MORAY INTEGRATION JOINT BOARD

AUDIT, PERFORMANCE AND RISK COMMITTEE

Thursday, 28 March 2019

Inkwell Main, Elgin Youth Café

NOTICE IS HEREBY GIVEN that a Meeting of the **Moray Integration Joint Board Audit, Performance and Risk Committee** is to be held in **Inkwell Main, Elgin Youth Café**, **Francis Place, Elgin, IV30 1LQ** on **Thursday, 28 March 2019** at **13:00** to consider the business noted below.

AGENDA

MORAY INTEGRATION JOINT BOARD

AUDIT, PERFORMANCE AND RISK COMMITTEE

MEMBERSHIP

Mrs Susan Webb (Chair)	Executive Board Member, NHS Grampian
Councillor Tim Eagle	Moray Council
Councillor Louise Laing	Moray Council
Mr Sandy Riddell	Non-Executive Board Member, NHS Grampian

NON-VOTING MEMBERS

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

ADVISORS

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

Clerk Name: Caroline Howie
Clerk Telephone: 01343 563302
Clerk Email: caroline.howie@moray.gov.uk

MINUTE OF MEETING OF THE INTEGRATION JOINT BOARD

AUDIT, PERFORMANCE AND RISK COMMITTEE

Thursday, 13 December 2018

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

PRESENT

Ms Elidh Brown, Councillor Tim Eagle, Ms Pam Gowans, Councillor Louise Laing, Mr Atholl Scott, Mrs Susan Webb

APOLOGIES

Ms Tracey Abdy, Mr Steven Lindsay

IN ATTENDANCE

Ms Patricia Morgan, Service Manager Primary Care Contracts; Ms Jeanette Netherwood, Corporate Manager; Mr Bruce Woodward, Performance Officer.

1 Chair of Meeting

The meeting was chaired by Mrs Susan Webb.

2 Declaration of Member's Interests

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

3 Minute of Meeting dated 27 September 2018

The minute of the meeting of the Moray Integration Joint Board Audit, Performance and Risk Committee dated 27 September 2018 was submitted and approved.

4 Action Log of Meeting dated 27 September 2018

The Action Log of the Moray Integration Joint Board Audit, Performance and Risk Committee dated 27 September 2018 was discussed and it was noted that other than the following, all actions due had been completed:

i. item 2 - Quarter 1 (April - June 2018) Performance Report - Report giving more detail on the five indicators showing red in appendix 1 of the report; to be presented to the next meeting in March 2019.

5 Internal Audit Update

Under reference to paragraph 8 of the Minute of the meeting dated 27 September 2018 a report by the Chief Internal Auditor provided an update on audit work concluded since the last meeting.

Lengthy discussion took place on the audit work completed since the last meeting. The External Consultants Review of Learning Disabilities came under particular scrutiny and it was stated that transitioning to more independent living was a big transition for families who had historical care packages. The audit identified that services commissioned are not meeting the needs of service users and transformation will address this by 2020. The Chair raised questions as to the impact this was having on service users and their families. This had not been subject to audit and it was suggested that this could be a focus of further audits. As no one was otherwise minded the Committee agreed to seek further audits of the commissioning of Learning Disabilities.

Following further discussion the Committee agreed to:

i. note the contents of the update report;

ii. note that a further report relating to payroll testing will be presented to Committee in March 2019; and

iii. seek further audits on the commissioning of Learning Disabilities services.

6 Internal Audit Reports – Follow Up Protocol

Under reference to paragraph 9 of the Minute of the meeting dated 27 September 2018 a report by the Chief Internal Auditor addressed the request made at that meeting for a follow up protocol to be drafted, covering oversight and monitoring of the implementation of audit recommendation agreed by management.

During discussion of the protocol it was stated that management should be reporting to Committee if actions are not carried out to the given timescales and as no one was otherwise minded it was agreed to seek a further follow up report in March 2019.

Thereafter the Committee agreed to:

i. the 'follow-up' protocol for ensuring the effective implementation of internal audit recommendations; and

ii. a further report being presented to Committee in March 2019.

7 Strategic Risk Register - December 2018

A report by the Chief Officer provided an overview of the current strategic risks, along with a summary of actions which are in place to mitigate those risks, updated as at November 2018.

The Corporate Manager advised an action plan had been prepared but had not been issued with the papers for the meeting. She apologised for the omission and undertook to issue the action plan following the meeting.

Thereafter, following discussion, the Committee agreed to note the updated Strategic Risk Register.

8 Quarter 2 (July - September 2018) Performance Report

A report by the Chief Financial Officer updated the Committee on the performance of the Moray Integration Joint Board as at Quarter 2 (July - September) 2018/19.

The Chief Officer advised Delayed Discharges were volatile for a host of reasons; this is being investigated and an action plan will be produced to deal with this and will be shared with the Committee in March 2019 as part of a report on unscheduled care.

In response to a query on how quickly it is known that an issue has arisen with Unscheduled Care the Chief Officer advised this had a four-hourly indicator and therefore issues were known quickly.

Following further discussion the Committee agreed to note the performance of local indicators, linked to strategic priorities for Quarter 2 (July - September 2018) shown in appendix 1 of the report and the detailed analysis contained in appendix 2 of the report.

9 Audit Scotland - Update Report on Health and Social Care Integration

A report by the Chief Financial Officer provided the Committee with the opportunity to discuss and comment on the update report published in November 2018 by Audit Scotland on Health and Social Care Integration.

During discussion it was stated this was the second of a series of three reports; the next one being due for publication in 2023/24.

The Chief Officer stated a development session would be delivered early in 2019 to work through the document in detail.

It was further stated that collaborative leadership would help reinforce messages and themes contained in the report.

Following discussion the Committee agreed to note the:

i. update on progress attached as appendix 1 to the report; and

ii. intention to utilise the document as a self-assessment tool in relation to the progress of the Moray Integration Joint Board and present a further report to this Committee on 28 March 2019.

10 Payment Verification Assurance Update

A report by the Chief Officer updated the Committee on the activity of the Payment Verification (PV) Assurance Group during 2017/18 and the Revised PV Protocols for all contractor groups as detailed in the Document List (2018/19) and allowed the Committee to be sighted on the key issues highlighted during the course of the year.

Concerns were raised regarding access to Dental Reference Officers through the Practitioner Services Division. Following discussion, given this was an ongoing issue it was agreed to seek a report to the next Committee on how concerns will be resolved.

Thereafter Committee agreed to:

i. note the arrangements in place in Grampian for the management of the PV process;

ii. note the outcomes from the PV process during 2018/19;

iii. note the review of the PV Service provided by National Services Scotland Practitioner Services Divisions on behalf of NHS Grampian; and

iv. seek a report to the next Committee on how concerns over Scottish Dental Reference Service performance will be resolved.

MEETING OF MORAY INTEGRATION JOINT BOARD

AUDIT, PERFORMANCE AND RISK COMMITTEE

THURSDAY 13 DECEMBER 2018

ACTION LOG

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY
1.	Action Log of Meeting dated 27 September 2018	Item 2 - Quarter 1 (April - June 2018) Performance Report – Report giving more detail on the five indicators showing red in appendix 1 of the report; to be presented to the next meeting.	Mar 2019	P Gowans
2.	Internal Audit Update	Report relating to payroll testing. Further audits on the commissioning of Learning Disabilities services to be undertaken.	Mar 2019 June 2019	A Scott A Scott
3.	Internal Audit Reports – Follow Up Protocol	Further report to the next Committee.	Mar 2019	A Scott
4.	Audit Scotland – Update Report on Health and Social Care Integration	Further report to be presented in March.	Mar 2019	T Abdy
5.	Payment Verification Assurance Update	Report to the next meeting on how concerns over Scottish Dentail Reference Service performance will be resolved.	Mar 2019	P Morgan

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 28 MARCH 2019**

SUBJECT: **QUARTER 3 (OCTOBER – DECEMBER 2018) PERFORMANCE REPORT**

BY: **CHIEF FINANCIAL OFFICER**

1. REASON FOR REPORT

1.1 To update the Audit, Performance and Risk Committee on the performance of the Moray Integration Joint Board (MIJB) as at Quarter 3 (October – December) 2018/19.

2. RECOMMENDATION

2.1 It is recommended that the Audit Performance and Risk Committee consider and:

i) note the performance of local indicators for Quarter 3 (October – December 2018) as presented in the summary report at APPENDIX 1; and

ii) provide comment on the detailed analysis of the local indicators that have been highlighted as requiring further analysis as contained within APPENDIX 2.

3. BACKGROUND

3.1 The purpose of this report is to ensure the 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 that are linked to the strategic priorities of the MIJB and the functions delegated by NHS Grampian and Moray Council, to allow wider scrutiny by this Committee.

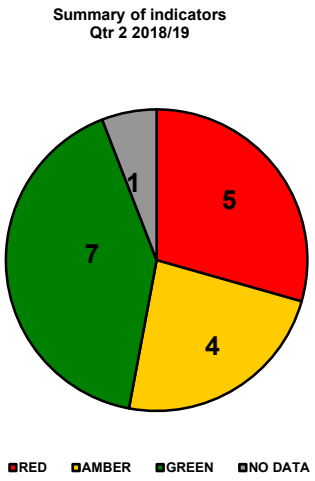
4. KEY MATTERS RELEVANT TO RECOMMENDATION

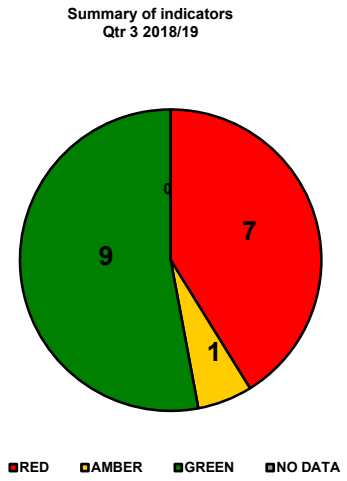
4.1 Indicators are assessed on their performance via a common performance monitoring Red, Amber, Green (RAG) traffic light rating system.

RAG scoring based on the following criteria:	
GREEN	If Moray is performing better than target.
AMBER	If Moray is performing worse than target but within 5% tolerance.
RED	If Moray is performing worse than target by more than 5%.
▲ – ▼	Indicating the direction of the current trend.

4.2 The performance information for quarter 3 is attached in **APPENDIX 1.** Moray has 17 local indicators 9 of which are green, 1 amber and 7 indicators showing their status as red.

4.3 Of the 5 red indicators in Q2, 2 are now green and 3 remain red (one of these is L14 which is only updated yearly so no change was expected). There were 4 amber indicators in Q2 of which only 1 is still amber (L09 65+ Emergency Admissions), two are now green and one is red (L20 – NHS Sickness). Of the 7 green indicators in quarter 2, 5 remain green however two are now red (L19A - NHS Complaints responded to within 20 days and L41- Psychological Therapy within 18 weeks). Additionally there is now information on L21 – Council Sickness Absence which was grey below but is now red.





4.4 Indicators which are RED (not meeting local targets and outwith tolerances) at quarter 3 have been highlighted by the Performance Team with the relevant Service Managers. An investigation into the reasons why the indicator is red has been undertaken and potential remedial actions have been identified, discussed and implemented to improve performance where possible.

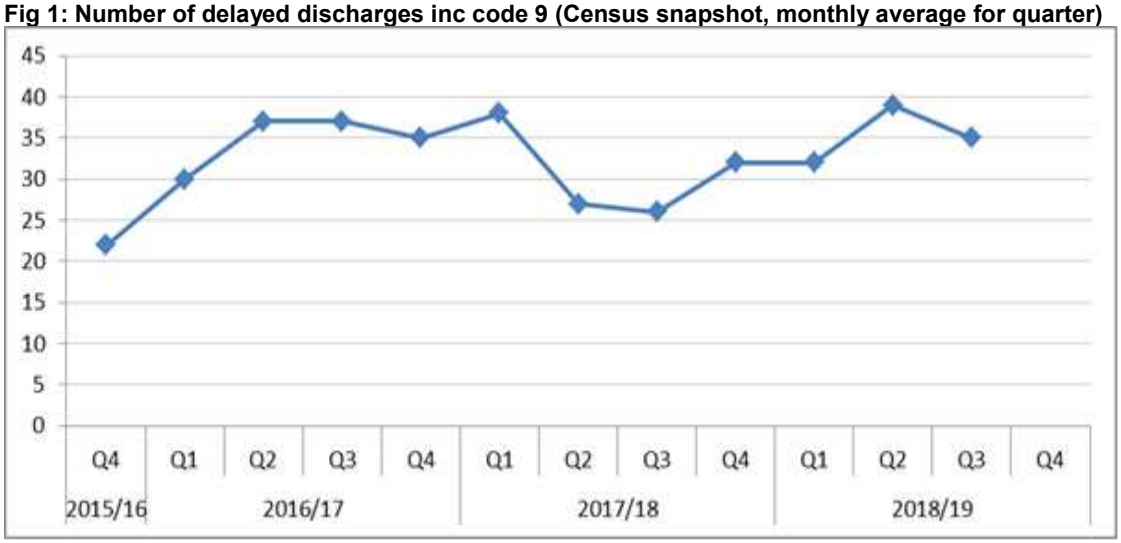
4.5 **APPENDIX 2** provides supplementary information which explains the background to current performance and the management action being undertaken to address the underlying issues.

5. EXCEPTION REPORTING: DELAYED DISCHARGE

5.1 At a meeting of this committee on 13 December 2018 the performance report for quarter 2, 2018/19 was presented (para 8 of the draft minute refers). At that time the Committee requested further detailed analysis of the high number of Delayed Discharges being reported, in addition to extended analysis of the other indicators highlighted as red.

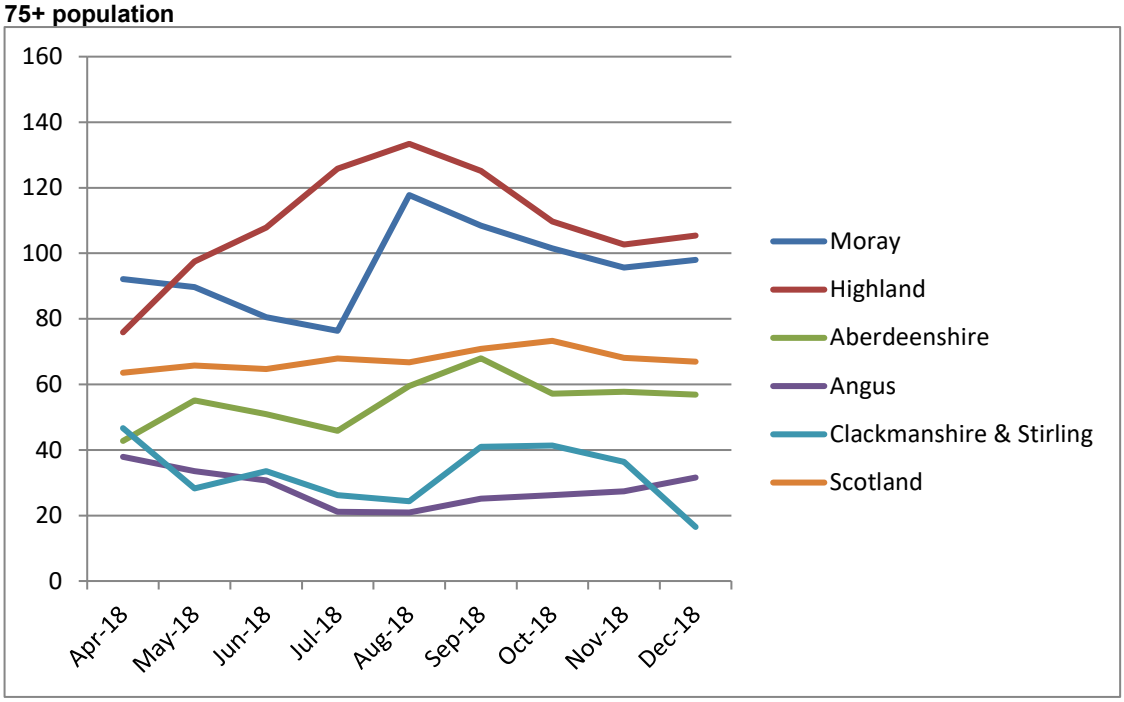
5.2 The number of Delayed Discharges (DDs) recorded at the census date has steadily increased since Q3 2017/18. While there has been a decrease in Q3 2018/19 (Fig 1) and further decreases that are evidenced in weekly management reporting that should translate to a further reduction in the Q4 figure there is still a concern as to why this figure has been so volatile.

