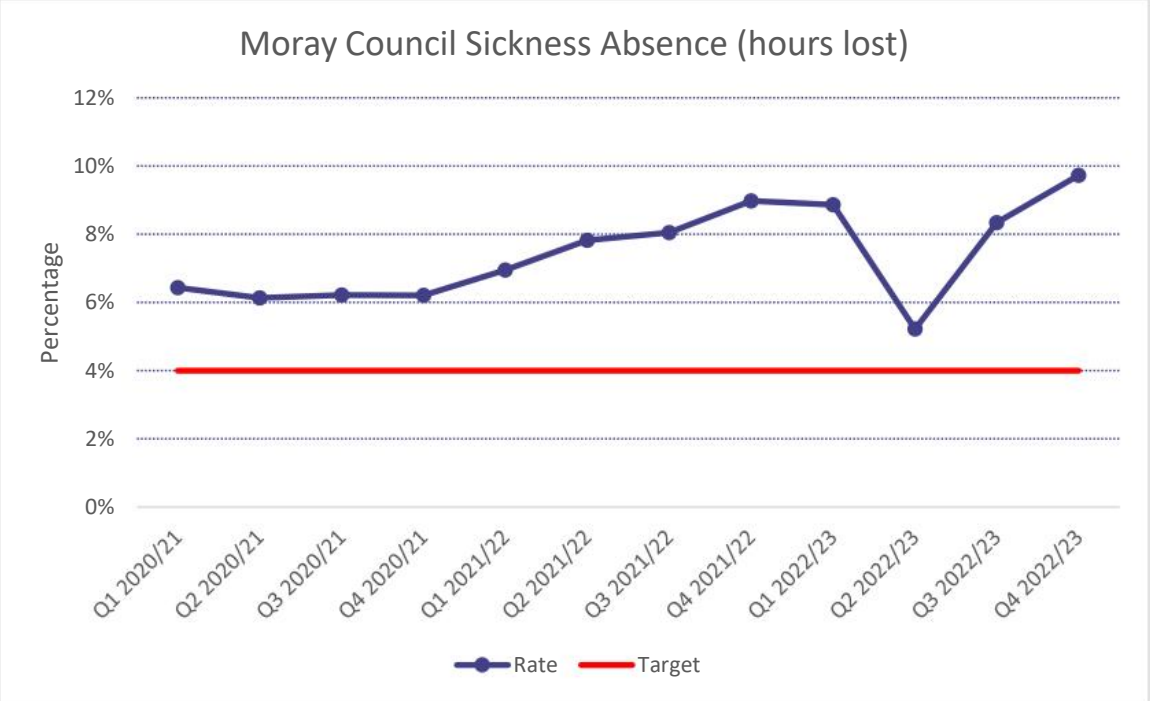
Source	Health Intelligence

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	Q3 21/22	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
4%	8.05%	8.98%	8.87%	5.22%	8.34%	9.73%

Figure 12 – Moray Council Sickness Absence



Indicator Trend – Increasing

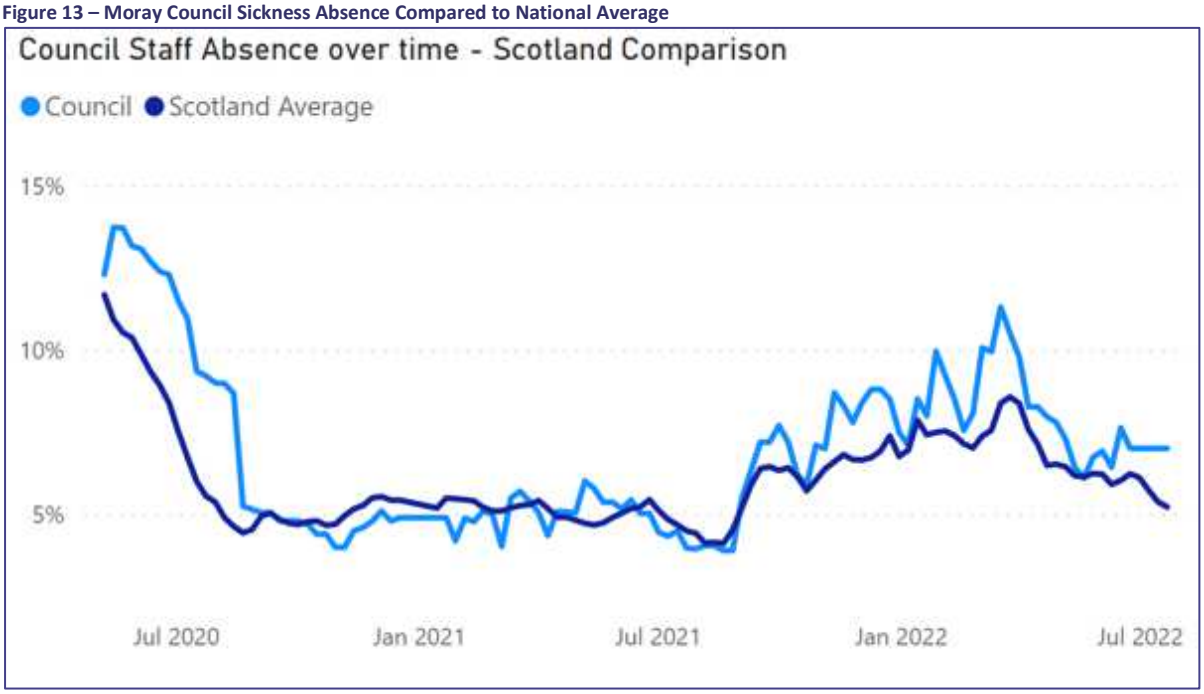
This indicator continues to rise, remaining double the target and close to the figure of 10%.

Source	Council HR

COUNCIL STAFF ABSENCE OVER TIME – SCOTLAND COMPARISON

Chart provided by the Improvement Service using data from the from weekly SOLACE council returns. This update captures data from the week ending 22 July 2022. Moray remains above the Scottish average.

Figure 13 – Moray Council Sickness Absence Compared to National Average



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.

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 29 JUNE 2023**

SUBJECT: **INTERNAL AUDIT SECTION - UPDATE REPORT**

BY: **CHIEF INTERNAL AUDITOR**

1. REASON FOR REPORT

1.1 Committee is asked to consider the contents of this report; seek clarification on any points noted and otherwise note the report.

2. RECOMMENDATION

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

3. BACKGROUND

3.1 Public Sector Internal Audit Standards (PSIAS) require the Chief Internal Auditor to prepare and present reports to committee on internal audit's activity relative to the audit plan and on any other relevant matters.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

Public Sector Internal Audit Standards (PIAS)

4.1 The Local Authority Accounts (Scotland) Regulations 2014 require public bodies to operate a professional and objective internal auditing service in accordance with recognised standards and practices in relation to internal auditing, the Public Sector Internal Audit Standards.

4.2 Internal performance monitoring against PSIAS has been ongoing over the last few years. However, a more structured internal assessment was completed in preparation for the External Quality Assessment, scheduled for later in 2023. Enclosed in **Appendix 1** is an Action Plan detailing recommendations for compliance with PSIAS.

Follow Up Reviews

4.3 Internal Audit reports are regularly presented to members detailing not only findings but also the responses by management to the recommendations with agreed dates of implementation. Internal Audit will also undertake follow up

reviews to evidence the effective implementation of these recommendations. Please see detailed the following completed follow up reviews:

Health and Social Care Moray - Self-Directed Support (SDS) Financial Review

4.4 This audit has reviewed the arrangements for monitoring service users who receive an SDS direct payment to purchase their own support. This involved the random selection of a sample of care packages and a check made to ensure compliance with operating procedures, expenditure incurred by the service user is in accordance with the agreed budget and support plans, and surplus funds are recovered from service users where appropriate. It was noted that a total of 150 adult service users receive an SDS direct payment to purchase their own support at a cost of approximately £3 million annually. The Follow Up Report to review the implementation of the agreed recommendations is given in **Appendix 2**. Unfortunately, it was found that the majority of the recommendations had not been implemented. The Service detailed particular issues regarding staff shortages and revised dates of implementation have been agreed.

Health and Social Care Moray - Client Monies

4.5 An audit was undertaken of the processes undertaken by the Community Care Finance Team in how they administer the corporate bank account. In addition, a sample of individuals was also selected, and a check was made on how the Health and Social Care Officer appointed as the named "Corporate Appointee" manages and supports individuals to access their funds appropriately. The Adults with Incapacity (Scotland) Act 2000 enables a Health and Social Care Officer to be appointed by the DWP to have "Corporate Appointeeship" responsibility for managing the benefits received by an individual. At the time of the audit, it was found that 59 individuals are being managed within the "Corporate Apppointeeship" Scheme with a combined value of £483,000 held within a corporate bank account. The Follow Up Report to review the implementation of the agreed recommendations is given in **Appendix 3**. The Service detailed that it has not been possible to implement a number of the recommendations within the previously agreed timescales. There will therefore be a need to undertake a further follow up review of this audit and thereafter report progress to a future Audit Performance and Risk Committee.

Procurement and Creditor Payments

4.6 An audit was undertaken to review payments made to suppliers of goods and services. The purpose of the audit was to confirm that effective controls are operating to ensure all payments are appropriately authorised, accurate and paid in accordance with financial regulations and agreed terms and conditions. This audit review is related to testing a sample of transactions generated under the direction of the Moray Integration Joint Board. Through the use of computer audit software, a sample of payments was randomly selected from this period with a value of £1.05 million. The testing undertaken was developed from the Chartered Institute of Public Finance and Accountancy's Audit Programme. The Follow Up Report to review the implementation of the agreed recommendations is given in **Appendix 4**. It is pleasing to report that all recommendations have now been implemented

Social Media Accounts

4.7 A follow up review was undertaken of the audit undertaken regarding the use of Social Media. The scope of the review was to understand which services use social media websites as a means of communication and how it is managed. Social media refers to websites and applications, e.g., Facebook and Twitter that are designed to allow people to share content quickly, efficiently, and in real time. Officers use social media as a form of communication across various services. The Follow Up Report confirming the implementation of the agreed recommendations is given in **Appendix 5**.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Partners in Care 2022 – 2032"

Internal audit work supports good governance and assists in securing appropriate systems of internal control.

(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 and Mitigation

Audit reports highlight risk implications and contain recommendations for management to address as a means of mitigating.

(e) Staffing Implications

No implications directly arising from this report

(**f) Property**

No implications.

(g) Equalities/ Socio Economic Impacts

No implications.

(h) Climate Change and Biodiversity Impacts

None directly arising from this report.

(i) Directions

None arising directly from this report.

(j) Consultations

There have been no direct consultations during the preparation of this report.

6. CONCLUSION

6.1 This report provides committee with an update on internal audit work progressed in the latest review period.

Author of Report:	Dafydd Lewis, Chief Internal Auditor
Background Papers:	Internal Audit Files
Ref:	mijb/ap&rc/29062023

Moray Council

Internal Audit Section

Recommendations - Internal Audit Section – Public Sector Internal Audit Standards

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: Internal Audit governance and operating arrangements comply with the Public Sector Internal Audit Standards.						
5.01	A copy of the Internal Audit Charter should be issued to all officers within the Internal Audit Section. (PSIAS Ref: 1100.8)	Low	Yes	Further to the approval of the Internal Audit Charter at the Audit & Scrutiny Committee on 23 November 2022, a copy will be provided to all officers of the Internal Audit Section.	Audit and Risk Manager	23/11/2022

Moray Council

Internal Audit Section

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**
5.02	In accordance with the Public Sector Internal Auditing Standards, Committee Reports from the Internal Audit Service to elected members should be from the Audit and Risk Manager. (PSIAS Ref: 1100.1/2600.1)	High	Yes		Depute Chief Exec. Education, Communities & Organisational Development	Immediate
5.03	The Council's Annual Governance Statement (AGS) is prepared by the Audit and Risk Manager, in addition to providing an annual opinion report on the overall adequacy and effectiveness of the Council's framework of governance, risk management and control**.**	Medium	Yes	The Annual Governance Statement will be prepared in future by the Head of Governance, Strategy & Performance with the support of the Business	Head of Governance, Strategy & Performance	Immediate

Moray Council

Internal Audit Section

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**
	Preparation of the Annual Governance Statement should be undertaken by an officer out with the Internal Audit Section. (PSIAS Ref: 1100.9/2400.12/2600.1)			Continuity and Risk Management Officer.		
5.04	Consideration should be given to the development of Assurance Mapping to aid the preparation of the Annual Internal Audit Plan. (PSIAS Ref: 2000.2/2000.10)	Low	Yes	This issue has been raised within the Scottish Local Authority Chief Internal Auditors Group with the intention of developing a consistent methodology.	Audit and Risk Manager	Ongoing

Moray Council

Internal Audit Section

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**
5.05	Findings from follow-up reviews should be reported to Audit & Scrutiny Committee on a regular basis. (PSIAS Ref: 2500.2)	Medium	Yes	Findings from follow-up reviews will be reported within an Update Report to Audit & Scrutiny Committee on a regular basis.	Audit and Risk Manager	23/11/22

Moray Council

Internal Audit Section

DEPARTMENT: **Health and Social Care Moray**

SUBJECT: **Self-Directed Support**

REPORT REF: **22'013**

Follow Up Audit Review

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)**	**Date of Completion**	**Status / Explanation**
Key Control: Clear and current policy documents and operational guidelines have been developed for the financial administration of SDS packages.					
5.01	The SDS Direct Payment guidance and financial monitoring procedures should be reviewed and updated on a regular basis.	Low	Yes	30/04/2022	Implemented. Financial Monitoring Procedures were updated in October 2021 and SDS Direct Payments Guidance was revised in April 2022.

Moray Council

Internal Audit Section

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)	Date of Completion	Status / Explanation
Key Control: Financial reviews are being carried out to monitor the usage of SDS funding in accordance with operational guidelines.					
5.02	Annual financial reviews should be undertaken in line with the direct payment financial monitoring procedures.	High	Yes	31/01/2022	Not implemented. The review found a backlog in the Service undertaking annual financial reviews. Discussions with the Service noted there had been multiple staffing changes and vacancies for a prolonged period. It is hoped that with a stable staffing position, the resources are now available for implementing this recommendation by 31/08/2023.
5.03	Consideration should be given to the routine production of reports from the Care First System which can be used to detail financial reviews falling due and allow management to prioritise workloads accordingly. The	Medium	Yes	31/12/2021	Implemented. Reports are being produced by the CareFirst system to detail financial reviews due and their priority. The reports have also indicated a data cleansing need within CareFirst which is being undertaken to ensure data remains accurate.

Moray Council

Internal Audit Section

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)**	**Date of Completion**	**Status / Explanation**	
	requirement of manual spreadsheets should be minimised wherever possible to ensure information reference points come direct from the Care First system.					
5.04	A risk based approach should be initiated by management to prioritise outstanding financial reviews and work through the backlog in an order which makes best use of limited resources.	High	Yes	31/12/2021	Not implemented. The review noted a backlog remains in the Service undertaking financial reviews. It was found the service had developed a prioritisation plan, but due to resourcing issues, it has not been possible to implement this recommendation. A revised implementation date of 31/08/2023 has been agreed.	

Moray Council

Internal Audit Section

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)**	**Date of Completion**	**Status / Explanation**	
5.05	A reminder should be issued to service users, and approved payroll providers where applicable, to inform the Authority when funds in excess of the contingency amount are held. This may assist in the prioritisation of early financial reviews and highlight issues for further investigation.	High	Yes	30/04/2022	Implemented. Assurance has been obtained from the Service that this has been undertaken. Further reminders are to be issued in January 2023 and will be scheduled annually each January going forward, incorporated into an annual data check.	
5.06	A review should be undertaken of all Service Users in regard to the current balances held within their SDS bank account. Action should then be taken to recover excess funds.	High	Yes	30/04/2022	Not implemented. Significant surpluses were reclaimed on managed accounts as a result of obtaining details of all bank balances following the audit undertaken. The Service commenced work on a review of unmanaged accounts, but this has not been completed due to staffing issues. A revised implementation date of	

Moray Council

Internal Audit Section

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)**	**Date of Completion**	**Status / Explanation**	
					31/08/2023 has been agreed.	
5.07	In compliance with established procedures, one-off direct payments should be subject to a financial monitoring review 3 months (or in limited circumstances at another interval) after the funding has been distributed to confirm its appropriate usage.	Medium	Yes	30/04/2022	Not implemented. The Service has detailed staffing issues as the reason for not implementing this recommendation. A revised implementation date of 31/08/2023 has been agreed.	
5.08	The Service should comply with the monitoring requirements detailed within an agreement between the Council and Service User for the purchase and	Medium	Yes	31/12/2021	Not implemented. The Service has detailed staffing issues within the SDS Team and Social Work as the reason for not implementing this recommendation. While some details of the purchase have been obtained, many other conditions in the legal	

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)**	**Date of Completion**	**Status / Explanation**	
	adaptation of a mini van.				agreement between the Council and the Service User have not been evidenced. SDS Team to liaise with Social Work, and a revised implementation date of 31/03/2023 has been agreed.	
5.09	Closing financial reviews of SDS care packages should be undertaken in accordance with agreed procedures. Evidence should be retained of any expenditure outwith the agreed support plan and of the full discussions held and decisions made by Social Workers regarding retrospective authorisation.	Medium	Yes	31/12/2021	Not implemented. At the end of a direct payment package monies are returned, but closing reviews have not been carried out to confirm monies have been applied appropriately. The Service has detailed staffing issues as the reason for not implementing this recommendation. A revised implementation date of 31/08/2023 has been agreed.	

