Audit, Performance and Risk Committee

Thursday, 31 August 2023

Council Chambers

NOTICE IS HEREBY GIVEN that a Meeting of the **Audit, Performance and Risk Committee, Council Chambers**, **Council Office, High Street, Elgin, IV30 1BX** on **Thursday, 31 August 2023** at **14:00** to consider the business noted below.

AGENDA

MORAY INTEGRATION JOINT BOARD

SEDERUNT

Councillor Scott Lawrence (Chair)

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

Mr Stuart Falconer (Non-Voting Member)

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

MINUTE OF MEETING OF THE AUDIT, PERFORMANCE AND RISK COMMITTEE

Thursday, 29 June 2023

Council Chambers, Council Office, High Street, Elgin, IV30 1BX

PRESENT

Mr Simon Bokor-Ingram, Councillor John Divers, Ms Sonya Duncan, Councillor Scott Lawrence, Mr Derick Murray, Ms Deborah O'Shea, Mr Sandy Riddell

APOLOGIES

Mr Sean Coady, Mr Stuart Falconer, Mr Graham Hilditch

IN ATTENDANCE

Also in attendance at the above meeting were the Chief Internal Auditor, Angela Pieri, External Auditor (Grant Thornton) and Democratic Services Manager.

1. Declaration of Member's Interests

The Committee noted that there were no declarations of member's interests.

2. Unaudited Annual Accounts

A report by the Interim Chief Financial Officer informed the Committee of the Unaudited Annual Accounts of the Moray Integration Joint Board (MIJB) for the year ended 31 March 2023.

Following consideration the Committee agreed to note:

i) the unaudited Annual Accounts prior to their submission to the external auditor, noting that all figures remain subject to audit;

ii) the Annual Governance Statement contained within the unaudited Annual Accounts; and

iii) the accounting policies applied in the production of the unaudited Annual Accounts, pages 46 to 47 of the accounts.

3. Local Code of Corporate Governance - Update

A report by the Interim Chief Financial Officer provided the Committee with an opportunity to comment on the updated sources of assurance for informing the governance principles as set out in the Chartered Institute of Public Finance (CIPFA) /Society of Local Authority Chief Executives (SOLACE) 'Delivering Good Governance in Local Government Framework document. Also for information the self assessment of good practice as set.

Mr Murray highlighted that the Audit Performance and Risk Committee had not been included in the table at Principle F of Appendix 1. The interim Chief Financial Officer, apologised for the omission and confirmed that she would ensure Appendix 1 was updated to include Audit, Performance and Risk Committee.

Following consideration the Committee agreed to:

i) note the content of the report;

ii) note the sources of assurance utilised in reviewing and assessing the effectiveness of the MIJBs governance arrangements;

iii) approve the updated Local Code of Corporate Governance which supports the Annual Governance Statement in Appendix 1; and

iv) approve the self assessment of good practice, in Appendix 2.

MINUTE OF MEETING OF THE AUDIT, PERFORMANCE AND RISK COMMITTEE

Thursday, 29 June 2023

Council Chambers, Council Office, High Street, Elgin, IV30 1BX

PRESENT

Mr Simon Bokor-Ingram, Councillor John Divers, Ms Sonya Duncan, Councillor Scott Lawrence, Mr Derick Murray, Ms Deborah O'Shea, Mr Sandy Riddell

APOLOGIES

Mr Sean Coady, Mr Stuart Falconer, Mr Graham Hilditch

IN ATTENDANCE

Also in attendance at the above meeting were the Chief Internal Auditor, Interim Planning and Strategy Lead, Mr John Campbell, Service Manager and Democratic Services Manager.

1. Declaration of Member's Interests

The Committee noted that there were no declarations of Member's interests.

2. Minute of the meeting of 30 March 2023

The minute of the meeting of 30 March 2023 was submitted and approved.

3. Action Log of Meeting of 30 March 2023

The action log of the meeting of 30 March 2023 was discussed and updated accordingly.

4. Quarter 4 Performance

A report by the Interim Strategy and Planning Lead updated the Audit, Performance and Risk Committee on performance as at Quarter 4 (January to March 2023).

Mr Riddell expressed concern about the staff sickness levels and asked for more detail on what is being done in regards to staff wellbeing.

Following consideration, the Committee agreed to note:

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

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

5. Internal Audit Section - Update

A report by the Chief Internal Auditor asked the Committee to consider the contents of this report; seek clarification on any points noted and otherwise note the report.

Following consideration the Board agreed to note the audit update.

6. Internal Audit Section Completed Projects

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

Following consideration the Committee agreed to note the audit update.

7. Strategic Risk Register

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 June 2023.

Following consideration the Committee agreed to note the Strategic Risk Register included at Appendix 1.

8. Internal Audit Annual Report 2022-23

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

Following the audit carried out during 2022/23 the Chief Internal Auditor is only able to provided limited assurance that the MIJB has adequate systems of governance and internal control. He further raised concern about the progress of the implementation of the recommendations provided.

Mr Riddell echoed the Chief Internal Auditor's concerns and highlighted the issue of following through on issues. As a Board assurances need to be given that actions are being carried out but he felt at the moment for some issues, this is not being received. He further added that the issues should be escalated to the Board to highlight the issues to them.

In response, the Chief Officer agreed that the issues should be escalated.

Mr Murray suggested that there should be a report back to the Committee on what was found and what has been done to address the issues.

Following further consideration the Committee agreed:

i) to note the contents of the annual report at Appendix 1;

ii) a further report to come back to the Committee to identify the issues and what has been done to address them; and

iii) escalate the issues to the Moray Integration Joint Board.

9. Resilience in Care at Home May 2023

A report by the Provider Services Manager updated the Audit, Performance and Risk Committee on work being done in Care at Home to address the Unmet Need in Moray.

Following consideration the Committee agreed to note:

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

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

10. Directions Update

A report by the Interim Chief Financial Officer informed the Board of the issues Directions of the Moray Integration Joint Board (MIJB) for the period 1 October to 31 March 2023.

11. Improvement Plan for Adult Social Care Commissioning

A report by the Head of Service/Chief Social Work Officer informed the Committee of progress regarding the improvement plan for Adult Social Care Commissioning in line with the external review conducted by KPMG, finalised in February 2023.

Following consideration the Committee agreed to:

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

ii) approve the contents of the plan.

MEETING OF MORAY INTEGRATION JOINT BOARD

AUDIT, PERFORMANCE AND RISK COMMITTEE

THURSDAY 29 JUNE 2023

ACTION LOG

Item No.	Title of Report	Action Required	Due Date	Action By	Update for 31 August 2023
1.	Quarter 4 Performance	More information required on what is being done in regards to staff wellbeing to try and reduce sickness levels	August 2023	Carmen Gillies	On agenda
2.	Internal Audit Annual Report 2022-23	Report back to the Committee on the issues found in the audit reports and what has been done to address them.	August 2023	Tracy Stephen	On agenda
3.	Internal Audit Annual Report 2022-23	Escalate the issues highlighted to the MIJB			

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 31 AUGUST 2023**

SUBJECT: **QUARTER 1 (APRIL TO JUNE 2023) PERFORMANCE REPORT**

BY: **INTERIM STRATEGY AND PLANNING LEAD**

1. REASON FOR REPORT

1.1 To update the Audit, Performance and Risk (APR) Committee on performance as at Quarter 1 (April to June 2023).

2. RECOMMENDATION

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

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

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

3. BACKGROUND

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

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

4. KEY MATTERS RELEVANT TO RECOMMENDATION

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

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

4.2 Detailed charts and indicator data is attached in **APPENDIX 1.**

Summary

4.3 Performance within Health and Social Care Moray (HSCM) as demonstrated by the agreed indicators up to the end of quarter 1 of the financial year 2023/24 is showing as mostly in the red. Only one of the indicators is presenting as green, one is amber and nine are red.

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

EMERGENCY DEPARTMENT - RED

There was an increase in the A&E attendance rate per 1,000 this quarter from 20.6 to 23.6, below the number presenting at the same period last year.

DELAYED DISCHARGES – RED

The number of delays at the June snapshot increased to 30, from a low of 16 in May and 26 in the previous quarter. There is a lot of variation weekly (and even daily) operationally and the figure of 30 for this measure is high for this period.

Bed days lost due to delayed discharges reduced from 751 last quarter to 732 this quarter. This is a reduction despite the increase in the more volatile snapshot days (DD-01) measure and demonstrates that the trend is showing a decrease overall in length of time delayed.

EMERGENCY ADMISSIONS – RED

For the first quarter since March 2021 there was not an increase in the rate of emergency occupied bed days for over 65s. Since the end of quarter 4 2022/23 the rate has decreased from 2,749 to 2,699, however this still exceeds the target of 2,320 per 1,000 population.

The emergency admission rate per 1000 population for over 65s has increased this quarter from 185.8 to 186.8 above the target of 177.

Similarly, the number of people over 65 admitted to hospital in an emergency also increased from 129.2 to 129.8 over the same period. Both of these indicators are now RED.

HOSPITAL RE-ADMISSIONS - AMBER

The 28-day re-admissions remain on target at 8.1%, as does the 7-day re-admissions which have increased slightly to 4.0%.

MENTAL HEALTH – RED

After achieving 79% in quarter 3 2022/23 there has been a reduction in performance for the second quarter in row with now 63% of patients being referred within 18 weeks at the end of quarter 1 2023/24.

STAFF MANAGEMENT – RED

Sickness absence for NHS employed staff reduced to 4.7% during quarter 1 2023/24. Council employed staff sickness has reduced this quarter from a

high of 9.7% to 7.0 %, which is lower than the figure for the same period last year.

Figure 1 – Performance Summary

Health and Social Care Moray Performance Report								
Code	**Barometer (Indicator)**	**Q1 2223** Apr-Jun	**Q2 2223** Jul-Sep	**Q3 2223** Oct-Dec	**Q4 2223** Jan-Mar	**Q1 2324** Jan-Mar	**Target**	**RAG**
AE	**Accident and Emergency**							
AE-01	A&E Attendance rate per 1000 population (All Ages)	24.3	24.0	22.6	20.6	23.6	21.9	R
DD	**Delayed Discharges**							
DD-01	Number of delayed discharges (including code 9) at census point	46	47	29	26	30	10	R
DD-02	Number of bed days occupied by delayed discharges (including code 9) at census point	1207	1197	1063	751	732	304	R
EA	**Emergency Admissions**							
EA-01	Rate of emergency occupied bed days for over 65s per 1000 population	2320	2469	2547	2749	2699	2320	R
EA-02	Emergency admission rate per 1000 population for over 65s	177.5	172.4	173.3	185.8	186.8	177	R
EA-03	Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population	122	118.6	117.4	129.2	129.8	121	R
HR	**Hospital Readmissions**							
HR-01	% Emergency readmissions to hospital within 7 days of discharge	4.3%	3.0%	3.8%	3.6%	4.0%	3.9%	A
HR-02	% Emergency readmissions to hospital within 28 days of discharge	8.3%	6.7%	8.0%	7.5%	8.1%	8.4%	G
MH	**Mental Health**							
MH-01	% of patients commencing Psychological Therapy Treatment within 18 weeks of referral	27%	33%	79%	73%	63%	90%	R
SM	**Staff Management**							
SM-01	NHS Sickness Absence (% of hours lost)	4.2%	5.0%	5.1%	5.9%	4.7%*	4%	R
SM-02	Council Sickness Absence (% of hours lost)	8.9%	5.2%	8.3%	9.7%	7.0%	4%	R

* SM-01 - Data to May 23

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

AREAS NOT MEETING TARGETS

Delayed Discharge

4.5 The number of delays at the June snapshot was up to 30, up from a low of 16 in May and 26 in the previous quarter. There is a lot of variation operationally and the figure of 30 for this measure is on high side for this period with daily figures generally falling in the low 20s.

4.6 The average number of daily delays in June was 24 compared to in the same period last year where the number of delays was 46 and continued to rise to 52 by October 2022. Additionally in June 2022, there were 9 delays over 90 days, in June 2023 there were 2. Although there has been an increase in delays from May, delays have reduced over the long term.

4.7 Bed days lost due to delayed discharges reduced from 751 last quarter to 732 this quarter. This is a reduction despite the increase in the more volatile snapshot days (DD-01) measure and demonstrates that the trend is decreasing overall in length of time delayed over this period.

4.8 Measures mentioned in previous reports continue to be in place:

- Whole system Moray Portfolio meetings occur daily with operational staff from all services to ensure system wide awareness of the pressures that might cause issues with patient flow.
- More care home beds have been made available due to an agreement to pay from offer of care home bed to ensure beds are free on discharge date.
- The Planned Discharge Date (PDD) system changed the criterion from ‘medically fit’ to ‘clinically fit’.
- More people have been recruited into the Care at Home team enabling more rotas to be opened.

4.9 Challenges that remain include:

- Staffing pressures across the care sector in Moray.
- An aging population is resulting in more complex care requirements.
- Lack of respite facility- both planned and emergency.

4.10 Despite still not achieving the target an immense amount of work has gone into ensuring the figures in Moray have not escalated and both measures are now regularly below the pre-pandemic targets.

Emergency Department

4.11 There was an increase in the A&E attendance rate per 1,000 this quarter from 20.6 to 23.6, below the number presenting at the same period last year.

4.12 The increase can be attributed to 2 public holidays and the additional Kings Coronation holiday during this reporting period, which impacts on attendance levels at ED as there is no Primary care provision on these dates.

Emergency Admissions

4.13 For the first quarter since March 2021 there was not an increase in the rate of emergency occupied bed days for over 65s (EA-01). Since the end of quarter 4 2022/23 the rate has decreased from 2,749 to 2,699, while this still exceeds the target of 2,320 per 1,000 population this decrease is in line with expectations as the reduction in DD-01 and DD-02 over the recent months is now impacting this measure.

4.14 The emergency admission rate per 1000 population for over 65s (EA-02) has increased this quarter from 185.8 to 186.8 above the target of 177. Similarly, the number of people over 65 admitted to hospital in an emergency (EA-03) also increased from 129.2 to 129.8 over the same period. Both of these indicators are now RED and will explain why the reduction in EA-01 was small.

4.15 The increase in admissions in ED can be directly correlated with the increase in admissions in this period and it is expected that EA-02 and EA-03 should return to GREEN in the next quarter.

Mental Health

4.16 After achieving 79% in quarter 3 2022/23 there has been a reduction in performance for the second quarter in row with now 63% of patients being referred within 18 weeks at the end of quarter 1 2023/24.

4.17 A variety of factors have an impact on this measure:

- An increase in the number and complexity of referrals,
- Long term sickness absence within the team,
- Ongoing maternity leave and
- A further period of planned sick leave.

The team continue to work hard to reduce waiting times and are addressing this through current and planned group work, allowing for more people to be seen in a timely manner. However, this is not suitable for all people referred into the service.

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

4.19 Recruitment to the maternity leave post was not possible due to no applicants meeting the criteria. As a result of further planned sick leave, it is difficult to predict when this position may change.

Staff Management

4.20 Sickness absence for NHS employed staff reduced to 4.7% during quarter 1 2023/24. Council employed staff sickness has also reduced this quarter from a high of 9.7% to 7.0%, which is lower than the figure for the same period last year.

4.21 The latest available breakdown of data is for quarter 4 2022/23 and this shows that the percentage of absences that are long term is 53% for NHS employed staff and 56.5% for council employed staff.

4.22 Within NHS employed staff 29.9% of absences are marked as “Other known causes - not otherwise classified” or “Unknown Causes/Not Specified”. While the top recorded reasons are “Anxiety/stress/depression/other psychiatric illnesses” with 11.5% of total absences and “Cold, cough, flu-influenza” with 10.1% of total absences.

Table 1 - NHS Top Ten Absence Reasons (Quarter 4 2022/23)

Absence Reason	% of all Absences
Other known causes - not otherwise classified	16.8 %
Unknown causes/not specified	13.1 %
Anxiety/stress/depression/other psychiatric illnesses	11.5 %
Cold, cough, flu - influenza	10.1 %
Gastro-intestinal problems	7.0 %
Covid-related illness	7.0 %
Other musculoskeletal problems	6.9 %
Chest & respiratory problems	6.8 %
Injury, fracture	3.7 %
Pregnancy related disorders	3.4 %
Back problems	3.0 %

4.23 Within council employed staff the profile is different with 21.5% of absences recorded as “Depression/Stress/Anxiety” and the second highest recorded reason being “Joint Pain/Injury” with 8.7% of total absences.

Table 2 - Council Top Ten Absence Reasons (Quarter 4 2022/23)

Absence Reason	% of all Absences
Depression/Stress/Anxiety	21.5%
Joint Pain/Injury	8.7%
Chest Infection/Bronchitis	7.2%
Covid-19	7.1%
Operation/Post Operation	6.1%
Cold	5.7%
Back Pain/Injury	5.3%
Broken Bones	4.8%
Stomach Upset/Sick/Diarrhoea	4.3%
Bereavement	3.1%

4.24 Our absence statistics are reflective of NHSG and Council staff and occupational health reports with mental health reasons representing our first and largest and muscular-skeletal (MSK) injuries our second largest indicator of absence. It should be noted that mental health reasons consists of stress in all varieties: work stress in particular is not specified, and also includes depression and anxiety. HSE have specified moving and handling and associated MSK injury as targets for action in 2023-2024.

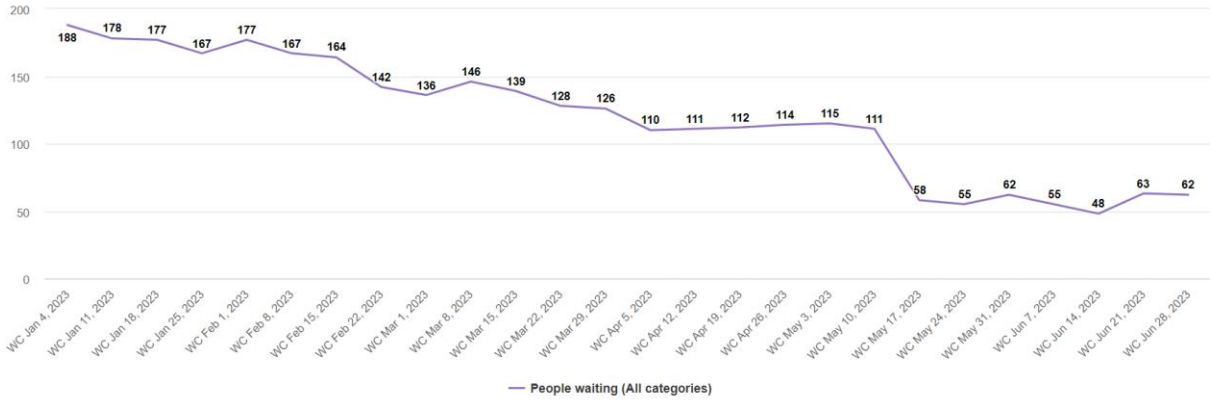
4.25 Mitigations for these absences are increased focus on health and wellbeing within teams and/or services with an emphasis on self-education and self-

awareness. Assurance is sought from teams regularly that up-to-date training is in situ and key performance indicators for manual handling will be implemented. Our new delivery plan for HSCM 2023 specifies removing the stigma from mental health as one of our designated actions and we are keen to reinforce this with our staff.

Social Care – Unmet Need

4.26 The unmet need pressure has shifted throughout the last quarter, the test of change introduced in January 2023 (outlined in quarter 4) has reduced the number of people awaiting an assessment from 188 people in January 2023 to 62 at the end of June 2023.

Figure 2 - People awaiting a social care assessment



4.27 The increase in completing social work assessments can be attributed to the rise in figure 3 below is a result of the improved practice. The number of people who are waiting for a package of care has increased in the period and the number of hours of care to be provided has increased accordingly as shown in Figure 4. This increase for care in the community is from 118 people in March to 170 people in June 2023. An additional factor impacting this is care homes having fewer available beds as the quarter has progressed.