Fig 1: Number of delayed discharges inc code 9 (Census snapshot, monthly average for quarter)



5.3 A breakdown of the monthly Bed Days Occupied due to Delayed Discharges has Moray showing as not particularly high or low. When adjusted for population in the 75+ age group (Fig 2) Moray shows as having a high proportion of bed days occupied per 1000 population. In December 2018 Moray had 98 bed days lost per 1000 75+ population compared to a Scottish average of 67 and Aberdeenshire (57), Angus (32) and Clackmanshire & Stirling (16).

Fig 2: Number of Bed Days Occupied by Delayed Discharges per quarter (inc code 9) per 1000 75+ population



5.4 Currently Moray has a higher proportion of 75+ clients occupying beds as delayed discharges as shown in Fig 3. While there is volatility in this figure across comparators, more recently Moray has shown as higher than the Scottish Average and has placed in the top two highest rate since July 2018.

Fig 3: % of Delayed Discharge bed days occupied by 75+ clients

% of DDs over 75	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Moray	75%	71%	71%	76%	79%	76%	80%	89%	82%
Highland	72%	76%	81%	85%	77%	74%	68%	73%	75%
Aberdeenshire	73%	79%	72%	68%	75%	79%	72%	73%	70%
Angus	82%	81%	63%	65%	84%	70%	74%	66%	80%
Clackmanshire & Stirling	79%	67%	73%	58%	59%	75%	68%	66%	42%
Scotland	69%	68%	68%	70%	68%	70%	69%	69%	70%

5.5 As has been described in previous reports there have been initiatives where Whole System Weekly Huddles are taking place to discuss each patient individually, and teams within Health and Social Care Moray are working to ensure that those in hospitals are being highlighted to the relevant teams prior to a discharge date being known to facilitate those teams to plan more efficiently.

5.6 Key actions from these meetings include:

- Looking at patients who have been at hospital over 21 days to ensure progression;
- Checking those awaiting transfer to a community hospital to ensure the appropriateness;
- Reviewing Forres patients with the GP from that area via video link to see if it is appropriate they return to Forres under the Forres Multi Disciplinary Team (MDT).
- The Hospital Discharge Team check and monitor those admitted who have existing services in place to facilitate flow and ensure safe and timely discharge.

5.7 Whilst this practice has experienced some success, it was not able to mitigate two long term care providers (Mears and H1) handing back a large number of

care packages in Q2 of 2018/19. This resulted in Internal Homecare services being required to absorb all care packages in the Speyside area and becoming the sole providers for this year. The consequence of absorbing the additional service users with no additional staff resource has placed increased pressure on Internal Homecare services across Moray where recruitment and sickness absence is already an area for concern.

5.8 Efforts to streamline the Internal Homecare process have been made whereby patients in hospital, assessed as requiring long term care (Tier 3), are now passed directly to the brokerage team and no longer dealt with by the Independent Living Team (ILT) who specialise in Tier 2 care. Whilst beneficial for the patient, resulting in a much more consistent care experience, it has resulted in those waiting for care, to be held in hospital as opposed to with the ILT. This has highlighted an issue where Tier 3 care, primarily provided for by external providers, is more difficult to source at an appropriate level, due to there being no contractual obligation for them to accept the patient.

5.9 Currently Service Managers are carrying out three streams of work to address the issues identified in 5.8 above:

- Provider Services are further developing the role of the ILT and how they work with patients in hospital requiring care.
- A long term sickness, that has impacted on the Brokerage team, is being investigated and cover is being sought.
- Commissioning are revisiting the Homecare contract with external providers with a view to addressing the highlighted issue.

5.10 Delayed Discharges continue to be a key focus of the evolving Strategic Plan and consideration is being given to the wider context of Health and Social Care Moray and the related indicators that influence performance in this area.

6. SUMMARY OF IMPLICATIONS

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

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

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

(b) Policy and Legal

None directly associated with this report.

(c) Financial implications

None directly associated with this report. .

(d) Risk Implications and Mitigation

The report highlights the difficulties being experienced in staff recruitment and sickness absence and the subsequent impact on service delivery, with particular regard to Delayed Discharge. Further detailed analysis is being undertaken and management are exploring additional approaches and solutions to address this issue

(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 its purpose is to underpin the strategic direction for the service and there will be no differential impact, as a result of the report, on people with protected characteristics.

(h) Consultations

Consultation on this report has taken place with the following staff who are in agreement with the content in relation to their area of responsibility:-

- Chief Officer, MIJB
- Caroline Howie, Committee Services Officer
- Service Managers, Health and Social Care Moray
- Corporate Manager

7. CONCLUSION

7.1 This report requests the Audit, Performance and Risk Committee comment on performance of local indicators and actions summarised in the highlight report (APPENDIX 2).

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

Moray Health and Social Care Partnership: Performance at a Glance Quarter 3 (October to December 2018)

Item 5 APPENDIX 1

Local Indicators

RAG scoring based on the following criteria (Where there is no target, previous quarter is used)		
G	If Moray is performing better than target	
A	If Moray is performing worse than target but within 5% tolerance	
R	If Moray is performing worse than target by more than 5%	
▲ – ▼	Indicating direction of current trend	

Item 5

ID.	Indicator Description	Source	Q3 (Oct-Dec 17)	Q4 (Jan-Mar 18)	Q1 (Apr-June 18)	Q2 (Jul-Sept 18)	Q3 (Oct-Dec 18)	Target	RAG Status
L07	Rate of emergency occupied bed days for over 65s per 1000 population	NHS	2495	2444	2380	2375	**2344**	2360	G▼
L08	Emergency Admissions rate per 1000 population for over 65s	NHS - PMS	182	186	191	189	**187**	193	G▼
L09	Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population	NHS - PMS	130	129	132	130	**130**	125	A -
L10	Number of Bed Days Occupied by Delayed Discharges per quarter (inc code 9) per 1000 18+ population	NHS	30	38	42	45	**41**	-	G▼
L11	Number of delayed discharges inc code 9 (Census snapshot, monthly average for quarter)	NHS	26	32	32	39	**35**	35	G▼
L12	A&E Attendance rates per 1000 population (All Ages)	NHS	56.1	57.6	63.8	62.6	**58.0**	-	G▼

R	If Moray is performing worse than target by more than 5%
▲ – ▼	Indicating direction of current trend

ID.	Indicator Description	Source	Q3 (Oct-Dec 17)	Q4 (Jan-Mar 18)	Q1 (Apr-June 18)	Q2 (Jul-Sept 18)	Q3 (Oct-Dec 18)	Target	RAG Status
L13	A&E Percentage of people seen within 4 hours, within community hospitals	NHS	100%	100%	100%	100.0% (681)	**100.0% (564)**	98%	G -
L14	Percentage of new dementia diagnoses who receive 1 year post-diagnostic support	ISD	Reported Annually		90.7% (2015/16)	66.7% (2016/17)	**2017/18 data Expected in Q1**	70%	R▼
L15	Smoking cessation in 40% most deprived after 12 weeks	NHS	17	14	49	29	**12**	-	R▼
L16	Percentage of clients receiving alcohol treatment within 3 weeks of referral	NHS	100%	98.6%	98.3%	100%	**100.0%**	90%	G -
L17	Percentage of clients receiving drug treatment within 3 weeks of referral	NHS	100%	95.6%	100%	100%	**100.0%**	90%	G -
L18	Number of Alcohol Brief Interventions being delivered (includes ABIs in priority and wider settings where data can be aligned to HSCP)	NHS	106	142	208	186	**136**	259	R▼
L19A	Number of complaints received and % responded to within 20 working days - NHS	NHS	10% (10)	68.4% (19)	50% (8)	55.0% (11)	**50.0% (18)**	-	R▼
L19B	Number of complaints received and % responded to within 20 working days - Council	SW	-	-	-	100% (6)	**100% (6)**	-	G -
L20	NHS Sickness Absence % of Hours Lost	NHS	4.6%	5.8%	4.9%	4.6%	**4.7%**	4.0%	R▲
L21	Council Sickness Absence (% of Calendar Days Lost)	SW	-	-	7.9%	8.1%	**8.3%**	5.9%	R▲
L41	Percentage of patients commencing Psychological Therapy Treatment within 18 weeks of referral	NHS	100.0%	100.0%	100.0%	100.0%	**80.0%**	90%	R▼

HSCM Q3 PERFORMANCE ANALYSIS

Indicators not Achieving Target in Q3 (RED)

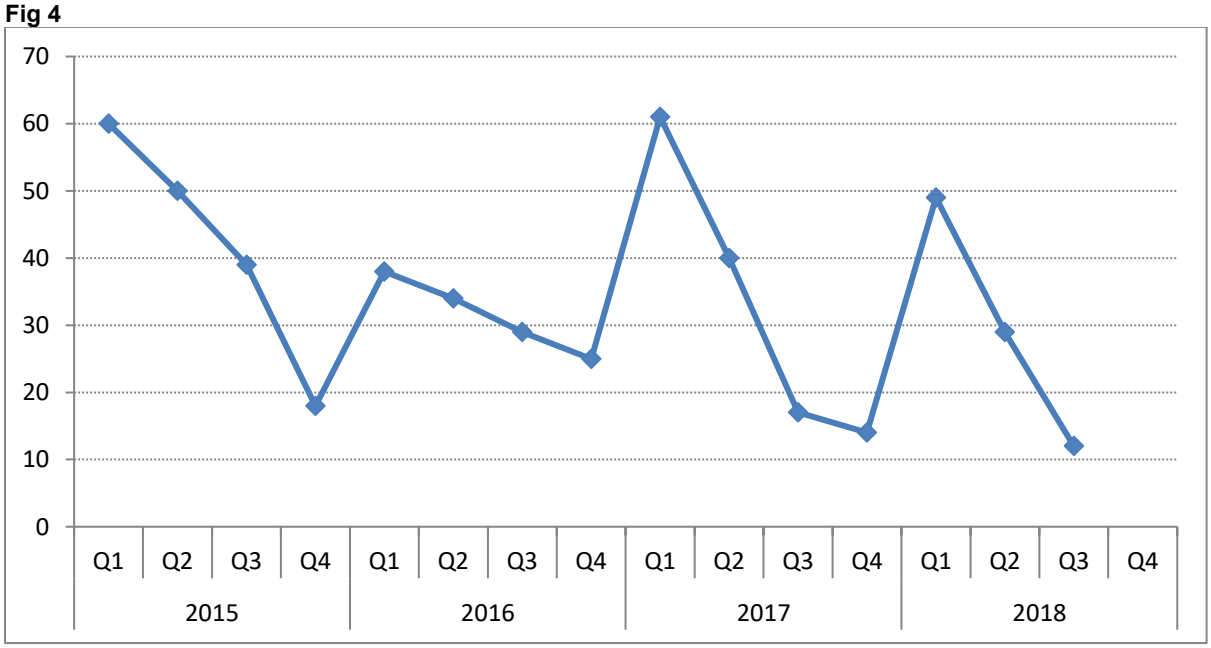
L14 Percentage of new dementia diagnoses who receive 1 year post-diagnostic support

Management figures (not yet officially published) show Moray at over 95% for this measure in 2017/18. This is a significant increase on 66.7% in 2016/17 and is higher than the Scottish Average and our neighbours in Aberdeenshire and Highland as well as other comparators (Stirling and Angus). Following publication of this data, more accurate comparison will be possible.

In 2016/17 there was a change in the management of the service from Alzheimers Scotland Post Diagnostic Support (PDS) Link Worker to the Community Mental Health Team who have two Support Workers undertaking PDS on a part time basis and Community Psychiatric Nurses provide services for those who require more complex follow up. Data regarding this service is now collected and monitored monthly. The raw numbers of those who have undergone PDS have risen from 29 in 2016 to 135 in 2018 (currently only calendar year figures are available) which show that the current system is able to provide support within the 12 months for more people.

L15 Smoking cessation in 40% most deprived after 12 weeks

Fig 4



There is a seasonal trend in this measure and whilst we expect Q3 to be lower than the previous quarters there is a general annual downturn in those accessing the Smoking Advice Service. In 2018/19 Q3 was the lowest Q3 in the past 4 years. This pattern replicates experience across Grampian and the rest of Scotland.

A reduction in the pool of smokers within Moray in the 40% most deprived communities means that there are fewer people requiring these services. Those that remain are difficult to reach in addition to more smokers turning to e-cigarettes /

vaping devices to help them quit so not accessing services in the same manner as previously.

To increase reach and provide a holistic, person centred approach, the Healthpoint and Smoking Advice Service is merging. There are an increasing number of smoking advisors in Moray working alongside the range of support services available, which include pharmacies. Advisors are available within the Community (based within GP practices, throughout Moray) and Dr Gray's Hospital, including; in the pre-assessment, Mental Health and Maternity services.

Working in partnership, the aim is to build on success to date and further embed and sustain the Making every Opportunity Count (MeOC) approach within Health and Social Care Moray and partner organisations. MeOC is a 3-tiered approach and provides practitioners with a range of flexible tools; including a DIY MOT self-check, which provides a framework for practitioners to support clients to identify any health and wellbeing concerns they may have. Once identified, practitioners can signpost clients to the most appropriate support service, one of which is smoking cessation.

L18 Number of Alcohol Brief Interventions being delivered *(includes ABIs in priority and wider settings where data can be aligned to HSCPs)*

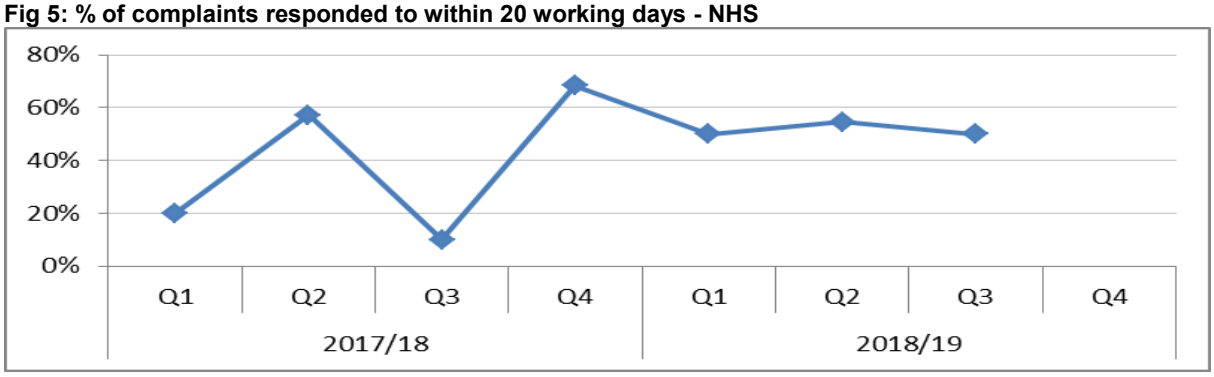
The Alcohol Screening and Brief intervention (ABI) strategy was approved by the Moray Alcohol and Drug Partnership (MADP) in January 2019, and a local group is being formed to take forward an action plan. Areas of development include:

- Increase in the number of ABI trainers available in Moray (from one individual to four by the end of 2019).
- Identification and preliminary work has been completed with key partners to support ABI delivery (criminal justice, maternity etc). A performance report is being developed to monitor the 2018-2023 strategy and direct improvement efforts.

L19A Number of complaints received and % responded to within 20 working days - NHS

For quarter 3 there were a total of 18 complaints received, 9 were responded to within 20 days, 7 of the 18 complaints were not upheld and 1 was partially upheld. Of the upheld complaints the longest wait for a response was 66 days followed by 32 days, the others were all under 30 days. After an overall average of 45% in 2017/18 this measure has been around 50% consistently every quarter this year. There is variation in month on month figures (between 8 and 18 in the past 7 quarters) but no correlation between high numbers of complaints and the response rate. The complexity of the complaints are what contribute to a late resolution.