Moray Council

Internal Audit Section

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)	Date of Completion	Status / Explanation
Key Control: SDS Funding is only used to support the service user's support plan outcomes and compliance is monitored to ensure public funds are spend appropriately.					
5.10	Care and Support Plans should be reviewed annually to ensure the agreed care is being provided and continues to meet the service user's needs.	High	Yes	01/05/2022	Not implemented. The follow-up audit exercise noted that since the pandemic annual support plan reviews have not recommenced across all parts of the Service. Limitations were stated in resources with staffing vacancies and workload pressures due to an increased demand for care, including the requirement to deal with particularly complex cases and increasing difficulties in sourcing care. Priority has been given to support plans for new and changing care arrangements rather than routine annual reviews. The newly appointed Head of Service will review current procedures. The current status of this recommendation will be reviewed in the follow-up audit after 31/08/2023.

Moray Council

Internal Audit Section

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)	Date of Completion	Status / Explanation
5.11	All Social Workers should be reminded of the requirement to inform the SDS Team of any amendment to a Support Plan that will have a financial change to a service user's care package.	High	Yes	01/12/2022	Implemented. The SDS Team sends reminders to Social Work regarding the requirement to refer support package changes where there is a financial implication. A recent reminder to officers was noted on 01/12/2022.
Key Control: SDS service has effective arrangements in place to monitor support packages and report on performance.					
5.12	Consideration should be given to the development of appropriate performance monitoring measures to be reported to service management on a regular basis. Given the current backlog of reviews and consequences of direct payment accounts not being	Low	Yes	30/09/2022	Not implemented. Performance measures for Health & Social Care as a whole are being developed using Pentana. Initial work on developing these measures is being led by the Performance Team and started in July 2022. A delay has been experienced due to workload pressures and the 30/09/2022 target has not been met. The Performance Team is to commence engagement with the SDS Team

Moray Council

Internal Audit Section

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)**	**Date of Completion**	**Status / Explanation**	
	scrutinised on a timely schedule, it may be beneficial for performance information to be made available for management to identify any resourcing issues arising and assess risks involved.				on their specific performance measures in November 2022. The Commissioning Manager has agreed to a revised implementation date of 31/03/2023.	

Moray Council

Internal Audit Section

DEPARTMENT: **Health & Social Care Moray**

SUBJECT: **Client Monies**

REPORT REF: **22'011**

Follow Up Audit Review

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)**	**Date of Completion**	**Status / Explanation**
Key Control: Clear and current policy documents and operational guidelines have been developed for the financial management of client monies.					
5.01	The Procedures for Managing Service User's Money and Corporate Appointeeship should be reviewed and updated and a subsequent regular cycle of review maintained.	Medium	Yes	31/10/2022	Not implemented. Procedures have not been reviewed and updated as intended due to staffing absence. This will now be prioritised and a revised implementation date of 30/06/2023 has been agreed.

Moray Council

Internal Audit Section

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)**	**Date of Completion**	**Status / Explanation**	
5.02	Procedures for the management of client monies should be promoted to ensure there is an awareness of their requirements by all officers involved in client finance administration.	Medium	Yes	31/10/2022	Not implemented. As procedures have not been reviewed per 5.01, the intended promotion activity after update has not been undertaken. A revised completion date of 30/06/2023 has been agreed.	
Key Control: Correct formal powers to administer client monies have been obtained.						
5.03	Clarification should be obtained from Legal Services regarding the length of time funds must be retained on behalf of deceased clients and potential action which can be taken should the funds not be claimed within the timeframe.	Medium	Yes	31/10/2022	Implemented. A process is now in place for active pursual of estate settlement and referral to National Ultimus Haeres Unit to aid fund dispersement where applicable. The balance held in relation to these funds has significantly decreased since the audit was undertaken.	

Moray Council

Internal Audit Section

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)**	**Date of Completion**	**Status / Explanation**	
	Consideration should also be given to holding these funds separate to the corporate bank account for increased visibility.				A separate balance record is being maintained for increased visibility of deceased client funds and to record actions taken.	
Key Control: All transactions should be for benefit of the client with justifiable supplier selection, verified to source documentation and in line with the client's Financial Management Plan. Any cash held is done so securely and with full accounting arrangements.						
5.04	Due to changes in operating practices a full review of current cash handling procedures should be undertaken. The review should include a risk assessment to ensure best practices are followed regarding the safety and security of both officers and client funds. Documented procedures should thereafter be updated to reflect	High	Yes	31/07/2022	Not implemented. The topic was initially referred to Practice Governance Group, however, the service has decided a full review of the corporate account is required and a meeting has been instigated with all relevant staff. As this will take time and resources to complete a revised implementation date of 31/07/2023 has been agreed.	

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)**	**Date of Completion**	**Status / Explanation**
	any agreed changes.				
Key Control: Robust records of fund administration per client are maintained.					
5.05	Confirmation of the monthly reconciliation of the Corporate bank account to manual records should be undertaken by Community Care Finance management. This should also include the verification of a sample of transactions to source cumentation.	High	Yes	31/05/2022	Implemented. There is now a monthly management check of the corporate bank account reconciliation and a sample of transactions are independently checked for validity. The follow-up exercise has resulted in further enhancements to the management check being advised such as types of transactions for increased focus, which will increase the strength of the scrutiny process.

Moray Council

Internal Audit Section

DEPARTMENT: **Health & Social Care Moray**

SUBJECT: **Procurement and Creditor Payments**

REPORT REF: **23'008**

Follow Up Audit Review

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)**	**Date of Completion**	**Status / Explanation**
Key Control: Effective controls in the processing of creditor payments to ensure compliance with Financial Regulations and Procurement Guidelines					
5.01	A review should be undertaken across all social care external providers to ensure that payments are not made in advance of the service delivery	High	Yes	15/08/22	Implemented- A review of providers has been undertaken, and testing noted only one example where payment had been made before the service was delivered. However, further investigation found that approval had

Moray Council

Internal Audit Section

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)	Date of Completion	Status / Explanation
					been obtained from the Chief Financial Officer in accordance with Financial Regulations.
5.02	Monitoring arrangements within the Community Care Finance Team should be amended to include a requirement to record all invoices processed for payment	Medium	Yes	31/08/22	Implemented - The monitoring database recording invoices passed for payment has been amended to include additional information on when care has been provided to service users. It was also noted that a revised Standard Operating Procedures (SOP) had been prepared but has not been finalised. The SOP details requirement for recording information on the monitoring database.
5.03	The Community Care Finance Team should check invoices received from Care Providers to ensure the care delivered to each	Medium	Yes	31/08/22	Implemented – Invoices are matched to CareFirst to ensure that the care being billed for agrees to the support package as detailed

Moray Council

Internal Audit Section

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)**	**Date of Completion**	**Status / Explanation**	
	service user corresponds to their individual authorised support package detailed within CareFirst				in the system. Where discrepancies arise, confirmation is sought from Social Work.	
5.04	Payments should be made to the agreed Care Provider and not a sub contracted company	High	Yes	31/08/22	Implemented. - The follow up review has confirmed that payments are no longer being made to a third party but to the Care Provider.	

Moray Council

Internal Audit Section

DEPARTMENT: **Chief Executive**

SUBJECT: **Social Media**

REPORT REF: **22'012**

Follow Up Audit Review

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)	Date of Completion	Status / Explanation
Key Control: The use of social media to facilitate council activities i.e communications, has adequate controls and monitoring					
5.01	A single guidance document should be developed for officers in the use of social media accounts.	Medium	Yes	31/04/2022	Implemented. A Social Media Guidance Document has been prepared and is currently going through an employee consultation process.

Moray Council

Internal Audit Section

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)**	**Date of Completion**	**Status / Explanation**	
5.02	The Media and Communications Section should be informed prior to a Service setting up a Social Media Account.	Medium	Yes	31/11/2022	Implemented. Evidence noted of the Media and Communications Section being informed of the setting up of new Social Media Accounts.	
5.03	The Media and Communications Section should maintain a record of social media accounts and officers authorised to post information across all Council services.	Medium	Yes	31/11/2022	Implemented. Noted that a record is now maintained of Council social media accounts and officers authorised to post information.	
5.04	Consideration should be given that prior to allowing officers access to a Council social media account, training should be undertaken.	Medium	Yes	16/12/2022	Implemented. An E-Learning module is now available to officers, and in-person sessions can also be provided when requested. Officers must complete the E-Learning module before access is allowed.	

Moray Council

Internal Audit Section

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)**	**Date of Completion**	**Status / Explanation**	
5.05	Further exploration should be undertaken to the benefits of introducing additional security controls available from social media website providers.	Medium	Yes	Ongoing	Implemented. Two step authorisation is required for all Facebook Council accounts. In addition, a review of other social media platforms has been completed with the intention of also requiring a two step authorisation procedure before access is allowed.	

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 29 JUNE 2023**

SUBJECT: **INTERNAL AUDIT SECTION COMPLETED PROJECTS REPORT**

BY: **CHIEF INTERNAL AUDITOR**

1. REASON FOR REPORT

1.1 To provide an update on audit work completed since the last meeting of the Committee.

2. RECOMMENDATION

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

3. BACKGROUND

3.1 Public Sector Internal Audit Standards (PSIAS) require the Chief Internal Auditor to prepare and present reports to the committee on internal audit's activity relative to the audit plan and any other relevant matters.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 In line with the approved internal audit plan, the following reviews were completed:

Emergency Planning

4.2 The annual audit plan for 2022/23 provides for an audit review of the Council's Emergency Planning arrangements. The Civil Contingencies Act 2004 places a legal obligation upon emergency services and local authorities to assess the risk of, plan, and exercise for emergencies, such as floods, adverse weather, pandemic or other emergencies that could have a significant impact on the community. Effective emergency planning is an essential component of the Council's overall governance arrangements to ensure the resilience of all key services in the event of a major incident.

4.3 The audit noted a need for updating Emergency Plans in addition to supporting Policies and Procedures. However, it is appreciated the limited staffing resources available within the Service. The executive summary and recommendations for this project are given in **Appendix 1.**

Self Directed Support

4.4 A review has been undertaken of the financial monitoring arrangements for Self-Directed Support (SDS) packages. The Social Care (SDS) (Scotland) Act 2013 came into force in April 2014 and introduced the Self Directed Support (SDS) term to describe how people can exercise choice and control over the support or services that allow them to live independently and meet agreed outcomes. The Act requires all Local Authorities to offer options to individuals who have been assessed as needing a care service.

4.5 The scope of this audit was to review systems and procedures for the following care delivery options:

- An individual choose their own support but managed by Health & Social Care Moray.
- The care provider is arranged by Health & Social Care Moray at the request of the service user.

Annual expenditure for these type of care delivery options amounted to approximately £40 million and £17 million respectively for external and Health & Social Care Moray care providers. The executive summary and recommendations for this project are given in **Appendix 2.**

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Partners in Care 2022 – 2032"

Internal audit work supports good governance and assists in securing appropriate systems of internal control.

(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 and Mitigation

Audit reports highlight risk implications and contain recommendations for management to address as a means of mitigating.

(e) Staffing Implications

No implications directly arising from this report

(f) Property

No implications.

(g) Equalities/ Socio Economic Impacts

No implications.

(h) Climate Change and Biodiversity Impacts
None directly arising from this report.

(i) Directions
None arising directly from this report.

(j) Consultations
There have been no direct consultations during the preparation of this report.

6. CONCLUSION

6.1 This report provides Committee with a summary of findings arising from audit projects completed during the review period.

Author of Report:	Dafydd Lewis, Chief Internal Auditor
Background Papers:	Internal Audit Files
Ref:	mijb/ap&rc/29062023

AUDIT REPORT 23'021

EMERGENCY PLANNING

Executive Summary

The annual audit plan for 2022/23 provides for an audit review of the Council's Emergency Planning arrangements. The Civil Contingencies Act 2004, places a legal obligation upon emergency services and local authorities to assess the risk of, plan, and exercise for emergencies, such as floods, severe weather, industrial accident or other emergencies that could have a significant impact on the community. Effective emergency planning is an essential component of the Council's overall governance arrangements to ensure the resilience of all key services in the event of a major incident. An Emergency Planning Officer supports Council Services' delivery of emergency planning arrangements.

The objective of this audit was to provide assurance over the adequacy and effectiveness of current controls over emergency planning. The audit scope reviewed that adequate training, planning and testing systems have been developed to ensure the Council is prepared in the event of an emergency. However, emergency planning arrangements cannot exist in isolation as effective business continuity plans are required to ensure the Council can not only deal with an emergency but also continue to function and recover effectively afterwards.

The audit was carried out in accordance with Public Sector Internal Audit Standards (PSIAS).

The audit found significant work has been undertaken to ensure the Council maintains effective emergency planning arrangements and the ability to respond operationally to emergency events. This has been achieved despite limited staff resources. The review highlighted the following key points:

- The Emergency Planning Policy and Procedures have not been updated since 2014. This document is currently being reviewed and provides guidance to officers for coordinating action in dealing with an emergency. The Emergency Planning Policy and Procedures should be updated to reflect current operating arrangements and staffing structures.

- Emergency Plans have been developed detailing actions to be undertaken in the event of an incident. It is appreciated the limited staffing resources available, however it was found that some plans still need to be reviewed and updated to reflect the current staffing structures of the Council and partner organisations. After updating, testing should be undertaken to ensure effectiveness and highlight any further improvements to Emergency Plans.

- It was noted the Council maintains a weekly rota of senior managers designated as Moray Emergency Response Co-Ordinators (MERC) in the event of an incident. However, it was found that limited training is provided or documented guidance and instructions to support officers in their duties. It was noted that work is being carried out to improve guidance available to MERC's. In addition, it was also found a need to update the emergency contact details of officers.