Figure 3 - Number of people waiting for a package of care

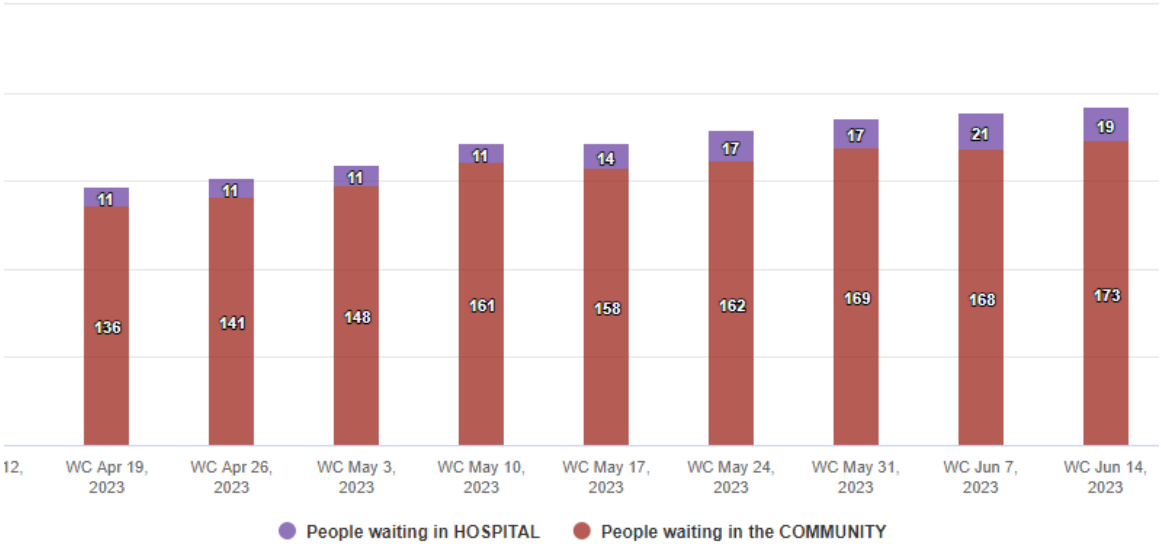
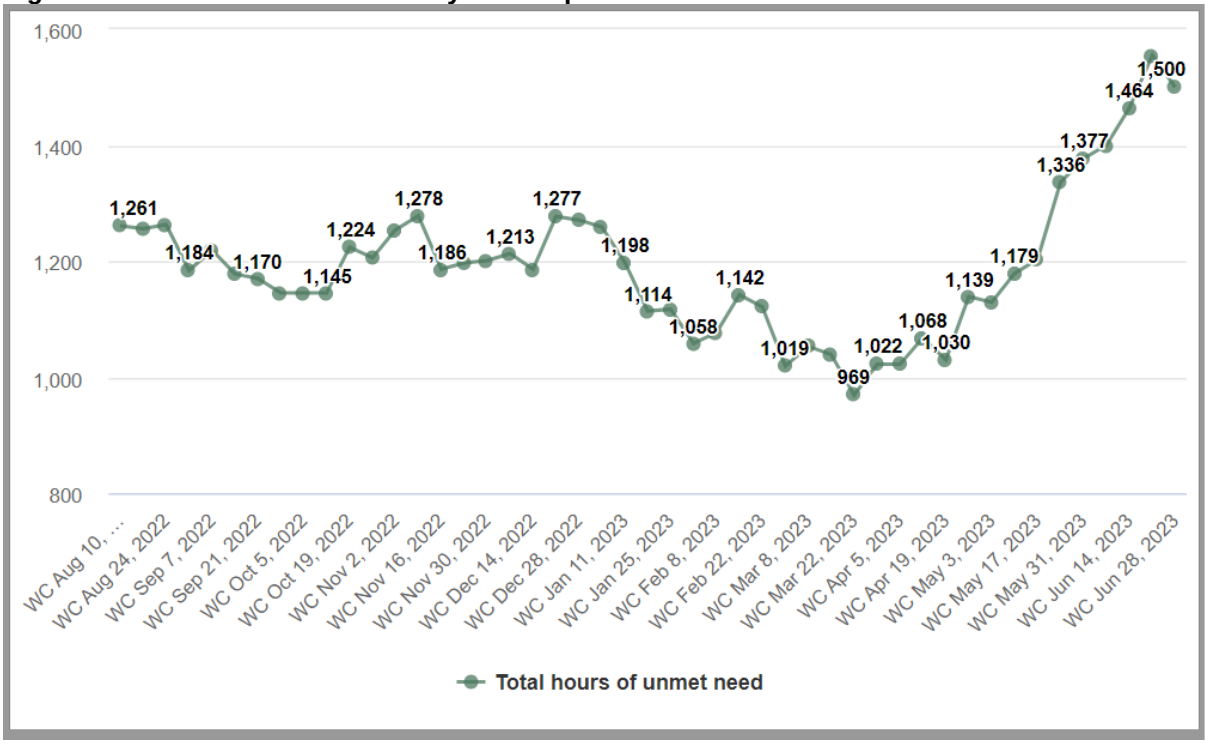


Figure 4 - Number of hours of care yet to be provided



4.28 A positive factor for care at home is an improved trend in recruitment with an additional 21 new staff members during this quarter. This has resulted in an increase of 3.3% in contractual hours. Absence rate for care at home staff has reduced to 5.1% which slightly above the baseline of staff absence of 4%.

4.29 Additionally Care Enablers completed over 200 assessment this quarter to assist with flow across the system. The Care Enablers support the 'waiting well' agenda, initiating regular supportive conversation whilst waiting for care.

4.30 Weekly Collaborative Care Home Support Team meetings continue to scrutinise and support partnership services across Moray.

5. SUMMARY OF IMPLICATIONS

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

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

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

(b) Policy and Legal

None directly associated with this report.

(c) Financial implications

None directly associated with this report.

(d) Risk Implications and Mitigation
There are no risk issues arising directly from this report. The long-term impact of the COVID-19 on the Health and Social Care system are still unknown and performance measurement will remain flexible to enable the service to be prepared and react to any future developments.

(e) Staffing Implications
None directly associated with this report.

(f) Property
None directly associated with this report.

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

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

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

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

6. CONCLUSION

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

Authors of Report: Bruce Woodward, Performance Support Officer

Background Papers: Available on request
Ref:

PERFORMANCE REPORT SUPPORTING CHARTS

QUARTER 1 2023/24

(1 APRIL 2023 – 31 JUNE 2023)

1. TABLE OF CONTENTS

1. PERFORMANCE SUMMARY

BAROMETER OVERVIEW

Moray currently has **11 local indicators**. Of these **1 is Green**, **1 is Amber** and **9 are Red**.

Figure 1 - Performance Summary

Health and Social Care Moray Performance Report										
Code	**Barometer (Indicator)**	**Q1 2223** Apr-Jun	**Q2 2223** Jul-Sep	**Q3 2223** Oct-Dec	**Q4 2223** Jan-Mar	**Q1 2324** Jan-Mar	**Target**	**New Target** (from Q1 2324)	**Previous Target** from Q1 2022 or earlie	**RAG**
AE	**Accident and Emergency**									
AE-01	A&E Attendance rate per 1000 population (All Ages)	24.3	24.0	22.6	20.6	23.6	21.9	21.9	21.7	R
DD	**Delayed Discharges**									
DD-01	Number of delayed discharges (including code 9) at census point	46	47	29	26	30	10	no change	10	R
DD-02	Number of bed days occupied by delayed discharges (including code 9) at census point	1207	1197	1063	751	732	304	no change	304	R
EA	**Emergency Admissions**									
EA-01	Rate of emergency occupied bed days for over 65s per 1000 population	2320	2469	2547	2749	2699	2320	2320	2037	R
EA-02	Emergency admission rate per 1000 population for over 65s	177.5	172.4	173.3	185.8	186.8	177	177	179.9	R
EA-03	Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population	122	118.6	117.4	129.2	129.8	121	121	123.4	R
HR	**Hospital Readmissions**									
HR-01	% Emergency readmissions to hospital within 7 days of discharge	4.3%	3.0%	3.8%	3.6%	4.0%	3.9%	3.9%	4.2%	A
HR-02	% Emergency readmissions to hospital within 28 days of discharge	8.3%	6.7%	8.0%	7.5%	8.1%	8.4%	8.4%	8.4%	G
MH	**Mental Health**									
MH-01	% of patients commencing Psychological Therapy Treatment within 18 weeks of referral	27%	33%	79%	73%	63%	90%	no change	90%	R
SM	**Staff Management**									
SM-01	NHS Sickness Absence (% of hours lost)	4.2%	5.0%	5.1%	5.9%	4.7%*	4%	no change	4%	R
SM-02	Council Sickness Absence (% of hours lost)	8.9%	5.2%	8.3%	9.7%	7.0%	4%	no change	4%	R

2. DELAYED DISCHARGE - RED

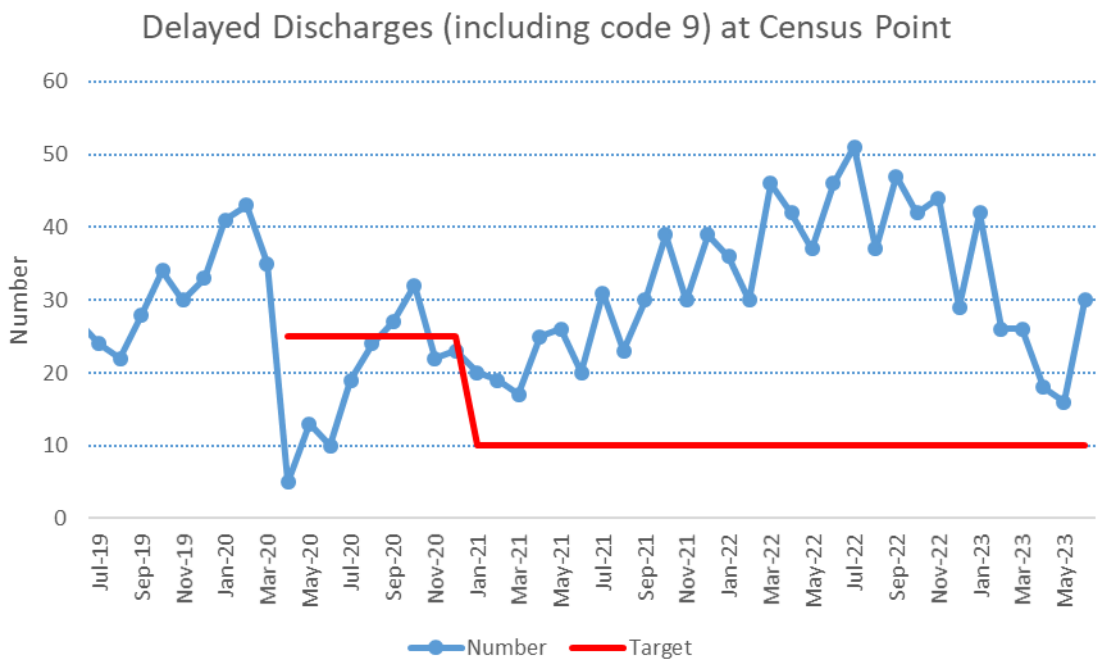
Trend Analysis

The number of delays at the June snapshot was up to **30**, up from a low of **16** in May and **26** in the previous quarter. There is a lot of variation weekly (and even daily) operationally and the figure of **30** for this measure is on high side for this period.
Bed days lost due to delayed discharges reduced from **751** last quarter to **732** this quarter. This is a reduction despite the increase in the more volatile snapshot days (DD-01) measure and demonstrates that the trend is decreasing overall in Delayed Discharges over this period.

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

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

Figure 2 – Delayed Discharges

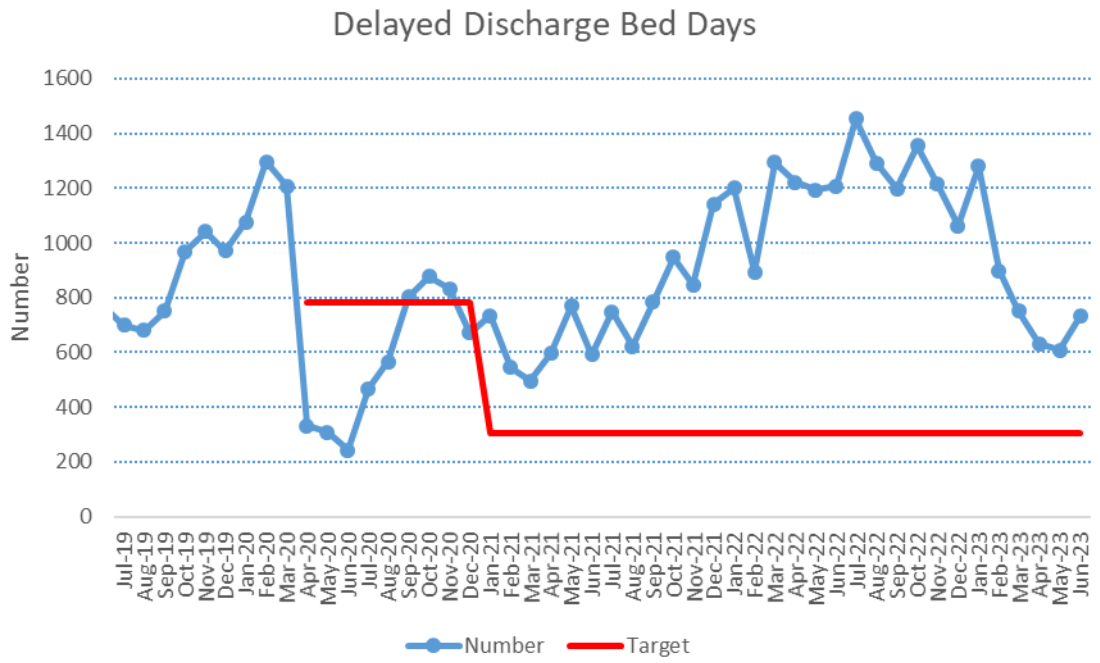


Indicator Trend – Decreasing
Despite some volatility in numbers from month to month the underlying trend for the number of people experiencing Delayed Discharge had been decreasing since the end of Quarter 2 2022/23.

Source	Public Health Scotland

DD-02: NUMBER OF BED DAYS OCCUPIED BY DELAYED DISCHARGES PER QUARTER (INC CODE 9) PER 1000 18+ POPULATION			
Purpose	This monitors the number of people delayed in hospital once medically fit for discharge. Longer stays in hospital are associated with increased risk of infection, low mood, and reduced motivation.		
Strategic Priority	2: HOME FIRST	**Linked Indicator(s)**	DD-01
National Health & Wellbeing Outcomes	2, 3, 5, 7		

Figure 3 – Delayed Discharge Bed-days



Indicator Trend – Decreasing

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

Source	Public Health Scotland

3. EMERGENCY ADMISSIONS - RED

Trend Analysis

For the first quarter since March 2021 there was not an increase in the rate of emergency occupied bed days for over 65s. Since the end of quarter 4 2022/23 the rate has decreased from **2,749** to **2,699**, however this still exceeds the target of **2,320** per 1,000 population.

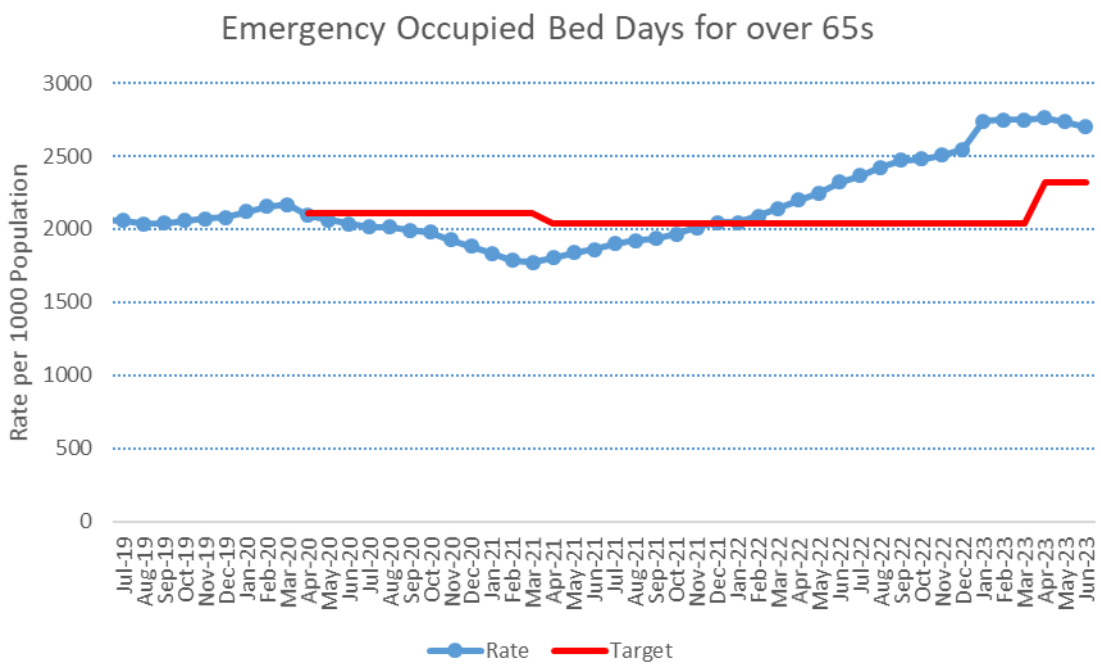
The emergency admission rate per 1000 population for over 65s has increased this quarter from **185.8** to **186.8** above the target of 177.

Similarly, the number of people over 65 admitted to hospital in an emergency also increased from **129.2** to **129.8** over the same period. Both of these indicators are now **RED.**

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

Purpose	EA-01, EA-02, and EA-03 are all interconnected and provide a narrative when viewed together of whether emergency admissions and bed days are within tolerance and indicate where potential risks could arise.		
Strategic Priority	1: BUILDING RESILIENCE	**Linked Indicator(s)**	EA-02, EA-03
National Health & Wellbeing Outcomes	1, 2, 3, 5		

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



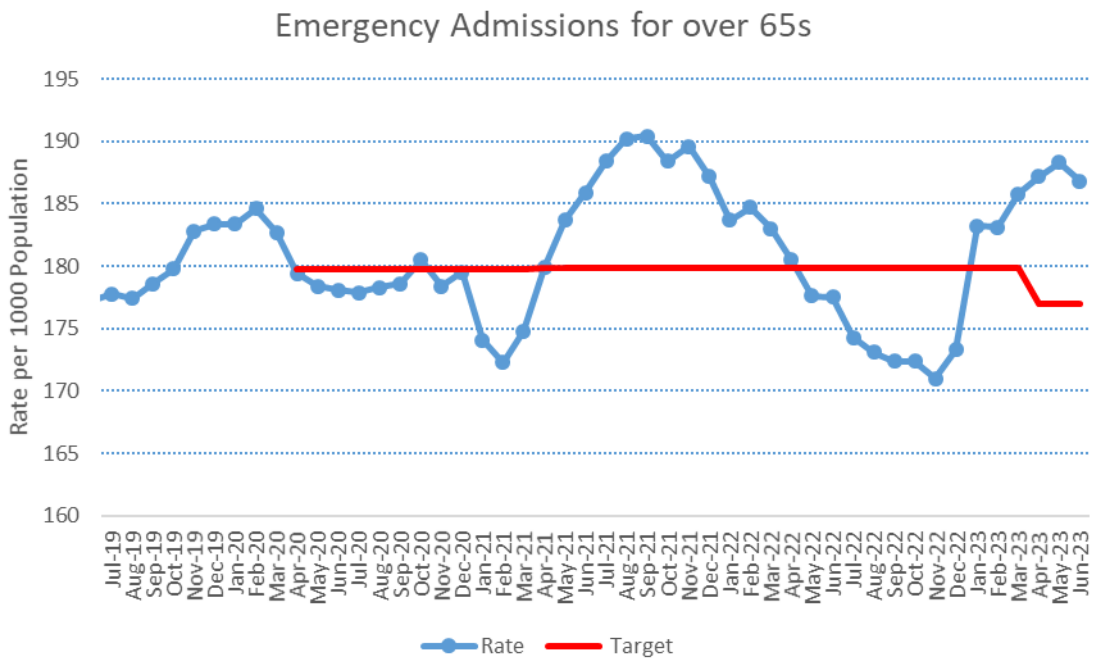
Indicator Trend – Increasing

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

Source	Health Intelligence

EA-02: EMERGENCY ADMISSIONS RATE PER 1000 POPULATION FOR OVER 65s			
Purpose	EA-01, EA-02, and EA-03 are all interconnected and provide a story when viewed together of whether emergency admissions and bed days are within tolerance and indicate where potential risks could arise.		
Strategic Priority	1: BUILDING RESILIENCE	**Linked Indicator(s)**	EA-01, EA-03
National Health & Wellbeing Outcomes	1, 2, 3, 5		

Figure 5 – Emergency Admissions (Over 65s)



Indicator Trend – Increasing

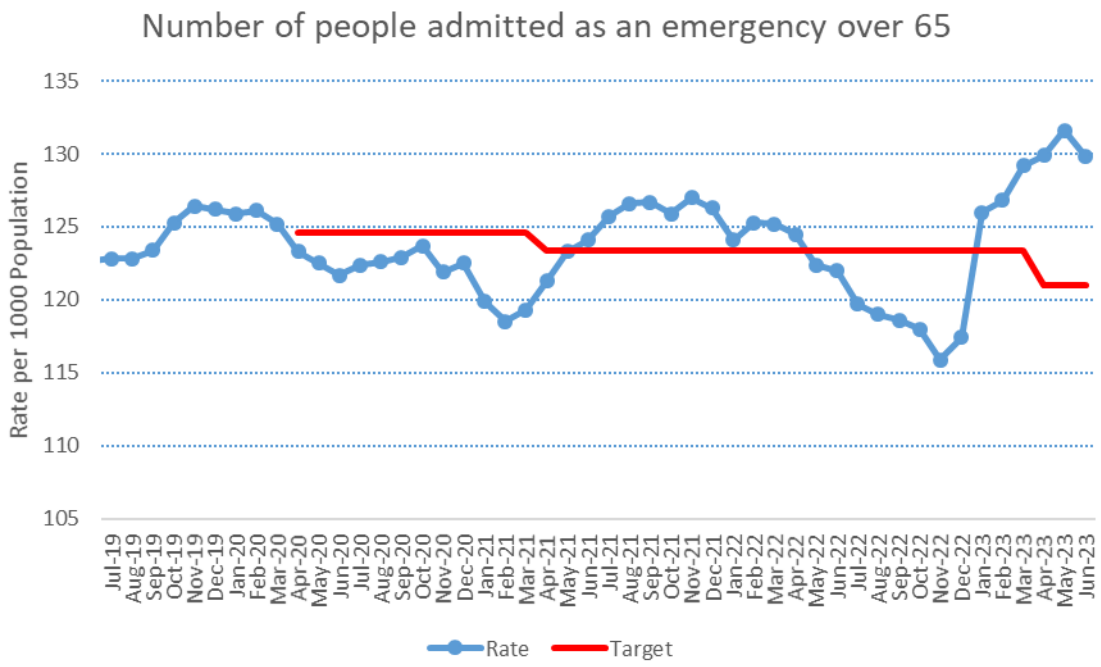
The trend is now increasing, after a sustained reduction over the latter half of 2022, and above levels seen at the same point in 2022.