Fig 5: % of complaints responded to within 20 working days - NHS

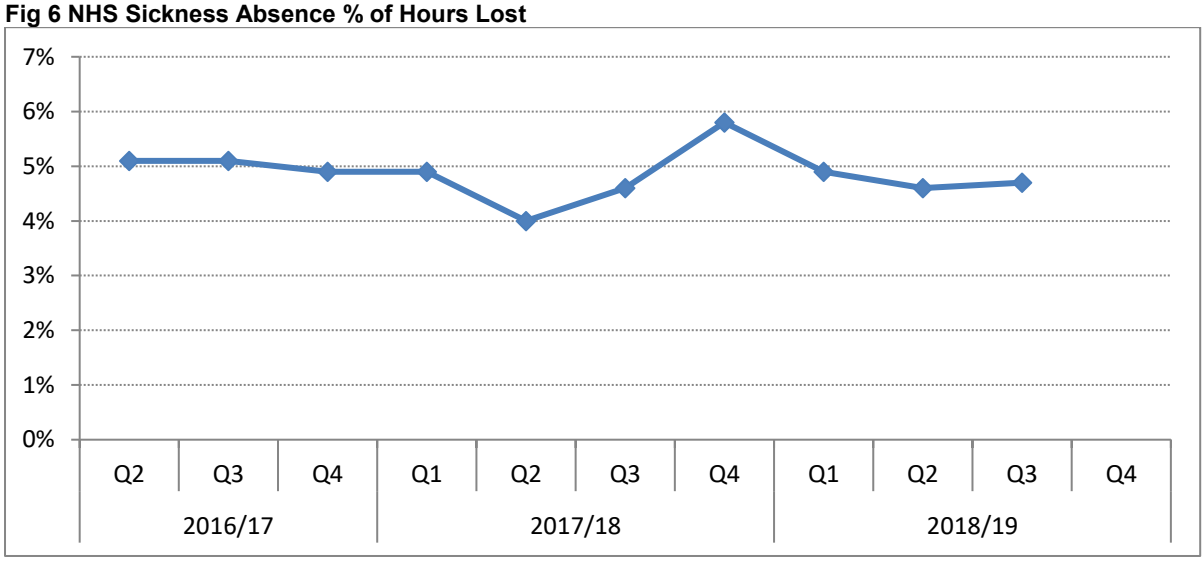


L20 NHS Sickness Absence % of Hours Lost

The percentage of hours lost has remained above the 4% target this year so far, however when looking at the monthly rate, December decreased to 4% which is positive. In comparison Grampian was above target in all three months, (4.5% in Oct, and 4.3% in Nov and Dec). The latest available Scotland figure in November 2018 was 5.1%.

There is an issue with achieving the target as HSCM figures have hovered around 5% consistently and has only been below the quarterly target once in the past two years (Q2 2017/18). Sickness absence is being monitored by appropriate staff according to NHS Grampian policies.

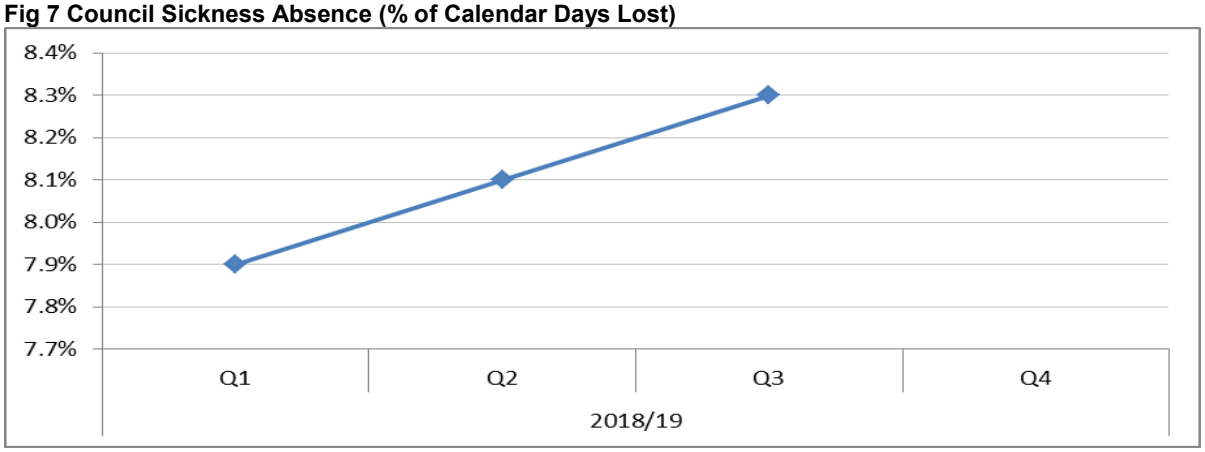
Fig 6 NHS Sickness Absence % of Hours Lost



L21 Council Sickness Absence (% of Calendar Days Lost)

The percentage of days lost in the council contracted staff is recorded as 8.3% which is much higher than the Moray Council target of 5.9% and the NHS Grampian target of 4%. The majority of these absences are recorded in the Homecare and Residential Learning Disability groups (1686 out of the 2727 total days lost). While studies into sickness absence have shown that those in the caring profession tend to have higher sickness rates than other sectors, this percentage is very high. Further investigation is being undertaken by the Provider Services Manager to identify specific issues for action, in order to reduce absences across the service and support the management teams in attaining sustainable services and reductions in team absence.

Fig 7 Council Sickness Absence (% of Calendar Days Lost)



As well as ensuring absence management is a standing item on the agenda of the monthly Provider Services management meeting, specific actions have already been undertaken by the internal homecare services management team. To address the absences, staff have met and reviewed the process around how they are conducting back to work interviews and ensuring these are both consistent across the service and compliant with current policies.

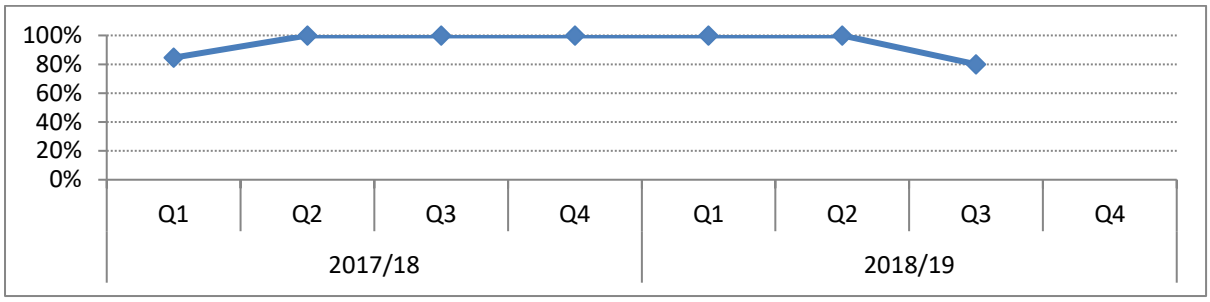
L41 Percentage of patients commencing Psychological Therapy Treatment within 18 weeks of referral

The adult mental health psychology team have carried a 1.0 whole time equivalent (wte) clinical psychology vacancy since July 2018. This is being advertised for the third time, however, the delay in recruitment has resulted in an increase in the number of people waiting to be seen. This post will not be advertised in the British Psychological Society (BPS) until 18 April 2019 due to a miscommunication regarding deadlines from the advertising agency.

The resignation of the only full time member of staff within primary care had resulted in an increase in the number of people waiting to be seen with additional pressure on the remaining 1.4 wte staff resource. However, additional external funding was secured to appoint a further 0.8 wte member of staff for 11 months who commenced on 28 January 2019 which will alleviate some of the current pressure on the service. Due to time limited funding the 1.0 wte post can only be recruited to for six months and following an unsuccessful recent round of interviews this was re-advertised on 21 February 2019.

This measure has consistently hit 100% in the 5 quarters preceding this and while it is unlikely to reach 100% in Q4, the actions being taken should translate to provide reasonable assurance of a return to 100% in 2019/20.

Fig 8: Percentage of patients commencing Psychological Therapy Treatment within 18 weeks of referral*



*The number of patients in this cohort is under 10 so cannot be shared publicly.

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 28 MARCH 2019**

SUBJECT: **STRATEGIC RISK REGISTER – MARCH 2019**

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 as at March 2019.

2. RECOMMENDATION

2.1 It is recommended that the Audit, Performance and Risk Committee consider and note the updated Strategic Risk Register

3. BACKGROUND

3.1 The strategic risk register is reviewed regularly 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 as **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 any mitigation actions being taken to reduce the impact of the risks.

3.3 Following consideration of the Strategic Risk Register at the meeting of 13 December 2018 (para 7 of the minute refers) the committee requested that an action log be circulated and this is now attached as **APPENDIX 2**. This action log is owned and progress monitored by Senior Management Team.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

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

4.2 Changes such as inclusion or removal from the register are agreed by the Chief Officer and Senior Management Team before submission to Audit, Performance and Risk Committee for review.

4.3 Strategic Risks will be reviewed as the new Strategic Plan for 2019-2022 is developed and this document will be revised accordingly.

5. SUMMARY OF IMPLICATIONS

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

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, this Committee 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 Committee 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 IJB.

(e) Staffing Implications

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

(f) Property

There are no property implications arising from this report.

(g) Equalities/Socio Economic Impact

An Equalities Impact Assessment has not been completed because there are no service, policy or organisational changes being proposed.

(h) Consultations

Consultations have been undertaken with the Chief Financial Officer and Chief Internal Auditor and comments have been incorporated in this report.

6. CONCLUSION

6.1 This report recommends the Committee note the revised and updated version of the Strategic Risk Register.

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

HEALTH AND SOCIAL CARE MORAY STRATEGIC RISK REGISTER

AS AT MARCH 2019

1

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 whilst ensuring staff are fully able to manage changes resulting from integration.
4. Inability to demonstrate effective governance and effective communication with stakeholders.
5. Inability to deal with unforeseen external emergencies or incidents as a result of inadequate emergency planning and resilience.
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. Risk of major disruption in continuity of ICT operations including data securitybeing compromised.
9. Requirements for ICT and Property 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: *Political*	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	**HIGH**
Risk Movement:	Increase/ decrease/ no change	**NO CHANGE**
Rationale for Risk Rating:	Changes in membership of IJB committees have settled down and members have all attended more than one cycle of meetings. Moray Council political balance has remained consistent since July 2018.	
Rationale for Risk Appetite:	The MIJB has zero appetite for failure to meet its legal and statutory requirements and functions.	
Controls:	• Integration Scheme. • Strategic Plan. • Governance arrangements formally documented and approved. • Agreed risk appetite statement. • Performance reporting mechanisms. • Consultation with legal representative for all reports to committees and attendance at committee for key reports.	
Mitigating Actions:	Induction sessions are held for new IJB members. IJB voting member briefings are held regularly. Conduct and Standards training held for IJB Members July 18 SMT regular meetings and directing managers and teams to focus on priorities. Regular development sessions held with IJB, Operational Management Team and SMT Strategic Plan is being developed for implementation. New organisation structure and wider system re-design and transformation governance structures being developed for implementation at the same time and will be presented to IJB in June 2019 for consideration	
Assurances:	• Audit, Performance and Risk Committee oversight and scrutiny. • Internal Audit function and Reporting • Reporting to Board.	

Gaps in assurance:	None known
Current performance:	Scheme of administration is reported when any changes are required. Report outlining the development of the transformation plan and the Strategic Planning and Commissioning Group providing oversight was presented and approved by MIJB on 29 November 2018. Report on Standards Officer submitted to IJB for consideration March 2019
Comments:	Draft Performance Management Framework, aligned to strategic planning and resources was presented to MIJB (Jan 18). Framework is under further development and Implementation is being progressed through HSCM Performance meetings. The Framework will continue to be developed as we confirm our new organisational structure and alignment to the new Strategic Plan will be a key focus. A report will be submitted to MIJB in June 2019 as part of the suite of reports outlining the direction and governance arrangements for the IJB.

2		
Description of Risk: *Financial*	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	
Lead:	Chief Officer/Chief Financial Officer	
Risk Rating:	Low/ medium/ high/ very high	**VERY HIGH**
Risk Movement:	Increase/ decrease/ no change	**NO CHANGE**
Rationale for Risk Rating:	The impact of funding cuts from both Moray Council and NHS Grampian in previous years are still being felt. Funding cuts from Moray Council have been significant 2017/18 (£1.3m) and 2018/19 (£1.759m Gross). NHS Grampian provided no uplifts for pay and price increases in 2017/18 creating increased pressure. Financial settlements are set to continue on a one year only basis which does not support sound financial planning Demand on services continues to rise and the IJB has no remaining reserves to be utilised. At the end of Qtr 3 in the 2018/19 financial year the IJB is showing a £2.8m overspend on core services. At Qtr 3 the financial forecast to the end of the financial year shows an overspend on core services of £3.1m and after consideration of slippage on strategic funds this is reduced to £1.5m. A recovery plan has been developed and agreed with the Finance Directors in the partner organisations. This was presented to the MIJB in November 2018 and will be monitored closely. The financial risk to the Partners in the event of an overspend has been agreed and the split of the final overspend to be met by the partners will be 63% NHSG and 37% Moray council. The MIJB Chair has written to the two Chief Exec's accordingly.	

Rationale for Risk Appetite:	MIJB recognises the pressures on the funding partners but also recognises the significant range of statutory services and nationally agreed contracts it is required to deliver on within that finite budget. MIJB has expressed a zero appetite for risk of harm to people.
Controls:	Chief Finance Officer appointed - this role is crucial in ensuring sound financial management and supporting financial decision making, budget reporting and escalation. Corrective action has been implemented through correspondence with budget holders and increased scrutiny at senior management level. Recovery Plan agreed and to be monitored regularly
Mitigating Actions:	Risk remains that the MIJB can deliver transformation and efficiencies at the pace required. Financial information is reported regularly to both the MIJB and Senior Management Team. The Chief Officer and Chief Financial Officer (CFO) have continued to engage in the budget setting processes of both NHS Grampian and Moray Council ahead of the 2019/20 budget setting to ensure the MIJB perspective is considered as part of the budget setting processes of the Partners. In an attempt to lessen the anticipated overspend – budget restrictions have been applied and communicated to all service managers for onward distribution to budget managers. Budget restrictions include the implementation of a higher level of authorisation for single items of expenditure over 5k (head of service) and 10k (senior management team). Senior management team scrutiny of vacancies and emerging pressures. Chief Officer and CFO will continue to engage with the partner organisations in respect of the forecast of overspend, corrective action and a recovery plan during 2018/19. The MIJB is acutely aware of the recurring overspend on its core services. In addition to the Recovery Plan, service reviews will be carried out during 2019/20 to ensure services are prioritised in accordance with the Strategic Plan whilst working within the funding allocated.
Assurances:	MIJB oversight and scrutiny of budget. Reporting through MIJB, NHS Grampian Board and Moray Council.
Gaps in assurance:	None known
Current performance:	Indicative budget for 2018/19 was approved to allow service 4.5m. A further paper was presented to the board on 28 June 2018 displaying a reduced budget shortfall of £3.3m. The forecast overspend to the end of the financial year as at Qtr 3 after consideration of strategic funds is £1.5m. Plans are being progressed in relation to service planning and financial review during 2019/20.

Comments:	Senior managers to work with Chief Officer and Chief Financial Officer to address the continuing financial challenge and forecast overspend. Through reporting, regular updates will be provided to the MIJB, Moray Council and NHS Grampian as part of the risk sharing arrangement in place.