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: The Council's emergency planning arrangements are fit for purpose to respond effectively in the event of a major incident						
5.01	The Emergency Planning Policy and Procedures should be updated to reflect current operating arrangements and staffing structures.	Medium	Yes	A new Moray Council General Emergency Plan is in development / draft. Updating both the strategic and operational requirements of the Moray Councils Emergency Response arrangements and outlining the responsibilities	Emergency Planning Officer	31/05/2023

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**
				of responder partners.		
5.02	Regular meetings should be held between the Emergency Planning Officer and the Business Continuity and Risk Management Officer to ensure ongoing alignment of emergency and business continuity plans.	High	Yes	A Closer working relationship will continue between the Emergency Planning Officer and the Business Continuity and Risk Management Officer, to further develop alignment of emergency planning and business continuity plans.	Emergency Planning Officer / Business Continuity and Risk Management Officer	Ongoing

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**
5.03	Emergency plans should be updated to reflect current risks, working practices and staffing structures of the Council and partner organisations. After updating the emergency plans, testing should be undertaken to evidence their effectiveness and highlight any areas for further improvement.	Medium	Yes	Emergency Plans are being updated to reflect risks, and strategic and operational requirements. However this process requires commitment from the heads of services to ensure implementation of this recommendation Once developed, a test exercise schedule will be developed to stress test and learn lessons and update the agreed plans.	Emergency Planning Officer	31/12/2024

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**
5.04	Further training and documented guidance should be provided to Moray Emergency Response Co-Ordinators (MERC) to support officers in best practices to follow in the event of an emergency incident.	Medium	Yes	The Emergency Planning Officer has previously sourced, on a number of occasions, free Scottish Government Crisis Management training for officers. This training is now being re-run in May 2023 and all MERC's yet to undertake have been invited to attend. The Emergency Planning Officer has also sourced a MERC induction package from a neighbouring authority and this	Emergency Planning Officer / Senior HR Adviser	31/12/2023

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**
				will be developed along with Organisational Development for future MERC training delivery. New Action Cards (step by step) guidance is in development for MERC's to use at time of incidents.		
5.05	Emergency contact details of the Moray Emergency Response Co-Ordinators (MERC) saved within Sharepoint should be restricted to only officers that require access to this information.	Medium	Yes	ICT/Sharepoint to provide the Emergency Planning Officer with a list of access names for review. The Emergency Planning Officer to	Emergency Planning Officer	31/07/2023

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**
				review and clarify those that need requirement and advise ICT accordingly.		
5.06	An Annual Report should be provided to elected members detailing the work undertaken and planned within emergency planning.	Medium	Yes	An Annual Emergency Planning Report will be submitted to members.	Consultancy Manager	31/03/2024
5.07	A review of the hyperlinks contained within emergency planning webpages should be undertaken to ensure they connect to the intended document or website.	Medium	Yes	The Emergency Planning Officer in Liaison with the Senior Communications Officer is making arrangements to progress updating of relevant hyperlinks.	Emergency Planning Officer/ Senior Comms. Officer	30/08/2023

AUDIT REPORT 23'025

SELF DIRECTED SUPPORT

Executive Summary

The Internal Audit Plan for the 2022/23 year provides for a review of the financial monitoring arrangements for Self-Directed Support (SDS) packages of adults as part of the coverage of Health & Social Care Moray activities. The Social Care (SDS) (Scotland) Act 2013 came into force in April 2014 and introduced the SDS term to describe how individuals can exercise choice and control over the support or services that allow them to live independently and meet agreed outcomes. The Act requires all Local Authorities to offer the following 4 Options to individuals who have been assessed as needing a care service:

- option 1 - a direct payment, which is a payment to a person or third party to purchase their own support
- option 2 - the person directs the available support
- option 3 - the local council arranges the support
- option 4 - a mix of the above

The scope of the audit was to review systems and procedures in the delivery and management of adult social care provided under Options 2 and 3 of the SDS Scheme. This included examination of the processes to support individuals in their preferred care delivery option, contractual relationships with care providers, financial management and monitoring of individual care packages. Annual expenditure for individuals in receipt of SDS Option 2 and & 3 care packages amounted to approximately £40 million and £17 million respectively for external and internal care providers.

The audit was carried out in accordance with the Public Sector Internal Audit Standards (PSIAS).

The key areas identified for management attention include the following :-

- The Social Care (SDS) (Scotland) Act 2013 requires Councils to provide individuals and their families with information and support to decide on a service user's preferred SDS care delivery option. A review of the support packages of individuals using care services found limited evidence of discussions between social workers and service users/families regarding the range of SDS care delivery options. A clear audit trail should be maintained to evidence the discussions held with service users in determining their care package.

- It was noted that where care is delivered through SDS Option 2, a tripartite agreement should be agreed to detail the care provided, signed by the provider, Council, and the supported person. From a random sample of individuals using care services, it was found the majority had no tripartite agreement in place to

formalise their care arrangements. The audit found, through a documentation review and discussions with social workers, examples where no referral had been made to the SDS Team to finalise a tripartite agreement or where the process still needed to be completed. The current workload pressures within the Service are appreciated.

- The Council does not charge individuals receiving a day care service. A review of practices within other Local Authorities notes charging policies where individuals contribute to the cost of receiving a day care service. The Council's charging policy should be reviewed regarding day care and a decision should be made as to whether a charge should be levied for the service in future.

- Audit testing noted examples where supporting documentation concerning an individual's care package was either not recorded or could not be found within the CareFirst System. In addition, changes to care packages were noted regarding the care delivered or the provider where again this was not reflected within the CareFirst System. CareFirst is the primary database that records and manages social care cases within Health & Social Care Moray. The limitations of the CareFirst System are appreciated, highlighted in a separate audit review in 2022/23. The Service has committed to investigate a replacement to the current recording databases used within Health & Social Care Moray.

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 controls operate in the management and recording arrangements for the delivery of SDS Options 2 and 3 care packages						
5.01	In accordance with SDS Regulations, evidence should be maintained to document the discussions held by social workers regarding the various care delivery options discussed with the individual using care services.	High	Yes	Discussions will be held by Social Workers as part of the assessment and recorded as part of the Support Plan on Care First. Team Managers will be accountable to ensure implementation and delivery through supervision, which will be monitored and reviewed at	Chief Social Work Officer / Head of Service	30/09/2023

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**
				Practice Governance Board monthly.		
5.02	Documented procedures should be developed to support social workers and individuals using care services in the selecting of SDS care delivery options.	High	Yes	Relevant Guidance will be developed and a process map will be distributed to all Social Workers. This will be monitored at Practice Governance Board monthly.	Chief Social Work Officer / Head of Service	31/03/2024
5.03	An annual reference document detailing a breakdown of the rates paid to care providers should be provided to all relevant officers to assist in budgetary	High	Yes	A document containing all providers and costs will be issued to all relevant	Provider Services Manager	30/06/2023

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**
	planning and the accurate preparation of an individual's support package.			officers. A process to maintain and update the document going forward will be developed and monitored through the Practice Governance Board on a regular basis.		
5.04	All officers should be reminded to update the CareFirst System to ensure the database is up-to-date and accurate for each individual using care services.	High	Yes	Discussions will be held by Social Workers as part of the assessment and recorded in the Support Plan on Care First. Team	Chief Social Work Officer / Head of Service	30/09/2023

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**
				Managers will be accountable to ensure implementation and delivery through supervision, which will be monitored and reviewed at Practice Governance Board monthly.		
5.05	A tripartite agreement between the individual using the care service, Council and care provider should be agreed for all SDS Option 2 care packages.	Medium	Yes	Social Workers will refer to the SDS Team when setting up a new package and this will be reviewed and monitored through	Chief Social Work Officer / Head of Service	30/09/2024

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**
				supervision. SDS Team to then put in place a Tripartite Agreement. This will be monitored and reviewed at the Practice Governance Board regularly.		
5.06	A contractual agreement detailing service delivery and costs should be agreed with the 3 providers of day care services noted within the findings.	High	Yes	Clarification will be given from SDS Team and Social Work as to the direction regarding contractual agreement.	Provider Services Manager	31/03/2024

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**
5.07	Annual support plan reviews of individuals in receipt of SDS Option 2 and 3 care packages should be undertaken in accordance with agreed procedures.	High	Yes	Work with Social Work to develop a strategy to ensure all reviews are completed on time. There is a significant capacity issue across Social Work. This will be monitored and reviewed regularly through the Practice Governance Board.	Chief Social Work Officer / Head of Service	30/09/2024

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**
5.08	Consideration should be given for management to undertake regular reviews of the accuracy and recording of the checks completed to ensure the accuracy of payments made to care providers.	Medium	Yes	Continuous audit to be implemented through Community Care Finance.	Interim Community Care Finance Officer	30/09/2023
5.09	The Council's charging policy should be reviewed in regard to day care and a decision made as to whether a charge should be levied for the service in the future.	High	Yes	Review the Moray Council charging policy to allow the IJB to make recommendations regarding future iterations.	Interim Chief Finance Officer (MIJB)	30/09/2023
5.10	A review of arrangements regarding the authorisation of individual care packages should be undertaken.	Medium	Yes	Review the current authorisation practice in line with financial	Chief Social Work Officer / Head of Service	31/08/2023

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**
	Thereafter, authorisation requirements should be documented and communicated to all appropriate officers.			regulations. Develop a process map highlighting authorisation levels for all Social Workers. Monitor and review through the Practice Governance Board.		

REPORT TO: MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 29 JUNE 2023

SUBJECT: STRATEGIC RISK REGISTER – JUNE 2023

BY: 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 June 2023.

2. RECOMMENDATION

2.1 It is recommended that the Audit, Performance and Risk Committee consider and note the Strategic Risk Register included in APPENDIX 1.

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. This report is presented to Audit, Performance and Risk Committee for their oversight and comment. Any changes made to the risk register since it was last presented to the Committee are highlighted using red text.

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 Partners in Care 2022-2032 strategic plan which was agreed at MIJB on 24 November 2022 (para 14 of the minute refers).

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The Risk Management Framework review was completed and outcome was approved by the Board on 25 June 2020 (para 9 of the minute refers). The approved Risk Appetite Statements have been included in **APPENDIX 1**.

4.2 The challenge to return to a new 'business as usual' from the Covid-19 pandemic continues.

4.3 The senior leadership teams continually consider the appetite for risk whilst planning and effecting transformational change and redesign, cognisant of the significant financial challenges for the financial year 2023/24.

4.4 Work continues across teams to ensure the Risk Register is updated in the timescales dictated by the criteria. Work continues to support teams with this continuous improvement and review.

4.5 A review of our governance structures across the system has commenced, as we recover from the adaptations made to many reporting structures during the pandemic. During 2023/24 the partnership will also be focusing on the structures including the delegation of Children's Services to MIJB.

4.6 The continued safe delivery of services is a priority and as such, dedicated management time is being directed to support oversight of operational risks. The Grampian Operational Escalation System (GOPES) continues to be utilised to assist in the identification of pressure points across the whole system so that they can be addressed and prioritised appropriately. These principals continue to be revisited across the system in Grampian.

4.7 Recruitment and retention continues to provide challenges across all disciplines. The Moray Health and Social Care Workforce Plan was approved by MIJB on 29 Sep 2022 (para 12 of the minute refers). Over the next three years, the workforce plan will focus on the five key areas known as 'pillars'; they include, Plan, Attract, Train, Employ and Nurture staff. A report discussing the challenges and plans of Recruitment and Retention was presented to MIJB on 26 January 2023 (para 13 of the minute refers).

4.8 The possibility of planned power outages continues to be a focus for Civil Contingency groups and Business Continuity Planning continues. Additional support has also been provided by HSCM to assist Primary Care Contractors with their planning. Further work is now being carried out to test the resilience of hospital sites with back up generation power only.

4.9 There continues to be significant financial risk in the system. The 2022-23 final unaudited accounts are presented to the Audit, Performance and Risk Committee and MIJB on 29 June 2023.

4.10 There continues to be a significant number of hours per week of unmet need for care at home, with little change in these figures this year. Regular meetings and action plans continue to take place to support teams.

4.11 The Strategic Risk Register will continue to be updated to ensure that it reflects any potential risks to realise 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 "Partners in Care 2022 – 2032"
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. The risks are outlined in the body of the report in section 4.

(e) Staffing Implications
There are no additional staffing implications arising from this report.

(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) Climate Change and Biodiversity Impacts
There are no impacts arising from this report.

(i) Directions
None arising from this report.

(j) Consultations
Consultation on this report has taken place with the Senior Management Team.

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 outlines the current position and recommends the Committee note the revised and updated version of the Strategic Risk Register.

Author of Report: Sonya Duncan, Corporate Manager
Background Papers: held by HSCM
Ref:

HEALTH AND SOCIAL CARE MORAY STRATEGIC RISK REGISTER

AS AT JUNE 2023

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 "Partners in Care 2019-2029" was revised and presented as "Partners in Care 2022 to 2032", this was approved by MIJB in November 2022. Membership of IJB committees recently changed due to the elections in May. An amendment to the Scheme to increase membership by one from each of the partner organisations was ratified in March 2022 by the Scottish Government following due process and approval by Moray Council and NHS Grampian Board. During the initial Covid 19 response, normal business was suspended and emergency arrangements were implemented. IJB, CCG and APR meetings restarted during August 2020. Weekly meetings were instigated with Chair/Vice Chair and Chief Officer and these continue. A delivery plan for the new Strategic Plan "Partners in Care" 2022-32 will be presented Spring 2023.	
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" 2022-32 • Governance arrangements formally documented and approved by MIJB January 2021. • Agreed risk appetite statement. • Performance reporting mechanisms. • Consultation with legal representative for all reports to committees and attendance at committee for key reports. • Standing orders have been reissued to all members	
Mitigating Actions:	Induction sessions were held for new IJB members after May elections. Further sessions will be arranged for recent appointees. IJB member briefings are held regularly as development sessions.	

	Conduct and Standards training held for IJB Members in June 2022 provided by Legal Services. SMT regular meetings and directing managers and teams to focus on priorities. Regular development sessions held with IJB and System Leadership Group Strategic Plan and locality management structure is in place. The work that has been progressed through the Covid19 response has escalated developments in some areas as a matter of priority. This has been achieved 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. • The Moray Transformation Board has recently recommenced and will support an oversight of planned business across HSCM.
Gaps in assurance:	The new strategic delivery plan and will incorporate the work being taken forward for Self-Directed support, Hospital at Home and Locality Planning.
Current performance:	The Scheme of Administration is reported when any changes are required. Legal advisors are currently working on the requirements to the integration scheme in relation to the proposed The integrated scheme of delegation of Children's and Families and Justice Services was presented and accepted by MIJB on 26th January 2023. The Governance Framework was approved by IJB 28 January 2021. Re-appointment of Standards Officer agreed by IJB 31 March 2022. Members Handbook has been updated and circulated to all members in June 2022.
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. These groups have now recently recommenced following the pause during the Covid19 response. The Interim Strategy and Planning Lead is now taking this forward and prioritising and focusing on strategic planning and priorities over the short and longer term.

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	**INCREASING**
Rationale for Risk Rating:	The 2021/22 and 2022/23 settlement saw additional investment for health and social care that was passed through to the MIJB and in 2023/24 saw funding for recurring commitments. ~~T~~There remains a significant pressure due to the recurring core overspend, since most 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. In addition, many uncertainties have arisen relating to the carried forward ear marked reserves with the clawback of the Covid reserve and reduction of the PSIF funding in 2022/23 as well as other funding being looked at. The impact of which will be to reduce the level of ear marked reserves in the MIJB. The Revenue Budget 2023/24 was approved by MIJB on 30 March 2023 as a balanced budget. A significant ambitious savings plan of £4.1 million was approved ~~and achieved~~. Additional Scottish Government funding was provided again for 2023/24, this is to meet additional recurring policy commitments in respect of adult social care pay uplift for externally provided services and free personal and nursing care rates. The update medium Term Financial Framework was presented as part of the budget papers on the 30th March 2023 this will be further reviewed during the 2023/24 year to ensure alignment with the recently reviewed Strategic Plan and for the delegation of Childrens Services and Criminal Justice is planned to be presented to MIJB by 30 September 2023.	
Rationale for Risk Appetite:	The Board recognises the financial constraints all partners are working within. While we are cautious and 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 Whilst we are now officially in the Covid-19 recovery and transformation stage there has been no additional change in the pressures felt by the system.	
Controls:	There is an interim arrangement for CFO cover from Moray Council. Permanent recruitment efforts have not been successful. The Chief Officer is working with both the Council and NHS Finance Leads to secure a longer term interim arrangement. The CFO and Senior Management Team have worked together to address ~~further~~ savings which were approved by the Board as part of the budget setting procedures for 2023/24. This will be a focus of continuous review to ensure any	

	investment is made taking cognisance of existing budget pressures. A revised Financial Framework was presented to the MIJB on 30 March 2023, and a further review will take place by 30 September 2023. The Senior Management Team will continue to consider and plan for the financial challenges for 2024/25 and beyond.
Mitigating Actions:	Risk remains of the challenge that the MIJB can deliver transformation and efficiencies at the pace required whilst dealing with the emerging financial pressures. 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 regularly engage in finance discussions with key personnel of both NHS Grampian and Moray Council. Chief Officer and CFO will continue to engage with the partner organisations in respect of the financial position throughout the year. Cross partnership performance meetings are in with partner CEOs, Finance Directors and the Chair/Vice Chair of the MIJB.
Assurances:	MIJB oversight and scrutiny of budget. Reporting through MIJB, NHS Grampian Board and Moray Council.
Gaps in assurance:	None known
Current performance:	An overspend of ~~£1,454,162~~ 1,297,158 as at December 2023 was reported to the IJB on 30 March 2023 at 30 Sept 2022.
Comments:	Senior managers continue to work with Chief Officer and Chief Financial Officer to address the continuing financial challenge, continuing to seek efficiencies and opportunities for real transformation as we look to make efficient and effective investment in services that are truly transformational. There are additional pressures from the cost of living crisis, increasing energy bills, inflation and staff pay awards.