Source	Health Intelligence

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

Purpose	EA-01, EA-02, and EA-03 are all interconnected and provide a story when viewed together of whether emergency admissions and bed days are within tolerance and indicate where potential risks could arise.		
Strategic Priority	1: BUILDING RESILIENCE	**Linked Indicator(s)**	EA-01, EA-02
National Health & Wellbeing Outcomes	1, 2, 3, 5		

Figure 6 – Number of Over 65 People Emergency Admissions



Indicator Trend – Increasing

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

Source	Health Intelligence

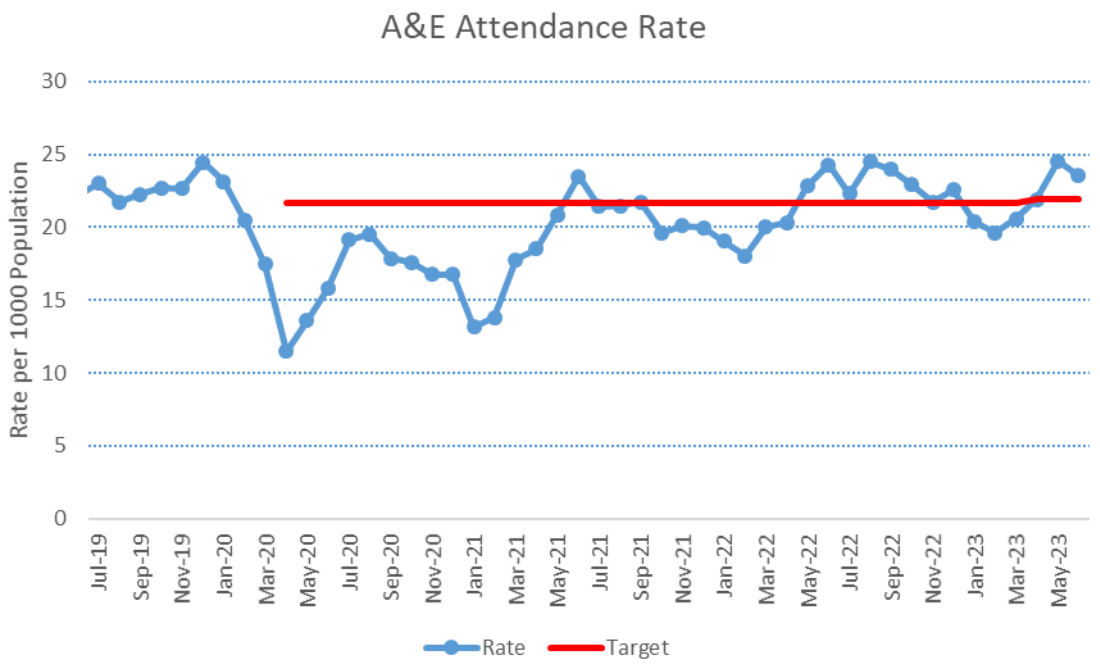
4. EMERGENCY DEPARTMENT – RED

Trend Analysis

There was an increase in the rate per 1,000 this quarter from **20.6** to **23.6**, below the number presenting at the same period last year.

AE-01: ED ATTENDANCE RATES PER 1,000 POPULATION (ALL AGES)			
Purpose	A greater system-wide understanding of how people access emergency care, and why certain choices are made, will allow local health systems to develop intelligence about avoidable attendances at emergency departments and target their responses.		
Strategic Priority	3: PARTNERS IN CARE	**Linked Indicator(s)**	HR-01, HR-02
National Health & Wellbeing Outcomes	1, 2, 3, 5		

Figure 7 – ED Attendance Rate



Indicator Trend – Stable

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

Source	Health Intelligence

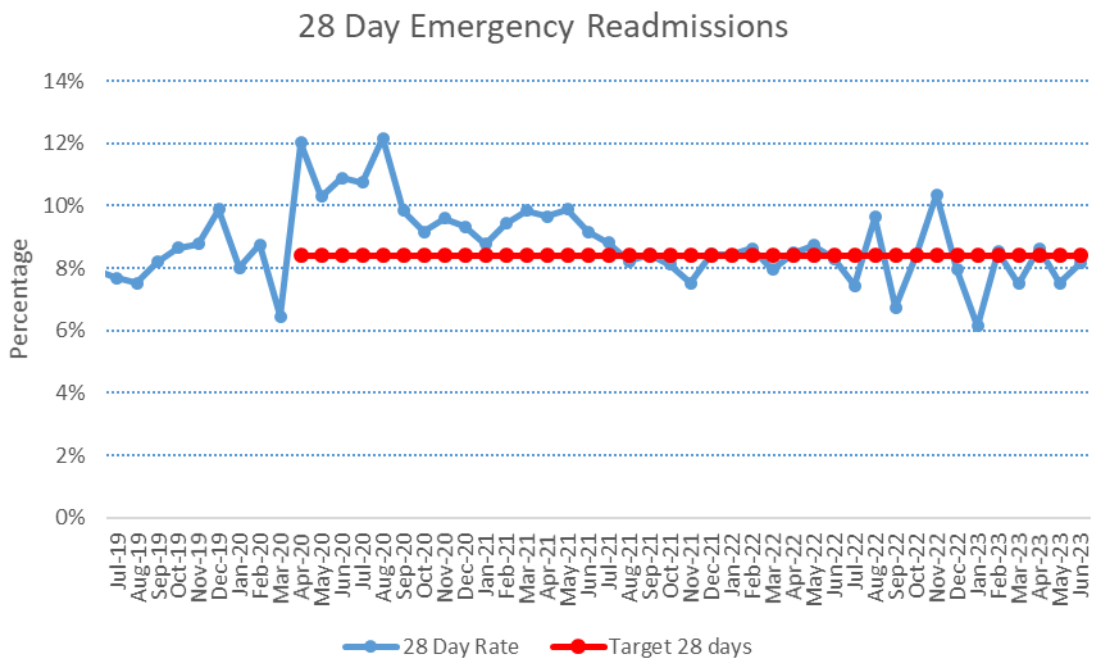
5. HOSPITAL RE-ADMISSIONS - GREEN

Trend Analysis

The 28-day re-admissions remain on target at **8.1%**, as does the 7-day re-admissions which have increased slightly to **4.0%**.

HR-01: PERCENTAGE OF EMERGENCY RE-ADMISSIONS TO HOSPITAL WITHIN 28 DAYS - MORAY PATIENTS			
Purpose	Re-admissions are often undesirable for patients and have also been shown to be associated with the quality of care provided to patients at several stages along the clinical pathway, including during initial hospital stays, transitional care services and post-discharge support. (This measure lags by a month due to the time required for a potential 28 day discharge to occur)		
Strategic Priority	1: BUILDING RESILIENCE	**Linked Indicator(s)**	HR-02, AE-01
National Health & Wellbeing Outcome	1, 2, 3, 5		

Figure 8 – 28-dayEmergency Readmissions

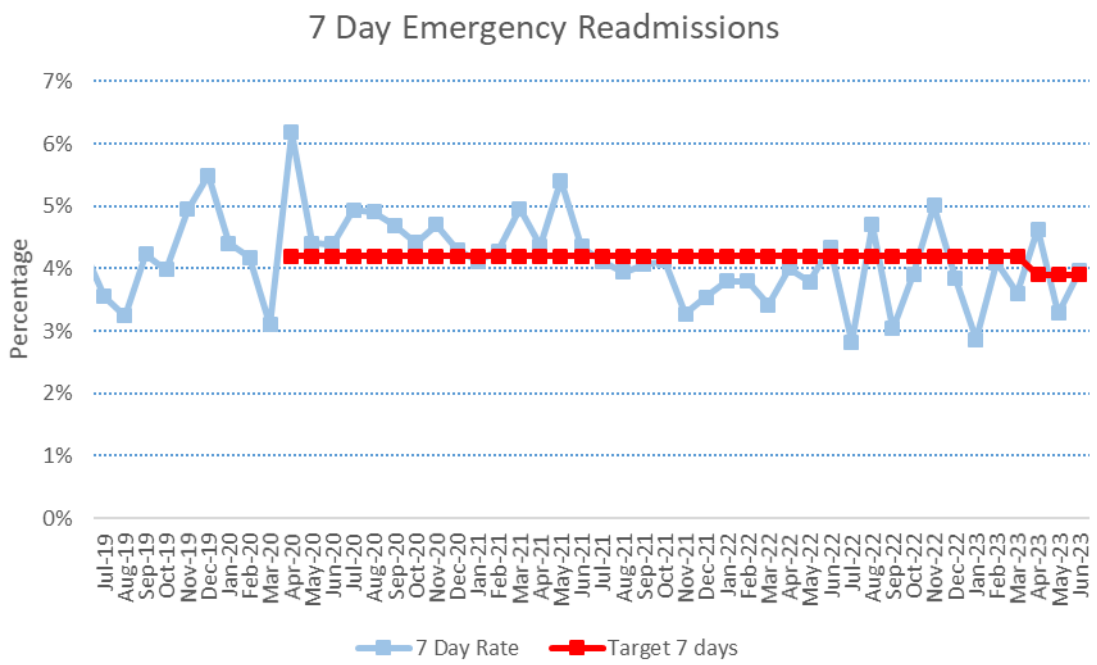


Indicator Trend – Stable
28-day Hospital Re-admissions have remained around the target of 8.4% for this quarter.

Source	Health Intelligence

HR-02: PERCENTAGE OF EMERGENCY RE-ADMISSIONS TO HOSPITAL WITHIN 7 DAYS - MORAY PATIENTS			
Purpose	Re-admissions are often undesirable for patients and have also been shown to be associated with the quality of care provided to patients at several stages along the clinical pathway, including during initial hospital stays, transitional care services and post-discharge support.		
Strategic Priority	1: BUILDING RESILIENCE	**Linked Indicator(s)**	HR-01, AE-01
National Health & Wellbeing Outcome		1, 2, 3, 5	

Figure 9 – 7-day Emergency Readmissions



Indicator Trend – Stable

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

Source	Health Intelligence

6. MENTAL HEALTH – RED

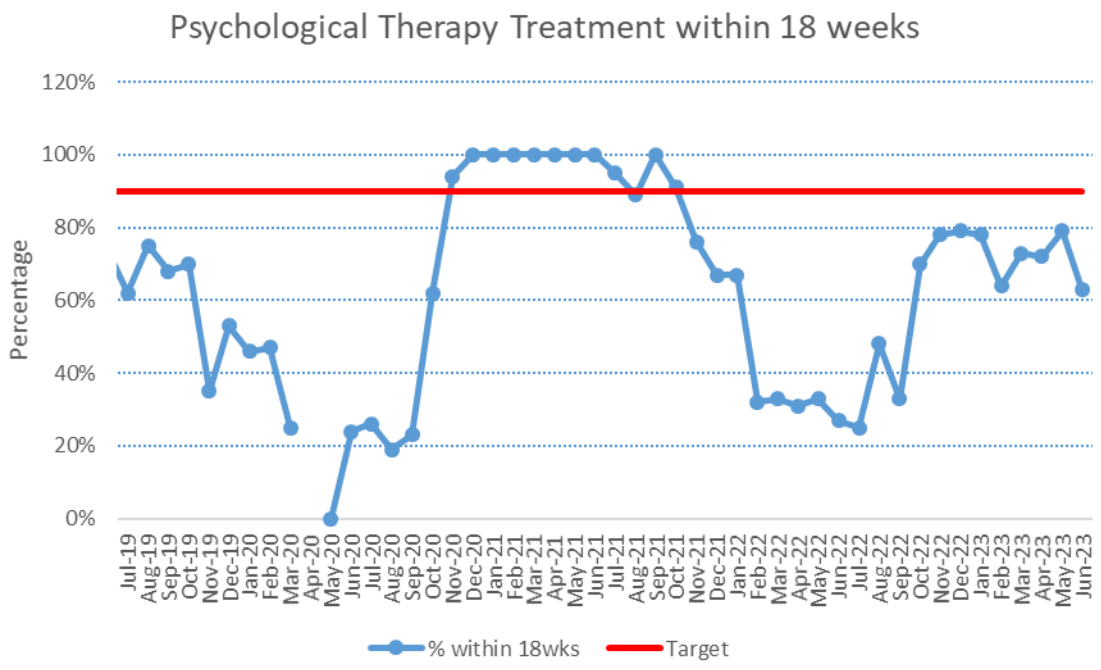
Trend Analysis

After achieving **79%** in quarter 3 2022/23 there has been a reduction in performance for the second quarter in row with now **63%** of patients being referred within 18 weeks at the end of quarter 1 2023/24.

MH-01: PERCENTAGE OF PATIENTS COMMENCING PSYCHOLOGICAL THERAPY TREATMENT WITHIN 18 WEEKS OF REFERRAL

Purpose	Timely access to healthcare is a key measure of quality and that applies equally in respect of access to mental health services.		
Strategic Priority	3: PARTNERS IN CARE	**Linked Indicator(s)**	
National Health & Wellbeing Outcome		1, 2, 3, 5	

Figure 10 – Psychological Therapy Treatment within 18 Weeks



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

Source	Health Intelligence

7. STAFF MANAGEMENT - RED

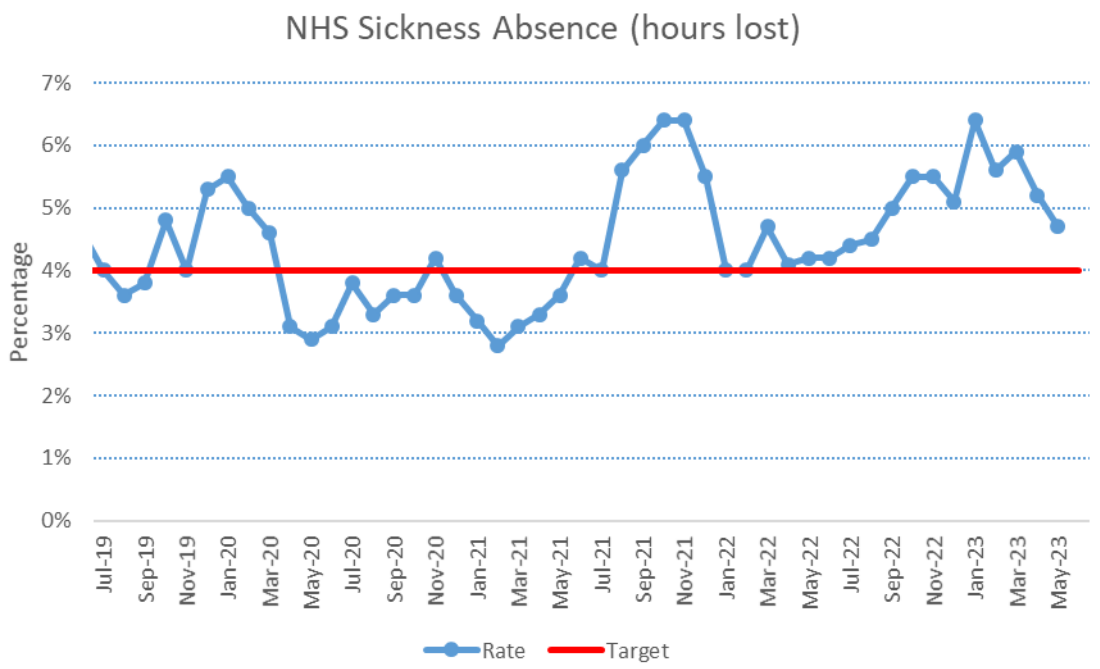
Trend Analysis

Sickness absence for NHS employed staff reduced to **4.7%** during quarter 1 2023/24. Council employed staff sickness has reduced this quarter from a high of **9.7%** to **7.0 %**, which is lower than the figure for the same period last year.

SM-01: NHS SICKNESS ABSENCE % OF HOURS LOST

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

Figure 11 – NHS Sickness Absence



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

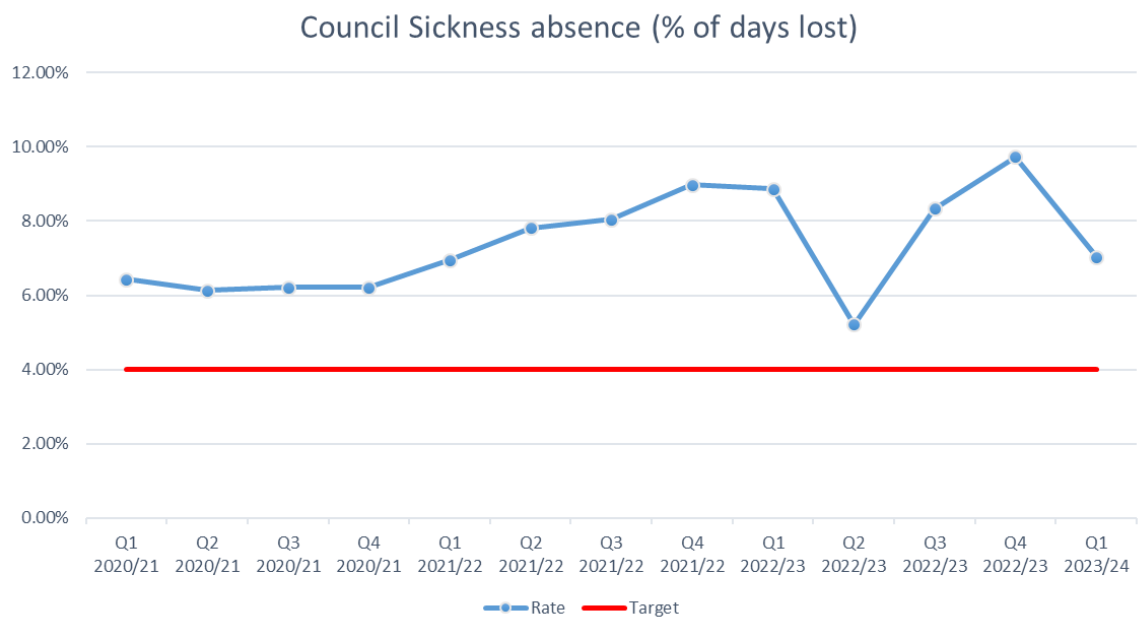
Source	Health Intelligence

SM-02: COUNCIL SICKNESS ABSENCE (% OF CALENDAR DAYS LOST)

Purpose	Attendance at work of all employees is essential in the interests of the effective and efficient operation of services.		
Strategic Priority	1: BUILDING RESILIENCE	**Linked Indicator(s)**	SM-01

National Health & Wellbeing Outcome	1, 2, 3, 5

Figure 12 – Moray Council Sickness Absence



Indicator Trend – Increasing

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

Source	Council HR

APPENDIX 1: KEY AND DATA DEFINITIONS

RAG SCORING CRITERIA

GREEN	If Moray is performing better than target.
AMBER	If Moray is performing worse than target but within specified tolerance.
RED	If Moray is performing worse than target but outside of specified tolerance.