3		
Description of Risk: *Human Resources (People):*	Inability to recruit and retain qualified and experienced staff whilst ensuring staff are fully able to manage change resulting from Integration	
Lead:	Chief Officer	
Risk Rating:	Low/ medium/ high/ very high	**MEDIUM**
Risk Movement:	Increase/ decrease/ no change	**NO CHANGE**
Rationale for Risk Rating:	Increasing workload experienced – being managed by recruiting to senior posts however the process for recruitment is proving time consuming through NHS processes, due to the number of posts required to be filled time as a result of the short term transformation funding. The impact of budgetary decisions by the Council in relation to reducing staffing levels, may result in reduced levels of support provided in some key areas for Health and Social Care Moray (HSCM), such as ICT, HR, Legal and design. Until the Council services affected have determined what elements of service provision has to reduce we will not know if there are changes to our level of support. .	
Rationale for Risk Appetite:	The MIJB is acutely aware of the lean management team in place and the strain this can place on the wider system.	
Controls:	Management structure in place with updates reported to the MIJB. Organisational Development and Workforce Plans have been developed and aligned with service priorities. Continued activity to address specific recruitment and retention issues. Management competencies being developed. Communications Strategy developed and approved in June 2017 with the associated commitments are progressing as anticipated. Incident reporting procedures in place per NHSG and Moray Council arrangements. Council and NHS performance systems in operation with HSCM reporting being further developed. SMT review vacancies and approve for recruitment	

Mitigating Actions:	System re-design and transformation. Support has been provided from NHSG with transformation and our co-ordinated working with Dr Grays in a one system – one budget approach through the Moray Alliance The Management Structure has been progressed and an update will be presented to the MIJB meeting on 28 March 2019 Joint Workforce Planning. 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 and reported to MIJB. Organisational Steering Group is overseeing the management structure review
Gaps in assurance:	Joint or single system not yet agreed for incident reporting. Organisational Development Plan presented and approved at MIJB in January 2018 is overdue for update.
Current performance:	iMatter survey undertaken during July 2018 across all operational areas. Insufficient responses from some services has meant that action plans have not been developed. This is to be addressed through Operational Management Team. Representation on NHS Grampian's HSE Expert Group and operational H&S meeting established in HSCM .
Comments:	Regular reporting and management control in place The Workforce plan will be developed and aligned with the strategic plan 2019- 2022

4		
Description of Risk: *Regulatory:*	Inability to demonstrate effective governance and effective communication with stakeholders.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**MEDIUM**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Locality planning assessed as medium in relation to ability to work at the pace required and current workforce capacity. Performance framework to be further developed from a planning perspective to show the links through operational service delivery to strategic objectives.	
Rationale for Risk Appetite:	The MIJB has a low risk appetite to failure.	

Controls:	Annual Governance statement produced as part of the Annual Accounts 2017/18 and submitted to External Audit by the statutory deadline, in hand for 2018/19 Performance reporting mechanisms in place and being further developed through performance management group. Community engagement in place for key projects areas such as Forres with information being made available to stakeholders and the wider public via HSCM website.
Mitigating Actions:	Schedule of Committee meetings and development days in place and taking place. Good working relationship established with Audit Scotland, the MIJB's appointed external auditors since 16/17. The second Annual Performance Report published in August 2018. Lessons learnt will be addressed and incorporated into the approach for the production of the 2018/19 Report.
Assurances:	Oversight and scrutiny by Clinical and Care Governance Committee, Audit Performance and Risk Committee and MIJB. A recent internal audit has been carried out by PricewaterhouseCoopers. The findings will be reported to a future meeting of the Audit, Performance and Risk committee following scrutiny by NHSG Audit Committee.
Gaps in assurance:	Following discussions at the development session held by Clinical and Care Governance Committee on 29 November 2018 to identify areas that they wish to see covered at Committee in future reports a programme will be developed for 2019/20.
Current performance:	Communications Strategy developed and approved by MIJB in June 2017. Annual Performance Report 2017/18 published August 2018 Draft Annual Accounts (2017/18) published by the statutory deadline of 30 June. Audited Accounts published 27 September 2018
Comments:	NHS Grampian Senior Leadership Team are developing their framework for governance and HSCM are fully engaging and participating in this process. HSCM are progressing with setting out the Governance framework for their functions across services (ie Health and Safety, Civil Contingencies, Risk Management, Performance Management etc) and linkages with NHS and Council groups to facilitate communication flows. PwC Internal Audit of Health Governance completed

5		
Description of Risk: *Environmental:*	Inability to deal with unforeseen external emergencies or incidents as a result of inadequate emergency planning and resilience.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**HIGH**
Risk Movement:	increase/decrease/no change	**INCREASED**
Rationale for Risk Rating:	Resilience standards and implementation plan agreed however progress is behind target. Potential impact of Brexit is being assessed at a National level and have highlighted key areas for assessment. Work is being undertaken by NHS Grampian and Moray Council to assess potential issues on workforce and potential impacts resulting from supply chain disruption (medical supplies, energy/fuel supplies) as well as potential for increased civil disruption. Scottish Government will set up a response co-ordination unit with effect from 18 March and requests for information will be made to Local Authorities and NHS. As yet it is not clear what information will be required and from whom. HSCM are being guided by colleagues in Moray Council and NHSG. There is no specific requirement for any HSCM staff involvement at this stage, however this may change.	
Rationale for Risk Appetite:	The MIJB understand the requirement to meet the statutory obligations set out within the Civil Contingencies Act.	
Controls:	Surge Plan in place and has been tested alongside NHSG plans for winter. Lead Officer identified working alongside Emergency Planner. Local resilience plan developed. NHS Grampian Resilience Standards Action Plan approved (3 year). Business Continuity Plans in place for most services. Surge Plan developed and approved by MIJB 29 November 2018	
Mitigating Actions:	Meeting of HSCM resilience group held on 4 December to consider and prioritise actions in relation to the Resilience standards. Next meeting will be on 25 March 2019. Pandemic awareness briefing by Maha Saeed, Consultant Lead, scheduled for 12 December for service managers across 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. Participation in NHSG exercise Pices on 19 March which will test the setup of our control room and communication channels with NHSG as part of preparation for EU Exit.
Assurances:	Audit, Performance and Risk Committee and NHS Grampian Civil Contingencies Group oversight and scrutiny.
Gaps in assurance:	Programme and implementation of Table top exercises for business continuity. Some progress has been made however further work 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. Identification of staff resource to support managers in reviewing business continuity arrangements is being considered to progress completion. In addition to preparation for normal business continuity arrangements, the three HSCP in Grampian have been requested by NHSG Civil Contingencies group to complete their pandemic flu plans by end of April 2019.
Current performance:	Many services have business continuity arrangements however the majority are overdue for an update. These updates will include consideration of the impact of a Pandemic following the briefing session held on 12 December 2018.
Comments:	The HSCM resilience group will schedule and review progress in achieving the NHSG resilience standards, reporting updates to Operational Management Team and by exception to Senior Management Team.

6		
Description of Risk: *Reputational*	Risk to MIJB decisions resulting in litigation/judicial review. Expectations from external inspections are not met.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**MEDIUM**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Considered medium risk due to the reporting arrangements being relatively new	
Rationale for Risk Appetite:	The MIJB has some appetite for reputational risk relating to testing change and being innovative. The MIJB has zero appetite for harm happening to people.	
Controls:	Clinical and Care Governance (CCG) Committee established and future reporting requirements identified Links for operational Risk Registers being developed Complaints procedure in place Adverse events and duty of candour procedures in place and being actioned where appropriate. 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.	
Mitigating Actions:	This is discussed regularly by the three North East Chief Officers. Additional resource has been allocated to support the analysis of information for presentation to CCG committee Process for sign off and monitoring actions arising from Internal and External audits is being set out as part of the HSCM governance arrangements.	
Assurances:	Audit, Performance and Risk and Clinical and Care Governance Sub-Committees oversight and scrutiny.	
Gaps in assurance:	Process for highlighting recurring themes or strategic expectations from external inspections requires further development to ensure Committee has sight of significant issues.	
Current performance:	External inspection reports are reviewed and actions arising are allocated to officers for taking forward. Internal Audits by Price Waterhouse Cooper on Health and Safety Governance and Unscheduled Care Discharge Process have not raised any significant issues.	
Comments:	Self-Directed Support Thematic review by the Care Inspectorate took place during October 2018, awaiting the report	

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	**MEDIUM**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Potential impacts to the wide range of services in NHS Grampian and Moray Council commissioned by the MIJB arising from reductions in available staff resources as budgetary constraints impact. Unplanned admissions or delayed discharges place additional cost and capacity burdens on the service and currently there is no reduction in the levels being experienced.	
Rationale for Risk Appetite:	Zero tolerance of harm happening to people as a result of action or inaction.	
Controls:	Performance Management reporting framework. Strategic Plan and Implementation Plan developed and approved. Performance regularly reported to MIJB. Revised Scorecard being developed. Best practice elements from each body brought together to mitigate risks to MIJB's objectives and outcomes. Chief Officer and SMT managing workload pressures as part of budget process.	
Mitigating Actions:	Service managers monitor performance regularly. Performance Management Group are reviewing key performance indicators across HSCM services Delayed discharges and associated indicators are monitored closely locally via weekly "huddle" meetings and there is a monthly focus on aspects of unscheduled care. In addition HSCM are contributing information to a review by Chief Officers Group Health and Social Care Scotland, working with Scottish Government, in relation to reducing Delayed Discharges.	

Assurances:	Audit, Performance and Risk Committee oversight. Operationally managed by OMT, receiving reports from Performance management group (which has a specific focus on performance). Strategic direction provided by SMT.
Gaps in assurance:	Development work will be undertaken to establishing clear links to performance that describe the changes proposed by actions identified in the new Strategic Plan
Current performance:	Close monitoring and performance management in place. The process for production of the Strategic Plan 2019-22 is underway and will facilitate further linkages across operational, Local and National Performance Indicators with progress in delivery of the National Outcomes as a clear focus.
Comments:	Regular and ongoing reporting. Work is progressing with performance monitoring and reporting with key performance indicators and appropriate owners being identified in Mental Health, Drug and Alcohol and Provider Services. Development of the Ministerial Steering Group indicators and links to local indicators that underpin them is underway.

8		
Description of Risk: *ICT*	Risk of major disruption in continuity of ICT operations, including data security, being compromised	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**MEDIUM**
Risk Movement:	increase/decrease/no change	**INCREASED**
Rationale for Risk Rating:	Corporate Information Security policies in place and staff are required to complete training and confirm they have read, understood and accept the terms of use. Impact of Brexit may result in disruption to energy supplies which could impact on continuity of ICT operations in the short term	
Rationale for Risk Appetite:	MIJB has a low tolerance in relation to not meeting requirements.	
Controls:	Computer Use Policies and HR policies in place for NHS and Moray Council and staff are required (through and automated process) to confirm they have read these every 6 months Business Continuity Plans being updated to fully reflect ICT disruption.	

	PSN accreditation secured by Moray Council Guidance regularly issued to staff. Guidance on effective data security measures issued to staff.
Mitigating Actions:	Protocol for access to systems by employees of partner bodies to be developed. Information Management arrangements to be developed and endorsed by MIJB. Integrated Infrastructure Group established, with ICT representation from NHSG and Moray Council, to consider and provide solutions to data sharing issues and ICT infrastructure matters. Linkages to Infrastructure board and Information sharing groups have been established. Data sharing groups for Grampian and Health and Social Care Moray have been established and meetings are held regularly. They will have oversight of any issues arising from Data protection and GDPR matters from either Council or NHS systems.
Assurances:	Strict policies and protocols in place with NHS Grampian and Moray Council.
Gaps in assurance:	None known
Current performance:	Training programme to be developed on records management, data protection and related issues for staff working across and between partners.
Comments:	Business Continuity arrangements are being reviewed with ICT colleagues with a focus on impact of loss of energy and consequential impact on ICT

9		
Description of Risk: *Infrastructure*	Requirements for ICT and Property 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, in predicting a budget deficit for the current financial year have implemented special arrangements to ensure only essential expenditure is incurred. This includes the consideration to the deferring of projects already in the Capital plan.	

	Interim Premises, Infrastructure and Digital Manager in place to provide additional leadership in relation to major infrastructure projects.
Rationale for Risk Appetite:	Low tolerance in relation to not meeting requirements.
Controls:	Chief Officer has regular meetings with partners Infrastructure Programme Board established with Chief Officer as Senior Responsible Officer/Chief Officer member of CMT. Process for submission of projects to the infrastructure board has been refined and in process for approval to ensure appropriate oversight of all projects underway in HSCM.
Mitigating Actions:	Dedicated project Manager in place – monitoring/managing risks of the Programme Membership of the Board reviewed and revised to ensure representation of all existing infrastructure processes and funding opportunities. Process for ensuring infrastructure change/investment requests developed Infrastructure Manager linked into other Infrastructure groups within NHSG & Moray Council to ensure level of 'gatekeeping'
Assurances:	Infrastructure Programme Board functions to provide robust governance and assurance that proposed projects have a robust business case and meets requirements of the respective partner organisations. This board reports to Strategic Planning and Commissioning Group.
Gaps in assurance:	Further work is required on developing the process for approval for projects so that they are progressed timeously. Need to review all existing processes in relation to infrastructure changes/projects/investments and streamline to avoid duplication of effort.
Current performance:	The Infrastructure Board met on 5 March and carried out and initial review of existing projects. Meetings will initially take place more frequently to embed the new processes.
Comments:	The prioritisation of existing projects will be reviewed as part of the revised process, to ensure resources are being dedicated appropriately and aligned to the emerging Strategic priorities.

Strategic Risk – Action Log

Risk	Action required	Lead	Target	Comment
1. 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.	Development of a final approved Performance Management Framework, aligned to the new Strategic Plan will be a key focus.	Chief Financial Officer	Initial target March 2019 Revised date 27 June 2019	Document to be presented as part of governance surrounding the new Strategic plan in June 2019
2. Inability to recruit and retain qualified and experienced staff whilst ensuring staff are fully able to manage change resulting from Integration	Update Organisational Development Plan (presented to MIJB in January 2018) and present to MIJB	Heads of Service	30 June 2019	Initial intention was to have a dedicated resource however recruitment was not successful. Senior Managers are now considering options for utilising the available financial resource for specific targeted actions to address key areas in a different way.
	The Workforce plan will be developed and aligned with the strategic plan 2019- 2022	Heads of Service	September 2019	
***3.* Inability to demonstrate effective governance and effective communication with stakeholders.**	Programme of future reports for Clinical and Care Governance Committee to be developed	Professional Lead for Clinical Governance / Heads of Service	June 2019	
	Communications Strategy developed and approved by MIJB in June 2017 – to be	Chief Officer	June 2019	As part of the Alliance funding a new appointment will start April 2019 and a report will be

	reviewed and updated			submitted to MIJB in June
	Governance Frameworks documented and communicated for:- • Clinical Governance • Health and Safety • Civil Contingencies • Risk management • Performance management • Staff Governance	Corporate Manager	28/2/19 31/3/19 31/7/19 31/3/19 30/6/19 31/7/19	Clinical Governance completed, Health and Safety and Risk Management are progressing. Civil Contingencies requires input from partner organisations and this is being developed.
4. **Inability to deal with unforeseen external emergencies or incidents as a result of inadequate emergency planning and resilience.**	Programme of implementation of table top exercises for business continuity to be established and implemented	HSCM Civil Contingencies Group (CCG)	31/7/19	
	Identification of staff resource to progress outstanding BC arrangements	SMT	31/3/19	
	Completion of major infectious disease/pandemic plans	Corporate Manager / HSCM CCG	30/4/19	Discussion to be held with colleagues in Aberdeen City and Aberdeenshire to ensure consistent approach
5. Risk to MIJB decisions resulting in litigation/judicial review. Expectations from external inspections are not met.	Process for sign off and monitoring actions arising from Internal and External audits is being set out as part of the HSCM governance arrangements.	Corporate manager / Chief Internal Auditor	31/3/19	
6. Inability to achieve progress in relation to	Development work will be undertaken to establish clear	Chief Financial Officer /	31/7/19	

	national Health and Wellbeing Outcomes. Performance of services falls below acceptable level.	links to performance that describe the changes proposed by actions identified in the new Strategic Plan	Corporate manager / Service Managers
7.	**Risk of major disruption in continuity of ICT operations, including data security, being compromised**	Protocol for access to systems by employees of partner bodies to be developed.	

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT PERFORMANCE AND RISK COMMITTEE ON 28 MARCH 2019**

SUBJECT: **EXTERNAL AUDIT PLAN FOR THE YEAR ENDING 2018/19**

BY: **CHIEF FINANCIAL OFFICER**

1. REASON FOR REPORT

1.1. To inform the Audit, Performance and Risk Committee of the Auditor's Annual Plan for 2018/19

2. RECOMMENDATION

2.1. **It is recommended that the Audit, Performance and Risk Committee considers and notes the contents of the External Auditor's Annual Plan for 2018/19.**

3. BACKGROUND

3.1. In September 2016, Audit Scotland was confirmed as the external auditor of the Moray Integration Joint Board (MIJB). This appointment remains in place for a period of five years commencing 2016/17. The 2018/19 financial year is the third year of the current appointment.