3		
Description of Risk: *Human Resources (People):*	Inability to recruit and retain qualified and experienced staff to provide and maintain sustainable, safe care, whilst ensuring staff are fully able to manage change resulting from response to external factors such as the impact of Covid and the actions that arose from the recommendations from the Independent Review of Adult Social Care 2021.	
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 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. Allied Health Professions, Social Work and Nursing are some of the particular areas experiencing difficulties with obtaining people with the appropriate skills and training. Care at Home staffing levels are pressured for Internal services and externally with local providers all experiencing the same difficulties. There are also impacts on recruitment of Dentists and other graduates arising from Covid as the number graduating has reduced during the period. The various impacts of Covid-19 has placed a significant strain on the Partnerships resources across frontline and support functions and this has resulted in delays for the progress of projects relating to the achievement of strategic objectives. HSCM continues to review the large number of fixed term and seconded posts. This will continue as temporary contracts conclude. It is hoped that this will improve some of the instability teams felt during the pandemic response. This will also allow consideration of post redesign, service needs and potential financial savings. This will continue to be reviewed by the Senior Management Team. Care Homes in Moray continue to face difficulties with recruitment and retention of staff. Efforts are being made to provide support but the situation remains challenging. The transition from EU membership has not presented any specific concerns for workforce and this will continue to be monitored. The impact of forthcoming budget allocations and the withdrawal of all Covid funding will also mean that HSCM will face some challenging decisions in 2023. 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. The lack of suitable housing for Health and Social Care staff has resulted in people not being able to take up posts in Moray.	
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. Management competencies continue to be developed through Kings Fund training although this was suspended due to Covid19. A 2 day event was held on 16/17 May 2023, attended by the Senior Management Team as part of a Grampian wide event. Communications & Engagement Strategy was approved in November 2019 and continues. 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. Managers are highlighting any areas of concern and where appropriate this is identified in operational risk registers. HSCM services have commenced weekly reporting of workforce sit reps for Senior Management Team oversight highlighting vacancies, annual leave, sickness absence and Covid impacts so that issues can be identified and assessed quickly. Moray Council are carrying out a study of accommodation needs, including people working in the Health and Care sector.
Mitigating Actions:	System re-design and transformation. Organisational Development Plan and Workforce plan were updated and approved by MIJB in November 2019. The updated Workforce plan has been submitted to Scottish Government and comments were received by the HSCP in October 2022. These are currently being worked through. These plans are core documents for the Workforce Forum which has recently re-commenced following a temporary suspension during the first quarter of this year due to Covid impact. Staff Wellbeing is a key focus and there are many initiatives being made available to all staff including training, support, information and access to activities. Locality Managers are developing the Multi-disciplinary teams in their areas and some project officer support has been provided to develop the locality planning model across Moray. 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:	Operational oversight by Moray Workforce Forum has resumed and will report to MIJB in accordance with the agreed Governance framework. The HSCM Response Group was in place over the whole period of the Covid19 pandemic providing focussed leadership around emerging issues and resolving them. This group stood up again in April and is meeting daily whilst the system is pressured, this will be reviewed as the situation evolves. The Heads of Service are co-ordinating and escalate to SMT where necessary. These meetings have been increased as service needs dictate.
Gaps in assurance:	Further work required to develop workforce plans to reflect strategic plan implementation programmes.
Current performance:	The iMatter survey results for 2022 were received by managers for review and action plans. Preparatory work has commenced on the plans for iMatter 2023/24. Discussions are underway with HR in both Council and NHS to develop access to appropriate HR information at a summarised level to facilitate the necessary workforce planning and subsequent monitoring of plans. There continues to be a need for more streamlining in recruitment processes as the delay in approval to recruit to having a member of staff available is in excess of 8 weeks. There is also a lack of suitable applicants for various posts which is impacting on ability to appoint for some roles.
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 in the past. For some professions there is a potential risk that staff move from one position to a new position within HSCM will just move the vacancy to elsewhere in the system, so Senior Management Team are aware of this risk and taking it into account in considerations for vacancies. This needs to be considered when fixed term contracts and secondments are planned, consideration needs to be given to the whole of HSCM and not services in isolation. Many of our staff may have transferrable skills and experience. The continuing system issues and lack of available beds may mean operations cannot be scheduled to reduce the backlog and key staff may not have the necessary time in surgery to maintain essential skills. This in turn may add to the staff retention issues within certain specialties.

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. Recent engagement with individuals representing their communities or third sector organisations in a variety of forums is highlighting that problems with their capacity to fulfil our needs so more co-ordination and clearer focus is required to ensure that the communication, engagement and outcomes are meeting identified needs.	
Rationale for Risk Appetite:	The Board is cautious but 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:	Governance Framework approved by IJB January 2021 Communication and Engagement Strategy approved November 2019 Annual Governance statement produced as part of the Annual Accounts 2021/22 and submitted to External Audit. The unaudited accounts and governance statement for 2022/23 will be presented to MIJB June 2023 and then the audited accounts will return to committee in September 2023 for agreement. Annual Performance Report for 2021/22 was published in November 2022. 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, Keith and Lossiemouth with information being made available to stakeholders and the wider public via HSCM website. Participation of stakeholders in a variety of meetings such as Home First project, carer strategy, Strategic, Planning and Commissioning groups.
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 2016/17. Discussions at leadership meetings to ensure all standards are being met around Public Sector Equality Duty and published where appropriate. There is a new programme of training to ensure all policies are Equalities Impact Assessed and the findings are published. The SMT are currently considering how any proposed service changes consider the PSED as part of the consultation process. Annual Performance Report for 2022/23 will be published in July 2023 after being presented to the IJB in June 2023. Social media is actively used as a method of engaging with the public, with short videos focussing on particular services being trialled. SMT have considered the existing arrangements for engagement with stakeholders and work is being undertaken to align our framework with the Scottish Government "Planning with people guidance" and ensure that mechanisms are in place across services to evidence and evaluate their impact.
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. Due to the impact of COVID and requirement for social distancing the normal mechanism for engagement were not all available. More use is being made of social media and Microsoft teams and other options and methods for engagement with staff are being used via NHSG such as videos on YouTube and one question surveys. Going forward there may be more opportunity for face to face meetings to take place again but it should be considered that this will not be beneficial for all. A Public Engagement and Communications Officer is currently being recruited to. This work stream will rapidly restart as a priority.
Current performance:	Communications Strategy was reviewed approved by IJB November 2019. Annual Performance Report 2021/22 published November 2022. Audited Accounts for 2022/23 were audited and approved in March 2023 and are now published. 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.

Comments:	A communication cell was established as part of the Local Resilience Partnership Covid and storms response with representation from Councils, HSCP and NHSG. This was led by Aberdeen City Council and was an example of the collaborative working that took place. This forum provides assurance that messages to all stakeholders are consistent. There has been representation from the Home first project at the Wellbeing forum to facilitate sharing of information and seeking views.

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:	As a result of the Covid 19 response, progress was 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. Teams continue to do their best but there are areas where they still feeling overwhelmed and service delivery is challenging. With effect from March 2021 MIJB is defined as a Category 1 responder under the Civil Contingencies (Scotland) Act and there are additional requirements for preparedness that is being taken forward in partnership with NHSG and Moray Council emergency planners.	
Rationale for Risk Appetite:	The MIJB understand the requirement to meet the statutory obligations set out within the Civil Contingencies Act and the Category 1 status applied in March 2021, and work with partner organisations to meet these obligations.	
Controls:	Winter Preparedness Plan was updated (but not tested as in previous years) alongside NHSG plans as NHSG implemented their crisis management framework which required participation of partners at Daily System Connect meetings to discuss and prioritise resource to address issues with system flow. HSCM Civil Contingencies group established and meeting regularly to address priority subjects. NHS Grampian Resilience Standards Action Plan approved (3 year). Business Continuity Plans are now updated for most services and this review continues across HSCM. Knowledge of critical functions and ability to respond quickly and effectively has been in evidence during incidents such as Gas outages in Keith (January and February 2021) and Covid response, Storms (Arwen, Malik and Corrie) – debriefs carried out and learning identified. A Resilience Newsletter started in December 2022 to ensure all staff receive some personal resilience information together with resources for teams to plan. Regular updates to SMT and SLG regarding potential power outages across the country. Additional sessions delivered to Primary Care Contractors to assist with their Business Continuity Planning around power outages. Regular system wide meetings to discuss potential Industrial Action implications and service planning.	

	A review of the Festive season arrangements was completed and as a result all services are now required to provide information about service cover available over holiday long weekends which enables a more collaborative and supportive approach.
Mitigating Actions:	Information from the updated BIA/BCP informed elements of the Winter Preparedness Plan A Friday huddle continues, this allows the status of services across the whole system to provide information and contact details to the Senior Manager on Call (SMOC) over the weekend. If any potential issues are highlighted the relevant Persons at Risk Data is compiled and if appropriate, shared with relevant personnel. NHSG have introduced system wide daily huddles to manage the flow and allocation of resources which require attendance from Dr Grays and HSCM. 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. HSCM continues to monitor the local situation regarding impacts on staffing and is engaged with NHSG emergency planning arrangements and Council Response and Recovery management team to be ready to escalate response if required. Work was undertaken within NHSG, Aberdeenshire HSCP and Aberdeen City HSCP to look at Surge flows and establish a mechanism that will provide easy identification of “hot spots” across the whole system in Grampian, to facilitate a collaborative approach to addressing the issues through the use of a common Operational Pressure Escalation approach. This work could underpin surge responses in winter and at other times of pressure and having a standard approach across Grampian could aid communication and understanding.
Assurances:	Audit, Performance and Risk Committee and NHS Grampian Civil Contingencies Group oversight and scrutiny. HSCM Civil Contingencies group review specific risks and action plans to mitigate, developing plans and testing arrangements in partnership with NHSG and Council
Gaps in assurance:	Moray Integrated Joint Board (MIJB) was designated as a Category 1 responder under the Civil Contingencies Act 2004 from March 18th 2021. That designation imposed a number of statutory duties in terms of the Act and the associated Scottish Regulations[1]. MIJB has no dedicated, specialist in post and is reliant on the Corporate Manager covering this increasingly demanding role in addition to other duties without the necessary background, knowledge, skills and

[1] Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005

	experience. This presents a potential organisational risk in terms of compliance, and our ability to provide assurance on discharging our civil contingency arrangements. This has been highlighted to the Chief Officer and IJB. The debriefs from the storms in 2021/22 have identified lessons learnt for Grampian Local Resilience Partnership and more locally for the response co-ordination within Moray. Action plans are being developed in collaboration with Moray Council's emergency planning officer to address the issues identified. The main issues related to developing wider awareness of roles and responsibilities, and improving general awareness of response structures and meeting protocols. This will be incorporated into training schedules going forward. It has also highlighted the need for a robust arrangement for out of hours contact and clarity of roles and responsibilities across the system which is being discussed at SMT. Option Appraisal discussions have commenced. 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. The 'Care for People' strategic document has been presented to HSCM SMT and CMT for comment it will then be presented to MIJB. It is anticipated this will be completed by end August 2023. A draft operational response plan has been drawn up and will also be presented for approval shortly after. An information session including the 'Care for People' element was delivered on 2 May 2023, to senior managers who carry out the role of SMoC, this included input from Moray Council Emergency Planning Officer and NHS Grampian. The intention is to hold a table top exercise with managers from HSCM and Moray Council to test the invocation arrangements to ensure common understanding of roles and responsibilities. Table top style exercises are currently being arranged with some of those services who have submitted their finalised Business Continuity plans for February 2023. Development of a HSCM Persons at Risk Database continues and all partners are now involved, looking to improve the quality of the data held.
Current performance:	The Senior Management Team participated in Strategic Leadership in a Crisis training in 2020 and a programme of further training for the wider management team is scheduled. A follow up session was held in September 2022. A further session took place in Moray in May 2023. 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. A schedule of review and exercising of business impact

	assessments and plans has been scheduled for this year across services. All services have been requested to prioritise their Business Continuity planning with a particular lens on power outages. Annual report on progress against NHS resilience standards was presented to the APR committee on 30 March 2023. Report on the implications of the designation as a Category 1 responder was presented to MIJB 25 November 2021. Work is currently underway to plan for possible National Power Outages across the UK. This is being co-ordinated across Grampian to ensure all Partners are involved. Information/planning sessions were also delivered via HSCM to our Primary Care partners. They were invited to share any emergency plans with the partnership.
Comments:	The requirements of a Category 1 Responder continue to increase in demand placing increased pressures across already overstretched services and managers. MIJB does not have a subject matter expert leading on these topics.

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 impact of Covid-19 and resultant efforts required to remobilise services and/or the increase in workloads stretching a workforce that has been under sustained pressure for a considerable time. The ongoing impact of the Covid 19 pandemic is stretching resources to deliver care in the community across all providers (internal and external) so there is a potential increased risk of expected standards not being achieved despite the best efforts of all concerned.	
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 and require to be developed, no longer apply, 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 Clinical Risk Management and Practice Governance group has oversight of their respective professional standards and feed into Clinical and Care Governance Group, which then escalates to CCG Committee as necessary. 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. Workshops took place in January and February 2023, 'A conversation about Clinical Governance'. Additional operational workshops will continue in 2023. Complaints and compliments procedures in place and monitored. Clinical incidents and risks are being reviewed on a fortnightly 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, albeit there was a reduction in some areas of external inspection reporting during the Covid period due to social distancing restrictions. It is anticipated that these will begin to increase over the coming year. Care Home Oversight Group meets 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 All High and Very High risks are now brought before the senior management team in Moray. 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. Governance Framework in place and operational.
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. Two Days of Audit took place across Moray on 25th and 26th January, 2023 respectively. These were led by the Clinical Service Leads. The findings of these events were compiled and outcomes are assessed by the relevant service leads and SMT. A further round of audits on Social Care will now be completed and a full report will be considered if necessary, dependant on outcomes. A summary of inspections is included in the Annual Performance report. The level is marked as an increasing risk on the basis that services are under pressure with the issues with staffing capacity and the need to focus on delivery of critical functions which may mean external inspection are not the priority at this moment in time. The Adult Support Protection inspection took place in April/May and an action plan has been developed and is now in place.
Comments:	No major concerns have been identified for HSCM services in any audits or inspections during 2021/22.

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 and delayed discharges place additional cost and capacity burdens on the service. The level of delayed discharges has remained high, reflecting the sustained pressure in the system following the Covid -19 pandemic impact and the lack of availability of care in the community. There are sustained focussed and collective efforts by all those working in the pathway. However this is a complex area and will require continued effort to realise reductions and maintain them.	
Rationale for Risk Appetite:	The Board is cautious but open about risks that could affect outcomes that are priorities for people in Moray. There is a slightly higher appetite to risks that may mean nationally set outcomes – that by design are not given a high priority in Moray - are not met. There is new focus on addressing positive risk taking to ensure the most appropriate and timely measure of care for the population of Moray, this is being supported through various work streams across the system. 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. 2022 to 2032 “Partners in Care” Strategic Plan was approved and development of delivery plan is underway. Performance is 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. A daily Huddle and write up circulates the picture on performance across community and acute services for the Portfolio and service managers have a shared understanding of the pressures in the system and mitigations taking	

	place. Work continues on refinement of G-OPES (Grampian Operating Pressures and Escalation System) led by NHSG but being developed locally to identify the triggers and resultant actions required in services to respond to pressure points.
Mitigating Actions:	Service managers monitor performance regularly with their teams and escalate any issues to the System Leadership Group (SLG) for further discussion to provide wider support, developing shared ownership and a greater understanding across the whole system. Key operational performance data is collated and circulated daily to all managers. A Daily dashboard is held on illuminate for managers to access to ensure any potential issues are identified quickly so action can be taken. This dashboard is being reviewed and will be further developed with the intention of further dashboards to provide a whole system overview. This has been discussed at SLG and agreed. Performance information is presented to the Performance sub group of Practice Governance Group to inform Social Care managers of the trends in service demands so that resources can be allocated appropriately.
Assurances:	Audit, Performance and Risk Committee oversight. Operationally managed by service managers, summary reports to Practice Governance and clinical and care governance group and to System Leadership Group. Strategic direction provided by Senior Management Team. HSCM Response Group continues to meet and reviews 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 Strategic Plan has recommenced but is at an early stage. This will be progressed as the revised outcomes are determined and associated KPI are identified. Progress will be reported to future Board meetings. Review of systems and processes will commence across HSCM to ensure they are fit for purpose and ensure that there are no indirect consequences of structure changes resulting in any gaps in assurance processes.
Current performance:	Services continue to recover from the pandemic and discover a new 'battle rhythm', taking into account all new learning and experience from the pandemic.. There are likely to be changes to ways of working and this may also have impact on the performance information required. The Unmet need report continues to show improvement in a number of Performance Indicators, with a number of them now showing continued improvement over the longer-term.
Comments:	Locality profile information has been provided to Locality Steering Group/Locality Manager to inform potential priorities for consideration in Localities and work will be taken forward regarding development of performance monitoring and reporting of key performance indicators in relation to Localities once it has been determined what the intended outcomes are. Locality plans are now scheduled to report to MIJB on a quarterly basis.