PEER GROUP DEFINITION

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

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

APPENDIX 2: STRATEGIC PRIORITIES

1. THE HEALTH AND SOCIAL CARE STRATEGY AT A GLANCE

BUILDING RESILIENCE

- **EA-01**: RATE OF EMERGENCY OCCUPIED BED DAYS FOR OVER 65S PER 1000 POPULATION
- **EA-02**: EMERGENCY ADMISSIONS RATE PER 1000 POPULATION FOR OVER 65S
- **EA-03**: NUMBER OF PEOPLE OVER 65 YEARS ADMITTED AS AN EMERGENCY IN THE PREVIOUS 12 MONTHS PER 1000 POPULATION
- **HR-01**: PERCENTAGE OF EMERGENCY RE-ADMISSIONS TO HOSPITAL WITHIN 28 DAYS - MORAY PATIENTS
- **HR-02**: PERCENTAGE OF EMERGENCY RE-ADMISSIONS TO HOSPITAL WITHIN 7 DAYS - MORAY PATIENTS
- **SM-01**: NHS SICKNESS ABSENCE % OF HOURS LOST
- **SM-02**: COUNCIL SICKNESS ABSENCE (% OF CALENDAR DAYS LOST)

HOME FIRST

- **DD-01**: NUMBER OF DELAYED DISCHARGES (INCLUDING CODE 9, CENSUS SNAPSHOT, AT END OF QUARTER)
- **DD-02**: NUMBER OF BED DAYS OCCUPIED BY DELAYED DISCHARGES PER QUARTER (INC CODE 9) PER 1000 18+ POPULATION
- **UN-01**: NUMBER OF LONG-TERM HOME CARE HOURS UNMET AT WEEKLY SNAPSHOT
- **UN-02**: NUMBER OF PEOPLE WITH LONG-TERM CARE HOURS UNMET AT WEEKLY SNAPSHOT

PARTNERS IN CARE

- **OA-01**: NUMBER OF REVIEWS OUTSTANDING AT END OF QUARTER SNAPSHOT
- **MH-01**: PERCENTAGE OF PATIENTS COMMENCING PSYCHOLOGICAL THERAPY TREATMENT WITHIN 18 WEEKS OF REFERRAL
- **AE-01**: A&E ATTENDANCE RATES PER 1000 POPULATION (ALL AGES)

APPENDIX 3: NATIONAL HEALTH AND WELLBEING OUTCOMES

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

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

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

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

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

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

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

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

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

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 31 AUGUST 2023**

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

BY: **CHIEF INTERNAL AUDITOR**

1. REASON FOR REPORT

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

2. RECOMMENDATION

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

3. BACKGROUND

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

4. KEY MATTERS RELEVANT TO RECOMMENDATION

Audit Plan 2023/24

4.1 It is pleasing to report that the Internal Audit Section is progressing with completing the Audit Plan for 2023/24. An audit to review the system for administering the disabled parking permits, also known as Blue Badges has been completed. Fieldwork is progressing with the review of the Occupational Therapy Services Stores. This audit used the Chartered Institute of Public Finance Accountants audit programme as the basis to review the systems and controls. The audit of the commissioning and delivery of social care services to children has also been started. This review will compliment the audit undertaken of the adult social care commissioning service that a private firm of auditors completed in 2022/23.

Follow Up Reviews

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

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

Business Continuity

4.3 An audit review was undertaken of the management arrangements for Business Continuity. Business Continuity Management concerns how potential incidents are identified and how the risk is managed to ensure the Service can continue delivering essential services in an emergency or during a disruption of normal day-to-day activities. The follow up review found that several recommendations had not been fully implemented. However, with the appointment last year of a part time Business Continuity and Risk Management Officer, this has facilitated progress to further develop business continuity arrangements within Services. Revised implementation dates for the recommendations have been agreed. The Follow Up Report is given in **Appendix 1**.

5. SUMMARY OF IMPLICATIONS

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

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

(b) Policy and Legal

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

(c) Financial Implications

No implications directly arising from this report.

(d) Risk Implications

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

(e) Staffing Implications

No implications directly arising from this report

(**f) Property**

No implications.

(g) Equalities/ Socio Economic Impacts

No implications.

(h) Climate Change and Biodiversity Impacts

None directly arising from this report.

(i) Directions

None arising directly from this report.

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

6. CONCLUSION

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

Author of Report:	Dafydd Lewis, Chief Internal Auditor
Background Papers:	Internal Audit Files
Ref:	mijb/ap&rc/31082023

Moray Council

Internal Audit Section

DEPARTMENT: **Education, Communities & Organisational Development**

SUBJECT: **Business Continuity**

REPORT REF: **22'008**

Follow Up Audit Review

Risk Ratings for Recommendations					
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	**Medium**	Less critically important controls absent, not being operated as designed or could be improved.	**Low**	Lower level controls absent, not being operated as designed or could be improved.

No.	**Audit Recommendation**	**Priority**	**Accepted (Yes/ No)**	**Date of Completion**	**Status / Explanation**
Key Control: The Council's Business Continuity Policy has been formally approved, is reviewed at regular intervals and is supported by procedures and guidelines for consistent application across the organisation.					
5.01	The Council's Business Continuity Policy should be reviewed and updated as required. Policies and procedures once implemented should be reviewed at regular,	Medium	Yes	28/02/2022	Not implemented. The policy has been acknowledged as requiring updating. This needs to be done having regard to statutory obligations, critical functions of the Council, the response to the pandemic, and identified links with risk management and emergency planning. These

Moray Council

Internal Audit Section

Risk Ratings for Recommendations						
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	**Medium**	Less critically important controls absent, not being operated as designed or could be improved.		**Low**	Lower level controls absent, not being operated as designed or could be improved.
No.	**Audit Recommendation**	**Priority**	**Accepted (Yes/ No)**	**Date of Completion**	**Status / Explanation**	
	stated, intervals.				matters are under consideration with CMT/SMT and the timescale for finalising the policy has been extended to 31st October 2023. This will ensure the final approved version reflects up-to-date strategic priorities and makes best use of resources available to support this area of work.	
Key Control: Business Continuity Plans are in place for all critical service areas and these plans are fully tested and regularly reviewed.						
5.02	Current and finalised Business Continuity Plans, should be held covering all critical services identified by the organisation.	Medium	Yes	31/10/2022	Not implemented. Critical functions of the Council were affirmed during the pandemic. These have been reviewed in the context of impacts from potential power outages that threatened disruption over the winter period. This identified the specific plans that need to be updated as a priority and work on these is ongoing. Plans for other critical service areas will be updated dependent on assessed risk as work continues to align business continuity requirements with risk management practice. A programme of work will be developed for the 23/24	

Risk Ratings for Recommendations						
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	**Medium**	Less critically important controls absent, not being operated as designed or could be improved.		**Low**	Lower level controls absent, not being operated as designed or could be improved.
No.	**Audit Recommendation**	**Priority**	**Accepted (Yes/ No)**	**Date of Completion**	**Status / Explanation**	
					year with a revised implementation date for business plans covering all critical activities to be in place by 31st March 2024.	
5.03	All Business Continuity Plans should be reviewed and tested on at least an annual basis, with outcomes analysed and documented, to ensure plans are capable of supporting an effective recovery position.	Medium	Yes	28/02/2023	Not implemented. The focus currently is on bringing the business continuity plans up-to-date; part of this process will involve discussions with relevant managers to ensure proposals are achievable in practice. Updating of plans will continue with a revised completion date of 31st March 2024 and formal testing of plans thereafter will be on an 'as and when' required basis.	
Key Control: Business Continuity is embedded into the culture of the organisation with all relevant officers appropriately trained and sound central governance arrangements in place.						
5.04	A training programme should be developed to assist officers in the preparation and implementation of	Medium	Yes	30/06/2022	Implemented. Service Managers are being supported in the development of service risk registers and business continuity plans through briefing sessions held by the Business Continuity &	

Moray Council

Internal Audit Section

Risk Ratings for Recommendations						
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	**Medium**	Less critically important controls absent, not being operated as designed or could be improved.		**Low**	Lower level controls absent, not being operated as designed or could be improved.
No.	**Audit Recommendation**	**Priority**	**Accepted (Yes/ No)**	**Date of Completion**	**Status / Explanation**	
	the business continuity management process.				Risk Management Officer appointed in June 2022.	
5.05	The roles and responsibilities of the Business Continuity Officer as detailed within the Business Continuity Policy should be undertaken.	Medium	Yes	28/02/2022	Implemented. A Business Continuity and Risk Management Officer was appointed on a part-time basis in June 2022. The Officer is currently progressing the business continuity agenda and implementing the recommendations within this audit report.	

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 31 AUGUST 2023**

SUBJECT: **STRATEGIC RISK REGISTER – AUGUST 2023**

BY: **CHIEF OFFICER**

1. REASON FOR REPORT

1.1 To provide an overview for the Audit, Performance and Risk Committee of the current strategic risks, along with a summary of actions which are in place to mitigate those risks, updated August 2023.

2. RECOMMENDATION

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

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

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

3. BACKGROUND

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

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

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

3.4 The Strategic Risks received an initial review to ensure they align to the Moray Partners in Care 2019-2029 strategic plan which was agreed at MIJB on 22 November 2022 (para 14 of the minute refers).

4. KEY MATTERS RELEVANT TO RECOMMENDATION

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

4.2 There remains considerable financial pressure as presented to the MIJB on 30 March 2023. There is additional pressure to achieve further savings in 2023/24 and beyond. The Chief Officer and Chief Financial Officer continue to work with Senior Managers to seek efficiencies and opportunities for real transformation.

4.3 GP and Dental service sustainability remains a significant issue nationally.

4.4 There is a continued risk of Industrial Action that may affect service delivery and potentially increase the financial cost pressures to meet any pay awards, if not funded centrally.

4.5 The responsibilities placed on Health and Social Care Moray (HSCM) as a Category 1 responder continues to increase. This is without any additional resource allocation.

4.6 Demand for unscheduled hospital care has not reduced, as levels of elective activity increase to capacity, that continues to be managed alongside significant bed occupancy for emergency medicine.

4.7 Work is ongoing to ensure all Risk Registers are updated in the timescales dictated by the criteria. Adverse events and Risk are regularly reviewed and discussed by Service Managers and Senior Managers. These now feature on the Senior Leadership Group agenda to ensure full transparency across the system.

4.8 Recruitment and retention continues to provide challenges across all disciplines. The Moray Health and Social Care Workforce Plan was approved by MIJB on 29 September 2022 (section 12 minute refers to). Work has started to consider the implications of the Health and Care (Staffing) (Scotland) Act 2019.

5. SUMMARY OF IMPLICATIONS

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

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

(b) Policy and Legal

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

There are no legal implications arising from this report.

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

(d) Risk Implications and Mitigation
This report forms part of the governance arrangements for identifying and managing strategic risks of the MIJB. The risks are outlined in the body of the report in section 4.

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

(f) Property
There are no property implications arising from this report.

(g) Equalities/Socio Economic Impact
An Equalities Impact Assessment is not required because there are no service, policy or organisational changes being proposed.

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

(i) Directions
None arising from this report.

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

6. CONCLUSION

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

6.2 The report outlines the current position and recommends the Board note the revised and updated version of the Strategic Risk Register.

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

Appendix 1

HEALTH AND SOCIAL CARE MORAY STRATEGIC RISK REGISTER

AS AT AUGUST 2023

RISK SUMMARY

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

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

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

1		
Description of Risk: *Regulatory*	The Integration Joint Board (IJB) does not function as set out within the Integration Scheme, Strategic Plan and Scheme of Administration and fails to deliver its objectives or expected outcomes.	
Lead:	Chief Officer	
Risk Rating:	Low/ medium/ high/ very high	**MEDIUM**
Risk Movement:	Increase/ decrease/ no change	**NO CHANGE**
Rationale for Risk Rating:	The strategic plan "Partners in Care 2019-2029" was revised and presented as "Partners in Care 2022 to 2032", this was approved by MIJB in November 2022. Membership of IJB committees recently changed due to the elections in May. An amendment to the Scheme to increase membership by one from each of the partner organisations was ratified in March 2022 by the Scottish Government following due process and approval by Moray Council and NHS Grampian Board. During the initial Covid 19 response, normal business was suspended and emergency arrangements were implemented. IJB, CCG and APR meetings restarted during August 2020. Weekly meetings were instigated with Chair/Vice Chair and Chief Officer and these continue. A delivery plan for the new Strategic Plan "Partners in Care" 2022-32 will be presented in 2023.	
Rationale for Risk Appetite:	The Board, staff and providers across Moray are all committed to ensuring high standards of clinical care & governance through operational policies. Innovation and new ways of working may mean traditional regulations do not exist, or are contradictory. We will only take regulatory risks knowingly, following consultation with the relevant regulatory body and where we have clear risk mitigation in place.	
Controls:	• Integration Scheme. • Strategic Plan "Partners in Care" 2022-32 • Governance arrangements formally documented and approved by MIJB January 2021. • Agreed risk appetite statement. • Performance reporting mechanisms. • Consultation with legal representative for all reports to committees and attendance at committee for key reports. • Standing orders have been reissued to all members	
Mitigating Actions:	Induction sessions were held for new IJB members after May elections. Further sessions were arranged for newest appointees. IJB member briefings are held regularly as development sessions.	

	Conduct and Standards training held for IJB Members in June 2022 provided by Legal Services. SMT regular meetings and directing managers and teams to focus on priorities. Regular development sessions held with IJB and System Leadership Group Strategic Plan and locality management structure is in place. The work that has been progressed through the Covid19 response has escalated developments in some areas as a matter of priority. This has been achieved through collaborative working with partner organisations and the third sector.
Assurances:	• Audit, Performance and Risk Committee oversight and scrutiny. • Internal Audit function and Reporting • Reporting to Board. • The Moray Transformation Board has recently recommenced and will support an oversight of planned business across HSCM.
Gaps in assurance:	The new strategic delivery plan and will incorporate the work being taken forward for Self-Directed support, Hospital at Home and Locality Planning.
Current performance:	The Scheme of Administration is reported when any changes are required. Legal advisors are currently working on the requirements to the integration scheme in relation to the proposed The integrated scheme of delegation of Children's and Families and Justice Services was presented and accepted by MIJB on 26th January 2023. The Governance Framework was approved by IJB 28 January 2021. Re-appointment of Standards Officer agreed by IJB 31 March 2022. Members Handbook has been updated and circulated to all members in June 2022.
Comments:	Strategic Planning and Commissioning Group approved the generic Terms of Reference and Chairs of the transformation boards at the meeting on 19 December 2019.~~These groups have now recently recommenced following the pause during the Covid19 response.~~ The Interim Strategy and Planning Lead is now taking this forward and prioritising and focusing on strategic planning and priorities over the short and longer term.

2		
Description of Risk: *Financial*	There is a risk of MIJB financial failure in that the demand for services outstrips available financial resources. Financial pressures being experienced both by the funding Partners and Community Planning Partners will directly impact on decision making and prioritisation of MIJB.	
Lead:	Chief Officer/Chief Financial Officer	
Risk Rating:	Low/ medium/ high/ very high	**VERY HIGH**
Risk Movement:	Increase/ decrease/ no change	**INCREASING**
Rationale for Risk Rating:	The 2023/24 settlement only saw ~~additional investment for health and social care that was passed through to the MIJB and in 2023/24 saw~~ funding for recurring commitments. There remains a significant pressure due to the recurring core overspend, since most of the new investment related to new commitments. Financial settlements are set to continue on a one year only basis, which does not support sound financial planning. In addition, the carried forward ear marked reserves have been significantly reduced with the clawback of the Covid reserve and reduction of the PSIF funding in 2022/23 . The impact of which will be to reduce the level of ear marked reserves in the MIJB. The Revenue Budget 2023/24 was approved by MIJB on 30 March 2023 as a balanced budget. A significant ambitious savings plan of £4.1 million was approved. Additional Scottish Government funding was provided again for 2023/24, this is to meet additional recurring policy commitments in respect of adult social care pay uplift for externally provided services and free personal and nursing care rates. The update medium Term Financial Framework was presented as part of the budget papers on the 30th March 2023 this will be further reviewed during the 2023/24 year to ensure alignment with the recently reviewed Strategic Plan and for the delegation of Childrens Services and Criminal Justice is planned to be presented to MIJB by 30 September 2023.	
Rationale for Risk Appetite:	The Board recognises the financial constraints all partners are working within. While we are cautious and open about accepting financial risks this will be done: • Where a clear business case or rationale exists for exposing ourselves to the financial risk • Where we can protect the long term sustainability of health & social care in Moray	
Controls:	There is an interim arrangement for CFO cover from Moray Council. Permanent recruitment efforts have not been successful. The Chief Officer is working with both the Council and NHS Finance Leads to secure a longer term interim arrangement. The CFO and Senior Management Team have worked together to address ~~further~~ savings which were approved by the Board as part of the budget setting procedures for 2023/24. This will be a focus of continuous review to ensure any investment is made taking cognisance of existing budget pressures. A revised Financial Framework was presented to	

	the MIJB on 30 March 2023, and a further review will take place by 30 September 2023. The Senior Management Team will continue to consider and plan for the financial challenges for 2024/25 and beyond.
Mitigating Actions:	Risk remains of the challenge that the MIJB can deliver transformation and efficiencies at the pace required whilst dealing with the emerging financial pressures. Financial information is reported regularly to both the MIJB, Senior Management Team and System Leadership Group. The Chief Officer and Chief Financial Officer (CFO) continue to regularly engage in finance discussions with key personnel of both NHS Grampian and Moray Council. Chief Officer and CFO will continue to engage with the partner organisations in respect of the financial position throughout the year. Cross partnership performance meetings are in with partner CEOs, Finance Directors and the Chair/Vice Chair of the MIJB.
Assurances:	MIJB oversight and scrutiny of budget. Reporting through MIJB, NHS Grampian Board and Moray Council.
Gaps in assurance:	None known
Current performance:	An overspend of £5,280,372 on Core services for the 2022/23 financial year was reported to the IJB on 29 June 2023.
Comments:	Senior managers continue to work with Chief Officer and Chief Financial Officer to address the continuing financial challenge, continuing to seek efficiencies and opportunities for real transformation as we look to make efficient and effective investment in services that are truly transformational. There are additional pressures from the cost of living crisis, increasing energy bills, inflation and staff pay awards.

3		
Description of Risk: *Human Resources (People):*	Inability to recruit and retain qualified and experienced staff to provide and maintain sustainable, safe care, whilst ensuring staff are fully able to manage change resulting from response to external factors such as the impact of Covid and the actions that arose from the recommendations from the Independent Review of Adult Social Care 2021.	
Lead:	Chief Officer	
Risk Rating:	Low/ medium/ high/ very high	**HIGH**
Risk Movement:	Increase/ decrease/ no change	**NO CHANGE**
Rationale for Risk Rating:	There continues to be issues with recruitment to front line services that require specific skills and experience. This has been the case for some time now and continues to place pressure on existing staff. Allied Health Professions, Social Work and Nursing are some of the particular areas experiencing difficulties with obtaining people with the appropriate skills and training. Care at Home staffing levels are pressured for Internal services and externally with local providers all experiencing the same difficulties. There are also impacts on recruitment of Dentists and other graduates arising from Covid as the number graduating has reduced during the period. The various impacts of Covid-19 has placed a significant strain on the Partnerships resources across frontline and support functions and this has resulted in delays for the progress of projects relating to the achievement of strategic objectives. HSCM continues to review the large number of fixed term and seconded posts. This will continue as temporary contracts conclude. It is hoped that this will improve some of the instability teams felt during the pandemic response. This will also allow consideration of post redesign, service needs and potential financial savings. This will continue to be reviewed by the Senior Management Team. Care Homes in Moray continue to face difficulties with recruitment and retention of staff. Efforts are being made to provide support but the situation remains challenging. The transition from EU membership has not presented any specific concerns for workforce and this will continue to be monitored. The impact of forthcoming budget allocations and the withdrawal of all Covid funding will also mean that HSCM will face some challenging recruitment decisions in 2023. The impact of budgetary decisions by the Council in relation to reducing staffing levels has reduced levels of support provided in some key areas Health and Social Care Moray (HSCM), such as ICT, HR, Legal and design. The lack of suitable housing for Health and Social Care staff has resulted in people not being able to take up posts in Moray. GP sustainability remains a national issue.	