3.2. Audit Scotland work together with the Auditor General and the Accounts Commission to deliver public audit in Scotland and provide independent assurance to the people of Scotland that public money is spent appropriately and provides value. Audit work is carried out in accordance with International Standards on Auditing, the Code of Audit Practice http://www.audit-scotland.gov.uk/uploads/docs/report/2016/code_audit_practice_16.pdf and any other relevant guidance.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. An Annual Audit Plan for 2018/19 has been received from Audit Scotland and is attached at **APPENDIX 1** to this report. The Plan sets out the scope of the audit work and the auditors approach to the audit. The Plan details the initial risks

identified by Audit Scotland and planned work to be undertaken for the audit of the financial statements for the year ending 2018/19. Audit Scotland also aim to add value to the MIJB through its work.

4.2. The Audit Plan identifies the main risks for the MIJB which will be the focus of audit testing and are outlined in Exhibit 1 on page 4 of the Plan.

4.3. On page 6 of the Audit Plan, Audit Scotland has shown the External Audit fee for 2018/19 as being £25,000. This fee is consistent with the charges being made by Audit Scotland across the country and represents a 4% increase on the previous year.

4.4. The annual accounts timetable, including key deadlines are shown in Exhibit 4 on page 8 of the audit plan and requires the MIJB to submit the Unaudited Annual Accounts along with supporting working papers to Audit Scotland by 27 June 2019 following consideration by those charged with governance at the meeting of the MIJB of the same date. The Audit, Performance and Risk Committee will be asked to approve the audited annual accounts and to consider the Annual Audit Report at its meeting of 19 September 2019.

5. SUMMARY OF IMPLICATIONS

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

The work undertaken by External Audit seeks to provide assurance to the MIJB on the financial governance and resource management. It will express a view on the key risks to be managed in order to secure operational efficiency in line with the Strategic Plan 2016 – 19.

(b) Policy and Legal

The external audit is conducted in terms of statutory powers afforded to the appointed External Auditor and in accordance with Audit Scotland's Code of Practice.

(c) Financial implications

The annual audit fee set for 2018/19 by Audit Scotland and paid by the MIJB is £25,000.

(d) Risk Implications and Mitigation

The risks associated with the Audit Plan have been identified and categorised within the Plan under section 'Exhibit 1'.

(e) Staffing Implications

Preparation of the MIJB's financial statements will require input and coordination from the MIJB Chief Financial Officer and the finance teams

of both Moray Council and NHS Grampian which forms part of the scheduled work.

(f) Property

None arising directly from this report.

(g) Equalities/Socio Economic Impact

An Equality Impact Assessment is not required because there is no change to policy as a result of this report.

(h) Consultations

The content of the Plan has been discussed with the Chief Officer, Chief Internal Auditor and Senior Managers prior to production and their comments have been incorporated where appropriate.

6. CONCLUSION

6.1. The Annual Audit Plan informs the MIJB, its Committees and officers of the work to be undertaken by External Audit (Audit Scotland) in the year ahead.

Author of Report: Tracey Abdy
Background Papers: with author
Ref:

Moray Integration Joint Board

Annual Audit Plan 2018/19

AUDIT SCOTLAND

Prepared for Moray Integration Joint Board
March 2019

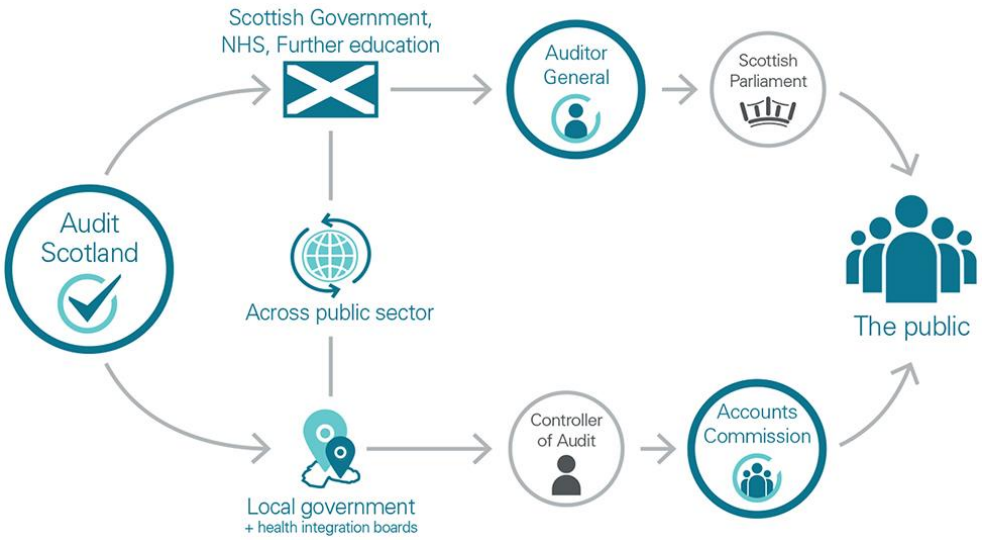
Who we are

The Auditor General, the Accounts Commission and Audit Scotland work together to deliver public audit in Scotland:

- the Auditor General is an independent crown appointment, made on the recommendation of the Scottish Parliament, to audit the Scottish Government, NHS and other bodies and report to Parliament on their financial health and performance

- the Accounts Commission is an independent public body appointed by Scottish ministers to hold local government to account. The Controller of Audit is an independent post established by statute, with powers to report directly to the Commission on the audit of local government

- Audit Scotland is governed by a board, consisting of the Auditor General, the chair of the Accounts Commission, a non-executive board chair, and two non-executive members appointed by the Scottish Commission for Public Audit, a commission of the Scottish Parliament.



About us

Our vision is to be a world-class audit organisation that improves the use of public money.

Through our work for the Auditor General and the Accounts Commission, we provide independent assurance to the people of Scotland that public money is spent properly and provides value. We aim to achieve this by:

- carrying out relevant and timely audits of the way the public sector manages and spends money

- reporting our findings and conclusions in public

- identifying risks, making clear and relevant recommendations.

Contents

Risks and planned work

1. This annual audit plan contains an overview of the planned scope and timing of our audit and is carried out in accordance with International Standards on Auditing (ISAs), the Code of Audit Practice, and any other relevant guidance. This plan sets out the work necessary to allow us to provide an independent auditor's report on the financial statements and meet the wider scope requirements of public sector audit.

2. The wider scope of public audit contributes to assessments and conclusions on financial management, financial sustainability, governance and transparency and value for money.

Adding value

3. We aim to add value to Moray Integration Joint Board (the IJB) through our external audit work by being constructive and forward looking, by identifying areas for improvement and by recommending and encouraging good practice. In so doing, we intend to help the IJB promote improved standards of governance, better management and decision making and more effective use of resources.

Audit risks

4. Based on our discussions with staff, attendance at committee meetings and a review of supporting information we have identified the following main risk areas for the IJB. We have categorised these risks into financial risks and wider dimension risks. The key audit risks, which require specific audit testing, are detailed in Exhibit 1.

Exhibit 1
2018/19 key audit risks

⚠ Audit Risk	Source of assurance	Planned audit work
Financial statements issues and risks		
1 **Risk of management override of controls** ISA 240 requires that audit work is planned to consider the risk of fraud, which is presumed to be a significant risk in any audit. This includes consideration of the risk of management override of controls to change the position disclosed in the financial statements.	Owing to the nature of this risk, assurances from management are not applicable in this instance.	Assurance from host body auditors on the accuracy and completeness of year end financial reports. Detailed testing of significant adjustments at year end. On-going review of financial position.

⚠ Audit Risk	Source of assurance	Planned audit work
Wider dimension issues and risks		
2 Financial management and sustainability The 2018/19 budget agreed by the IJB in March 2018 identified a funding shortfall of £4.6 million. This gap was subsequently reduced to £3.3 million, at the end of June, following the identification of additional savings of £0.5 million and the use of all of the IJB's reserves (£0.8 million). This represented an unbalanced budget which was underpinned by partner deficit funding in line with the integration scheme. In November 2018, the IJB agreed a financial recovery plan with NHS Grampian and Moray Council aimed at reducing the 2018/19 funding shortfall and addressing the underlying overspend on core services in future years. In February 2019, the Chair of the IJB wrote to the chief executives of its partner bodies to advise that a £1.5 million deficit (after the use of reserves) was being forecast for 2018/19 and that this would require to be funded by NHS Grampian (63%) and Moray Council (37%). We have previously reported that the IJB has yet to develop medium to long term financial plans. Although the financial recovery plan covers the period 2019/20 to 2021/22, it only sets out projected savings to recover the underlying deficit on core services and does not include any additional budget pressures. There is a risk that: • the recovery plan is not robust, and the required savings are not realised • the IJB is not planning adequately over the medium to long term to manage or respond to significant financial risks.	Progress has been made during 2018/19 through enhanced scrutiny and restrictions in relation to expenditure. This has been positive in reducing the forecast deficit (after use of reserves) for the year. The Recovery Plan has been agreed by partners and the risks inherent in the plan have been highlighted to members of the IJB. To further address this, the Senior Management Team will be conducting service reviews to ensure strategic priorities can be delivered within the financial framework. The medium term financial strategy will be aligned to the new Strategic Plan and presented to the IJB in June 2019 as part of a suite of reports addressing transformation. It is acknowledged by IJB members that this should be considered in the context of longer-term financial planning.	Ongoing review of financial monitoring reports. Continuing to monitor the in-year and year end financial position and additional funding required from NHS Grampian and Moray Council. Consideration of the quality of the recovery plan and deliverability of actions proposed. Review the development of medium/long term financial planning.

Source: Audit Scotland

Reporting arrangements

5. Audit reporting is the visible output for the annual audit. All annual audit plans and the outputs as detailed in Exhibit 2, and any other outputs on matters of public interest will be published on our website: www.audit-scotland.gov.uk.

6. Matters arising from our audit will be reported on a timely basis and will include agreed action plans. Draft management reports will be issued to the relevant officers to confirm factual accuracy.

7. We will provide an independent auditor's report to the IJB and the Accounts Commission setting out our opinions on the annual accounts. We will provide the Chief Officer and Accounts Commission with an annual report on the audit containing observations and recommendations on significant matters which have arisen during the audit.

Exhibit 2
2018/19 audit outputs

Audit Output	Target date	Audit, Performance and Risk Committee date
Annual Audit Report	9 September 2019	19 September 2019
Independent Auditor's Report	20 September 2019 (Signed)	19 September 2019 (Proposed)

Source: Audit Scotland

Audit fee

8. The agreed audit fee for the 2018/19 audit of the IJB is £25,000 (2017/18: £24,000). In determining the audit fee, we have taken account of the risk exposure of the IJB, the planned management assurances in place and the level of reliance we plan to take from the work of internal audit. Our audit approach assumes receipt of the unaudited annual accounts, with a complete working papers package on 27 June 2019.

9. Where our audit cannot proceed as planned through, for example, late receipt of unaudited annual accounts or being unable to take planned reliance from the work of internal audit, a supplementary fee may be levied. An additional fee may also be required in relation to any work or other significant exercises out with our planned audit activity.

Responsibilities

Moray Integration Joint Board and Chief Financial Officer

10. Audited bodies have the primary responsibility for ensuring the proper financial stewardship of public funds, compliance with relevant legislation and establishing effective arrangements for governance, propriety and regularity that enable them to successfully deliver their objectives.

11. The audit of the annual accounts does not relieve management or the IJB, as those charged with governance, of their responsibilities.

Appointed auditor

12. Our responsibilities as independent auditors are established by the Local Government (Scotland) Act 1973 and the Code of Audit Practice (including supplementary guidance) and guided by the Financial Reporting Council's Ethical Standard.

13. Auditors in the public sector give an independent opinion on the financial statements and other information within the annual accounts. We also review and report on the arrangements within the audited body to manage its performance, regularity and use of resources. In doing this, we aim to support improvement and accountability.

Audit scope and timing

Annual accounts

14. The annual accounts, which include the financial statements, will be the foundation and source for most of the audit work necessary to support our judgements and conclusions. We also consider the wider environment and challenges facing the public sector. Our audit approach includes:

- understanding the business of the IJB and the associated risks which could impact on the financial statements
- obtaining assurances from the auditors of the partner bodies (NHS Grampian and Moray Council) on the key systems of internal control, and establishing how weaknesses in these systems could impact on the financial statements
- assessing the risks of material misstatement in the financial statements
- determining the nature, timing and extent of audit procedures necessary to provide us with sufficient audit evidence as to whether the financial statements are free of material misstatement.

15. We will give an opinion on whether the financial statements:

- give a true and fair view of the state of affairs of the IJB as at 31 March 2019 and of its income and expenditure for the year then ended
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs), as adopted by the European Union, and as interpreted and adapted by the 2018/19 Code of practice on local authority accounting in the UK
- have been prepared in accordance with the requirements of the Local Government (Scotland) Act 1973, the Local Authority Accounts (Scotland) Regulations 2014, and the Local Government in Scotland Act 2003.

Other information in the annual accounts

16. We also review and report on other information published within the annual accounts including the management commentary, annual governance statement and the remuneration report. We give an opinion on whether these statements have been compiled in accordance with the appropriate regulations and frameworks in our independent auditor's report.

17. We also read and consider any information in the annual accounts other than the financial statements and audited part of the remuneration report and report any uncorrected material misstatements.

Materiality

18. We apply the concept of materiality in planning and performing the audit. It is used in evaluating the effect of identified misstatements on the audit, and of any uncorrected misstatements, on the financial statements and in forming our opinions in the independent auditor's report.

19. We calculate materiality at different levels as described below. The calculated materiality values for the IJB are set out in Exhibit 3.

Exhibit 3
Materiality values

Materiality	Amount
Planning materiality – This is the calculated figure we use in assessing the overall impact of audit adjustments on the financial statements. It has been set at 1% of projected gross expenditure for the year ended 31 March 19 based on the revenue budget for 2018/19.	£1.3 million
Performance materiality – This acts as a trigger point. If the aggregate of errors identified during the financial statements audit exceeds performance materiality this would indicate that further audit procedures should be considered. Using our professional judgement, we have calculated performance materiality at 50% of planning materiality.	£0.6 million
Reporting threshold (i.e., clearly trivial) – We are required to report to those charged with governance on all unadjusted misstatements more than the 'reporting threshold' amount. This has been calculated at 4% of planning materiality.	£50,000

Source: Audit Scotland

Timetable

20. To support the efficient use of resources it is critical that a timetable is agreed with us for the audit of the annual accounts. Exhibit 4 sets out the agreed timetable which takes account of submission requirements and planned Audit, Performance and Risk Committee meeting dates.

Exhibit 4
Annual accounts timetable

Key stage	Date
Consideration of unaudited annual accounts by those charged with governance	27 June 2019
Latest submission date of unaudited annual accounts with complete working papers package	27 June 2019
Latest date for final clearance meeting with Chief Financial Officer	30 August 2019
Agreement of audited unsigned annual accounts Issue of Annual Audit Report including ISA 260 report to those charged with governance	9 September 2019
Audit, Performance and Risk Committee meeting to approve the audited annual accounts for signature and to consider the Annual Audit Report	19 September 2019
Independent auditor's report signed	20 September 2019

Internal audit

21. Internal audit is provided by Moray Council internal audit section. As part of our planning process we carry out an annual assessment of the internal audit function to ensure that it operates in accordance with Public Sector Internal Audit Standards (PSIAS).

22. In our 2017/18 audit report we noted that an external assessment against the PSIAS had not yet taken place and so internal audit could not demonstrate full compliance with these Standards. The assessment took place in February 2019. We will review the findings and report the results in our Annual Audit Report

Using the work of internal audit

23. Auditing standards require internal and external auditors to work closely together to make best use of available audit resources. We seek to rely on the work of internal audit wherever possible to avoid duplication. We do not plan to place any formal reliance on the work of internal audit in 2018/19. We will consider internal audit's work on corporate governance as part of our wider dimension audit responsibilities.

Audit dimensions

24. Our audit is based on four audit dimensions that frame the wider scope of public sector audit requirements as shown in Exhibit 5.

Exhibit 5
Audit dimensions

Source: Code of Audit Practice

Financial sustainability

25. As auditors we consider the appropriateness of the use of the going concern basis of accounting as part of the annual audit. We will also comment on the IJB's financial sustainability in the longer term. We define this as medium term (two to five years) and longer term (longer than five years) sustainability. We will carry out work and conclude on:

- the effectiveness of financial planning in identifying and addressing risks to financial sustainability in the short, medium and long term
- the appropriateness and effectiveness of arrangements in place to address any identified funding gaps.