	The delayed discharge group has produced an action plan for implementation and progress is being made. Practice Governance have reviewed their operational performance requirements and have a comprehensive data set used to inform operational priorities. The Home First priorities are being taken forward and updates are reported to this committee or MIJB on a regular basis. This work is being undertaken across the Moray Portfolio to improve wider system flow. Progress in this area has been hampered due to the increased demand for urgent or critical services requiring staff resource to be prioritised to frontline service delivery. The Council has procured new modules for their performance reporting system Pentana and HSCM performance team have been developing its use for reporting. HSCM are working in partnership with the Rural Centre of Excellence on transformation projects, the foundation of planning is addressing how we can improve the delivery of health and wellbeing outcomes and also the strategic aims of 'Partners in Care'.

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	**HIGH**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	There are many issues that will impact on the ability to progress to deliver Strategic Objectives. The Strategic Planning & Commissioning group has been refreshed and re-launched and key work is being progressed. There was an initial meeting held on 22 September 2021 to consider terms of reference and the proposed structure for oversight, prioritisation and assurance in relation to key developments, their fit with IJB strategy and enabling elements. The interim appointment of the Strategic and Planning Lead provides capacity to take this forward and to align the priorities arising nationally, Grampian-wide and locally. The remobilisation plan for HSCM services that were suspended or reduced is progressing with Providers services and social work implementing the IJB decision to return to delivery of both substantial and critical eligibility criteria. Work has progressed risk assessments are completed and assessments have been or are in the process of being reviewed to ensure equality. The impact of Covid 19 on the population of Moray is still not fully realised. It is therefore not possible to predict the extent of the impact on the ability to progress with delivery of Strategic Objectives. There are some aspects that have progressed very well such as introduction of Near Me consultations but there are others that are more difficult to progress. There is concern that due to the workloads and challenges over the last year that teams are weary and/or do not have capacity at this moment in time, to progress with delivery of development plans at this moment in time. In addition the pandemic is still present in the community so services are still responding to the impacts it has for the population of Moray. Managers are working with teams to establish “readiness” and their capacity and sense of wellbeing and the collated output will inform plans going forward. 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 ICT kit and information during the response to Covid.	

Rationale for Risk Appetite:	The Board has a high appetite for risks associated with delivery of transformational redesign. 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:	It is recognised that there will be significant changes taking place in Social Work practice with the implementation of the Self Directed Support standards and the move to outcomes based services, so governance arrangements are being set up to facilitate the same type of oversight and communication that is in place for the Home First programme.
Mitigating Actions:	Integrated Infrastructure Group previously established, with ICT representation from NHSG and Moray Council, to consider and provide solutions to data sharing issues and ICT infrastructure matters which is an area that will be taken forward alongside the Moray Growth Deal projects. The Moray Transformation Board has recently restarted and will link to all relevant groups.
Assurances:	Strict ICT and data sharing policies and protocols in place with NHS Grampian and Moray Council. A Moray Portfolio Infrastructure Programme Board has been established to support the operational delivery of the aims and objectives set e.g. Analogue to Digital changeover, Buildings and Assets oversight and Smarter Working will support this agenda.
Gaps in assurance:	Transformation/implementation planning is in development and will inform outcomes and performance reporting on the delivery of the strategic plan. Protocol for access to systems by employees of partner bodies are in place. 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. The strict information sharing protocols can cause issues when trying to work across system in an open and transparent way. Smarter Working programmes are being progressed in partnership with Council and NHSG.
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	**NO CHANGE**
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 however the paper has been out for consultation. NHSG have advised that staff should continue to work from home at present whilst policies and protocols are developed. Moray Council have a dedicated MC officer leading on a hybrid working plan with input from HSCM on their requirements. It is anticipated that this will conclude December 2023. 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. Council employed staff requiring mobile technology have now been provided with it and some staff are still working from home.	
Rationale for Risk Appetite:	Low tolerance in relation to not meeting requirements.	
Controls:	Chief Officer has regular meetings with partners Computer Use Policies and HR policies in place for NHS and Moray Council and staff. PSN accreditation secured by Moray Council Infrastructure Programme Board was established with Chief Officer as Senior Responsible Officer/Chief Officer member of CMT. Process for submission of projects to the infrastructure board approved and implemented to ensure appropriate oversight of all projects underway in HSCM. The Board has only recently restarted, so in the interim, project requests are being processed via Senior Management Team. The interim Strategy and Planning Lead will support the Infrastructure Programme Board for Moray portfolio.	

Mitigating Actions:	Membership of the Board was reviewed and revised to ensure representation of all existing infrastructure processes and funding opportunities. Process for ensuring infrastructure change/investment requests developed Dr Gray's strategy (vision for the future) 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. Both of these groups have been recently refreshed and remobilised. Workforce Forum meeting regularly with representation of HR and unions from both partner organisations
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. Infrastructure Board is in development and priority issues are being addressed in relation to infrastructure and premises risk. Due to staff changes this work will now be incorporated into other roles. This will likely mean that this work will complete with other priorities of already busy roles. Legal services have reduced capacity to provide support due to budget cuts and vacancies so any requests may take longer. Internal Audit Services have indicated that their capacity to complete all work required by MIJB may be an issue. This is being discussed with Moray Council. Recruitment for vacancies takes considerable time due to various factors and is presenting a strain on services to maintain normal service whilst covering vacancies. There have been several posts that have had to go out to advert more than once extending the time other staff are covering gaps.
Current performance:	No update.
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. Our requirements for support will be communicated via appropriate channels

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 29 JUNE 2023**

SUBJECT: **INTERNAL AUDIT ANNUAL REPORT – 2022/23**

BY: **CHIEF INTERNAL AUDITOR**

1. REASON FOR REPORT

1.1 This report provides the Audit, Performance and Risk Committee with details of internal audit work undertaken relative to the Moray Integration Joint Board (MIJB) for the financial year ended 31 March 2023, and the assurances available on which to base the internal audit opinion on the adequacy of the MIJB's systems of internal control.

2. RECOMMENDATION

2.1 The Audit, Performance and Risk Committee is asked to consider and note the contents of the annual report given as Appendix 1 to this report.

3. BACKGROUND

3.1 The purpose of this report is to present the Audit, Performance and Risk Committee with the Internal Audit Annual Report for the year to 31 March 2023 which includes the Chief Internal Auditor's independent assurance opinion on the adequacy of the MIJB's systems of internal control.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The Public Sector Internal Audit Standards (PSIAS) require that the Chief Audit Executive (CAE), the MIJB's Chief Internal Auditor, provide an annual internal audit opinion and report on the adequacy and effectiveness of the MIJB's systems of governance, risk management and internal controls to support the preparation of the Annual Governance Statement. This is in support of the overall governance arrangements of the MIJB.

4.2 The report covers the year to 31st March 2023 and is provided as **Appendix 1**.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Partners in Care 2022 – 2032"

Internal audit work supports good governance and assists in securing appropriate systems of internal control.

(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 and Mitigation

No implications directly arising from this report.

(e) Staffing Implications

No implications directly arising from this report.

(f) Property

No implications directly arising from this report.

(g) Equalities/ Socio Economic Impacts

No implications directly arising from this report.

(h) Climate Change and Biodiversity Impacts

No implications directly arising from this report.

(i) Directions

No implications directly arising from this report.

(j) Consultations

There have been no direct consultations during the preparation of this report.

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: Dafydd Lewis, Chief Internal Auditor
Background Papers: Internal Audit Files
Ref: mijb/ap&rc/29062023

APPENDIX 1

INTERNAL AUDIT

ANNUAL REPORT and OPINION

1 APRIL 2022 to 31 MARCH 2023

CONTENTS

SECTION 1 – INTRODUCTION

Purpose of this report

Public Sector Internal Audit Standards (PSIAS) requires that the Chief Internal Auditor provide a written statement to inform the Annual Governance Statement. This report constitutes the required statement. In compliance with PSIAS, this report presents the opinion on the overall adequacy and effectiveness of the Moray Integration Joint Board (MIJB) risk management, control and governance processes based on the work Internal Audit has performed. In addition, my evaluation will also include an assessment of reports issued by other review agencies. The scope of Internal Audit work, the responsibilities of Internal Audit and the assurance given on the adequacy and effectiveness of the Internal Control System of the MIJB are explained further in Section 4 of this report.

Responsibilities of Management and Internal Audit

It is management's responsibility to maintain systems of risk management, internal control and governance. Internal Audit is an element of the internal control framework established by management to examine, evaluate and report on accounting and other controls over operations. Internal Audit assists management in effectively discharging its responsibilities and functions by examining and evaluating controls. Internal Audit cannot be held responsible for internal control failures.

Internal Audit's role includes assessing the adequacy of the risk management, internal controls and governance arrangements put in place by management and performing testing on a sample of transactions to ensure those controls were operating for the period under review. The responsibility for providing the Internal Audit Service to the MIJB is by the Moray Council's Internal Audi Section. However, reliance is also obtained from the Internal Audit Service Provider for NHS Grampian to support the annual internal opinion on the MIJB's internal control environment.

Public Sector Internal Audit Standards (PSIAS) require officers of the Internal Audit Section to communicate on a timely basis all facts and matters that may have a bearing on their independence. I can confirm that all staff members involved in the 2022/23 internal audit reviews were independent of operational processes and their objectivity was not compromised in any way.

SECTION 2 –BASIS OF OPINION

My evaluation on the adequacy and effectiveness of the MIJB framework of governance, risk management and internal control is based on the following:

- The audit work undertaken by Internal Audit during the year to 31 March 2023.
- The governance statement signed by the Chief Officer of the MIJB for the year ended 31 March 2023.
- Reports issued by the MIJB's External Auditor, and other external review agencies.
- My knowledge of the MIJB's governance, risk management and performance monitoring arrangements.

Assurance is also based on the wider audit work conducted by the Chief Internal Auditor in his capacity as the Audit and Risk Manager of the Moray Council and from an annual internal audit report prepared for the Grampian Health Board providing an opinion on the adequacy and effectiveness of its system of internal control.

SECTION 3- SUMMARY AND LIMITATIONS OF WORK THAT SUPPORTS THE OPINION

Progress on the 2022/23 internal Audit Plan

Internal Audit operates independently within the organisation. While there have been challenges due to changes in working practices with officers working from home, management has imposed no limitations on the scope of audit work. The Annual Audit Plan presented to the Audit, Performance and Risk Committee describes in some detail the framework around which audit work is developed. In addition, the selection of audit topics was selected having regard to corporate planning documents, budget data and information drawn from the corporate risk register, and takes into account input from senior management regarding possible areas for audit.

The internal audit work has been conducted in accordance with an established methodology that promotes quality and conformance with the Public Sector Internal Audit Standards and the agreed Internal Audit Annual Audit Plan.

A summary of the audit projects completed from the MIJB Audit Plan is summarised as follows:

- An audit was undertaken to review that an appropriate system exists in the management, security and transfer of data between the Council and care providers, including NHS Grampian. This audit was highlighted for review from discussions held with the internal audit providers of NHS Grampian, Aberdeen City and Aberdeenshire Councils, where it was agreed to try and develop a more coordinated audit approach with the intention of providing a more comprehensive opinion on the control environment of systems within Health and Social Care.
- The audit noted several areas where further improvements are required to current operating systems and procedures. The data-sharing arrangements for patient/ service user information between the Council and NHS Grampian

were found to be based on a Memorandum of Understanding from 2011. It was agreed that a Data Sharing Agreement would be developed between the Council and NHS Grampian to reflect the updated Data Protection Legislation. A Data Protection Impact Assessment (DPIA) is an essential requirement of the UK General Data Protection Regulation (GDPR). However, at the time of the audit, only one DPIA had been completed regarding the data sharing arrangements with care providers.

- An audit review tested a sample of creditor payments generated under the direction of the Moray Integration Joint Board. Testing used a data analysis software application to extract a random sample of transactions for review. The purpose of the audit was to confirm that effective controls are operating to ensure all payments are appropriately authorised, accurate and paid in accordance with regulations and agreed terms and conditions. A check was also made for duplicate payments by extracting listings where more than one invoice from a single supplier has been paid for the same amount. Findings noted payments had been made to Care Providers before the services were delivered and a need for further improvements in the recording and processing of invoices.

- A review was undertaken into how information relating to social care service users is recorded, accessed and kept up to date. The Council uses a system known as CareFirst to record and manage social care cases for both adult and children's services. CareFirst is a long standing widely used application within the public sector for recording social care data. The scope of the audit was to undertake a review of how information is recorded and managed for Adult, Children and Families Services. The audit also reviewed access controls around the management of case files. This included consideration of who can view, add, amend or delete information.

- The review found that information concerning a service user care package is recorded on multiple databases, i.e., CareFirst, shared drive and paper files. It is pleasing to report that Health & Social Care Moray is developing a Strategic Plan- Partners In Care that includes the replacement of the CareFirst System. In addition, the audit found a need to strengthen access controls within CareFirst and for managers to restart reviews of service user case files to ensure officers comply with operating guidelines. However, it is appreciated over the last few years duties have been diverted to support pandemic related activities.

- An audit of the financial monitoring arrangements for Self-Directed Support (SDS) packages was undertaken as part of the coverage of Health & Social Care Moray activities. The scope of the audit was to review systems and procedures in the delivery and management of care provided under Options 2 and 3 of the SDS Scheme. This included examination of the processes to support individuals in their preferred care delivery option, contractual relationships with care providers, financial management and monitoring of individual care packages. Annual expenditure for individuals in receipt of SDS Option 2 and & 3 care packages amounted to approximately £40 million and £17 million respectively for external and internal care providers.

- The review found a number of findings where further improvements are required in systems and procedures. It was noted that where care is delivered through SDS Option 2, a tripartite agreement should be agreed to detail the care provided, signed by the provider, Council, and the supported person. However, from the testing undertaken, it was found that most service users had no tripartite agreement to formalise their care arrangements. The audit also noted a large percentage of service users support plans tested had not been reviewed for over a year. The requirement for an annual review is detailed within the Social Care (Self-directed Support) (Scotland) Act 2013.

In addition, difficulty was also experienced in verifying current and changes in service user support plans to supporting documentation. The demands on the service are appreciated, but the findings noted from this review are of concern.

- Internal Audit reports are regularly presented to members detailing not only findings but also the responses by management to the recommendations with agreed dates of implementation. During the year, it was decided that Internal Audit would also report to the Audit, Performance and Risk Committee follow up reviews to evidence the effective implementation of these recommendations. Follow up reviews were completed of the audits previously undertaken of Self Directed Support direct payments made to service users and how Health and Social Care Officers manage income held for individuals under Corporate Appointeeship Arrangements. Unfortunately, it was found that a number of the recommendations are still to be implemented, requiring revised dates of implementation to be agreed. The Service has detailed that staff shortages have resulted in delays in implementing some of these recommendations.

Governance - from a review of the annual governance statement prepared for inclusion with the MIJB accounts; it was noted that the statement had been prepared in line with good practice guidance issued by CIPFA / SOLACE. The statement included an assessment of the effectiveness of governance arrangements within the MIJB regarding the seven principles of good governance identified within the guidance. It also referenced the governance processes of the principal partner bodies (NHS Grampian and Moray Council) as sources of additional assurance.

A review of the Moray Council's Chief Social Work Officer's annual report noted several governance arrangements to ensure effective service delivery. The quality of social work services is assured by Practice Governance meetings. Any issues are reported to the Clinical & Care Governance Committee of the MIJB for adults. Consultant Social Work Practitioner posts are well established in adult and children services. Consultants work with line managers to support social work in complex cases, model best practices and set practice standards in their respective area.

It was noted that the Head of Service / Chief Social Work Officer reported an audit review of Adult Social Care Commissioning Service undertaken by KPMG Governance, Risk & Compliance Services to the Audit, Performance and Risk Committee (item 11) of the Moray Integration Joint Board (MIJB) on 30 March 2023. This audit was requested by the Audit, Performance and Risk Committee of the MIJB on 31 March 2022. The need for the review was highlighted due to concerns raised by senior management of Health & Social Care Moray regarding administrative arrangements within the Commissioning Service, and the findings from a peer review report in January 2022.

The audit report by KPMG has detailed 11 key findings relating to governance, roles and responsibilities, strategy/processes and contract management. It is pleasing to note that all recommendations have been accepted. However, the Head of Service/ Chief Social Work Officer detailed within the report to the Audit, Performance and Risk Committee of the MIJB on 30 March 2023 (Item 11) the risks to achieving the set timescales for implementation of the recommendations due to staffing implications and related restructuring that has taken place following the external review. The Head of Service/ Chief Social Work Officer confirmed that a review would be undertaken regarding capacity issues and how that risk can be mitigated using interim support. In addition, the Head of Service / Chief Social Work Officer has also made a commitment that progress on implementation of the actions will be reported back to the Audit, Performance and Risk Committee of the MIJB on a quarterly basis.