Rationale for Risk Appetite:	Safety risks that could result in harm to service users, staff or the public are inherent in Health & Social Care services. The safety of individuals is paramount therefore standards of safety management and clinical care have to be high, and the Board will continue to seek assurances this is the case. The Board's ambition is for health & social care to be people centred. This means supporting people in decision making about their own health & care, which may expose individuals to higher risk where they make an informed decision. The Board will also seek to balance individual safety risks with collective safety risks to the community.
Controls:	Management structure in place with updates reported to the MIJB. Organisational Development plan in place and Workforce Plans are being updated to align to the new strategic plan. Continued activity to address specific recruitment and retention issues. Management competencies continue to be developed through Kings Fund training although this was suspended due to Covid19. A 2 day event was held on 16/17 May 2023, attended by the Senior Management Team as part of a Grampian wide event. Communications & Engagement Strategy was approved in November 2019 and continues. Council and NHS performance systems in operation with HSCM reporting being further developed and information relating to vacancies, turnover and staff absences is integral to this. Managers are highlighting any areas of concern and where appropriate this is identified in operational risk registers. HSCM services have commenced weekly reporting of workforce sit reps for Senior Management Team oversight highlighting vacancies, annual leave, sickness absence and Covid impacts so that issues can be identified and assessed quickly. Moray Council are carrying out a study of accommodation needs, including people working in the Health and Care sector.
Mitigating Actions:	System re-design and transformation. Organisational Development Plan and Workforce plan were updated and approved by MIJB in November 2019. The updated Workforce plan has been submitted to Scottish Government and comments were received by the HSCP in October 2022. These are currently being worked through. These plans are core documents for the Workforce Forum which has recently re-commenced following a temporary suspension during the first quarter of this year due to Covid impact. Staff Wellbeing is a key focus and there are many initiatives being made available to all staff including training, support, information and access to activities. Locality Managers have developed Multi-disciplinary teams in their areas and project officer support was been provided to develop the locality planning model across Moray.

	Lead Managers are involved in regional and national initiatives to ensure all learning is adopted to improve this position. Lead Managers and Professional Leads are linked to University Planning for intakes and programmes for future workforce development. HSCM are working with Digital Health and Care Innovation Centre as partners on the Digital Health Improvement programme to research and design innovative ways to address the needs of citizens, versus the challenges of recruitment and skills available within Moray. Incentives have been secured to try and attract additional NHS dentists and dental practices to our area. The Scottish Dental Access Initiative now includes Moray, with grants of £50,000 and above available to allow dental practices to be established or extended– provided there is a seven-year commitment to providing NHS treatment. A recruitment and retention bonus is also being offered to eligible new dentists in Moray. GP sustainability Group and Primary Care Vison for the Future Groups in situ. Work is underway across the system to consider the implications of the Health and Care (Staffing) (Scotland) Act 2019.
Assurances:	Operational oversight by Moray Workforce Forum has resumed and will report to MIJB in accordance with the agreed Governance framework. The HSCM Response Group was in place over the whole period of the Covid19 pandemic providing focussed leadership around emerging issues and resolving them. This group stood up again in April and is meeting daily whilst the system is pressured, this will be reviewed as the situation evolves. The Heads of Service are co-ordinating and escalate to SMT where necessary. These meetings have been increased as service needs dictate.
Gaps in assurance:	Further work required to develop workforce plans to reflect strategic plan implementation programmes.
Current performance:	The iMatter survey results for 2022 were received by managers for review and action plans. Preparatory work has commenced on the plans for iMatter 2023/24. Discussions are underway with HR in both Council and NHS to develop access to appropriate HR information at a summarised level to facilitate the necessary workforce planning and subsequent monitoring of plans. There continues to be a need for more streamlining in recruitment processes as the delay in approval to recruit to having a member of staff available is in excess of 8 weeks. There is also a lack of suitable applicants for various posts which is impacting on ability to appoint for some roles.

Comments:	Staffing issues are owned by the Systems Leadership Group who will work collaboratively across the system to seek opportunities to make jobs more attractive where it has proved difficult to recruit in the past. For some professions there is a potential risk that staff move from one position to a new position within HSCM will just move the vacancy to elsewhere in the system, so Senior Management Team are aware of this risk and taking it into account in considerations for vacancies. This needs to be considered when fixed term contracts and secondments are planned, consideration needs to be given to the whole of HSCM and not services in isolation. Many of our staff may have transferrable skills and experience. The continuing system issues and lack of available beds may mean operations cannot be scheduled to reduce the backlog and key staff may not have the necessary time in surgery to maintain essential skills. This in turn may add to the staff retention issues within certain specialties.

4		
Description of Risk: *Reputation:*	Inability to demonstrate effective governance and effective communication and engagement with stakeholders.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**MEDIUM**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Performance framework to be further developed from a planning perspective to show the links through operational service delivery to strategic objectives. Feedback from community representatives and third sector organisations, across a variety of forums, highlighted issues. Clear focus and communications is required to ensure engagement and outcome needs are met.	
Rationale for Risk Appetite:	The Board is aware of the importance of good relationships with stakeholders. It recognises many of our ambitions require effective collaboration, co-production and partnership working with a range of stakeholders. The board also recognises that not all partners will be able to move at the same pace, all the time. ~~We will seek to protect relationships and will not set out to antagonise stakeholders deliberately. For exampleWe will not be seen to exclude or prevent participation in the design of services where there is an appetite to do this~~.	

	We are aware of the need to protect and maintain good working relationships with all partners and stakeholders in order to deliver the outcomes set out in our strategic plan. ~~We must be mindful that repairing relationships is easier when there is already a well of goodwill to draw on, and that further damage to an already damaged relationship will not be conducive to good long term outcomes.~~
Controls:	Governance Framework approved by IJB January 2021 Communication and Engagement Strategy approved November 2019 Annual Governance statement produced as part of the Annual Accounts 2021/22 and submitted to External Audit. The unaudited accounts and governance statement for 2022/23 were presented to MIJB June 2023 and the audited accounts will return to committee in September 2023 for agreement. Annual Performance Report for 2022/23 was published in July 2023. Performance reporting mechanisms in place and being further developed through performance support team, home first group and system leadership team. Community engagement in place for key projects areas such as Forres, Keith and Lossiemouth with information being made available to stakeholders and the wider public via HSCM website. Participation of stakeholders in a variety of meetings such as Home First project, carer strategy, Strategic, Planning and Commissioning groups.
Mitigating Actions:	Schedule of Committee meetings and development days in place and implemented. New relationships are currently being established with Grant Thornton, the MIJB's newly appointed external auditor for 2022/23. ~~Good working relationship established with Audit Scotland, the MIJB's appointed external auditors since 2016/17.~~ ~~Discussions at leadership meetings to ensure all standards are being met around Public Sector Equality Duty and published where appropriate. There is a new programme of training to ensure all policies are Equalities Impact Assessed and the findings are published. The SMT are currently considering how any proposed service changes consider the PSED as part of the consultation process.~~ The principles of the Equalities Impact Assessment are now embedded in the business as usual processes within Health and Social Care Moray. Social media is actively used as a method of engaging with the public, with short videos focussing on particular services being trialled. SMT have considered the existing arrangements for engagement with stakeholders and work is being undertaken to align our framework with the Scottish Government "Planning with people guidance" and ensure that mechanisms are in place across services to evidence and evaluate their impact. A Public Engagement Communications Officer has now been appointed and started in post mid August 2023.

Assurances:	Oversight and scrutiny by Clinical and Care Governance Committee, Audit Performance and Risk Committee and MIJB. Summary reports of minutes of MIJB meetings are submitted to Council committee and NHS Board.
Gaps in assurance:	Progress on implementation of the Communication and Engagement Strategy was impacted by the Covid 19. Due to the impact of COVID and requirement for social distancing the normal mechanism for engagement were not all available. More use is being made of social media and Microsoft teams and other options and methods for engagement with staff are being used via NHSG such as videos on YouTube and one question surveys. Going forward there may be more opportunity for face to face meetings to take place again but it should be considered that this will not be beneficial for all.
Current performance:	Communication, Engagement & Participation Framework was reviewed approved by IJB November 2019. This will be reviewed by the new Public Engagement and Communication Officer. The Unaudited Accounts for 2022/23 were approved in March 2023, presented to MIJB and APR Committee in June 2023 and are now being audited, with the audited accounts to be presented in September 2023. The Annual Performance Report for 2022/23 was published in July 2023 after being presented to MIJB in June 2023.
Comments:	A communication cell is now established as part of the Local Resilience Partnership ~~Covid and storms~~ response with representation from Emergency Services, Councils, HSCP and NHSG. ~~This was led by Aberdeen City Council and was an example of the collaborative working that took place~~. This forum provides assurance that messages to all stakeholders are consistent. ~~There has been representation from the Home first project at the Wellbeing forum to facilitate sharing of information and seeking views.~~

5		
Description of Risk: *Environmental:*	Inability to cope with unforeseen external emergencies or incidents as a result of inadequate emergency and resilience planning.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**HIGH**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	As a result of the Covid 19 response, progress was made in a number of areas. SMOC information is updated, control room guidance updated and expanded, control centre protocols were implemented and remain in place and management teams have responded in an agile, responsive and collaborative way under very challenging conditions. Teams continue to do their best but there are areas where they still feeling overwhelmed and service delivery is challenging. With effect from March 2021 MIJB is defined as a Category 1 responder under the Civil Contingencies (Scotland) Act and there are additional requirements for preparedness that is being taken forward in partnership with NHSG and Moray Council emergency planners.	
Rationale for Risk Appetite:	The MIJB understand the requirement to meet the statutory obligations set out within the Civil Contingencies Act and the Category 1 status applied in March 2021, and work with partner organisations to meet these obligations.	
Controls:	Winter Preparedness Plan was updated (but not tested as in previous years) alongside NHSG plans as NHSG implemented their crisis management framework which required participation of partners at Daily System Connect meetings to discuss and prioritise resource to address issues with system flow. HSCM Civil Contingencies group established and meeting regularly to address priority subjects. NHS Grampian Resilience Standards Action Plan approved (3 year). Business Continuity Plans are now updated for most services and this review continues across HSCM. Knowledge of critical functions and ability to respond quickly and effectively has been in evidence during incidents such as Gas outages in Keith (January and February 2021) and Covid response, Storms (Arwen, Malik and Corrie) – debriefs carried out and learning identified. A Resilience Newsletter started in December 2022 to ensure all staff receive some personal resilience information together with resources for teams to plan. Regular updates to SMT and SLG regarding potential power outages across the country. Additional sessions delivered to Primary Care Contractors to assist with their Business Continuity Planning around power outages. Regular system wide meetings to discuss potential Industrial Action implications and service planning.	

	A review of the Festive season arrangements was completed and as a result all services are now required to provide information about service cover available over holiday long weekends which enables a more collaborative and supportive approach.
Mitigating Actions:	Information from the updated BIA/BCP informed elements of the Winter Preparedness Plan Daily Response Group continues, this allows the status of services across the whole system to provide information and contact details to the Senior Manager on Call (SMOC) over the weekend. If any potential issues are highlighted the relevant Persons at Risk Data is compiled and if appropriate, shared with relevant personnel. NHSG have introduced system wide daily huddles to manage the flow and allocation of resources which require attendance from Dr Grays and HSCM. The format and regularity of these are under review. ~~Practitioner group established for Moray with representation from HSCM, Dr Grays, Moray Council and NHSG to discuss matters arising from the Local Resilience Forum and within our respective organisations. In addition it will provide a forum for discussion of the linkages between organisational response plans to ensure there are no gaps or over reliance on particular local resources~~. HSCM continues to monitor the local situation regarding impacts on staffing and is engaged with NHSG emergency planning arrangements and Council Response and Recovery management team to be ready to escalate response if required. Work was undertaken within NHSG, Aberdeenshire HSCP and Aberdeen City HSCP to look at Surge flows and establish a mechanism that will provide easy identification of “hot spots” across the whole system in Grampian, to facilitate a collaborative approach to addressing the issues through the use of a common Operational Pressure Escalation approach. This work could underpin surge responses in winter and at other times of pressure and having a standard approach across Grampian could aid communication and understanding. NHSG and the three Health and Social Care Partnerships completed a considerable amount of planning for potential Industrial Action from staff groups. This has allowed for testing of a range of communications and plans to be tested and will continue to develop.
Assurances:	Audit, Performance and Risk Committee and NHS Grampian Civil Contingencies Group oversight and scrutiny. HSCM Civil Contingencies group review specific risks and action plans to mitigate, developing plans and testing arrangements in partnership with NHSG and Council
Gaps in assurance:	Moray Integrated Joint Board (MIJB) was designated as a Category 1 responder under the Civil Contingencies Act 2004 from March 18th 2021. That designation imposed a number of statutory duties in terms of the Act and the associated

	Scottish Regulations[1]. MIJB has no dedicated, specialist in post and is reliant on the Corporate Manager covering this increasingly demanding role in addition to other duties without the necessary background, knowledge, skills and experience. This presents a potential organisational risk in terms of compliance, and our ability to provide assurance on discharging our civil contingency arrangements. This has been highlighted to the Chief Officer and IJB. The debriefs from the storms in 2021/22 have identified lessons learnt for Grampian Local Resilience Partnership and more locally for the response co-ordination within Moray. Action were developed in collaboration with Moray Council's emergency planning officer to address the issues identified. The main issues related to developing wider awareness of roles and responsibilities, and improving general awareness of response structures and meeting protocols. This will be incorporated into training schedules going forward. It has also highlighted the need for a robust arrangement for out of hours contact and clarity of roles and responsibilities across the system which is being discussed at SMT. Option Appraisal discussions have commenced. Progress has been made however further work is required to address the targets in the implementation plan that have not been met and the Resilience standards as identified by the NHSG Civil Contingencies Group. The 'Care for People' strategic document has been approved by HSCM SMT and CMT. It will be presented to MIJB in September. A draft operational response plan has been drawn up and has been circulated within the Senior Leadership Group for comment. An information session including the 'Care for People' element was delivered on 2 May 2023, to senior managers who carry out the role of SMoC, this included input from Moray Council Emergency Planning Officer and NHS Grampian. An additional session with a specific focus on the draft Care for People framework has been arranged for September 2023. The intention is to hold a table top exercise with managers from HSCM and Moray Council to test the invocation arrangements to ensure common understanding of roles and responsibilities. Table top style exercises were carried out with some services who had submitted their finalised Business Continuity plans in February 2023. Development of a HSCM Persons at Risk Database continues and all partners are now involved, looking to improve the quality of the data held. HSCM is also working with Aberdeen City, Aberdeenshire and NHS Grampian at a system wide approach.
Current performance:	The Senior Management Team have undertaken 'Strategic Leadership in a Crisis' training since 2020 and continue to do so as the programme is delivered.

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

	Many services have business continuity arrangements and some are overdue for an update. Work has progressed in identification of a critical functions list for agreement by System Leadership Group that will inform planning arrangements going forward. There will need to be changes made to business continuity plans following the implementation of additional ICT resources in services which have provided a greater deal of resilience for some services and functions – albeit reliant on electricity supply. A schedule of review and exercising of business impact assessments and plans has been scheduled for this year across services. All services have been requested to prioritise their Business Continuity planning with a particular lens on power outages. Annual report on progress against NHS resilience standards was presented to the APR committee on 30 March 2023. Report on the implications and risks of the designation as a Category 1 responder was presented to MIJB 25 November 2021. Work is currently underway to plan for possible National Power Outages across the UK. This is being co-ordinated across Grampian to ensure all Partners are involved. Information/planning sessions were also delivered via HSCM to our Primary Care partners. They were invited to share emergency plans with the partnership.
Comments:	The requirements of a Category 1 Responder continue to increase in demand placing increased pressures across already overstretched services and managers. The Manchester Arena Inquiry has resulted in a focus on Category 1 responders responsibilities, together with an increase of additional policies and procedures to be written and implemented with no additional resource. MIJB does not have a subject matter expert leading on these topics. Recently NHS Grampian identified that 54 buildings/areas within their estate may potentially have Reinforced Autoclaved Aerated Concrete (RAAC) within the structure. This is a lightweight form of concrete used mainly in roof, floor and wall construction in the UK from mid 1950s to mid 1990s. It has proven not to be as durable as other concrete building materials and there is a risk it can fail. NHS Grampian are leading a project to identify the areas and put plans in place. Currently 5 buildings within HSCM have been identified, and NHS Grampian will be working with them to carry out surveys in the first instance.

6		
Description of Risk: *Regulatory*	Risk to MIJB decisions resulting in litigation/judicial review. Expectations from external inspections are not met.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**MEDIUM**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Considered medium risk due to the impact of Covid-19 and resultant efforts required to remobilise services and/or the increase in workloads stretching a workforce that has been under sustained pressure for a considerable time. The ongoing impact of the Covid 19 pandemic is stretching resources to deliver care in the community across all providers (internal and external) so there is a potential increased risk of expected standards not being achieved despite the best efforts of all concerned.	
Rationale for Risk Appetite:	The Board, staff and providers across Moray are all committed to ensuring high standards of clinical care & governance through operational policies. Innovation and new ways of working may mean traditional regulations do not exist and require to be developed, no longer apply, or are contradictory. We will only take regulatory risks knowingly, following consultation with the relevant regulatory body and where we have clear risk mitigation in place.	
Controls:	Clinical and Care Governance (CCG) Committee established and future reporting requirements identified Clinical Risk Management and Practice Governance group has oversight of their respective professional standards and also links into Clinical and Care Governance Group, which escalates to CCG Committee as necessary. High and Very High operational risks are reviewed by NHS Grampian Clinical Risk Management and System Leadership Group monthly and a review of all risks will be undertaken as part of the risk management framework. Workshops took place in January and February 2023, 'A conversation about Clinical Governance'. ~~Additional operational workshops will continue in 2023.~~ Complaints and compliments procedures in place and monitored. Clinical incidents and risks are being reviewed on a fortnightly basis to ensure processes are followed appropriately and consistently and responses are recorded in a timely manner. Adverse events and duty of candour procedures in place and being actioned where appropriate and summary reports submitted to CCG committee.	

	Reports from external inspections reported to appropriate operational groups and by exception to SMT for subsequent reporting to CCG or Audit Performance and Risk Committee as appropriate. ~~albeit there was a reduction in some areas of external inspection reporting during the Covid period due to social distancing restrictions. It is anticipated that these will begin to increase over the coming year.~~ Care Home ~~Oversight~~ Collaborative Support Group meets to oversee and manage risks in care homes. Children and Adult Protection services are being delivered and reported to their respective committee on a regular basis.
Mitigating Actions:	This risk is discussed regularly by the three North East Chief Officers. ~~Additional resource has been allocated to support the analysis of information for presentation to CCG committee~~ All High and Very High risks are now brought before the Senior Leadership Group in Moray. Process for sign off and monitoring actions arising from Internal and External audits has been agreed
Assurances:	Audit, Performance and Risk and Clinical and Care Governance Sub-Committees oversight and scrutiny. Governance Framework in place and operational. This is currently being refreshed and will be presented to the CCGG Committee in November 2023.
Gaps in assurance:	Process for highlighting recurring themes or strategic expectations from external inspections requires further development to ensure Committee has sight of significant issues.
Current performance:	External inspection reports are reviewed and actions arising are allocated to officers for taking forward. Two Days of Care Survey took place across Moray on 25th and 26th January, 2023 respectively. These were led by the Clinical Service Leads. The findings of these events were compiled and outcomes are assessed by the relevant service leads and SMT. A further round of audits on Social Care will now be completed and a full report will be considered if necessary, dependant on outcomes. A summary of inspections is included in the Annual Performance report. ~~The level is marked as an increasing risk on the basis that services are under pressure with the issues with staffing capacity and the need to focus on delivery of critical functions which may mean external inspection are not the priority at this moment in time.~~ ~~The Adult Support Protection inspection took place in April/May and an action plan has been developed and is now in place.~~
Comments:	No major concerns have been identified for HSCM services in any audits or inspections during 2021/22. An inspection of Childrens Services commenced in August 2023, this will take place over a number of months.