Financial management

26. Financial management is concerned with financial capacity, sound budgetary processes and whether the control environment and internal controls are operating effectively. We will review, conclude and report on whether the IJB:

- has arrangements in place to ensure systems of internal control are operating effectively
- can demonstrate the effectiveness of its budgetary control system in communicating accurate and timely financial performance
- has established appropriate and effective arrangements for the prevention and detection of fraud and corruption.

Governance and transparency

27. Governance and transparency is concerned with the effectiveness of scrutiny and governance arrangements, leadership and decision-making and transparent reporting of financial and performance information. We will review, conclude and report on:

- whether the IJB can demonstrate that the governance arrangements in place are appropriate and operating effectively
- whether there is effective scrutiny, challenge and transparency of decision-making
- the quality and timeliness of financial and performance reporting.

Value for money

28. Value for money refers to using resources effectively and continually improving services. We will review, conclude and report on whether the IJB can provide evidence that it is demonstrating value for money in the use of resources, has focus on improvement and that there is a clear link to the outcomes delivered.

Independence and objectivity

29. Auditors appointed by the Accounts Commission or Auditor General must comply with the Code of Audit Practice and relevant supporting guidance. When auditing the financial statements auditors must also comply with professional standards issued by the Financial Reporting Council and those of the professional accountancy bodies. These standards impose stringent rules to ensure the independence and objectivity of auditors. Audit Scotland has robust arrangements in place to ensure compliance with these standards including an annual “fit and proper” declaration for all members of staff. The arrangements are overseen by the Director of Audit Services, who serves as Audit Scotland’s Ethics Partner.

30. The engagement lead (i.e. appointed auditor) for Moray Integration Joint Board is Brian Howarth, Audit Director. Auditing and ethical standards require the appointed auditor to communicate any relationships that may affect the independence and objectivity of audit staff. We are not aware of any such relationships pertaining to the audit of the IJB.

Quality control

31. International Standard on Quality Control (UK and Ireland) 1 (ISQC1) requires that a system of quality control is established, as part of financial audit procedures, to provide reasonable assurance that professional standards and regulatory and legal requirements are being complied with and that the independent auditor’s report or opinion is appropriate in the circumstances.

32. The foundation of our quality framework is our Audit Guide, which incorporates the application of professional auditing, quality and ethical standards and the Code of Audit Practice (and supporting guidance) issued by Audit Scotland and approved by the Auditor General for Scotland. To ensure that we achieve the required quality standards Audit Scotland conducts peer reviews and internal quality reviews. Additionally, the Institute of Chartered Accountants of Scotland (ICAS) have been commissioned to carry out external quality reviews.

33. As part of our commitment to quality and continuous improvement, Audit Scotland will periodically seek your views on the quality of our service provision. We welcome feedback at any time and this may be directed to the engagement lead.

Moray Integration Joint Board

Annual Audit Plan 2018/19

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REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 28 MARCH 2019**

SUBJECT: **INTERNAL AUDIT UPDATE**

BY: **CHIEF INTERNAL AUDITOR**

1. REASON FOR REPORT

1.1 To provide an update on progress towards delivery of the internal audit plan for the 2018/19 year and on work being undertaken to inform the 2019/20 programme of internal audit work.

2. RECOMMENDATION

2.1 It is recommended that the Audit, Performance and Risk Committee considers and notes:

i) the contents of this update report,

ii) the internal audit reporting protocol as outlined in APPENDIX 1

3. BACKGROUND

3.1 At the meeting of this Committee on 13 December 2018 (paragraph 5 of the draft Minute refers), it was reported that internal audit had undertaken planned audit work on the payroll system used for all employees of the Moray Council.

3.2 In this current year to date, with particular reference to employee groups funded by council and working for Health and Social Care Moray, Internal Audit has;

- Collated an overtime analysis – not of large scale and in expected areas of home care and supported accommodation facilities;
- Looked at the payroll costs for the Independent Living Service – the Home from Hospital Team of Home Carers and therefore similar to mainstream Home Care covered in prior year audit;
- Analysed staff costs for the Hospital Discharge Team – the team of social workers providing liaison from acute discharge to community.

- Analysed staff costs for council funded Mental Health care staff – This is the team at Pluscarden Clinic providing support for adults with mental health issues in the community. A service review in this area is also ongoing and progress on this will inform the timing of further testing of these costs.
- Reviewed and confirmed staff costs for Employment Support Services and Moray Resource Centre which are prominent costs in these service areas.

3.3 Annual assurances on elements of the payroll system fall to be provided principally on grounds of materiality with payroll costs exceeding 70% of the total council budget. Reflecting this significance, the audit testing extends beyond social care with coverage in the 2018/19 year also taking in an overarching review of payroll system access controls (to ensure there is a clear audit trail as to who is accessing data and for what purpose), testing of specific staff groups subject to particular terms and conditions (e.g. supply teachers) and computation of wages paid to new starts and leavers.

3.4 In addition the annual audit plan prepared by PricewaterhouseCoopers (PwC) for NHS Grampian provides for a review of key financial controls, also to include payroll work. This work is scheduled for the current (4th) quarter of the financial year and will inform the assurances to be provided on payroll applicable to NHS systems.

3.5 In relation to the MIJB plan for 2018/19 an agreed audit input of 80 days was made available for audits relating to Social Care. The status of each one is as follows.

- **Learning Disabilities:** An interim report was prepared noting that the service had recognised a need to review existing contract arrangements to ensure these were aligned to service users requirements – this work had started but was at an early stage and is to be the subject of further audit work in 2019/20

- **Contributions Policy**: This work was to review a sample of financial assessments for service users to confirm the correct and consistent application of the contributions policy. The audit fieldwork has been completed and a draft report prepared and issued to management for comment and completion of the agreed action plan.

- **Governance Review**: This is an annual requirement to inform the audit opinion on the governance arrangements linked to Scottish Government guidance and best value requirements and will take place imminently so as to be able to inform governance arrangements for the full year. The work of PwC in this area will in part inform this review.

- **Self-Directed Support:** This work takes the form of ongoing participation in a service development working group and continues.

- **Payroll Testing:** as summarised above.

3.6 Coming up to the year end, consideration has also turned to what the audit plan for 2019/20 should include and two meetings have taken place with the

Health and Social Care Senior Management Team to discuss recent audit coverage and seek views as to potential audit topics. A meeting was also scheduled with the Chief Officers of the three IJBs and other relevant officers to discuss how planned NHS internal audit activity could inform assurances available to the IJBs. This meeting was postponed and has still to take place at the time of preparing this report. Any update available will be provided at the meeting.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 This report provides an update on audits progressed in relation to the planned work for 2018/19; and notes the work taking place to inform planned work and audit assurances that will be made available for the incoming financial year.

4.2 At a meeting on 13 December 2018 (para 6 of the draft Minute refers) the committee sought assurance of the monitoring of progress made in implementation of internal audit recommendations. **APPENDIX 1** outlines the protocol in place and a summary will be provided as part of the Annual Audit report on 25 July 2019.

5. SUMMARY OF IMPLICATIONS

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

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

(b) Policy and Legal

Internal audit provides independent assurances in line with Information Resources Advisory Group guidance

(c) Financial implications

No direct implications

(d) Risk Implications and Mitigation

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

(e) Staffing Implications

No implications

(f) Property

No implications

(g) Equalities/Socio Economic Impact

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

(h) Consultations

The Chief Financial Officer and Caroline Howie, Committee Services Officer have been consulted in respect of this report and their comments incorporated.

6. CONCLUSION

6.1 This report provides the Committee with an update on progress towards completion of the projects in the 2018/19 internal audit plan and on preparation work underway to inform internal audit coverage for the incoming financial year.

Author of Report: Atholl Scott
Background Papers: Internal audit files
Ref: MIJB/aprc/280319

	STAGE	WHO
Plan	Consideration of areas for audit plan	OMT/SMT/Chief Internal Auditor
	Co-ordination of audit activities across partner organisations	Chief Internal Auditor
	Audit scope agreed	SMT
	Audit Plan presented to Audit Performance and Risk Committee	Chief Internal Auditor
Implementation	Audit carried out	Service Manager / Internal Audit
	Findings discussed and recommendations agreed. Responsible officer/group identified. Action plan and timescales agreed	Service Manager / Internal Audit
	Final report circulated*	Internal Audit
Monitor	Monitor progress (at appropriate level)	Service Manager / appropriate group
Review	Follow up reporting	Internal Audit / Service manager
	Exception reporting to Audit Performance & Risk committee for areas of concern or wider implications	Chief Internal Auditor

* All agreed recommendations will be collated by corporate manager, to facilitate sharing of best practices and identification of areas that need to be addressed across the system.

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 28 MARCH 2019**

SUBJECT: **NHS GRAMPIAN: INTERNAL AUDIT REPORTS**

BY: **CHIEF INTERNAL AUDITOR**

1. REASON FOR REPORT

1.1. To inform the Committee of the outcomes from two recent internal audit reports prepared by PriceWaterhouseCoopers, the appointed Internal Auditor for NHS Grampian.

2. RECOMMENDATION

2.1 It is recommended that the Committee considers and notes the findings and recommendations from the internal audit reports.

3. BACKGROUND

3.1. PriceWaterhouseCoopers has been contracted by NHS Grampian to provide internal audit services, and in terms of this engagement undertakes a number of audit projects annually in line with an agreed audit plan.

3.2. The audit outcomes in the form of audit reports are considered by NHS management and its audit committee, however, it has been agreed that the audit reports may be shared with the three north east Integration Joint Boards (IJBs) to the extent that they may be of interest/relevance to these bodies.

3.3. The recently completed audits cover:

- Health and Safety Governance (**APPENDIX 1**); and
- Unscheduled Care Discharge Process (**APPENDIX 2**).

3.4. Recommendations in the audit reports are graded low, medium, and high. The Health and Safety Governance review highlighted one medium recommendation relating to the Terms of Reference for the NHSG Senior Leadership Team covering this topic. Management in response agreed to review the role and remit of the Senior Leadership Team.

3.5. The Unscheduled Care Discharge Process audit involved an audit visit to Dr Gray's hospital to look at how health staff and social care staff interact to coordinate the discharge process. From the audit two medium risk issues were highlighted, one recommendation being that a draft 'Patient Discharge from Hospital' protocol be finalised, and the second related to ensuring consistency in the process for recording, updating and interpreting Estimated Dates of Discharge for all patients. Both recommendations were accepted and actions agreed to have these implemented.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. Internal audit reports prepared on behalf of NHS Grampian where these have links to the work of the IJB provide additional assurances that can be relied on when concluding on the overall effectiveness of governance and control systems within Health and Social Care.

5. SUMMARY OF IMPLICATIONS

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

No direct implications.

(b) Policy and Legal

No direct implications.

(c) Financial implications

No direct implications.

(d) Risk Implications and Mitigation

Risk issues arising in the audit projects completed will be mitigated by management implementing the audit recommendations.

(e) Staffing Implications

No direct implications.

(f) Property

No direct implications.

(g) Equalities/Socio Economic Impact

An Equality Impact Assessment is not required because there is no change to policy as a result of this report.

(h) Consultations

There have been no consultations in respect of this report.

6. CONCLUSION

6.1 Committee is asked to note the outcomes from the two audits prepared by PricewaterhouseCoopers on behalf of NHS Grampian

Author of Report: Atholl Scott
Background Papers: PwC audit reports
Ref: AS/aprc/280319

Internal Audit Report 2018/2019

Health & Safety Governance

NHS Grampian

Final

March 2019

pwc

Contents

Distribution List	
For action	Director of Workforce
	Head of Occupational Health & Safety
	Chief Officer, Aberdeen City IJB
	Chief Officer, Aberdeenshire IJB
	Chief Officer, Moray IJB
For information	Audit Committee

This report has been prepared by PwC in accordance with our engagement contract dated 1 August 2017.

Internal audit work was performed in accordance with PwC's Internal Audit methodology which is aligned to the Public Sector Internal Auditing Standards. As a result, our work and deliverables are not designed or intended to comply with the International Auditing and Assurance Standards Board (IAASB), International Framework for Assurance Engagements (IFAE) and International Standard on Assurance Engagements (ISAE) 3000.

1. Executive summary

Report classification	*Trend*	**Total number of findings**				
			Critical	High	Medium	Low	Advisory
Low Risk	N/A – No prior year reviews for comparison	Control design	-	-	1	1	-
		Operating effectiveness	-	-	-	-	-
		Total	**-**	**-**	**1**	**1**	**-**

Summary of findings

The objectives of this review were to assess the control design and effectiveness of the Health and Safety governance and oversight structures established by NHS Grampian ('NHSG') and the Health and Social Care Partnerships (HSCPs) and to confirm that the issues identified by the HSE Improvement Notices served on NHSG have been, or are being, effectively managed through to resolution. In addition we reviewed the Health & Safety governance arrangements within NHSG Acute Services.

In summary we have identified one 'medium' risk finding and one 'low' risk finding in relation to control improvement opportunities and these result in this report being classified as 'low' risk overall.

The medium risk finding is as follows:

- Terms of Reference or Constitutions for six committees with Health and Safety governance and oversight responsibilities as part of their remit either exist as draft documents or are overdue for review. This finding spans the three HSCPs and NHSG.

The full details of the above finding, the low risk finding and the agreed actions, can be found in **Section 3**.

Management comment

Management welcomes the report and agrees in principle with the overall findings. Over the past 3 years there has been considerable advancement in the development of Health & Safety governance structures both within NHS Grampian and our Health & Social Care Partners. This report highlights these achievements and further encourages the strengthening of these partnerships in relation to Health & Safety governance and the evolution of safe systems of work Pan-Grampian.

Head of Occupational Health and Health & Safety

2. Background and scope

Background

The objectives of this review were to assess the control design and effectiveness of the governance and oversight structures established by NHSG and the HSCPs and to confirm that the issues identified by the HSE Improvement Notices have been, or are being, effectively managed through to resolution.

We noted the following:

1. **NHS Grampian Health & Safety Governance**

   There are a number of Committees, Teams and Groups with H&S responsibilities that report upwards to the NHS Grampian Board via an established governance hierarchy. Each of these governance bodies functions in accordance with agreed Terms of Reference or a Constitution. Each body is required to maintain appropriate records of meetings in order to demonstrate that it is carrying out the business for which it is responsible according to its remit.

2. **Health and Social Care Partnership Health & Safety Governance**

   NHS Grampian works in partnership with Aberdeen City, Aberdeenshire and Moray Councils to develop and implement arrangements to support health and social care integration. An Integration Joint Board ('IJB') exists for each of the three partnership arrangements to provide strategic leadership for the management and delivery of integrated services. Within each of the Health & Social Care Partnership organisations there are a number of Committees and Groups that report up to the IJBs on matters related to Health & Safety governance. As within NHS Grampian, each of these governance bodies functions in accordance with agree Terms of Reference. Each body is required to maintain appropriate records of meetings in order to demonstrate that it is functioning in accordance with its remit.

   There is collaboration and information sharing on Health and Safety matters between the HSCP committees and the counterpart NHS Grampian committees at all levels.

   As a point of good practice it is important that each Committee within a governance framework includes a standing agenda item to determine if there any issues or reports that require escalation to a higher level Committee. If there are no escalations or referrals then the minutes should confirm so. Alternatively if the meeting determines that escalations or referrals are required then these should be itemized in the minutes. Whilst these arrangements appear to be in place based on our limited sample, we take this opportunity to cite best practice as we cannot be certain that it happens in every case.

3. **Health and Safety Executive Improvement Notices Placed on NHS Grampian**

   In the past 24 months the Health and Safety Executive (HSE) has placed a total of seven Improvement Notices in different areas of NHSG. These related to:

   Falls x 2 Notices

Sharps x 2 Notices

Staff Immunisation x 1 Notice

Skin Health Surveillance x 1 Notice

Ligature Injuries x 1 Notice

Investigation and gap analysis work has been undertaken and documented in order to fully understand the nature of the issues raised by the HSE and to enable the formulation of plans to remediate gaps and resolve the issues. There are remediation plans in place that have been properly documented and approved and there are clearly assigned owns responsible to delivering these plans.