As the Chief Internal Auditor of the MIJB, I note the findings detailed within the audit report. I will be closely monitoring progress and undertaking a follow up review once the implementation dates for the recommendations have passed.

Risk Management - procedures are well developed with a risk management policy and strategy in place, a risk appetite statement has been prepared, and a risk register has been reviewed and updated regularly. The recently updated Risk Register summarises the principal risks facing the organisation under nine themes; these themes focus on critical risk areas including finance, environment and operational continuity, together with transformation risks associated with change and infrastructure risks given the reliance of the IJB on support from both the Council and the NHS.

Statement on Conformance with the Public Sector Internal Audit Standards

The Local Authority Accounts (Scotland) Regulations 2014 require public bodies to operate a professional and objective internal auditing service in accordance with recognised standards and practices in relation to internal auditing, the Public Sector Internal Audit Standards.

The Scottish Local Authorities Chief Internal Auditors' Group, comprising the audit managers or equivalent of all Scottish Councils, has developed a checklist for assessing compliance with the Standards. This supports the requirement for self-assessments and external assessments as part of Internal Audit's Quality Assurance and Improvement Programme. Internal performance monitoring against PSIAS has been ongoing over the last few years. However, a more structured internal review has recently been completed in preparation for the next External Quality Assessment.

SECTION 4 – OPINION

Any system of control can only ever provide reasonable and not absolute assurances that control weaknesses or irregularities do not exist or that there is no risk of error, fraud, or breaches of laws or regulations. Furthermore, it is the responsibility of management to establish an appropriate and sound system of internal control and monitor the effectiveness of that system. The Chief Internal Auditor is responsible for providing an annual assessment of the robustness of the internal control system. (Assurance was obtained in the interim form at the time of drafting this report from the Internal Audit Provider of Grampian NHS).

After consideration of the findings from work carried out by Internal Audit, taken together with other sources of assurance, with specific reference to the external assessment undertaken by a private firm into how the Commissioning Service manages adult social care contracts; it is my opinion that I can only provide limited assurance that the Moray Integration Joint Board has adequate systems of governance and internal control

Dafydd Lewis
Chief Internal Auditor
13 May 2023

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 29 JUNE 2023**

SUBJECT: **RESILIENCE IN CARE AT HOME (MAY 2023)**

BY: **PROVIDER SERVICES MANAGER**

1. REASON FOR REPORT

1.1. To update the Audit, Performance and Risk Committee on work being done in Care at Home to address the Unmet Need in Moray.

2. RECOMMENDATION

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

i) the actions being taken in Care at Home to address the unmet need in Moray; and

ii) the increasing demand on the Care at Home Service.

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. Weekly monitoring of the unmet need in Care at Home has been in place since August 2021.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

Assessments

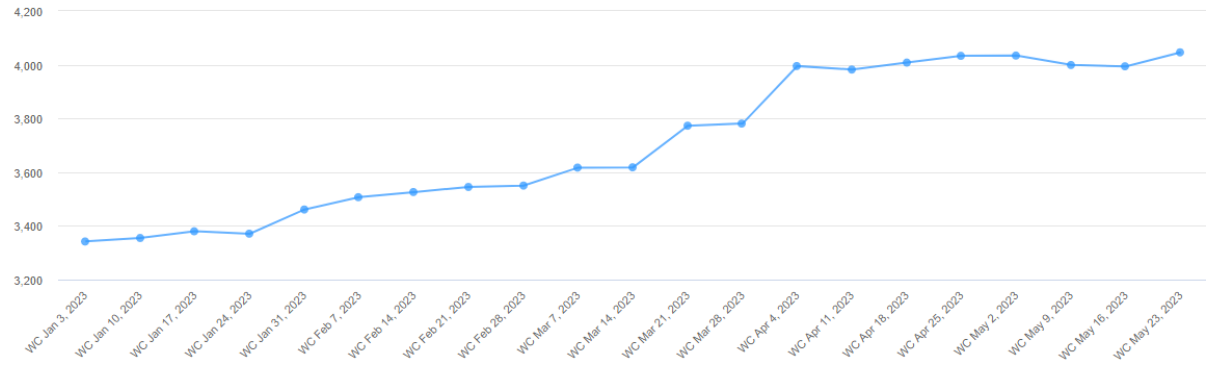
4.1. Since January 2023 the number of individuals awaiting a social care assessment has been decreasing steadily from 188. In the week commencing 17 May 2023 this decreased to 58. This is a 69% decrease since January 2023.

Figure 1

Care at Home Hours

4.2. Since January 2023 the number of weekly hours of Care at Home provided by Moray Council has increased from 3342 hours to 4046 hours. This is an increase of 21%.

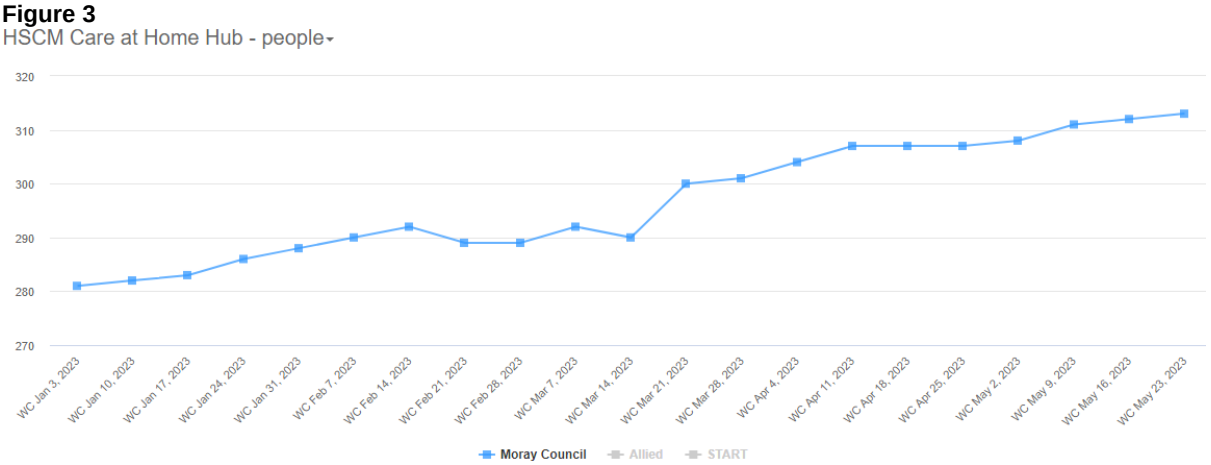
Figure 2



Care at Home People

Since January 2023 the number of people receiving a Care at Home package provided by Moray Council has increased from 281 to 313. This is an increase of 11.4%.

Figure 3



Waiting for Care

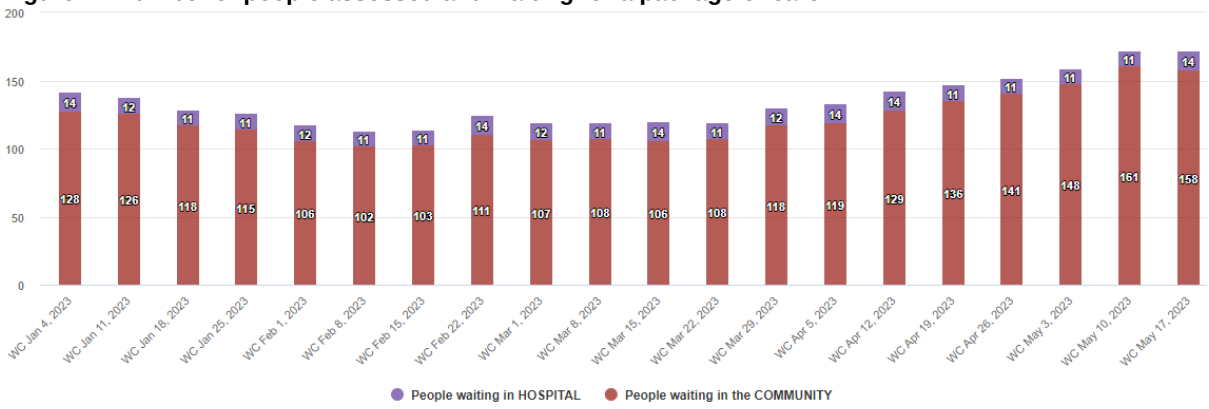
4.3. The increasing number of assessments being completed has led to an increase in the number of people who have been waiting a package of care as shown in the table below. This has shown that those waiting in the Community are

increasing rapidly, with an increase of 23.4% in the number of people waiting for a care package between January and May 2023.

Table 1

Number of people assessed and waiting for a package of care	W/c 02/01/2023	w/c 22/05/2023	% change from Jan-23 to May-23
In the Hospital	14	14	-
In the Community	128	158	+23.4%

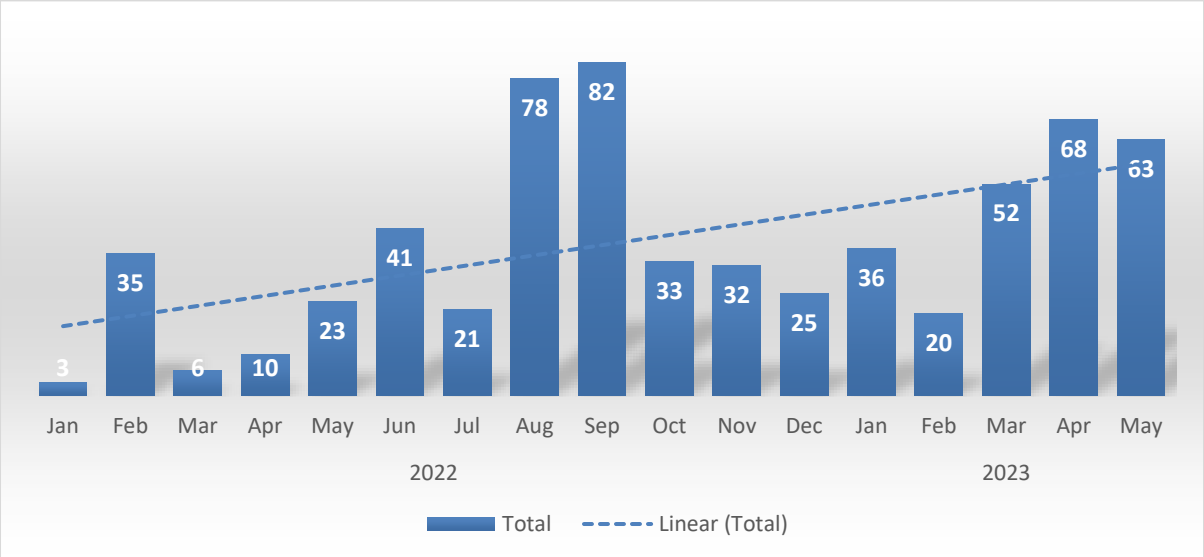
Figure 4 - Number of people assessed and waiting for a package of care



Care at Home Enablers

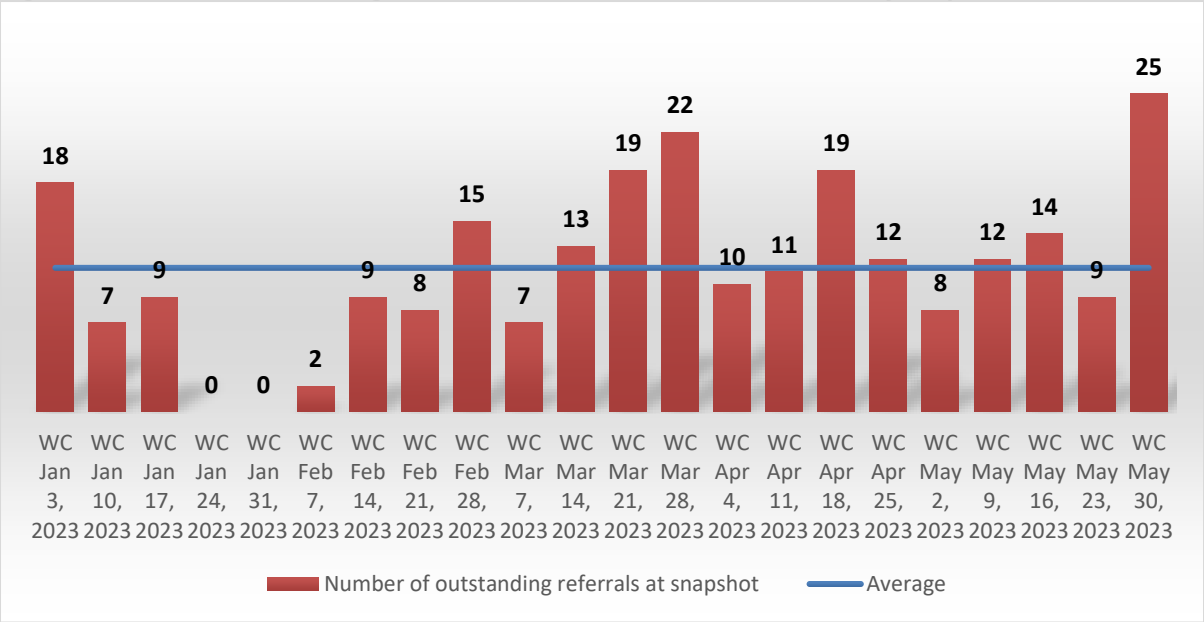
4.4. Care at Home Enablers carry out Care at Home assessments to determine if care is required. Since January 2023 the number of assessments completed by the Care at Home Enablers is 239, compared to 77 completed in the same period in 2022 (Jan-May). This is an increase of 210%

Figure 5 – Care at Home assessments completed by month



4.5. The chart below shows the number of outstanding referrals taken at the weekly snapshot time each week since January 2023. The average is 11, but has been as low as 0 and as high as 25. Staffing levels will affect the number of referrals that can be allocated on a weekly basis and also the caseload of each Enabler at any point in time.

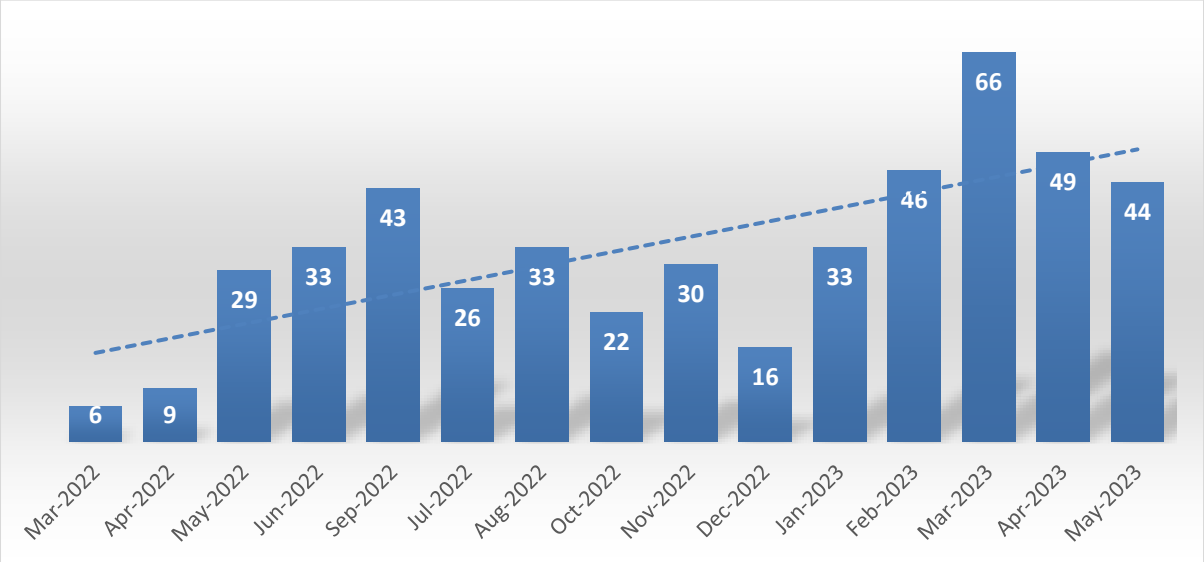
Figure 6 – Number of outstanding referrals to Care at Home Enablers at weekly snapshot



4.6. Since March 2022 there have been 496 referrals received for a Care at Home Assessment.

4.7. The chart below shows the number of referrals for assessment received each month since April 2022. The average is 33 per month, this has been as low as 9 and as high as 66 (March 2023). This is showing an increasing trend and is expected to remain high following the start of the Test of Change in the Access and Area Teams.