7		
Description of Risk: *Operational Continuity and Performance:*	Inability to achieve progress in relation to national Health and Wellbeing Outcomes. Performance of services falls below acceptable level.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**HIGH**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Potential impacts to the wide range of services in NHS Grampian and Moray Council commissioned by the MIJB arising from reductions in available staff resources as budgetary constraints impact. Unplanned admissions and delayed discharges place additional cost and capacity burdens on the service. The level of delayed discharges has remained ~~high~~ challenging, reflecting the sustained pressure in the system following the Covid -19 pandemic impact and the lack of availability of care in the community. There are sustained focussed and collective efforts by all those working in the pathway. However this is a complex area and will require continued effort to realise reductions and maintain them.	
Rationale for Risk Appetite:	The Board is cautious but open about risks that could affect outcomes that are priorities for people in Moray. There is a slightly higher appetite to risks that may mean nationally set outcomes – that by design are not given a high priority in Moray - are not met. There is new focus on addressing positive risk taking to ensure the most appropriate and timely measure of care for the population of Moray, this is being supported through various work streams across the system. This will only be accepted where there is a clear rationale, and preferably also a way of demonstrating what the IJB is doing to meet the aspiration the outcome was created for.	
Controls:	Performance Management reporting framework. 2022 to 2032 “Partners in Care” Strategic Plan was approved and development of delivery plan is underway. Performance is regularly reported to MIJB. Revised Scorecard being developed to align to the new strategic priorities. Best practice elements from each body brought together to mitigate risks to MIJB’s objectives and outcomes. Chief Officer and SMT managing workload pressures as part of budget process. A daily Huddle and write up circulates the picture on performance across community and acute services for the Portfolio and service managers have a shared understanding of the pressures in the system and mitigations taking	

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

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

8		
Description of Risk: *Transformation*	Inability to progress with delivery of Strategic Objectives and Transformation projects.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**HIGH**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	There are many issues that will impact on the ability to progress to deliver Strategic Objectives. The Strategic Planning & Commissioning group has been refreshed and re-launched and key work is being progressed. There was an initial meeting held on 22 September 2021 to consider terms of reference and the proposed structure for oversight, prioritisation and assurance in relation to key developments, their fit with IJB strategy and enabling elements. ~~The interim appointment of the Strategic and Planning Lead provides capacity to take this forward and to align the priorities arising nationally, Grampian-wide and locally.~~ The remobilisation plan for HSCM services that were suspended or reduced is progressing with Providers services and social work implementing the IJB decision to return to delivery of both substantial and critical eligibility criteria. Work has progressed risk assessments are completed and assessments have been or are in the process of being reviewed to ensure equality. The impact of Covid 19 on the population of Moray is still not fully realised. It is therefore not possible to predict the extent of the impact on the ability to progress with delivery of Strategic Objectives. There are some aspects that have progressed very well such as introduction of Near Me consultations but there are others that are more difficult to progress. There is concern that due to the workloads and challenges over the last year that teams are weary and/or do not have capacity at this moment in time, to progress with delivery of development plans at this moment in time. In addition the pandemic is still present in the community so services are still responding to the impacts it has for the population of Moray. Managers are working with teams to establish “readiness” and their capacity and sense of wellbeing and the collated output will inform plans going forward. One key aspect to facilitate transformation is the need for progress in relation to ICT infrastructure, data sharing and data security across the whole system. Work was undertaken by NHS Grampian and partners to address the needs for ICT kit and information during the response to Covid.	

Rationale for Risk Appetite:	The Board has a high appetite for risks associated with delivery of transformational redesign. The following should be considered when accepting these risks: • We understand and can mitigate other risk types that may arise, e.g. safety or financial within appetite • Service users are consulted and informed of changes in an open & transparent way • We will monitor the outcome and change course if necessary
Controls:	It is recognised that there will be significant changes taking place in Social Work practice with the implementation of the Self Directed Support standards and the move to outcomes based services, so governance arrangements are being set up to facilitate the same type of oversight and communication that is in place for the Home First programme. The Strategic Delivery Plan is being developed by the Heads of Service and Interim Stratgegic Planning Lead.
Mitigating Actions:	Integrated Infrastructure Group previously established, with ICT representation from NHSG and Moray Council, to consider and provide solutions to data sharing issues and ICT infrastructure matters which is an area that will be taken forward alongside the Moray Growth Deal projects. The Moray Transformation Board has recently restarted and will link to all relevant groups.
Assurances:	Strict ICT and data sharing policies and protocols in place with NHS Grampian and Moray Council. A Moray Portfolio Infrastructure Programme Board has been established to support the operational delivery of the aims and objectives set e.g. Analogue to Digital changeover, Buildings and Assets oversight and Smarter Working will support this agenda.
Gaps in assurance:	~~Transformation/implementation planning is in development and will inform outcomes and performance reporting on the delivery of the strategic plan.~~ Protocol for access to systems by employees of partner bodies are in place. Information Management arrangements to be developed and endorsed by MIJB. Process of identification of issue and submission to data sharing group requires to be reinforced to ensure matters are progressed. The strict information sharing protocols can cause issues when trying to work across system in an open and transparent way. Smarter Working programmes are being progressed in partnership with Council and NHSG.
Current performance:	Training to promote records management, data protection and related issues for staff working across and between partners using the learning and development resources of NHS Grampian and Moray Council.
Comments:	Where national systems are involved it may not be possible to identify a solution however the issues will be able to be raised at the appropriate level via the Grampian Data Sharing Group where all three partnerships are represented.

9		
Description of Risk: *Infrastructure*	Requirements for support services are not prioritised by NHS Grampian and Moray Council.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**HIGH**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Changes to processes and necessary stakeholder buy-in still bedding in. Moray Council is undertaking a Property review of office and depot accommodation and the potential impact for HSCM services requires consideration. The output was anticipated in October 2019 however due to changes with roles and responsibilities within the Council however the paper has been out for consultation. NHSG have advised that staff should continue to work from home at present whilst policies and protocols are developed. Moray Council have a dedicated MC officer leading on a hybrid working plan with input from HSCM on their requirements. It is anticipated that this will conclude December 2023. ICT infrastructure service plans in NHS Grampian and Moray Council are not yet visible to HSCM and development of communication and engagement process is required. ~~The impact of Covid has resulted in a change in ICT strategy for Moray Council. Council employed staff requiring mobile technology have now been provided with it and some staff are still working from home.~~	
Rationale for Risk Appetite:	Low tolerance in relation to not meeting requirements.	
Controls:	Chief Officer has regular meetings with partners. Computer Use Policies and HR policies in place for NHS and Moray Council and staff. PSN accreditation secured by Moray Council Infrastructure Programme Board was established with Chief Officer as Senior Responsible Officer/Chief Officer member of CMT. Process for submission of projects to the infrastructure board approved and implemented to ensure appropriate oversight of all projects underway in HSCM. The Board has only recently restarted, so in the interim, project requests are being processed via Senior Management Team. The interim Strategy and Planning Lead will support the Infrastructure Programme Board for Moray portfolio.	

Mitigating Actions:	Membership of the Board was reviewed and revised to ensure representation of all existing infrastructure processes and funding opportunities. Process for ensuring infrastructure change/investment requests developed
Assurances:	Infrastructure Programme Board functions to provide robust governance and assurance that proposed projects have a robust business case and meets requirements of the respective partner organisations. This board reports to Strategic Planning and Commissioning Group. Both of these groups have been recently refreshed and remobilised. Workforce Forum meeting regularly with representation of HR and unions from both partner organisations
Gaps in assurance:	Further work is required on developing the process for approval for projects so that they are progressed timeously. Need to review all existing processes in relation to infrastructure changes/projects/investments and streamline to avoid duplication of effort. Infrastructure Board is in development and priority issues are being addressed in relation to infrastructure and premises risk. Due to staff changes this work will now be incorporated into other roles. This will likely mean that this work will complete with other priorities of already busy roles. Legal services have reduced capacity to provide support due to budget cuts and vacancies so any requests may take longer. Internal Audit Services have indicated that their capacity to complete all work required by MIJB may be an issue. This is being discussed with Moray Council. Recruitment for vacancies takes considerable time due to various factors and is presenting a strain on services to maintain normal service whilst covering vacancies. There have been several posts that have had to go out to advert more than once extending the time other staff are covering gaps.
Current performance:	No update.
Comments:	Existing projects will be reviewed as part of the development of the transformation plans for the Strategic Plan to ensure resources are being dedicated appropriately and aligned to the emerging Strategic priorities. Our requirements for support will be communicated via appropriate channels

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 31 AUGUST 2023**

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

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

1. REASON FOR REPORT

1.1. To update the Committee of progress regarding the improvement plan for Adult Social Care Commissioning in line with the external review conducted by KPMG, finalised in February 2023, since the last Committee meeting on 29 June 2023.

2. RECOMMENDATION

2.1. It is recommended that the Committee considers and notes:

i) the actions within this report; and

ii) that further updates will be provided at the next Committee meeting, along with an updated Improvement Plan.

3. BACKGROUND

3.1. The Committee received an update regarding progress using the Improvement Plan at Committee on 29 June 2023 (para 11 of the minute refers). This report is a quarterly update as agreed at Committee on 30 March 2023 (para 11 of the minute refers).

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. The Governance around Commissioning activities has been further established with the reintroduction of the monthly Managers Commissioning Meeting. Aligning the Terms of Reference for this meeting to the escalation route of Practice Governance Board has been completed in draft. This will go through the consultation and approval process in September 2023.

4.2. The Commissioning Team are knowledgeable on national context regarding the approach to commissioning across the social care sector. The direction of travel is discussed at the Social Work Scotland Contract and Commissioning Sub group, at which Health and Social Care Moray are represented. This has supported the production of an awareness presentation regarding Ethical Commissioning that outlines the importance of co-production and co-design. This will be rolled out to colleagues and stakeholders and embedded in commissioning activities.

4.3. The Contract Record Document that evidences the commissioning cycle has been followed and clear decision making has been approved by the Service Manager with responsibility for Commissioning in Health and Social Care Moray. In order to embed continuous improvement within the commissioning team, this approach is due for review at the end of September 2023 so that management can be certain that it is fit for purpose and therefore it is being piloted using the Carers Contract.

4.4. The progression of bringing out of date contracts into date is steady. It is important that this is done following the principles of commissioning and within procurement legislation. To date this year there have been 6 contracts awarded and a further 2 contracts are with the provider for signature, one letter of extension has been agreed within the terms of the contract and a further 15 contracts are in various stages of the commissioning and procurement cycle.

4.5. In order to ensure that the commissioning work keeps momentum, an annual work plan needs to be produced with priority contracts agreed with Management. This will be included in the presentation offered to colleagues so that assurance is provided regarding the recommissioning of services. This does not take into account new pieces of work identified by gaps in the market. In order to prioritise these, a referral form has been created so that the commissioning team can allocate work appropriately.

4.6. The invoicing authorisation process remains in place and managers are authorising within the correct remit. Invoices are now aligned to contract numbers as well as providers so that greater clarity is provided to the authoriser regarding where the invoice pertains to. To strengthen assurance and understanding, a follow up workshop is being organised with Managers to progress this further so that authorisation training can be provided. Documentation is now retained in order to minimise the risk of future payment errors, e.g. variances in billed care time.

5. SUMMARY OF IMPLICATIONS

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

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

(b) Policy and Legal

The CSWO/Head of Service must ensure that services delegated by her

work within the legal and policy framework related to commissioning and delivery of services.

(c) Financial implications
There are no financial implications arising from this report.

(d) Risk Implications and Mitigation
The Improvement Plan implements robust systems and processes in response to the KPMG reports and findings. Regular monitoring and reviewing of the Improvement Plan takes place to ensure actions are progressed. It is noted that the current resource of the team may mean that timescales and outcomes could be delayed. However any risk or emerging risk will be escalated to Committee as part of the regular reporting schedule.

(e) Staffing Implications
There are no staffing implications.

(f) Property
There are no property implications

(g) Equalities/Socio Economic Impact
This report does not require an Equality Impact Assessment as there is no change to policy.

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

(i) Directions
None arising directly from this report.

(j) Consultations
Commissioning team and Social Work Service Manager.

6. CONCLUSION

6.1 The committee is requested to note this report and agree to receive an updated improvement plan at the next Committee Meeting.

Author of Report: Aimee Borzoni, Senior Commissioning Officer
Background Papers:
Ref:

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 31 AUGUST 2023**

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

BY: **CHIEF INTERNAL AUDITOR**

1. REASON FOR REPORT

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

2. RECOMMENDATION

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

3. BACKGROUND

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

4. KEY MATTERS RELEVANT TO RECOMMENDATION

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

Disabled Parking System

4.2 A review of the Disabled Parking Permit Scheme has been completed. Disabled parking permits, also known as blue badges, help people with disabilities or health conditions park closer to their destination. Local authorities are responsible for the day-to-day administration and enforcement of the scheme. However, the framework for the scheme is set by Transport Scotland. The audit reviewed systems and procedures in administering the Disabled Parking Permit Scheme. This included the processes for assessment, management and investigation of blue badge misuse. The executive summary and recommendations for this project are given in **Appendix 1.**

5. SUMMARY OF IMPLICATIONS

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

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

(b) Policy and Legal

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

(c) Financial Implications

No implications directly arising from this report.

(d) Risk Implications and Mitigation

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

(e) Staffing Implications

No implications directly arising from this report

(**f) Property**

No implications.

(g) Equalities/ Socio Economic Impacts

No implications.

(h) Climate Change and Biodiversity Impacts

None directly arising from this report.

(i) Directions

None arising directly from this report.

(j) Consultations

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

6. CONCLUSION

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

Author of Report: Dafydd Lewis, Chief Internal Auditor
Background Papers: Internal Audit Files
Ref: mijb/ap&rc/31082023

AUDIT REPORT 24'010

DISABLED PARKING PERMIT SCHEME

Executive Summary

The annual audit plan for 2023/24 provides for an audit review of the arrangements for managing the Disabled Parking Permit Scheme. Disabled parking permits, also known as blue badges, allow eligible people to park close to amenities they would otherwise have difficulty accessing. Local authorities are responsible for the day-to-day administration and enforcement of the scheme. However, the framework for the scheme is set by Transport Scotland, in addition to providing support to assist in consistent operating practices across all local authorities. A blue badge is subject to a charge of £20 and can be valid for up to three years.

The scope of this audit was to review systems and procedures in the administration of the Disabled Parking Permit Scheme. This included the processes for assessment, management and investigation of blue badge misuse. The expenditure for providing the service relates mainly to staffing and the cost of producing badges from approved suppliers. The Council issues approximately 1700 blue badges annually with an income of £29,000 collected in 2022/23.

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

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

- The Moray Council Financial Regulations detail that invoices must be raised within one month of providing goods or services. Once a blue badge is issued, an invoice of £20 should be issued to the applicant. Audit testing found that the Service did not raise invoices until several months after issuing the blue badge. It was noted that over recent years there have been significant increases in the number of applications received for blue badges, but staffing levels have remained unchanged. However, to ensure effective income collection arrangements and compliance with the Council's Financial Regulations, invoices should be raised promptly once the blue badge has been issued.

- Analysis of the Financial Management System noted a shortfall of approximately £24,000 in the income received compared to the blue badges issued. Further investigation noted that there were approximately 1200 blue badges provided to applicants in 2020 and 2021, where no invoices had been issued. Explanation sought as to why no invoices had been raised revealed this was due to workload issues and the extraordinary challenges faced by the Service during the pandemic. Invoices should be raised for these blue badges issued in 2020 and 2021 as a matter of urgency.

- Audit testing noted that the Service is following Transport Scotland Guidelines in assessing eligibility and managing the Disabled Parking Permits Scheme. However, it was found that the Blue Badge Scheme Policy was last updated in 2013. Policies and procedures should be updated to reflect current operating practices and legislation.

The Internal Audit Section provides Management with an opinion on the internal control environment and also categories risk ratings for recommendations as high, medium or low. The audit recommendations for this review have been classified as follows:

Risk Ratings for Recommendations		
High	**Medium**	**Low**
Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Less critically important controls absent, not being operated as designed or could be improved.	Lower level controls absent, not being operated as designed or could be improved.
2	**2**	**1**

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Recommendations

Risk Ratings for Recommendations						
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	**Audit Recommendation**	**Priority**	**Accepted (Yes/ No)**	**Comments**	**Responsible Officer**	**Timescale for Implementation**
Key Control: Effective management controls operate to ensure the delivery of the Disabled Parking Permit System is in accordance with Transport Scotland Guidelines.						
5.01	The Blue Badge Scheme Policy should be reviewed and updated. This should include reference to responsibility for investigating misuse and arrangements if required to cancel a service users blue badge.	Medium	Yes	The Blue Badge Scheme Policy will be updated to ensure all aspects of the service and its processes are incorporated, including badge misuse arrangements.	Interim Community Care Finance Officer/Support Manager	31/03/2024
5.02	All service users identified that have received a blue badge in 2020 a 2021 but not billed should be invoiced as a matter of priority.	High	Yes	Work is underway to review un-invoiced applications from 2020 and 2021 to establish the current position. On	Commissioning Manager	31/01/2024

Risk Ratings for Recommendations						
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	**Audit Recommendation**	**Priority**	**Accepted (Yes/ No)**	**Comments**	**Responsible Officer**	**Timescale for Implementation**
				completion of this review, invoices will be raised for all outstanding approved blue badges issued from this period.		
5.03	In accordance with Financial Regulations, service users should be invoiced within one month of receiving a blue badge. An action plan should also be agreed to resolve any backlog of blue badges issued to applicants who have yet to be invoiced.	Medium	Yes	An action plan is now in place to clear the current year invoice backlog, staff time has been ring fenced to facilitate this. All new applications are being invoiced within one month.	Interim Community Care Finance Officer/Support Manager	31/08/2023
	The audit review noted that the fee for a blue badge is payable on application in some Local	Low	Yes	Discussions are currently underway between the	Interim Community Care Finance	31/12/2023

Risk Ratings for Recommendations						
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	**Audit Recommendation**	**Priority**	**Accepted (Yes/ No)**	**Comments**	**Responsible Officer**	**Timescale for Implementation**
	Authorities. Consideration should be given to investigating the option for an individual to pay the charge for a blue badge on completion of the application form.			Community Care Finance team, the Payments team and Senior Management to develop the option of up-front payment for blue badges.	Officer/Support Manager	
5.04	All sensitive personal data held within the Community Care Finance Office should be stored securely with access restricted to only authorised officers.	High	Yes	There will be a purchase of lockable filing cabinets to replace those which are non-lockable and all staff will attend data protection training and be reminded of the clear desk policy with immediate effect. The lock on the door will be used without delay and	Interim Community Care Finance Officer/Support Manager	31/08/2023

Risk Ratings for Recommendations						
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	**Audit Recommendation**	**Priority**	**Accepted (Yes/ No)**	**Comments**	**Responsible Officer**	**Timescale for Implementation**
				without exception.		

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 31 AUGUST 2023**

SUBJECT: **SELF-DIRECTED SUPPORT OPTION 1 AUDIT UPDATE**

BY: **SERVICE MANAGER, PROVIDER SERVICES**

1. REASON FOR REPORT

1.1. To inform the Audit, Performance and Risk Committee in relation to the progress of the current work being undertaken to achieve the recommendations outlined in the most recent internal audit report regarding Self-Directed Support (SDS) Option 1.

2. RECOMMENDATION

2.1. It is recommended that the Audit, Performance and Risk Committee consider and note the current progress relating to the Self-Directed Support Option 1 audit report.

3. BACKGROUND

3.1. The Social Care (Self-Directed Support) (Scotland) Act 2013 was enacted on 1 April 2014 with the Self-Directed Support (SDS) Standards being implemented in March 2021. The focus of both the legislation and the standards is to deliver independent living, enabling people of all ages to have the same freedom, dignity and control as other citizens at home, work and in the community.

3.2. An internal audit was carried out through the lens of the financial reviews which are required to be carried out for those opting to receive their care and support via Option 1 of SDS (Direct Payments). The audit delivered key recommendations for the service to achieve.

3.3. An update report was requested from the Audit, Performance and Risk Committee on the issues found in the audit reports as presented by the Chief Internal Auditor at the Committee Meeting held on the 29 June 2023 (item 8 of the minute refers).