Plan progress is being suitably reported to and overseen by the appropriate groups and committees within the H&S governance structure with headline progress being reported up through the governance hierarchy to the NHSG Board. Policies relating to the areas identified by the HSE have been updated as necessary to ensure changes and improvements in working practices are sustainable and effectively communicated to staff. As at 30 October 2018 five out of the seven notices have been lifted. The other two notices have a timeline set by the HSE of 31 January 2019 (Falls - Manual Handling) and 31 March 2021 (Ligature). We understand that the HSE have ask for a postponement of the 31 January 2019 meeting with regard to the Falls notice with diaries currently being checked with a view to having the meeting at the end of February 2019. NB: The Falls notice was actually lifted on 31 January 2019 so the envisaged postponement was not required.

4. NHS Grampian (Acute Services)

There are health and safety policies and procedures in place and these been communicated to and are accessible to staff within Acute Services. These are kept up to date and reviewed in accordance with the document control procedures. The Board of NHS Grampian is ultimately responsible for ensuring that the organisation keeps up to date with and complies with Health and Satiety legislation. The Operational Group (Acute) in collaboration with the NHSG Health and Safety Expert Group and the NHSG Occupational Health & Safety Committee ensures that policies and procedures within Acute Services are updated appropriately and communicated to Acute Services staff and management. Health and Safety monitoring reviews are conducted within Acute Services and the results reported to NHSG Occupational H&S Committee. Circumstances when risk assessments should be completed are defined and risk assessments are performed by risk owners as required. Mandatory and specialists training are done to ensure that Acute Services staff follow the Health and Safety policies and procedures.

Scope and limitations of scope

Our approach focused on the following four areas:

1. **NHSG Governance**
2. **HSCP Governance**

3. **HSE Improvement Notices**
4. **Acute Services**

The scope of our review is outlined above and will be undertaken on a sample basis.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgment in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Our agreed Terms of Reference are set out at **Appendix 2**.

3. Detailed current year findings

3.01 Terms of Reference for Key Groups and Committees – control design

Finding
Each of the committees with Health & Safety governance and oversight responsibilities within the organisational structures of NHSG and the HSCPs should have a Terms of Reference or Constitution describing the purpose, scope and authority of the committee. It is good practice to review such Terms of Reference at least once a year. We noted that the Terms of Reference for the following committees either exist in draft format and/or have never been formally approved: 1. Aberdeen City HSCP – Staff Governance H&S Committee - July 2016 2. Aberdeen City HSCP H&S Committee Role and Remit - February 2017 (Draft) 3. Moray HSCP – H&S Group – 2018 (Draft) 4. Aberdeenshire – Clinical Health and Social Work Committee – June 2017 (never formally approved). The Terms of Reference or Constitutions for the following committees are overdue for review: 5. NHSG Staff Governance Committee (Constitution) – this is dated November 2015. The document states that there should be an annual review 6. NHSG Occupational H&S Committee (Constitution) – this is dated May 2009 and the document review cycle is stated as being every 3 years 7. NHSG Senior Leadership Team (Terms of Reference) – this is dated June 2016. The document has no stated review frequency.
Implications
• Terms of Reference may be outdated and not fully reflect the purpose and scope of the committee or properly describe the meeting arrangements.

Action plan		
Finding rating	*Agreed actions*	*Responsible person / title*
Medium	• All draft Terms of Reference will be reviewed, updated where necessary, approved and published as final. • All terms of reference that are overdue for review will be reviewed updated as necessary, approved and published as final. • Arrangements will be put in place to ensure that all Terms of Reference are reviewed in accordance with document control requirements set out in the ToRs. Management notes that it is best practice to schedule a ToR review at least once a year.	1.1 Chief Officer, Aberdeen City IJB 1.2 Chief Officer, Aberdeen City IJB 1.3 Chief Officer, Moray IJB 1.4 Chief Officer, Aberdeenshire IJB 1.5 Operational Director of Workforce 1.6 Head of Occupational Health and Health & Safety 1.7 Senior Leadership Team The Board's assurance framework including the role and remit of the Board's Core Governance Committee's (Staff, Clinical, Audit, Performance and Engagement and Participation) will be reviewed following feedback from the national review of governance arrangements currently underway and expected to report in Summer 2019 and internally following further consideration of how the business of these Core Governance Committees may be impacted by the Performance, Assurance, Improvement and Risk arrangements (PAIR) recently agreed by the System Leadership Team and the Board. *Target date:* 1.1 31 July 2019 1.2 31 July 2019 1.3 Completed 1.4 31 August 2019 1.5 Completed

1.6	30 June 2019
1.7	Summer 2019
Reference number:	
HSG / 01	

3.02 Key Groups and Committee's Meeting Arrangements– control design

Finding
We reviewed the meeting arrangements set out in the Terms of Reference for each governance committee with regard to such matters as meeting frequency and location, meeting procedures, quorum, details about agendas and minutes and how these will be distributed. We noted the following: • NHSG Senior Leadership Team – The Terms of Reference for the Senior Leadership Team specifies the frequency of meetings as being 'on two occasions each month'. We sample reviewed the records of meetings held for five months (February, March, April, May and June) noted that for May and June 2018 only one meeting was held.
Implications
Governance committees may not achieve their desired level of efficacy if they do not meet at the frequency set out in their Terms of Reference

Action plan		
Finding rating	*Agreed action*	*Responsible person / title*
Medium	The role and remit of the Senior Leadership Team will be reviewed under the recently agreed Performance, Assurance, Improvement and Risk arrangements (PAIR) agreed for implementation by the SLT and the NHSG Board.	Senior Leadership Team *Target date:* Summer 2019 *Reference number:* HSG / 02

Appendix 1. Basis of our classifications

Individual finding ratings

Finding rating	*Assessment rationale*
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences**;** or • ***Critical*** impact on the reputation or brand of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences**;** or • ***Significant*** impact on the reputation or brand of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation or brand of the organisation.
Low	A finding that could have a: • ***Minor*** impact on the organisation's operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***Minor*** impact on the reputation of the organisation.
Advisory	A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.

Report classifications

The report classification is determined by allocating points to each of the findings included in the report

Findings rating	Points
Critical	40 points per finding
High	10 points per finding
Medium	3 points per finding
Low	1 point per finding

Report classification	Points
Low risk	6 points or less
Medium risk	7– 15 points
High risk	16– 39 points
Critical risk	40 points and over

Appendix 2. Terms of Reference

Background and audit objectives

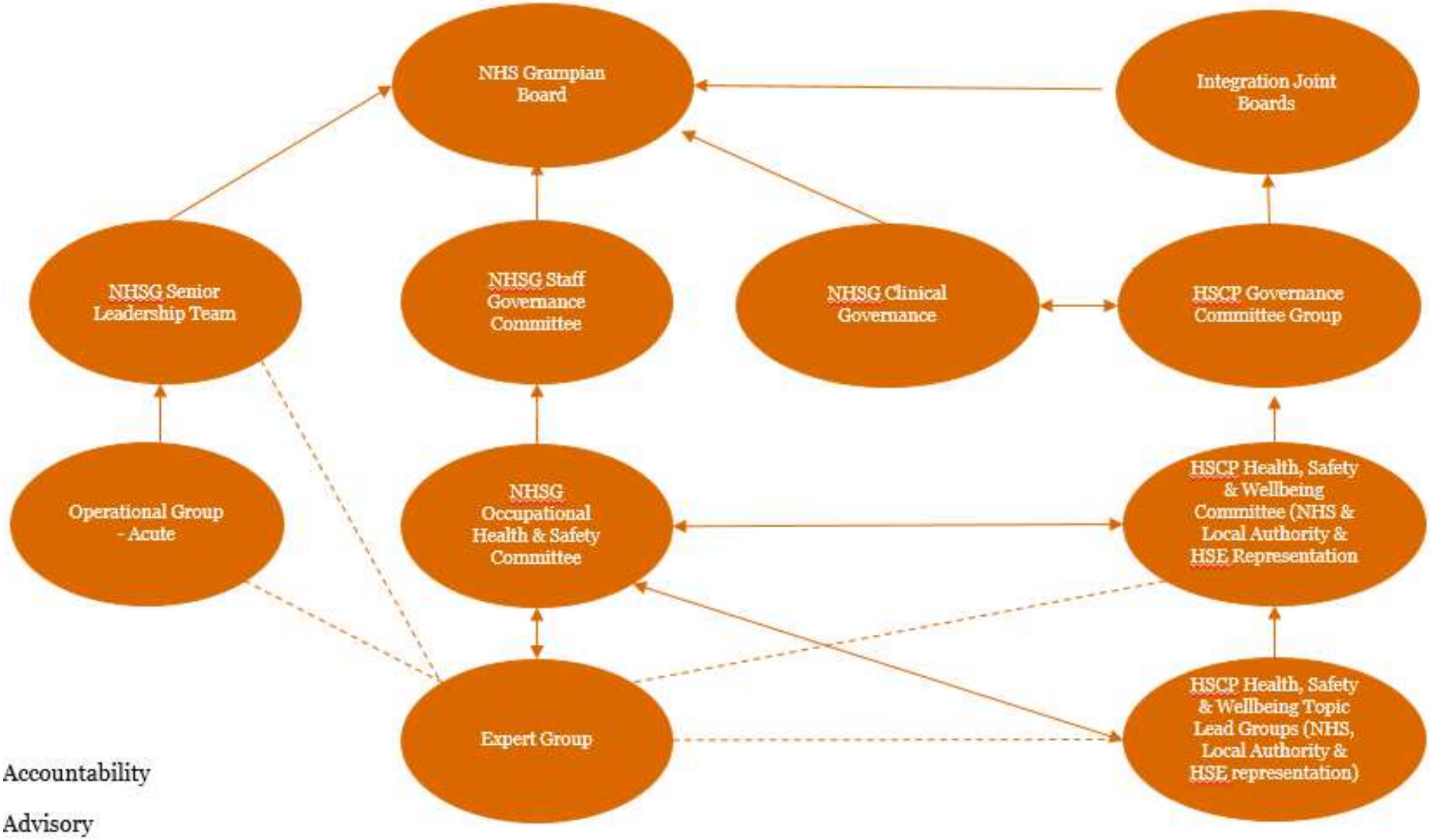
Health and Safety within the workplace refers to preventing accidents and injuries to employees, contractors, patients and visitors. Failing to efficiently and effectively manage Health and Safety risks through appropriate policies and controls can be extremely costly both at a financial and a reputational level. As an employer, NHS Grampian ('NHSG') has a responsibility to ensure that all of its sites adhere to the Health and Safety policies, standards and controls as implemented throughout the Health Board.

Crucial for the delivery of an effective health, safety and welfare strategy is the existence of adequate arrangements for governance, oversight and consultation on health, safety and wellbeing process and performance across NHSG and the three regional Health and Social Care Partnerships (HSCPs). On the slide overleaf we show the structure of the Group and Committees that have been established to provide this governance and oversight and who will take action as necessary to rectify and areas of concern.

During the past two years the Health and Safety Executive (HSE) have placed a total of seven Improvement Notices across various areas of NHSG and these have required NHSG to undertake gap analyses and develop and implement action plans in order to remediate the issues raised by the HSE and to strengthen the Health and Safety management regime across NHSG.

The objectives of this review are to assess the control design and effectiveness of the governance and oversight structures established by NHSG and the HSCPs and to confirm that the issues identified by the HSE Improvement Notices have been, or are being, effectively managed through to resolution.

Governance Structure



Scope

We will review the Health and Safety governance arrangements, including actions arising from HSE notices issued. The primary focus of the review will be governance arrangements in acute services but the review will also consider overall H&S governance at the IJB level.
The sub-processes, related control objectives included in this review are:

Sub-Process	Objectives
NHSG Governance	• There is a clearly defined and communicated governance structure. • Each Board, Committee and Group (hereinafter referred to as 'governance fora' within the structure has clearly defined roles and responsibilities and these are set out in approved Terms of Reference. • There is auditable evidence that each governance forum is functioning in accordance with its Terms of Reference with regard to such matters as frequency of meetings, attendance, agenda content, meeting conduct, inputs to and outputs from meetings including minutes and action lists. • There is effective escalation upwards through the governance hierarchy of reports, management information and other such information e.g., risk registers that needs to flow from the lower level governance fora up to the NHSG and Integration Joint Boards and between these Boards.
HSCP Governance	• There is a clearly defined and communicated governance structure within each HSCP. • Each Committee and Group within the structure has clearly defined roles and responsibilities and these are set out in approved Terms of Reference • There is auditable evidence that each governance forum is functioning in accordance with its Terms of Reference with regard to such matters as frequency of meetings, attendance, agenda content, meeting conduct, inputs to and outputs from meetings including minutes and action lists. • There is effective escalation upwards through the governance hierarchy of reports, management information and other such information e.g., risk registers that needs to flow from the lower level governance fora within the HSCPs up to the Integration Joint Boards and between comparable/collaborative forums across the NHSG and HSCP organisations.
HSE Improvement Notices	• Roles and responsibilities for responding to and addressing the issues raised by the HSE have been clearly allocated. • Appropriate investigations and gap analysis work have been undertaken and documented in order to fully understand the nature of the issues raised by the HSE and to enable the formulation of plans needed to remediate the gaps and resolve the issued. • Remediation plans have been properly documented and approved and have clearly defined owners. • Progress against remediation plans is being properly overseen by and reported to the appropriate governance fora with headline progress being reported up to the NHSG Board. • Requirements for external reporting on progress to the HSE are being properly fulfilled. • Policies, procedures and standard are updated where necessary to ensure that the actions taken in remediation of HSE are permanent and sustainable as required.

Acute Services	• Relevant health and safety policies and procedures are in place and have been communicated to staff within acute services. These are kept up to date and reviewed regularly. • Responsibility for keeping up to date with legislation and communicating changes has been assigned and policies and procedures are updated appropriately and communicated to acute services staff. • Health and Safety monitoring reviews are conducted within acute services and the results reported. • Circumstances when risk assessments should be completed are identified and risk assessments are performed by risk owners as required. • Action are taken to ensure that acute staff follow the Health and Safety policies and procedures, such as communication of responsibilities and providing up to date training for employees.

Appendix 3. Limitations and responsibilities

Limitations inherent to the internal auditor's work

We have undertaken the review of the health and safety governance, subject to the limitations outlined below.

Internal control

Internal control systems, no matter how well designed and operated, are affected by inherent limitations. These include the possibility of poor judgment in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Future periods

Our assessment of controls is for the period specified only. Historic evaluation of effectiveness is not relevant to future periods due to the risk that:

- the design of controls may become inadequate because of changes in operating environment, law, regulation or other; or
- the degree of compliance with policies and procedures may deteriorate.

Responsibilities of management and internal auditors

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We endeavour to plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we shall carry out additional work directed towards identification of consequent fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, do not guarantee that fraud will be detected.

Accordingly, our examinations as internal auditors should not be relied upon solely to disclose fraud, defalcations or other irregularities which may exist.

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Internal Audit Report 2018/2019

Unscheduled Care Discharge Process (incl. interaction with IJBs)

March 2019

Final

NHS Grampian

pwc

Contents

Distribution List

For action	General Manager – Acute Sector, NHS Grampian
	Acute Director (Nursing and Midwifery)
For information	Audit Committee
	Chief Officer, Aberdeenshire Health & Social Care Partnership
	Chief Officer, Aberdeen City Health & Social Care Partnership
	Chief Officer, Moray Health & Social Care Partnership

This report has been prepared by PwC in accordance with our engagement contract dated 1 August 2017.

Internal audit work was performed in accordance with PwC's Internal Audit methodology which is aligned to the Public Sector Internal Auditing Standards. As a result, our work and deliverables are not designed or intended to comply with the International Auditing and Assurance Standards Board (IAASB), International Framework for Assurance Engagements (IFAE) and International Standard on Assurance Engagements (ISAE) 3000.

1. Executive summary

Report classification	*Trend*	**Total number of findings**				
			Critical	High	Medium	Low	Advisory
Low Risk	N/A – No prior year reviews for comparison	Control design	-	-	-	-	-
		Operating effectiveness	-	-	2	-	-
		Total	**-**	**-**	**2**	**-**	**-**

Summary of findings

The scope of this audit review was to assess the discharge process in NHS Grampian following the creation of the Integration Joint Boards (IJBs) in Scotland. The review focused specifically on unscheduled care discharges and the process for managing and changing the flow and pathway of patients within and between NHS Grampian and the Moray, Aberdeenshire and Aberdeen City IJBs.