Figure 7 – Number of referrals to Care at Home Enablers by month

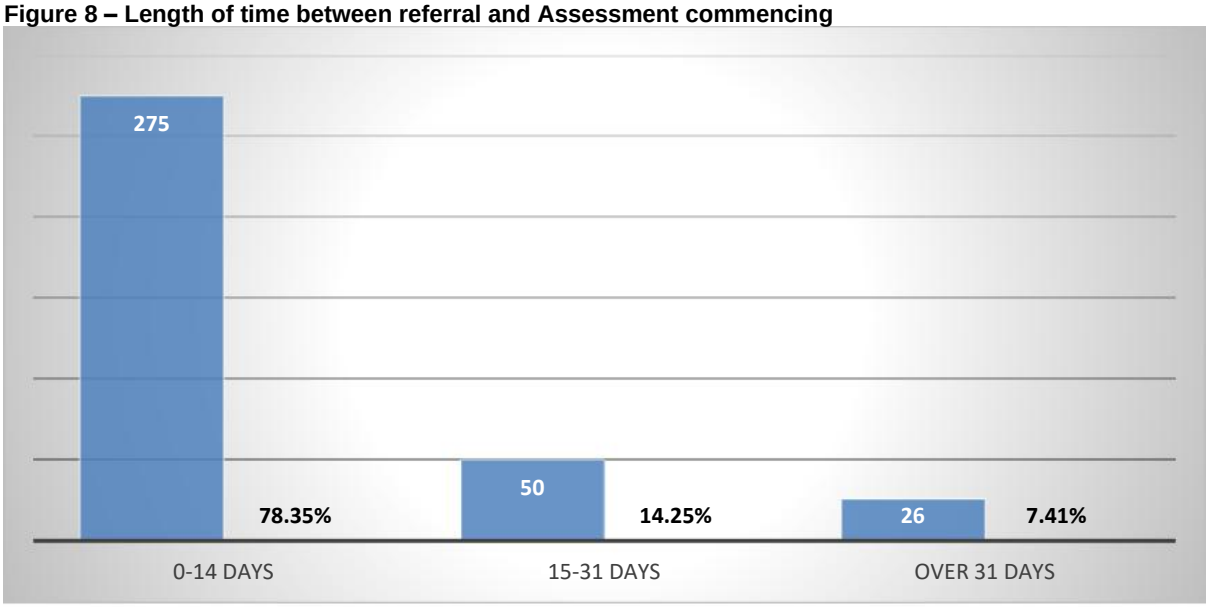


Assessment times

4.8. From the 496 referrals, 122 did not require or did not receive an assessment. This can be for a number of reasons for example, inappropriate referrals, crisis has ceased, care has been sourced elsewhere, person has decided to move to long term care. The remaining 60 assessments are ongoing. This leaves 382 assessments that have been completed.

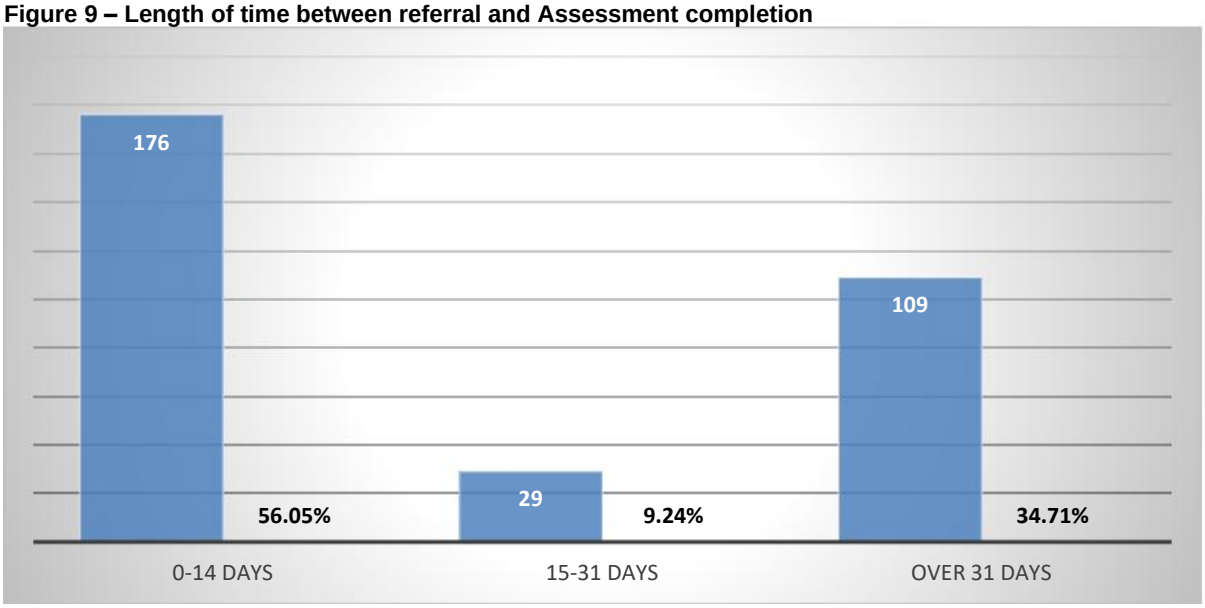
4.9. The Chart below shows the number of days people have waited for an assessment to commence following a referral.

Figure 8 – Length of time between referral and Assessment commencing



4.10. The Chart below shows the number of days people have waited for an assessment to be completed (from point of referral).

Figure 9 – Length of time between referral and Assessment completion



4.11. There are various reasons why assessments are taking longer than expected. One reason is that until recently light touch assessments were being carried out in hospital causing delays when the person was not deemed medically fit for assessment but referral had already been received by the team. The person could also be waiting for other assessments to take place before the Care at Home assessment to take place. The assessors could also have to wait for family or other guardians to be available to attend assessment in the persons home, rather than an over the phone assessment, and this can take some time. Finally the team may have trouble locating the person if their circumstances have changed since the referral was passed over.

Test of Change

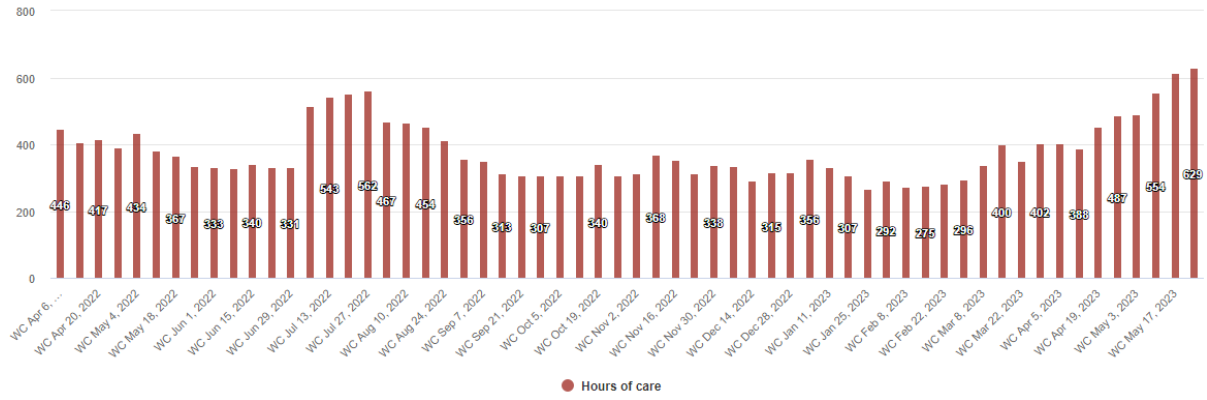
4.12. There is a Test of change in progress in the Area Social Work Teams in conjunction with the Access Team, allowing the East and West teams to take on long term pieces of work (e.g. assessments leading to care) which allows the Access Team to concentrate on the other (short term) pieces or work. This has moved the 'bottleneck' of the waiting lists for assessment along the process to those now awaiting care, and more specifically, those waiting for increases to their care package.

Brokerage List

4.13. Partial Care packages – The chart below shows the trend for those already in receipt of care, but not the full amount they have been assessed (or reassessed for).

Figure 10

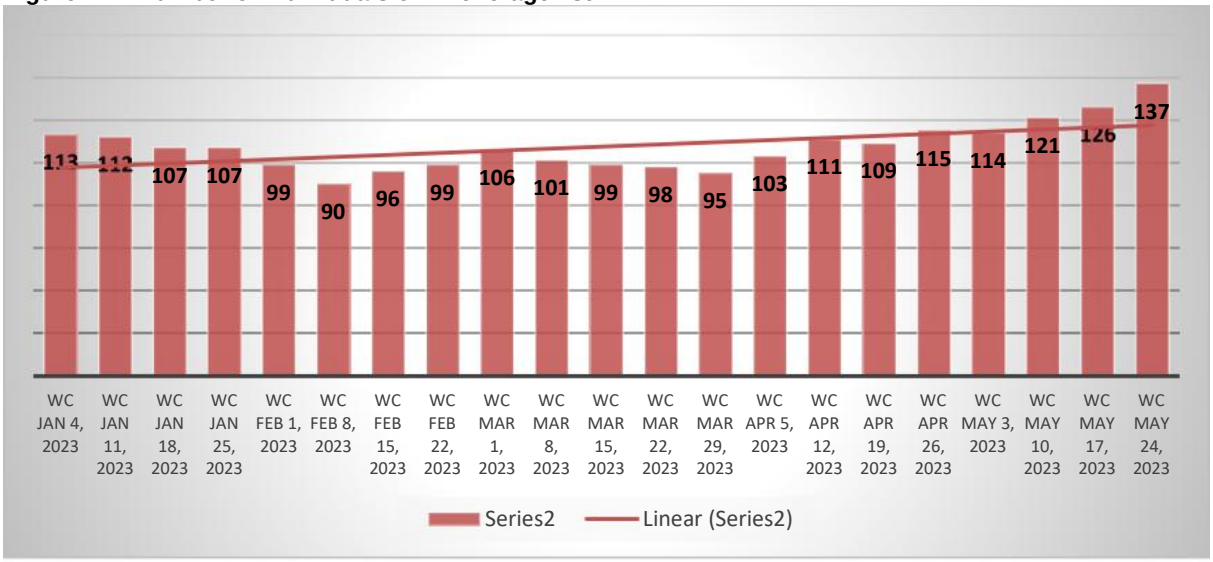
HSCM Unmet Needs - Number of hours of care assessed as needed and not provided for those in receipt of a care package



4.14 The number of hours of care assessed as needed and not provided for those in receipt of a care package is currently **629 hours**, the highest since recording of these figures commenced.
The number of weekly hours of care people are waiting for range from **15 minutes to 49 hours**.
The average number of care hours people are waiting for is **8 hours 30 minutes**.
There are 7 people who have been on the brokerage list for over **300** days.
32 people have been waiting longer than 2 months.
START, Moray Council and one external partner provide the majority **(64.6%**) of these partial package in terms of outstanding hours (**388 hours**). The remainder are provided by other external providers, Direct Payments, or NHS Teams.

4.15 The average number of people on the list is **107**. The lowest number was captured on week commencing February 13 2023, this was **90 people**.
The highest number was recorded this week at **137**.
If added to this list people in the community awaiting care from the START Team this number increases to **179**.

Figure 11 – Number of individuals on Brokerage list

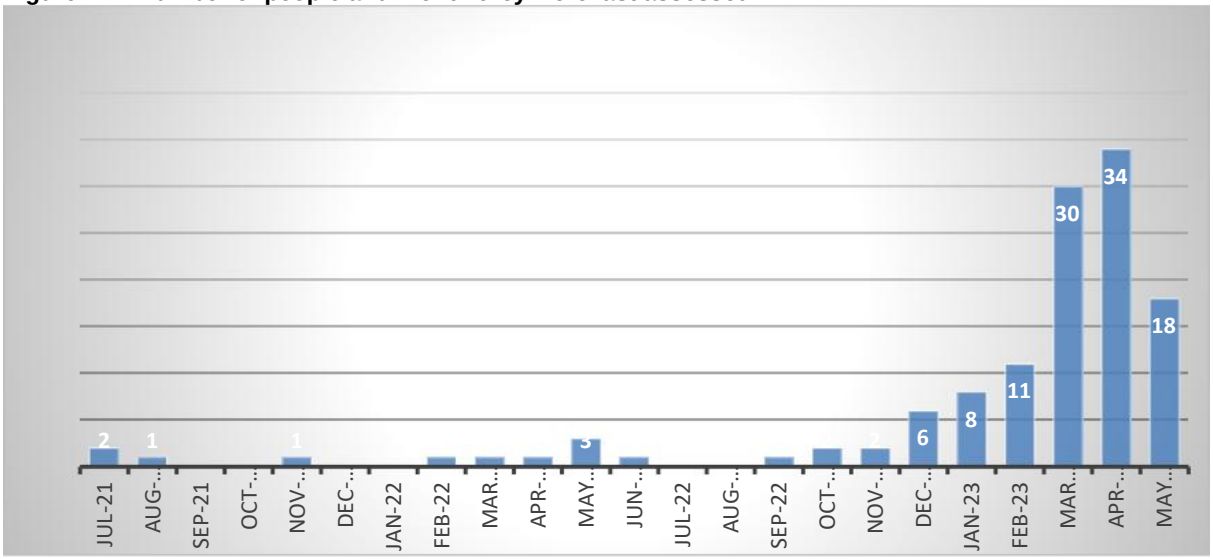


4.16 The effect of having an increased amount of assessments completed is that people may face a wait whilst care is sourced. The Broker has advised that they have seen an influx of care requests recently which has been exacerbated by our external partners having no capacity to take any care on.

4.17 The chart below shows the months the people on the Brokerage list were last assessed/reassessed.

- 82.11% have been assessed or reassessed since January 2023 (101 people)
- 17.89% have not been assessed in 2023 (22 people)

Figure 12 – Number of people and month they were last assessed



5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Partners in Care 2022 – 2032"

The aims of the Care at Home service align to those set out in the MIJB Strategic Plan and the Moray 10 Year Local Outcomes Improvement Plan.

(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.

(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 because there will be no impact, as a result of the report, on people with protected characteristics.

(h) Climate Change and Biodiversity Impacts
No climate change or biodiversity implications have been determined for this policy/activity. It should be noted that extreme weather events, such as the recent storms, are expected to occur more frequently and with greater ferocity in future years. In the longer-term there are likely to be issues with the reduction in availability and increases in costs of fossil fuels that will pose challenges for the delivery of care services to people living in rural areas.

(i) Directions
There are no directions arising from this report.

(j) Consultations
For Health and Social Care Moray the Chief Officer, Corporate Officer and Provider Service Manager have been consulted as has Joan Hall, Team Manager, Care at Home and Democratic Services Manager Moray Council and their comments are incorporated in the report.

6. CONCLUSION

6.1 This report outlines for the Committee the increasing demand for the Care at Home Service across Moray. It also provides the Committee with an overview of the actions being taken in Care at Home to address the unmet need in the area.

Author of Report: Aylsa Kennedy, Performance Officer
Background Papers: Available on request
Ref:

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 29 JUNE 2023**

SUBJECT: **DIRECTIONS UPDATE**

BY: **CHIEF FINANCIAL OFFICER**

1. REASON FOR REPORT

1.1. To inform the Board of the issues Directions of the Moray Integration Joint Board (MIJB) for the period 1 October to 31 March 2023.

2. RECOMMENDATION

2.1. It is recommended that the Audit Performance and Risk Committee consider and note the Directions issued in the period October to March of 2022/23.

3. BACKGROUND

3.1 The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) established the legal framework for integrating health and social care in Scotland. The Act required Integration Authorities to develop a Strategic Plan for the integrated functions and budgets delegated by the health board and local authority.

3.2 In accordance with Sections 26-28 of the Act, MIJB has in place a mechanism to action its Strategic Plan which takes the form of binding Directions to one or both of the Partners. Directions are the means by which the MIJB informs NHS Grampian and Moray Council of what is to be delivered using the integrated budget in order to achieve the strategic aims outlined in its Strategic Plan. A Direction must be issued in respect of every function that has been delegated to the MIJB. Directions are an obligatory legal mechanism.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 At the MIJB meeting on 31 March 2022, the Directions policy and procedures were approved (para 17 of the minute refers). This was to enhance governance, transparency and accountability between the MIJB and its Partner organisations, NHS Grampian and Moray Council through a clear framework for the setting and reviewing of Directions and to confirm adequate governance arrangements.