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. The high level action plan was delivered alongside the audit report, which has now been further developed into a more robust delivery plan to support in meeting the recommendations.

4.2. There is a requirement for 3 month, annual and closing reviews to be carried out on all Direct Payment packages, in addition to supporting with the setting up of Direct Payment packages (including recruitment, payroll, and insurance) and on-going support to individuals for the duration of the Direct Payment.

4.3. At the time of the audit, the team were supporting 150 Direct Payment recipients, at the time of writing, the team are now supporting 273 packages, consisting of 201 ongoing weekly payments, 30 SDS Carer one-off payments and 42 supported person one-off payments in the previous 12 month period.

4.4. The outstanding reviews have been heightened as a result of the COVID-19 pandemic, when the team had to reduce their delivery in line with the business continuity plan and staff redeployed to other critical areas of the wider service.

4.5. As can be evidenced through the delivery plan **(Appendix 1),** several actions have now been completed and have been built into the ongoing operations of the team, whilst others have been progressed. The team are completing financial reviews within the current resource available to the team, balancing this against the need to deliver front line support to those opting to receive a Direct Payment to ensure there is no delay in their care and support commencing.

4.6. Through the prioritisation of the financial reviews in line with the audit recommendations, closing reviews have been prioritised alongside those with unmanaged accounts. Furthermore those reviews due at 3 months of a package commencing, are prioritised to ensure individuals have got the necessary documents in place and to support in ensuring funds are being used to meet the agreed outcomes.

4.7. For reassurance, within the current financial year, a total of £292,812.65 has been reclaimed, of which £187,341.24 has been a result of carrying out closing reviews as a result of the targeted prioritisation.

4.8. To support the completion of the outstanding reviews, a 3 Minute Brief was presented to the Senior Management Team for additional resource, where approval was obtained for the advertisement of up to 4 temporary posts until March 2024 to dedicate to the completion of the reviews. The funding for the posts has been utilised from a portion of the funds the team have reclaimed to date in this financial year. An evaluation of the posts will be carried out early 2024 to ensure future planning and mitigating actions are in place for future delivery.

5. SUMMARY OF IMPLICATIONS

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

SDS supports the vision of the MIJB Strategic Plan, the Corporate Plan and LOIP. The strategy will support Theme 2, Home First Objective 3, we work together to give you the right care in the right place at the right time.

(b) Policy and Legal

Compliance with Social Care (Self-Directed Support) (Scotland) Act 2013, the accompanying statutory guidance and SDS Framework of Standards. The accompanying local Direct Payment policy and guidance utilises the Charted Institute of Public Finance and Accountancy (CIPFA) guidance relating to the monitoring of Direct Payments.

(c) Financial implications

There is a requirement for the reviews to be carried out in line with the given timescales to ensure governance over the Direct Payments funds. The recruitment to the temporary posts has been utilised from funds returned to Health & Social Care Moray, and will further support additional funds to be returned.

(d) Risk Implications and Mitigation

Increasing demand for care and support to be delivered through Option 1 of SDS drives the increase in financial reviews, this demand is being supported through the recruitment of dedicated posts to mitigate the risks associated with not carrying out the financial reviews.

(e) Staffing Implications

To support in the outstanding financial reviews, additional staffing resource is required due to the limited capacity within the team and the competing demands of the team.

(f) Property

None arising directly from this report.

(g) Equalities/Socio Economic Impact

No negative impact has been identified, the recruitment of additional resource will ensure the team are able to continue to support the front line delivery of Option 1 (Direct Payments) to ensure support is not delayed. The additional capacity will support to address the outstanding reviews alongside the increasing financial reviews required.

(h) Climate Change and Biodiversity Impacts

None arising directly from this report

(i) Directions
None arising directly from this report

(j) Consultations
Chief Social Work Officer/Head of Service, Head of Service, Provider Services Manager, SDS and Unpaid Carers Office, Equal Opportunities Officer, Accountancy

6. CONCLUSION

6.1 For Audit, Performance and Risk Committee to note the current progress in line with the SDS Option 1 Internal Audit Report

Author of Report: Michelle Fleming, Self-Directed Support and Unpaid Carers Officer
Background Papers: Moray Direct Payment Audit Delivery Plan (Appendix 1)
Ref:

Ref	Activities	Ref	Actions	Target Achievement Date	Reference To Separate Project Plan	Associated Risks (see Risk Log for detail on Med and High Risks) Low , Medium, High	Lead Person(S)	Supported by/Additional Resources Required	Progress Notes	Status - (Completed, In Progress, Not Started)	Reference to National SDS Improvement Plan 2023-2027	Reference Internal Audit	Reference to SDS Framework Standards
1	**The SDS Guidance Direct Payment guidance and financial monitoring procedures should be reviewed and updated on a regular basis**	**1.1**	Guidance was reviewed in April 2022. There is a requirement for an in-depth review of the SDS policy and the Direct Payment guidance needs to be undertaken to embed the SDS Standards and updated Statutory Guidance.	Sep-23	N/A	**Low**				Not started	2.1 Improve SDS Practice Resources	5.01	Standard 12: Access to Budgets & Flexibility of Spend
2	**Annual financial reviews should be undertaken in line with the direct payment financial monitoring procedures**	**2.1**	To concentrate on those accounts that are due to have 3 month annual reviews to ensure an early health check has been carried out		N/A	**High**	Service Manager		Three month reviews are being prioritised by the SDS team	In progress	4.3.2.3 Standard 12: Access to Budgets & Flexibility of Spend (including improving processes and approches to approving personal budgets)	5.02	Standard 12: Access to Budgets & Flexibility of Spend
		2.2	Review staffing resources to ensure ability to clear outstanding reviews	Aug-23	N/A	**High**	Service Manager	Additional posts to dedicate addressing financial reviews	Delegated Authority report has been authorised for the recruitment of up to 4 posts on a temporary basis until March 2024 to action the outstanding reviews. Vacancy Management Form completed and portal updated to recruit using reclaimed monies.	In progress		5.02	Standard 12: Access to Budgets & Flexibility of Spend
		2.3	Closing reviews to be undertaken as a further priority to ensure surplus funds are reclaimed timeously		N/A	**High**	Service Manager		Reviews prioritised in the team within the given capacity and prioritisation of workload	In progress		5.02	Standard 12: Access to Budgets & Flexibility of Spend
3	**Consideration should be given to the routine production of reports from the CareFirst system which can be used to detail financial reviews falling due and allow management to priortise workloads accordingly. The requirement of manual spreadsheets should be minimised wherever possible to ensure information reference points come direct from the Care First system**	**3.1**	All 3 month, annual and closing reviews need to be recorded on CareFIrst and allocated to the relevant SDS Coordinator	Apr-23	N/A	**Medium**	SDS & Carers Officer	Information Systems team support required	Complete	Complete		5.03	
		3.2	Reports to be generated weekly from the CareFirst system from the records created within	Apr-23	N/A	**Medium**	SDS & Carers Officer	Information Systems team support required	Complete, reports are being sent, admin from the team sends out individual reports from the master to each SDS Coordinator, highlighting those overdue and those due that month.	Complete		5.03	
4	**A risk based approach should be initiated by management to prioritise outstanding financial reviews and work through the backlog in an order which makes the best use of limited resources**	**4.1**	SDS Coordinators to priortise the reviews which are undertaken	Apr-23	N/A	**High**	SDS & Carers Officer	Support from Audit	Reviews have been prioritised, including closing reviews, unmanaged accounts, and those who are due 3 month reviews. Reviews are also prioritised where the team are made aware of discrepancies within accounts	Complete		5.04	Standard 12: Access to Budgets & Flexibility of Spend
5	**A reminder should be issued to service users, and approved payroll providers where applicable, to inform the Authority when funds in excess of the contingency amount are held. This may assist in the prioritisation of early financial reviews and highlight issues for further investigation**	**5.1**	Payroll providers contacted 6 monthly to remind them of the need to advise the SDS team of surplus funds in accounts, or where accounts are considerably under their permitted contingency	Feb-23	N/A	**High**	SDS & Carers Officer		Reminders were sent February 2023 and further reminder scheduled for August 2023	Completed and on-going		5.05	
		5.2	Individuals to be contacted to remind them of the need to monitor their DP balance, and advise the SDS team should there be excess funds	Feb-23	N/A	**High**	SDS & Carers Officer		Reminders were sent February 2023 and further reminder scheduled for August 2023. The reminder in August will also include the need to monitor PA annual leave (where applicable) to ensure compliance with employment law.	Completed and on-going		5.05	Standard 12: Access to Budgets & Flexibility of Spend
6	**A review should be undertaken of all Service Users in regard to the current balances held within their SDS bank account. Action should then be taken to recover excess funds**	**6.1**	Bank balances for all DP bank accounts to be obtained		N/A	**High**	SDS & Carers Officer		Bank balances have now been obtained for approximately 90% of all accounts. Reviews are being further prioritised where a significant surplus or low balance is found	In progress		5.06	
		6.2	Bank accounts with a surplus identified need to be prioritised for review to reclaim funds and to also ascertain the reason for the build up. To liaise with Social Worker where applicable in relation to the build up with the level of Direct Payment reduced if no longer required at the current level		N/A	**High**	SDS & Carers Officer		Delegated Authority report has been authorised for the recruitment of up to 4 posts on a temporary basis until March 2024 to action the outstanding reviews. Vacancy Management Form completed and portal updated. To recruit using reclaimed monies	In progress		5.06	
7	**In compliance with established procedures, one-off direct payments should be subject to a financial monitoring review 3 months (or in limited circumstances at another interval)after the funding has been distributed to confirm its appropriate usage**	**7.1**	Financial reviews for one off purchases to be reviewed within 3 months of the funds being paid		N/A	**Medium**	SDS & Carers Officer		Reviews for one off purchases are in progress and being addressed	In progress		5.07	Standard 12: Access to Budgets & Flexibility of Spend

		7.2	Financial reviews for purchases like short breaks through out the year or SDS Carer Payments to be reviewed 12 months after the payment is made		N/A	**Medium**	SDS & Carers Officer		Reviews for one off annual purchases like short breaks. SDS Carer payments are being progressed and brought up to date. Those where an on going payment is also being made are being addressed simultaneously	In progress		5.07	
8	**The service should comply with the monitoring requirements detailed within an agreement between the council and service user for the purchase and adaptation of a mini van**	**8.1**	Family to be contacted to provide further evidence of compliance with the agreement	Aug-23	N/A	**Medium**	SDS & Carers Officer/ SW Team Manager		Evidence obtained as far as possible, due to the age of the vehicle, the first service or MOT has not yet being undertaken. Recommendations are the service follows up again after 1st September when MOT is due and once the first service has been carried out at 12,000 miles. Recommended annual follow ups to evidence continued compliance. Evidence of V5, fully comp insurance seen, (cover until March 2024)	In progress		5.08	
		8.2	Social Work to be contacted to arrange a joint visit to see sight of the vehicle and ensure it meets the agreed specification and being used for the agreed outcome	Aug-23	N/A	**Medium**	SDS & Carers Officer/ SW Team Manager		Social Worker allocated and joint visit with SDS Coordinator scheduled 3rd August 2023.	In progress		5.08	
		8.3	Financial review to be carried out on the remainder of the On-going DP package	Aug-23	N/A	**Medium**	SDS & Carers Officer		SDS Coordinator progressing	In progress		5.08	
9	**Closing financial reviews of SDS Care Packages should be undertaken in accordance with the agreed procedures. Evidence should be retained of any expenditure out with the agreed support plan and of the full discussions held and decisions made by Social Workers regarding retrospective authorisation**	**9.1**	Reviews to be undertaken as a further priority to ensure surplus funds are reclaimed timeously		N/A	Medium	SDS & Carers Officer		Delegated Authority report has been authorised for the recruitment of up to 4 posts on a temporary basis until March 2024 to action the outstanding reviews. Vacancy Management Form completed and portal updated to recruit using reclaimed monies	In progress		5.09	
		9.2	Where additional retrospective funds are approved, these need to be recorded on CareFirst		N/A	**Medium**	SDS & Carers Officer		In the current process for the SDS Coordinators and recorded where applicable	In progress		5.09	
		9.3	Current policy and procedure needs to be reviewed in line with the national SDS Framework of Standards, in particular Standard 12, flexible budgets		N/A	**Medium**	SDS & Carers Officer		Scheduled in line with Action 1.1	Due Sep	4.3.2.3 Standard 12: Access to Budgets & Flexibility of Spend (including improving processes and approches to approving personal budgets)	5.09	Standard 12: Access to Budgets & Flexibility of Spend
10	**Care and support plans should be reviewed annually to ensure the agreed care is being provided and continues to meet service user's needs**	**10.1**	Social Work teams to review care and support packages on an annual basis across all options of SDS		Social Work Plan	**High**	CSWO		Being addressed within a separate overarching plan for Social Work	In progress		5.10	Standard 12: Access to Budgets & Flexibility of Spend
11	**All Social Workers should be reminded of the requirement to inform the SDS Team of any amendment to a Support Plan that will have a financial change to a service user's care package**	**11.1**	SDS Team send a reminder email to all Social Work teams as a reminder that any new, amend or end to a Direct Payment needs to be sent as a referral on CareFirst to the SDS Team	Jan-23	N/A	**High**	SDS & Carers Officer		Complete, a reminder was being sent 6 monthly, the team now do this every three months, with the latter being sent May 2023. this also includes a reminder for option 2 tri part agreements to be addressed in the same manner	Complete and on-going		5.11	Standard 12: Access to Budgets & Flexibility of Spend
12	**Consideration should be given to the development of appropriate performance measures to be reported to service management on a regular basis. Given the current backlog of reviews and consequences of Direct Payment accounts not being scrutinised on a timely schedule, it may be beneficial for performance information to be made available for management to identify any resourcing issues arising and access risks involved**	**12.1**	SDS & Carers Officer to discuss with Senior Management the concerns and capacity within the team to address the required actions	May-23	N/A	**Low**	SDS & Carers Officer		SDS & Carers Officer presented a 3 Minute Brief to SMT 31st May requesting additional support to address the outstanding reviews. Approved following discussion with Head of Service for up to 4 posts be recruited to on a temporary basis until March 2024. A further discussion will take place with the Head of Service January 2024 to monitor progress and develop a clear plan moving forward. DAR signed, Job description moved through HR, VMF completed for posts to be advertised on MJS	In progress		5.12	
		12.2	Monthly meetings to be arranged with Audit, Service Manager and SDS & Carers Officer to monitor progress	Feb-23	N/A	**Low**	Service Manager		Actioned, monthly meetings are in the diary	Complete and on-going		5.12	
		12.3	Weekly team meetings to be held to discuss the CareFirst reports, note progress and escalate any concerns to the Service Manager	Apr-23	N/A	**Low**	SDS & Carers Officer		Actioned, added to the agenda for weekly team meetings	Complete and on-going		5.12	

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE**

SUBJECT: **SELF-DIRECTED SUPPORT OPTION 2 & 3 AUDIT UPDATE**

BY: **SERVICE MANAGER, PROVIDER SERVICES**

1. REASON FOR REPORT

1.1. To inform the Audit, Performance and Risk Committee in relation to the progress of the current work being undertaken to achieve the recommendations outlined in the most recent internal audit report relating to SDS Option 2 and 3 delivery.

2. RECOMMENDATION

2.1. It is recommended that the Audit, Performance and Risk Committee consider and note the current progress relating to the Self-Directed Support (SDS) Option 2 & 3 audit report.

3. BACKGROUND

3.1. The Social Care (Self-Directed Support) (Scotland) Act 2013 was enacted on 1 April 2014 with the Self-Directed Support (SDS) Standards being implemented in March 2021. The focus of both the legislation and the standards is to deliver independent living, enabling people of all ages to have the same freedom, dignity and control as other citizens at home, work and in the community.

3.2. An internal audit was carried out looking in greater depth at the systems and procedures in place to support the delivery and management of adult social care through SDS Option 2 and 3.

3.3. An update report was requested from the Audit, Performance and Risk Committee on the issues found in the audit reports as presented by the Chief Internal Auditor at the Committee Meeting held on the 29 June 2023 (Item 8 of the minute refers).

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. The findings and subsequent actions from the recent option 2 and 3 audit have been a positive step forward to support the focus of SDS over the next 12 months. The Self-Directed Support (SDS) Framework of Standards and

supporting action statements were introduced in March 2021 (currently in review) to ensure consistency of outcomes and approaches in SDS practice in Scotland, with the aim to build a framework of good practice in assessment, support planning and provision of care and support resources. In light of this, current practices, alongside the supporting local policy and guidance need to be reviewed and updated in line with the framework. The delivery of SDS Option 2 has been a challenge both locally and nationally to ensure the greatest choice and flexibility to individuals, with a clear distinction between more formal commissioned services, which are primarily delivered via an Option 3 budget.

4.2. A high level action plan was delivered alongside the audit report, this has now been developed into an improvement plan, which several delivery plans will feed into to monitor the separate projects required to underpin the audit recommendations.

4.3. Health and Social Care Moray (HSCM) have been utilising a tri-part agreement to deliver a flexible approach to SDS option 2. This model agreement has been utilised since March 2022, which ensures all three parties (the individual, the provider and HSCM) have an understanding of their roles and responsibilities. All new support delivered through option 2 in Moray should utilise this model agreement, and all supports currently in place will have a tri-part agreement in place once the care package is reviewed.

4.4. Option 2 has been a challenge to fully embed across Scotland, with CCPS currently developing a more person centred three way (tri-part) agreement which makes option 2 less bureaucratic, more flexible and user-friendly. The timescales identified within the audit action plan for the embedding of the tri-part agreements aligns itself with those identified for the completion of the Social Work Care reviews. These timescales need to be realistic and achievable taking into account Social Work capacity, the competing challenges within the current Social Work and Social Care landscape and current vacancies and subsequent recruitment to Social Work posts.

4.5. Reassurance is given that the recent audit has highlighted the same challenges as faced by other Health and Social Care Partnership's across Scotland, with further action plans being developed to meet the recommendations within the national Improvement plan. These will be aligned to the findings of our internal audit and the subsequent improvement plan **(SEE APPENDIX 1).**

4.6. Supporting individuals to exercise choice and flexibility over their care and support is the ethos of SDS. This can be at times limited for individuals due to the availability of resources in Moray. The recording of these gaps in resource is vital for us to collate in terms of market intelligence, having a greater understanding of demand, and subsequently collaborating with our communities to ascertain how they can support to shape the demand is important going forward. With limited resources we know that we cannot continue to do more of the same, through taking a strength and asset based approach, in line with SDS Standard 3 (Strength and Asset-Based Approach) will support to embed this. Looking at the strengths of the individual, explore personal support networks (friends, family and unpaid carers) can support to meet their outcomes, explore supports from the community and external grants before identifying an SDS budget will support to ensure choice and flexibility of

support, delivered in an individual's own community. Capturing all identified resources through good support planning will support to evidence the choice and flexibility of an individual's care and support. Through developing SDS Standard 4, Meaningful and Measurable Recording Practice; we will be able to record and capture the data required to shape the market enabling greater choice for individuals to meet their outcomes in line with the development of new paperwork **(see Appendix 1 Action 1.3)**

4.7. Through further development of Option 2, and the proposed approved framework, it will afford greater governance in relation to the process, give clarity on approved rates, and provide a platform for individuals to consider a range of supports to meet their outcomes. The framework would not be the only means of delivery for SDS option 2, but give a platform to base support planning to generate outcomes, still enabling individuals to choose providers out with the framework once the appropriate checks have been carried out.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Partners in Care 2022 – 2032"
SDS supports the vision of the MIJB Strategic Plan, the Corporate Plan and LOIP. The strategy supports Theme 2, Home First Objective 3, we work together to give you the right care in the right place at the right time.

(b) Policy and Legal
Compliance with Social Care (Self-Directed Support) (Scotland) Act 2013, the accompanying statutory guidance and SDS Framework of Standards alongside the national SDS Improvement Plan.

(c) Financial implications
SDS Transformation funds are provided each year to support the embedding of SDS.

(d) Risk Implications and Mitigation
Through not embedding the recommendations we risk not meeting the required ethos and principles of SDS in line with the required governance.

(e) Staffing Implications
None arising directly from this report

(f) Property
None arising directly from this report.

(g) Equalities/Socio Economic Impact
No negative impact has been identified through embedding the actions from the audit. Delivering on the improvement plan will support fair access to SDS.