Overall conclusions

The current processes and controls in place are designed with a focus on patient rather than bed management and the provision of excellent patient care. Whilst there are areas for improvement, it is important to note that health and social care integration is relatively new and processes and controls are still being embedded into operations. Furthermore, with increasing demand for health and social care, both primary and acute care sectors are working to develop the necessary efficiencies in ensuring robust unscheduled care discharge processes. This is challenging, particularly with the social care sector, against a backdrop of workforce supply, recruitment and retention challenges with a reducing number in the working age population.

Key findings

In summary we have identified two 'medium' risk findings related to control improvement opportunities resulting in this report being classified as 'low' risk. The findings are:

- NHS Grampian 'Patient Discharge from Hospital Protocol' prepared in September 2016 as a draft document has not been finalised or updated.
- Variances in recording and interpreting Estimated Dates of Discharge (EDDs).

The full details of our findings and the agreed actions can be found in **Section 3** of this report.

Good practice noted

We attended a Monday 12 noon Multi-Disciplinary Team (MDT) meeting in Dr. Gray's hospital on 12 November 2018 in Elgin. It was noted that the multi-disciplinary team (MDT) ran through almost every patient admitted to Dr. Grays and discussed what stage of care they were at and the next stage in their care journey. Clear actions were assigned to individuals to drive forward each patient's care and to help ensure that they are discharged as quickly as possible. Furthermore, specific attention was paid to those patients that were already delayed discharges, for a number of reasons. This meeting involved all necessary individuals from both the acute sector and Moray Health and Social Care Partnership with individuals from social work, occupational therapy, physiotherapy, the Geriatric Consultant from Dr. Grays, hospital operational staff, and senior charge nurses from each ward within Dr Grays were all present.

Whilst Aberdeen Royal Infirmary (ARI) also has site wide MDT meetings we did not attend and observe such a meeting.

Management comments

We are pleased to note that the audit recognises the multi-agency and cross-system participation and as such there are examples of good practice in both Aberdeen Royal Infirmary and Dr Gray's Hospital with their respective Health and Social Care Partnerships.

The EDD process relies upon our systems being embedded, which is a current priority, and we welcome the report highlighting this issue.

General Manager (Acute Sector)

2. Background and scope

Background

The Public Bodies (Joint Working) (Scotland) Act 2014 is the legislative framework for the integration of health and social care services in Scotland. It created a number of new public organisations, known as integration authorities and aims to break down the barriers to joint working between NHS Boards and local authorities. As part of this, the Act requires the integration of the governance, planning and resourcing of adult social care services, adult primary care and community health services and some hospital services.

Improving unscheduled care across Scotland is a key ministerial priority for the Scottish Government.

There are many things which have the potential to cause delay and unnecessarily prolong a patient's stay in hospital. Some of these can be categorised as 'external' (services or resources external to the ward or hospital which may not be available when the patient needs them); however, there may also be internal causes of non-clinical delay, and these can also contribute to poor patient experience. Discharge plans begin on patient admission to acute care. Regardless of the terminology used, a delayed discharge is an interruption of a clear flow through a system of care and support. Such interruptions tend to be symptoms of systems that are not geared to work together. Therefore, discharge performance is a clear performance indicator of the effectiveness of integrated health and social services.

In the Performance Report to the NHS Grampian Board Meeting held on 6 December 2018 it was noted that during September 2018, patients spent 4,023 days in hospital due to delays in discharge in Grampian. The figure for September 2017 was 3,408 so 2018 has seen in increase in delayed discharges of approximately 18%.

Across Scotland patients spent 45,470 days in hospital during September 2018 due to delayed discharges. The national figures for September 2017 was 42,110 so 2018 has seen an increase of delayed discharges of approximately 8%.

Multi-disciplinary Team Planning

Within NHSG a multi-disciplinary team (MDT) aims to meet within twelve hours of a patient being admitted to either Aberdeen Royal Infirmary (ARI) or Dr. Grays hospital in Elgin. The MDT is comprised of a number of health professionals from both the acute sector and the individual Health and Social Care Partnerships. The MDT is made up of professionals or disciplines such as the on-shift consultant, senior charge nurse, staff nurse, social care, occupational therapy and physiotherapy. The MDT will discuss the patient's required treatment, specific pharmacy requirements, possible ongoing, external, care at home or in a community care setting. The MDT will identify each dependent task and will agree when each needs to start and finish to ensure that the patient can be discharged without delay.

Setting and Reviewing an Estimated Date of Discharge (EDD) and Discharge Planning

At the MDT meeting to discuss a patient's treatment and possible ongoing care an estimated date of discharge (EDD) will also be set for that patient. Every patient when entering either ARI or Dr. Grays should be given an EDD. An EDD is the date when the MDT believes the patient can be safely discharged from the acute hospital setting. This may be to home or another place of care. EDDs are input into the electronic patient management system (Trakcare), the data from which feeds through to an individual Wardview system that can be viewed by staff nurses and senior charge nurses. The EDD should be updated regularly and should reflect the ongoing

progress of the patient care journey.

EDDs are fundamental to discharge planning and within NHSG are reviewed daily during ward rounds and at the site-wide system and flow huddles held at 9am, 12 noon and 4pm at both ARI and Dr. Grays. The daily ward rounds are fundamental to daily dynamic discharging. Ward staff will meet to discuss each patient in the ward to agree and prioritise the day's tasks – including any patient who can be discharged before 12 noon or in the evening. Daily dynamic discharging and planning help hospital operational staff plan the bed capacity for the day at each site.

Measurement Framework

NHSG conducts Day of Care Surveys with two surveys completed each year. The surveys are conducted at both acute hospitals within NHSG. These surveys are carried out between 9am and 10:30am across all acute sector wards on the same day. The surveys do not include intensive care, medical and surgical high dependency and coronary care beds. The surveys will review those patients who are found to be appropriately in hospital and those who are not, the age profile of patients, wards with patients not appropriate to be in hospital, NHSG length of stay and will also review the main reasons for patients not being discharged – for example, those patients who are waiting for community beds.

On top of these surveys, there are Delayed Discharge Updates which analyses the delayed discharge performance within each Health and Social Care Partnership. These are specified, formal, six monthly updates on delayed discharge performance which are prepared for each IJB.

Delayed Discharge Performance Reporting and Action Plans

Each individual IJB will report delayed discharge census (number of patients delayed at a specific point in time during the month) and bed days lost each month using government criteria. The information is reported to the Information Services Division of the NHS National Services Scotland. Standard delays and complex delays are reported differently by the IJBs.

The IJBs have actions plans which are put in place to improve delayed discharge performance. These include details of performance and data reporting, discharge pathways and processes, plans to deal with complex delays, services and other resources required to support discharges. The Delayed Discharge Performance and Improvement Programme (the six monthly updates) are linked to each Health and Social Care Partnership strategic risk register. The updates explain plans to mitigate the risks identified in the risk registers.

Scope and limitations of scope

This review therefore concentrated on the five key sub-processes which together help ensure effective discharging. These were:

- **Multi-disciplinary (MDT) team planning.**
- **Setting and reviewing an Estimated Date of Discharge (EDD).**
- **Discharge planning.**
- **Measurement framework for measuring and reporting on patient discharge flow.**

- **Delayed discharge performance reporting and action plans.**

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgment in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Further details of the scope, key sub-processes and related control objectives are included in the agreed Terms of Reference set out in **Appendix 2** of this report.

3. Detailed current year findings

3.01 NHSG Patient Discharge from Hospital Protocol – operating effectiveness

Finding

NHSG has a draft 'Patient Discharge from Hospital Protocol' which is dated September 2016. The protocol is to be followed when a patient's needs indicate that they will require support from community health and social care services on discharge into the community. The aim is to provide a consistent co-ordinated approach with multi-disciplinary, multi-agency input while maintaining a patient's interests as central to the discharge planning process.

The protocol states that it is a 'working document and as services and practices develop, it will be reviewed to improve or add to ways of working and to accommodate new service developments'.

The protocol was drafted during the early days following the creation of the Health and Social Care Partnerships and Integration Joint Boards in April 2016. The protocol should be reviewed and updated as necessary to reflect any changes in responsibilities or processes that have arisen as the partnering arrangements have evolved and matured.

Implications

- Risk of ineffective discharge planning or sub-optimal co-ordination between NHS Grampian and the Health and Social Care Partnerships.

Action plan

Finding rating	*Agreed actions*	*Responsible person / title*
Medium	• Management will update and publish an approved Patient Discharge from Hospital Protocol. • Management will ensure the protocol is reviewed on a regular basis and updated as necessary to reflect legislative and regulatory changes, Scottish Government or NHS Scotland guidance and changes in partnering arrangements with the Health and Social Care Partnerships.	General Manager – Acute Sector *Target date:* 30 April 2019 *Reference number:* Unscheduled Care Discharges 3.01 – 18/19

3.02 *Recording, updating and interpreting Estimated Dates of Discharge (EDDs) – operating effectiveness*

Finding

NHS Grampian follows the Scottish Government's 'Daily Dynamic Discharge Approach' aimed at improving the timeliness and quality of patient care by planning and synchronising the day's activities. Under daily dynamic discharging every patient admitted to an acute sector hospital should be given an estimated date of discharge (EDD) as part of the overall discharge planning process. An estimated date of discharge (EDD) is the date when the Multi-Disciplinary Team (MDT) believes the patient can be safely discharged from the acute hospital setting. This may be to home or another place of care. An EDD should be set when the MDT meets within 12 hours of patient admission to an acute setting. It combines a clinical process to estimate and document a date of predicted medical fitness, followed by a MDT view which takes into account primary care requirements, and should be changed to reflect the most recent view of a patient's recovery rate. Through audit interviews and through attending the MDT cross-system huddle of all patients in Dr Grays, it was found that some patients in both ARI and Dr Gray's had no EDD recorded in Trakcare (the electronic patient management system). We observed whilst attending an MDT meeting in Dr Gray's that the senior staff nurse from the ward in which the identified patient was then given an action to go back after the meeting and record an EDD for that patient.

This then led to a discussion with the consultant and with social work staff as to what an EDD actually represents. For the consultant, the EDD represented the date on which the patient was medically fit to leave the hospital. For others, the EDD represented the most-likely, actual, date that the patient will leave the hospital - for example, when transitional issues have been sorted (namely, a community hospital bed, or care package at home). It was stated in the MDT meeting that there was a discrepancy as to what definition for an EDD should be used.

The definition of an EDD (as per NHS Scotland and the Daily Dynamic Discharging Approach Guidance document) combines a medical assessment to assess the likely date that a patient will be ready to leave an acute hospital and a more holistic view of when a patient is able to move from an acute setting to further primary care (complex discharges) which is dependent on the MDT meetings. During discussions with key individuals it was understood that NHSG and Health and Social Care Partnership staff interpret the definition of an EDD differently.

Implications

- Delays to patient discharge arise as the EDD is used to initiate referrals to community health-care providers and social care agencies (normally at least 48 hours prior to discharge)

Action plan

Finding rating	*Recommended action*	*Responsible person / title*
Medium	• Management will provide clear guidance to ensure every patient receives an EDD when admitted to hospital, and guidance for staff in order to set accurate EDDs and to ensure consistency in setting an EDD in full compliance with the Daily Dynamic Discharge Approach.	Acute Director (Nursing & Midwifery) *Target date:* 31 August 2019 *Reference number:*

Unscheduled Care Discharge 3.02 – 18/19

Appendix 1. Basis of our classifications

Individual finding ratings

Finding rating	*Assessment rationale*
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences**;** or • ***Critical*** impact on the reputation or brand of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences**;** or • ***Significant*** impact on the reputation or brand of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation or brand of the organisation.
Low	A finding that could have a: • ***Minor*** impact on the organisation's operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***Minor*** impact on the reputation of the organisation.
Advisory	A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.

Report classifications

The report classification is determined by allocating points to each of the findings included in the report

Findings rating	Points
Critical	40 points per finding
High	10 points per finding
Medium	3 points per finding
Low	1 point per finding

Report classification	Points
Low risk	6 points or less
Medium risk	7– 15 points
High risk	16– 39 points
Critical risk	40 points and over

Appendix 2. Terms of Reference

Background and audit objectives

Improving unscheduled care across Scotland is a key ministerial priority for Scottish Government. Through the National Unscheduled Care – 6 Essential Actions Improvement Programme the Government aims to improve the timeliness and quality of patient care from arrival to discharge from the hospital and back into the community and aiming to ensure that 95% of patients attending A&E anywhere in Scotland are seen, treated and discharged or admitted with four hours.

The Six Essential actions are:

1) Clinically-focussed and hospital management
2) Realignment of hospital capacity and patient flow
3) Patient rather than bed management – operational performance
4) Medical and surgical processes arranged to take patients from A&E through the acute system
5) Seven-day services targeted to increase weekend and earlier-in-the-day discharges
6) Ensuring patients are cared for in their own homes or a homely setting.
7)

This review will focus on the 'Patient rather than Bed Management – Operational Performance' action.

There are many things which have the potential to cause delay and unnecessarily prolong a patient's stay in hospital, some of which can be categorised as 'external' (services or resources external to the ward or hospital which may not be available when the patient needs then). However, there are also be internal causes of non-clinical delay, and these can also contribute to poor patient experience.
We will review the discharge process considering practices following the creation of the Integration Joint Boards. The review will focus specifically on unscheduled care discharges and the process for managing and changing the flow and pathway of patients within and between services and sectors.

Scope

The sub-processes and related control objectives included in this review are:

Sub-Process	Objectives
Multi-disciplinary team planning	• A multi-disciplinary team gets together within 12 hours of a patient's admission and develops an understanding of the component parts of a patient's discharge plan – what treatment is required, with what – and for how long. • The team also considers other things that need to be done in parallel with the clinical treatment, in order for each patient to be discharged safely onto the next appropriate area of care • There is effective identification of the dependent tasks and agreement on when they each need to start (and finish) to ensure the patient can be discharged without delay.
Setting and reviewing an Estimated Date of Discharge (EDD)	• There is a clinical process to estimate and document an EDD (i.e., when the patient no longer needs medical treatment in hospital. • There is a communication process to document an EDD based on a holistic/multi-disciplinary approach. • The EDD is subject to on-going review and changed to reflect the most recent view of a patient's recovery rate.

Discharge Planning	• Discharge plans are formulated and to record and communicate the tasks that require timely completion for an on-target discharge. • Discharge plans identify external factors such as; communication with family or home support, identification of transport needs, and identification of support needs. • Discharge plans identify internal factors such as the timing of making diagnostic decisions, fulfilment of pharmacy requests and production of discharge letters.
Measurement Framework	• Systems and procedures are in place for measuring and reporting on the performance of the patient admission to discharge flow. • There is an agreed range of performance metrics e.g., average length of stay, number of discharges per day and time, delay (number of patients and number of days), number of discharges pre-noon number of discharges in the evening and number of discharges Saturday and Sunday = Mid-week
Delayed Discharge Performance Reporting and Action Plans	• Discharge performance is reported by NHSG and the IJBs on a regular basis using Government set discharge delay categorisations. • Action plans are formulated and tracked by NHSG and the IJBs that document current initiatives and future plans for improving delayed discharge performance. • Action plans are suitably linked to strategic and operational risk registers so there is a clear view of the risks being mitigated by action plan initiatives.

Appendix 3. Limitations and responsibilities

Limitations inherent to the internal auditor's work

We have undertaken the review of the medicines homecare service, subject to the limitations outlined below.

Internal control

Internal control systems, no matter how well designed and operated, are affected by inherent limitations. These include the possibility of poor judgment in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Future periods

Our assessment of controls is for the period specified only. Historic evaluation of effectiveness is not relevant to future periods due to the risk that:

- the design of controls may become inadequate because of changes in operating environment, law, regulation or other; or
- the degree of compliance with policies and procedures may deteriorate.

Responsibilities of management and internal auditors

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We endeavour to plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we shall carry out additional work directed towards identification of consequent fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, do not guarantee that fraud will be detected.

Accordingly, our examinations as internal auditors should not be relied upon solely to disclose fraud, defalcations or other irregularities which may exist.