4.2 As part of the approved procedures, The Audit, Performance and Risk Committee are to review all live Directions on a six monthly basis for assurance of delivery and compliance through an update report. With any resulting concerns being escalated to the MIJB at the first available opportunity. The first report on the first six months for 2022/23 was noted by this Committee on 24 November 2022 (para 8 of the minute refers)

4.3 **APPENDIX 1** details the Directions approved during the period 1 October to 31 March 2023, for consideration.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Partners in Care 2022 – 2032"
This report is consistent with the objectives of the Strategic Plan and includes Directions detailed to the partners of the MIJB.

(b) Policy and Legal
The MIJB is, in terms of Section 26 to 28 of the Public Bodies (Joint Working) (Scotland) Act 2014 required to direct NHS Grampian and Moray Council to deliver services to support the delivery of the Strategic Plan is as far as the functions that have been formally delegated.

(c) Financial implications
None arising directly from this report.

(d) Risk Implications and Mitigation
The delivery of the Strategic Plan is put at risk should appropriate Directions not be issued. The quality of the Directions are also a factor in ensuring implementation as intended. Close monitoring of Directions and scrutiny by Committee provides reasonable assurance that Directions are being carried out as intended.

(e) Staffing Implications
None arising directly from this report.

(f) Property
None arising directly from this report.

(g) Equalities/Socio Economic Impact
None arising directly from this report.

(h) Climate Change and Biodiversity Impacts
None arising directly from this report.

(i) Directions
None arising directly from this report.

(j) Consultations
The Chief Officer and Corporate Manager of the MIJB have been consulted for comment where appropriate.

6. CONCLUSION

6.1 The Audit, Performance and Risk Committee are asked to consider and note the report content and Directions included in APPENDIX 1.

Author of Report: Deborah O'Shea, Interim Chief Financial Officer
Background Papers: with author
Ref:

Issue to	Agreed by IJB on	Effective from	Title of Direction and Reference	Functions covered by Direction	Link to direction
GHB	24 Nov 2022	01 April 2022	MIJB Updated Budget Position 2022/23 Ref: 20220401GHB03	All functions listed in Annex 1, Part 1 of the Moray Health and Social Care Integration Scheme and all functions listed in Annex 2, Part 1 of the Moray Health and Social Care Integration Scheme.	SPMAN-1236605834-1518
MC	24 Nov 2022	01 April 2022	MIJB Updated Budget Position 2022/23 Ref: 20220401MC03	All functions listed in Annex 1, Part 1 of the Moray Health and Social Care Integration Scheme and all functions listed in Annex 2, Part 1 of the Moray Health and Social Care Integration Scheme.	SPMAN-1236605834-1519
MC	30 Mar 2023	01 April 2022	MIJB Updated Budget Position 2022/23 Ref: 20230330MC04	All functions listed in Annex 1, Part 1 of the Moray Health and Social Care Integration Scheme and all functions listed in Annex 2, Part 1 of the Moray Health and Social Care Integration Scheme.	SPMAN-1236605834-1624
GHB	30 Mar 2023	01 April 2022	MIJB Updated Budget Position 2022/23 Ref: 20230330GHB04	All functions listed in Annex 1, Part 1 of the Moray Health and Social Care Integration Scheme and all functions listed in Annex 2, Part 1 of the Moray Health and Social Care Integration Scheme.	SPMAN-1236605834-1622

Issue to	Agreed by IJB on	Effective from	Title of Direction and Reference	Functions covered by Direction	Link to direction
MC	30 Mar 2023	01 April 2023	MIJB Updated Budget Position Ref: 20230330MC05	All functions listed in Annex 1, Part 1 of the Moray Health and Social Care Integration Scheme and all functions listed in Annex 2, Part 1 of the Moray Health and Social Care Integration Scheme.	SPMAN-1236605834-1625
GHB	30 Mar 2023	01 April 2023	MIJB Updated Budget Position Ref: 20230330GHB05	All functions listed in Annex 1, Part 1 of the Moray Health and Social Care Integration Scheme and all functions listed in Annex 2, Part 1 of the Moray Health and Social Care Integration Scheme.	SPMAN-1236605834-1623

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 29 JUNE 2023**

SUBJECT: **IMPROVEMENT PLAN FOR ADULT SOCIAL CARE COMMISSIONING**

BY: **HEAD OF SERVICE / CHIEF SOCIAL WORK OFFICER**

1. REASON FOR REPORT

1.1. To inform the Committee of progress regarding the improvement plan for Adult Social Care Commissioning in line with the external review conducted by KPMG, finalised in February 2023

2. RECOMMENDATION

2.1. It is recommended that the Committee:

i) consider and note the improvement plan attached at Appendix 1; and

ii) approve the contents of the plan.

3. BACKGROUND

3.1. The KPMG report was submitted to Committee on 30 March 2023 (para 11 of the minute refers). It was agreed at the Committee that progress will be reported quarterly.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. The Adult Services Commissioning Team have implemented an improvement plan with clear aims, objectives and target dates.

4.2. Clear roles and responsibilities in relation to the oversight and management of social care commissioning activities needs to be addressed through the governance structures defined within the MIJB. Contracting work is reported to the Managers Commissioning Meeting and then escalated if required. A review of the Practice Governance Board is currently underway. The Managers Commissioning Meeting will be aligned with this agreed process.

4.3. The partnership working between departments in Commissioning, Procurement and Finance is achieved through regular meetings to align the recording of contracts, budgets and auditing. This is structured with the Procurement service holding a Contract Register and the reviewed Departmental Contracts Database is held within the Commissioning team.

4.4. In the wider context of colleague's knowledge regarding commissioning within Health and Social Care Moray, the Commissioning team compiled a training programme regarding the remit of the commissioning team, the principles of Ethical Commissioning and the future direction of the commissioning function. Training events will be scheduled later in 2023.

4.5. An end to end Commissioning Procedure has been written that incorporates the commissioning and decommissioning process. A Contract Record Document has been created which requires sign off by Senior Management within Health and Social Care Moray.

4.6. The Commissioning team have prioritised the work plan for 2023 and 2024 to include reviewing and renewing out of date contracts. A plan requires to be created to address the rest of the contracts whilst ensuring future expiring contracts remain relevant and to standard. This is monitored within the team via a weekly team meeting.

4.7. Community Care Finance has systems in place to ensure every invoice is recorded and approved. Moray Council Payments Team have a check in place to confirm all invoices have appropriate approval. This process meets the process detailed in the Invoice Processing Standard Operating Procedure.

4.8. An audit trail process was created and trialled within the commissioning team. Commissioning Change of Service forms were produced. A cover sheet for contract letters was produced, which requires the signatures of all involved in the process, ensuring a robust audit trail.

4.9. The decision making process has a robust audit trail. The decision making in relation to an invoice query resolution is stored within the Community Care Finance team.

4.10. Commissioning and procurement liaised to align the contract data base and the procurement data base. Senior Commissioning Officers will monitor, review and update the database quarterly. The service manager will do spot checks.

4.11. A performance management system is tied in with the audit process.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Partners in Care 2022 – 2032"

In order to fulfil the MIJB strategic aims, it is essential that services are operating with optimum efficiency to ensure the needs of the Moray population can be met, that services are fit for purpose and that processes and accountability is clear.

(b) Policy and Legal

The CSWO/Head of Service must ensure that services delegated by her work within the legal and policy framework related to commissioning and delivery of services.

(c) Financial implications

There are no financial implications arising from this report.

(d) Risk Implications and Mitigation

There is a risk that timescales and outcomes may not be reached due to the current resource and restructure of the team, although, efforts will be made to minimise this risk.

(e) Staffing Implications

There are no staffing implications.

(f) Property

There are no property implications

(g) Equalities/Socio Economic Impact

This report does not require an EIA.

(h) Climate Change and Biodiversity Impacts

None

(i) Directions

None

(j) Consultations

Dafydd Lewis, Senior Auditor
Lorraine Paisey. Chief Financial Officer
Simon Bokor-Ingram, Chief Officer

6. CONCLUSION

6.1 The committee is requested to note the progress plan at APPENDIX 1.

Author of Report: Lizette Van Zyl
Background Papers:
Ref:

Moray Integration Joint Board

Commissioning Service

KPMG Recommendations **APPENDIX 1**

Risk Ratings for Recommendations						
High		Medium			Low	
No.	**Audit Recommendation**	**Priority**	**Accepted (Yes/ No)**	**Progress Update as at 09 MAY 23**	**Responsible Officer**	**Timescale for Implementation**
1. Governance - The Moray Integration Joint Board should prioritise having senior oversight to close the gap between the organisation and those charged with governance, as there is currently an insufficient grip on governance						
2.1.1	Clear roles and responsibilities in relation to the management and oversight of social care commissioning activities need to be representative thought governance.	High	Yes	Action plan created for Management Commissioning meeting and date set to write the Terms of Reference.	Service Manager	31 Aug 23
2.1.2	Attendance and expectance of attendees at governance meetings needs to be clarified	High	Yes	Head of Service has supported this process and clarity provided around meeting attendance	Service manager	29 Feb 24
2.1.3	Prioritise the production of action plans for each Managers Commissioning meeting.	High	Yes	Monthly meetings are scheduled and an action plan template and action log has been created.	Service Manager	31 May 23

Team Structure & Roles

Risk Ratings for Recommendations						
High		Medium			Low	
No.	**Audit Recommendation**	**Priority**	**Accepted (Yes/ No)**	**Progress Update as at 09MAY23**	**Responsible Officer**	**Timescale for Implementation**
2. Roles & Responsibilities – There is a lack of clarity and roles and responsibilities and poor cross organisational relationships						
2.2.1	Every member of staff within the commissioning team should have a clear job description	High	Yes	Job descriptions are accurate for the commissioning team and staff know where to find the documents for future reference.	Service Manager	31 May 23
2.2.2	There is a need for collaboration across the various Council teams to produce shared learning and increased efficiency.	High	Yes	The senior commissioning officer and payment manager are meeting to review the commissioning and procurement interaction. There has been an initial meeting with the chief finance officer to discuss better audit trails.	Service Manager	31 Aug 23

				Senior Commissioning Officer has been working on a presentation of the remit of the commissioning team and future direction of the commissioning function.		
2.2.3	Performance management of commissioning required to be monitored and tasks completed timelessly	High	Yes	The commissioning team meet every week and discuss workload this is monitored with the work tracker Contract and monitoring plans for the year are in progress.	Service Manager	29 Feb 24

Training

Risk Ratings for Recommendations						
High		Medium			Low	
No.	**Audit Recommendation**	**Priority**	**Accepted (Yes/ No)**	**Progress Update as at 09MAY23**	**Responsible Officer**	**Timescale for Implementation**
3. Training						

2.3.1	Implement a clearly defined staff training plan. Guidance documents needs to be available for staff to refer to.	Medium	Yes	All commissioning staff members are trained in core and service specific training. A training plan is in the process of being created.	Service Manager	31 Aug 23

Process Maps

Risk Ratings for Recommendations						
High		Medium			Low	
No.	**Audit Recommendation**	**Priority**	**Accepted (Yes/ No)**	**Progress Update as at 09MAY23**	**Responsible Officer**	**Timescale for Implementation**
4. Process Maps						
2.4.1	A commissioning procedure needs to be created.	High	Yes	A procedure has been created and is awaiting staff consultation. A Contract Record Document has been created which captures all activity within the commissioning cycle.	Service Manager	31 Aug 23

2.4.2	Commissioning staff will attend a session with management to discuss the commissioning procedure. A library of process maps is to be maintained and made available to staff for future reference.	High	Yes	A meeting has taken place between managers and staff. Work has begun to look at the process maps	Service Manager	31 Aug 23
2.4.3	Alignment with SDS financial regulations needs to take plane			SDS option 2 are approved and signed off by the budget manager	Service Managers	31 Aug 23

Sample Testing

Risk Ratings for Recommendations					
High		Medium		Low	

No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Progress Update as at 09MAY23	Responsible Officer	Timescale for Implementation
5. Sample Testing						
2.5.1	All contracts will be signed and copies of these singed contracts stored for future reference.	High	Yes	All of the new contracts are signed and stored for future reference	Service Manager	28 Feb 25
2.5.2	Community care finance to ensure approved expenditure can easily be tied back to the underlying invoice.	High	Yes	Invoices are matched against Service Agreements within the Carefirst system, ensuring approved expenditure matches provider invoice. This is detailed within the Invoice Processing Standard Operating Procedure (SOP).	Service Manager	28 Feb 25
2.5.3	Community care finance will ensure that Invoices are not processed without adequate approval. Implement Moray IJB Financial Regulations.	High	Yes	Invoices are recorded and approved by managers. Moray Council Payments Team have a further check in place to ensure all invoices have appropriate approval. This is detailed within the Invoice Processing Standard Operating Procedure (SOP).	Service Manager	28 Feb 25

2.5.4	Audits of documentation: Ensures that processes are consistently being followed across the organisation and fiscal responsibilities are being met.	High	Yes	Audit trail process created. Commissioning change of service and authorisation audit forms were created. Comments complaint and incidents form and contract monitoring forms were reviewed. Community Care Finance (CCF) participated in an internal audit of invoicing in 2022 and all recommendations have been met. It is anticipated a further follow up review will take place during 2023.	Service Manager	28 Feb 25

. Strategy

Risk Ratings for Recommendations					
High		Medium		Low	

No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Progress Update as at 09MAY23	Responsible Officer	Timescale for Implementation
6. Strategy						
2.6.1	Develop an implementation plan which supports the wider strategy.	Medium	Yes	The coming months will see all services contribute to the Moray HSCP Strategy by way of a delivery plan	Head of Service	29 Feb 24

Invoicing

Risk Ratings for Recommendations						
High		Medium			Low	
No.	**Audit Recommendation**	**Priority**	**Accepted (Yes/ No)**	**Progress Update as at 09MAY23**	**Responsible Officer**	**Timescale for Implementation**
7. Invoicing						
2.7.1	Formalise and document the approach to variances	Medium	Yes	The Community Care Finance (CCF) team have developed a Standard Operating Procedure (SOP) (February 2023) for the invoicing process.	Head of Service	29 Feb 24

2.7.2	To ensure the decision making process is more robust and that the process is evidenced based with a adequate audit trail.	Medium	Yes	Work is ongoing to achieve this target, governance is being considered across the whole system.	Head of Service	29 Feb 24

Contracts Register

Risk Ratings for Recommendations						
High		Medium			Low	
No.	**Audit Recommendation**	**Priority**	**Accepted (Yes/ No)**	**Progress Update as at 09MAY23**	**Responsible Officer**	**Timescale for Implementation**
8. Contracts Register						
2.8.1	To develop an expenditure contracts database.	High	Yes	Liaison work is continuing with procurement to align the contract data base and the procurement data base.	Service Manager	31 Aug 24
2.8.2	The database should be monitored, reviewed and routinely updated.	High	Yes	The Contract database is a protected document. Senior Commissioning Officers carries out 3 monthly checks for accuracy,	Service Managers	31 Aug 24

				Commissioning Departmental database is reviewed and redesigned and is in operation. Service Manager to do spot check on regular basis.		
2.8.3	Contract database will be shared and made available to all staff involved in the commissioning process.			Meetings are set up to share the database with the team.	Service Manager	31 Aug 24

Performance Management System

Risk Ratings for Recommendations						
High		Medium			Low	
No.	**Audit Recommendation**	**Priority**	**Accepted (Yes/ No)**	**Progress Update as at 09MAY23**	**Responsible Officer**	**Timescale for Implementation**
9. Performance Management System (PMP)						

2.9.1	To have a performance management system in place.	High	Yes	A performance management system will be tied in with the audit process.	Service Manager	29 Feb 24

Contract Review

Risk Ratings for Recommendations						
High		Medium			Low	
No.	**Audit Recommendation**	**Priority**	**Accepted (Yes/ No)**	**Progress Update as at 09MAY23**	**Responsible Officer**	**Timescale for Implementation**
10. Contract Review						
2.10.1	Implement a regular contract review procedure that assesses the suitability of providers.	Medium	Yes	Contract Management & Review process in use.	Service Manager	31 Aug 23

Block Contracts

Risk Ratings for Recommendations						
High		Medium			Low	
No.	**Audit Recommendation**	**Priority**	**Accepted (Yes/ No)**	**Progress Update as at 09MAY23**	**Responsible Officer**	**Timescale for Implementation**

11. Block Contracts						
2.11.1	Block contracts are appropriately monitored to ensure that best value is obtained	Low	Yes	Contracts are monitored in line with Contract Review Monitoring process. The process is to be reviewed.	Service Manager	31 Aug 23