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

(i) Directions
None arising directly from this report

(j) Consultations
Chief Social Work Officer/Head of Service, Head of Service, Services Manager, SDS and Unpaid Carers Officer, Equal Opportunities Officer, Accountancy

6. CONCLUSION

6.1 For Audit, Performance and Risk Committee to note the current progress in line with the SDS Option 2 and 3 Internal Audit Report.

Author of Report: Michelle Fleming, Self-Directed Support and Unpaid Carers Officer
Background Papers: Moray Option 2 & 3 Audit Improvement Plan (Appendix 1)
Ref:

Ref	Activities	Ref	Actions	Target Achievement Date	Reference To Separate Project Plan	Associated Risks (see Risk Log for detail on Med and High Risks) Low , Medium , High	Lead Person(S)	Supported by/Additional Resources Required	Progress Notes	Status - (Completed, In Progress, Not Started)	Reference to National SDS Improvement Plan 2023-2027	Reference Internal Audit	Reference to SDS Framework Standards
1	**In accordance with SDS Regulations, evidence should be maintained to document the discussions held by Social Workers regarding the various care delivery options discussed with the individual using care services**	**1.1**	Discussions to be held with Social Work staff in relation to the importance of having the right conversations and delivering information in a transparent way to enable individuals to make an informed decision	Sep-23		**High**	SDS Consultant Practitioner				1.3.1 Ensure SDS Communications are in accessible formats. This includes communication about support planning and the promotion and signposting of appropriate tools and language services. 2.2 Social Work education and incorporation of practice development for SDS	5.01	Standard 9 Transparency: 9.4 The offer of a range of options and choices made by the person will be clearly recorded to provide evidence that the person has been listened to and their preferences supported
		1.2	A training programme to be developed to support outcomes focussed conversations for all front line staff	Sep-23		**High**	SDS Consultant Practitioner				2.2 Social Work education and incorporation of practice development for SDS	5.01	
		1.3	Develop new Social Work support plan paperwork to enable recording of good conversations and the person's choices to be reflected within	Nov-23		**High**	CSWO					5.01	Standard 4; Meaningful & Measurable Recording Practice
		1.4	Social Work team managers to support the implementation through supervision and highlight good practice/ issues to Practice Governance Board	Sep-23		**High**	CSWO					5.01	Standard 5, Risk Enablement; Workers have clear practise guidance to address the balance between innovation, choice and risks
		1.5	Oversight of Social Work practice to be had at Practice Governance Board	Aug-23		**High**	CSWO		Role and remit of PGB underway following development sessions held by the CSWO. TOR's currently being developed	In progress		5.01	Standard 5, Risk Enablement; Workers have clear practise guidance to address the balance between innovation, choice and risks
		1.6	Ensure the use of the Support in the Right Direction (SiRD) project is utilised to support independent conversations around the options of SDS	Jul-23		**High**	SDS & Carers Officer		SiRD project funded by Scot Gov to Cornerstone is in place. Data sharing agreement in place, process and recording set up. Social Work teams aware of the process to refer into the service	Complete	1.1 Access to SDS Support, brokerage, advice, advocacy and tools	5.01	Standard 1: Independent Support & Advocacy
2	**Documented procedures should be developed to support social workers and individuals using care services in the selecting of SDS care delivery options**	**2.1**	Current SDS internal procedures to be updated to reflect the SDS Framework of Standards and the updated SDS Statutory Guidance	Oct-23		**High**	SDS & Carers Officer		To be reviewed in line with those under 1.1 of the Option 1 Audit Delivery plan	Not started		5.02	Standard 5; Accountability, Clear and supportive processes are in place for people to challenge and appeal all decisions affecting their experience of social care support
		2.2	Information material for individuals to be reviewed and updated in line with national developments (incl, review of resources work, SDS Standards, work of the PA Programme Board)	Oct-23		**High**	SDS & Carers Officer		Information guides are currently being reviewed through the SiRD project, noting areas for updating that will feed into the overarching review of documentation	In progress	1.3 Increase public information about SDS and improve it's reach	5.02	
		2.3	To review the SDS web page on the TMC internet and update	Dec-23		**Medium**	SDS & Carers Officer			Not started	1.3 Increase public information about SDS and improve it's reach	5.02	
3	**An annual reference document detailing a breakdown of the rates paid to care providers should be provided to all relevant officers to assist in budgetary planning and the accurate preparation of an individual's support package**	**3.1**	Commissioning team to ensure those services that are a commissioned service have the spreadsheet held within SharePoint updated on an annual basis at the start of each financial year to support budget forecasting	Aug-23		**High**	Commissioning Lead					5.03	
		3.2	SDS team to ensure up to date rates of pay for Personal Assistants, Insurance, Payroll & PVG's are updated annual by 1st April each year to support budget forecasting	Apr-23		**High**	SDS & Carers Officer	CFO	Rates updated 1st April 2023 on SharePoint, email sent to all SW teams to advise of the new rates following approval by CFO	Completed and on going annually		5.03	
		3.3	An approved framework to be developed for option 2 providers to ensure transparency of cost and clear recording of these costs for workers and individuals to make an informed decision in relation to their care and support	Jan-24	To be developed	**High**		Procurement Manager, SDS Community Collaborator	Work was previously underway to develop a robust process to give transparency and accountability to TMC, Individuals and Providers. This work needs to be re-started	To be progressed	1.2 Improving the availability and flexibility of options; work to address key barriers to use of SDS Option 2, Support Provider engagement with Option 2, develop and roll-out of tools and contractual models for Option 2 to increase workforce confidence and efficiency in offering it.	5.03	
		3.4	The approved framework to be developed to provide governance with the option 2 providers, a clear reporting structure, assurance and a process for rates to be increased in a governed and transparent way	Jan-24	To be developed	**High**		Procurement Manager, SDS Community Collaborator	Work was previously underway to develop a robust process to give transparency and accountability to TMC, Individuals and Providers. This work needs to be re-started	To be progressed	1.2 Improving the availability and flexibility of options; work to address key barriers to use of SDS Option 2, Support Provider engagement with Option 2, develop and roll-out of tools and contractual models for Option 2 to increase workforce confidence and efficiency in offering it.	5.03	
4	**All officers should be reminded to update the CareFIrst system to ensure the database is up-to-date and accurate for each individual using care services**	4.1	Team managers to reinforce through team meetings and practice supervision regarding the importance of accurate recording on CareFirst			**High**	CSWO					5.04	Standard 4; Meaningful & Measurable Recording Practice
		4.2	Governance of recording to be held by the Practice Governance Board with team managers highlighting	Sep-23		**High**	CSWO		Role and remit of PGB underway following development sessions held by the CSWO. TOR's	In progress		5.04	Standard 4; Meaningful & Measurable Recording Practice
5	**A tripartite agreement between the individual using the care service, Council and care provider should be agreed for all SDS Option 2 care packages**	**5.1**	Social Work to call upon the SIRD funded project to support individuals to make an informed choice and understand the roles and responsibilities that come with all options, and the need to agree to a tri part agreement for option 2	May-23		**High**	CSWO		SDS & Carers Officer has informed the SW teams of the independent support available to enable individuals to make an informed decision in relation to all option, namely option 2 in this case	Complete	1.1 Access to SDS Support, brokerage, advice, advocacy and tools 1.2 Improving the availability and flexibility of options; work to address key barriers to use of SDS Option 2, Support Provider engagement with Option 2, develop and roll-out of tools and contractual models for Option 2 to increase workforce confidence and efficiency in offering it.	5.05	Standard 1: Independent Support & Advocacy
		5.2	Approved Provider Framework for Option 2 to be developed as per action 3.3, 3.4	Jan-24	To be developed	**High**		Procurement Manager, SDS Community Collaborator	Work was previously underway to develop a robust process to give transparency and accountability to TMC, Individuals and Providers. This work needs to be re-started	To be progressed	1.2 Improving the availability and flexibility of options; work to address key barriers to use of SDS Option 2, Support Provider engagement with Option 2, develop and roll-out of tools and contractual models for Option 2 to increase workforce confidence and efficiency in offering it.	5.05	
		5.3	Social Work staff to be reminded via team meetings and practise supervision of the requirement to refer all option 2 start-up, amend or end to the SDS team via a CareFirst referral	Sep-23		**High**	CSWO	Team Managers		To be progressed	1.2 Improving the availability and flexibility of options; work to address key barriers to use of SDS Option 2, Support Provider engagement with Option 2, develop and roll-out of tools and contractual models for Option 2 to increase workforce confidence and efficiency in offering it.	5.05	
		5.4	SDS team to remind all SW teams on a quarterly basis of the requirement to inform the SDS team of all new, amend or end tri parts to be sent as a referral on CareFirst to enable the tri part to be put in place, varied or closed	Aug-23		**High**	SDS & Carers Officer		Actioned in line with the Direct Payment Audit Delivery Plan Action 11.1, a reminder was being sent 6 monthly, the team now do this every three months, with the latter being sent May 2023. This also includes a reminder for option 2 tri part agreements to be addressed in the same manner as Direct Payments	Actioned and ongoing		5.05	
		5.5	SDS team to maintain an individual spreadsheet detailing all triparts and share this with Community Care Finance and Procurement on a monthly basis to ensure correct payment by CCF and to enable the SDS Contracts database to be maintained in line with GDPR	May-23		**High**	SDS & Carers Officer		Actioned and in place, being sent at the end of each month to both CCF and Procurement	Actioned and ongoing		5.05	
		5.6	Governance and compliance to be monitored through Practice Governance Board	Aug-23		**High**	CSWO		Role and remit of PGB underway following development sessions held by the CSWO. TOR's currently being developed	In progress		5.05	
6	**A contractual agreement detailing service delivery and costs should be agreed with the 3 providers of day care services noted within the findings**	**6.1**	Lines of communication to be opened with the 3 named providers to work collaboratively with them to move the service modelling forward	Nov-23		**High**			Commenced via SDS Community Collaborator	In progress	1.2 Improving the availability and flexibility of options; work to address key barriers to use of SDS Option 2, Support Provider engagement with Option 2, develop and roll-out of tools and contractual models for Option 2 to increase workforce confidence and efficiency in offering it.	5.06	Standard 7, Flexible & Outcome Focussed Commissioning

		6.2	Discussion to be held with relevant Social Work teams to explore the future needs for the service and the contractual models moving forward	Nov-23		**High**				To be progressed		5.06	Standard 7, Flexible & Outcome Focussed Commissioning
		6.3	Discussion to be held with current attendees at the three services as to their preference on Option delivery to support to inform contractual modelling	Dec-23		**High**				To be progressed	3.1 Improved Involvement of Supported People in Planning: Review the involvement of supported people and carers in planning, evaluating social care support services and make improvements where identified, including through the use of Planning with People Guidance and in line with Equal Partners in Care principles	5.06	Standard 7, Flexible & Outcome Focussed Commissioning
		6.4	Align the work with the three providers to that around the Approved Provider Framework to explore developing in a collaborative way as per action 5.2, 5.3	Jan-24		**High**				To be progressed	1.2 Improving the availability and flexibility of options; work to address key barriers to use of SDS Option 2, Support Provider engagement with Option 2, develop and roll-out of tools and contractual models for Option 2 to increase workforce confidence and efficiency in offering it.	5.06	Standard 7, Flexible & Outcome Focussed Commissioning
7	**Annual support plan reviews of individuals in receipt of SDS Option 2 and 3 care packages should be undertaken in accordance with agreed procedures**	7.1	Work with Social Work to develop a strategy to ensure all reviews are completed in time	Sep-24	Separate Social Work plan	**High**						5.07	
		7.2	Monitoring to be carried out through the Practice Governance Board	Aug-23		**High**	CSWO		Role and remit of PGB underway following development sessions held by the CSWO. TOR's currently being developed	In progress		5.07	
		7.3	Moray Integrated Joint Board will be kept sighted on progress and through performance reporting to Scottish Government	Jan-24		**High**	CSWO		MIJB reports to be developed as requested, performance data scrutinised weekly	In progress		5.07	
8	**Consideration should be given for management to undertake regular reviews of the accuracy and recording of the checks completed to ensure the accuracy of payments made to care providers**	8.1	Staff to be reminded of the requirement to ensure CareFirst is up to date and service agreements accurately reflect the care and support provided as per action 4.1, 4.2			**High**			Role and remit of PGB underway following development sessions held by the CSWO. TOR's currently being developed			5.08	Standard 4; Meaningful & Measurable Recording Practice
		8.2	SDS team to ensure the Option 2 Tri part Spreadsheet in maintained and shared with Community Care Finance at the end of each month	May-23		**High**	SDS & Carers Officer		Actioned and in place, being sent at the end of each month to both CCF and Procurement	Complete and in progress		5.08	
		8.3	Community Care Finance to use the SDS Option 2 Tri part agreement spreadsheet to cross reference invoices against the approved budget on the tri part agreement	May-23		**High**	Interim Community Care Finance Officer		Actioned and in place, being sent at the end of each month to both CCF and Procurement	Complete and in progress		5.08	
		8.4	Commissioning team to ensure spreadsheet is maintained on Share Point to support the accurate development of option 3 support plans as per action 3.1	Aug-23		**High**	Commissioning Lead					5.08	
		8.5	SDS team to ensure the spreadsheet on Share Point is maintained as per action 3.3 to ensure accurate costing of option 1 support plans	Apr-23		**High**	SDS & Carers Officer			Complete and in annual progress		5.08	
9	**The Council's Charging Policy should be reviewed in regard to day care and a decision made as to whether a charge should be levied for the service in the future**	9.1	To review the use of Day Care and the eligibility for attendance in line with Free Personal Care and Day Opportunities	Dec-23		**High**	Services Manager			Not started		5.09	
		9.2	To review the Contributions Policy in place to ensure it is accurate and up to date	Dec-23		**High**	CFO	Interim CCF Officer		Not started		5.09	Standard 9, Transparency
		9.3	A report to be submitted to SMT and MIJB of the evaluation and recommendations for consideration	Jan-24		**High**	CSWO			Not started		5.09	
10	**A review of arrangements regarding the authorisation of individual care packages should be undertaken. Thereafter, authorisation requirements should be documented and communicate to all appropriate officers**	10.1	Review current practice in line with the current financial regulations (incl authorisation levels)	Sep-23		**Medium**	CSWO	CFO, Accountancy		Not started		5.10	
		10.2	Process map to be developed highlighting authorisation levels to ensure compliance with financial regulations	Oct-23		**Medium**	CSWO	CFO, Accountancy		Not started		5.10	Standard 9, Transparency
		10.3	Consideration to the reviewing of the current financial regulations in line with Standard 8 Worker Autonomy	Mar-24		**Medium**	CSWO	CFO, Accountancy		Not started		5.10	Standard 12, Worker Autonomy

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 31 AUGUST 2023**

SUBJECT: **CLIENT MONIES AUDIT UPDATE**

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

1. REASON FOR REPORT

1.1. To inform the Audit, Performance and Risk Committee of progress against recommendations outlined in the November 2022 Client Monies Internal Audit report.

2. RECOMMENDATION

2.1. It is recommended that the Audit, Performance and Risk Committee consider and note the current progress relating to Client Monies Internal Audit report.

3. BACKGROUND

3.1. Health and Social Care Moray (HSCM) manages income for individuals under Corporate Appointeeship arrangements. This is where an individual cannot manage their monies or also have no alternative person to do so, resulting in the Council being able to make an application to the Department for Work and Pensions (DWP) for a named officer to become the Corporate Appointee and have the legal authority to manage that individual's personal finances).

3.2. An audit to review how HSCM manages the income commenced in December 2021. The scope of the audit was to ensure funds were appropriately handled, stored, recorded and administered on behalf of clients, in line with agreed policy and procedures. There are a number of formal arrangements for assisting individuals in managing their personal income, such as DWP appointeeship, Access to Funds Scheme and Intervention or Guardianship orders. The focus for this audit was on the Corporate Appointeeship awarded by DWP for clients in receipt of benefit payments.

3.3. The audit final report was presented to HSCM's Practice Governance Board in May 2022. The audit presented four key recommendations and these were accepted by the service. Relevant actions to meet these recommendations were discussed and agreed.

3.4. A follow up review by Internal Audit was undertaken in February 2023 and it was noted that three of the four recommendations had not yet been fully implemented. This report seeks to update the Committee on progress to date in order to provide assurance that the service is committed to implementing the agreed recommendations.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. The Community Care Finance (CCF) team administers the corporate bank account. The audit involved scrutiny of the processes undertaken to administer this. In addition, a sample of individuals was also selected, and a check made as to how the Health and Social Care Officer appointed as the named "Corporate Appointee" managed and supported individuals to access their funds appropriately.

4.2. At the time of the audit, 59 individuals were being managed within the "Corporate Appointeeship" Scheme with a combined value of £483,000 held within the Council's corporate bank account.

Internal Audit Findings, recommendations and progress updates

4.3 The key findings and recommendations were accepted by HSCM and work is ongoing to meet those recommendations. The key findings could be summarised as:

- Procedures required updating and shared widely with relevant staff.
- Changes in working practices due to the pandemic resulted in an increased risk to cash handling.
- Processes needed strengthened to manage deceased client's monies and reconciliation.

4.4 A summary of findings and recommendations and progress recorded at the last Internal Audit Follow up Review (February 2023) is attached at **APPENDIX 1**. A further progress update meantime from HSCM is noted below:-

5.01 The Procedures for Managing Service User's Money and Corporate Appointeeship should be reviewed and updated and a subsequent regular cycle of review maintained.	NOT YET IMPLEMENTED: The Procedure is currently being updated and will be implemented within HSCM by end September 2023. (Original implementation date: 31/10/22).
5.02 Procedures for the management of client monies should be promoted to ensure there is an awareness of their requirements by all officers involved in client finance administration.	NOT YET IMPLEMENTED: Once the procedure is updated, this will be shared with the Community Care Finance (CCF) team and Social Work teams by end September 2023, with the implementation phase taking place from 1 October 2023. (Original implementation date: 31/10/22).

5.03 Clarification should be obtained from Legal Services regarding the length of time funds must be retained on behalf of deceased clients and potential action which can be taken should the funds not be claimed within the timeframe.	IMPLEMENTED: Evidence of actions taken to meet this recommendation was provided to the Audit team in January 2023. It was accepted by the Audit team that no further work was required and all actions have been met.
5.04 Due to changes in operating practices a full review of current cash handling procedures should be undertaken. The review should include a risk assessment to ensure best practices are followed regarding the safety and security of both officers and client funds. Documented procedures should thereafter be updated to reflect any agreed changes.	NOT YET IMPLEMENTED: Work is ongoing to review internal processes and an update will be provided at a future meeting. An Action Plan will be agreed by September 2023. (Implementation date was 31/7/23).
5.05 Confirmation of the monthly reconciliation of the Corporate bank account to manual records should be undertaken by Community Care Finance management. This should also include the verification of a sample of transactions to source cumentation	IMPLEMENTED. Evidence of actions taken to meet this recommendation was provided to the Audit team in January 2023. It was accepted by the Audit team that no further work was required and all actions have been met.

5. SUMMARY OF IMPLICATIONS

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

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

(b) Policy and Legal

The Adults with Incapacity (Scotland) Act 2000 enables a Health and Social Care Officer to be appointed by the DWP to have "Corporate Appointeeship" responsibility for managing the benefits received by an individual. Where no alternative exists, the Council can make an application to the Department for Work and Pensions (DWP) for a named officer to become the 'Corporate Appointee' and have the legal authority to manage an individual's personal finances.

(c) Financial implications

Depending on the outcome of the review (5.04), there is a potential for further staffing required to undertake other requirements required in managing clients monies – eg. review of best values, more regular cash transactions and reconciliations.

(d) Risk Implications and Mitigation

The follow up audit review highlighted risk implications and contained recommendations to address these as means of mitigating. Progress update is detailed in section 4.3 of the report.

(e) Staffing Implications

To support the continuing increase in corporate appointeeships, additional staffing is required due to the limited capacity within the team and the competing demands of the team.

(f) Property

None arising directly from this report.

(g) Equalities/Socio Economic Impact

xx

(h) Climate Change and Biodiversity Impacts

None arising directly from this report

(i) Directions

None arising directly from this report

(j) Consultations

Service Manager, Children and Families and Justice Services
Interim Chief Financial Officer, Moray Integrated Joint Board

6. CONCLUSION

6.1 For Audit, Performance and Risk Committee to note the current progress relating to the Client Monies Internal Audit report.

Author of Report: Catherine Quinn, Interim Community Care Finance Officer
Background Papers:
Ref: