MORAY INTEGRATION JOINT BOARD

AUDIT, PERFORMANCE AND RISK COMMITTEE

Thursday, 27 September 2018

Inkwell Main, Elgin Youth Café

NOTICE IS HEREBY GIVEN that a Meeting of the **Integration Join Board Audit, Performance and Risk Committee** is to be held at **Inkwell Main, Elgin Youth Café**, **Francis Place, Elgin, IV30 1LQ** on **Thursday, 27 September 2018** at **13:00.** to consider the business noted below.

AGENDA

MORAY INTEGRATION JOINT BOARD

AUDIT, PERFORMANCE AND RISK COMMITTEE

MEMBERSHIP

Dame Anne Begg (Chair)	Non-Executive Board Member, NHS Grampian
Councillor Tim Eagle	Moray Council
Councillor Louise Laing	Moray Council
Mrs Susan Webb	Executive Board Member, NHS Grampian

NON-VOTING MEMBERS

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

ADVISORS

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

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

MINUTE OF MEETING OF THE MORAY INTEGRATION JOINT BOARD

SPECIAL AUDIT, PERFORMANCE AND RISK COMMITTEE

THURSDAY 26 JULY 2018

INKWELL MAIN, ELGIN YOUTH CAFÉ

PRESENT

VOTING MEMBERS

Dame Anne Begg (Chair)	Non-Exec Board Member, NHS Grampian
Councillor Louise Laing	Moray Council
Mrs Susan Webb	Executive Board Member, NHS Grampian

NON-VOTING MEMBERS

Ms Elidh Brown	tsiMoray

IN ATTENDANCE

Ms Tracey Abdy	Chief Financial Officer
Ms Pamela Gowans	Chief Officer
Mr Atholl Scott	Chief Internal Auditor
Ms Jeanette Netherwood	Corporate Manager
Ms Heidi Tweedie	tsiMoray
Mrs Caroline Howie	Committee Services Officer, Moray Council, as Clerk to the Committee

APOLOGIES

Councillor Tim Eagle	Moray Council
Mr Steven Lindsay	NHS Grampian Staff Partnership Representative

1.	**DECLARATION OF MEMBERS' INTERESTS**
	There were no declarations of Members' interests in respect of any item on the agenda.
2.	**MINUTE OF MEETING OF THE MORAY INTEGRATION JOINT BOARD AUDIT AND RISK COMMITTEE DATED 29 MARCH 2018**

	The minute of the meeting of the Moray Integration Joint Board Audit and Risk Committee dated 29 March 2018 was submitted and approved.
3.	**ACTION LOG OF THE MORAY INTEGRATION JOINT BOARD AUDIT AND RISK COMMITTEE DATED 29 MARCH 2018**
	The Action Log of the Moray Integration Joint Board Audit and Risk Committee dated 29 March 2018 was discussed and it was noted that all actions had been completed.
4.	**RISK POLICY**
	A report by the Chief Officer presented the updated Risk Policy for the Moray Integration Joint Board for approval. It was advised there were no material changes to the Policy. Discussion took place on how risks are categorised and the frequency of review. It was stated that a risk categorised as very high may be reviewed every three months whereas those risks that are likely to be rare will not need to be reviewed so often as the controls will not change. It was noted that in the matrix of risk in appendix 1 of the report that if a risk was likely to have a rare occurrence then the consequence/impact, even if extreme, would lead to the risk being no more than medium. It was agreed that even if an event was rare if it was extreme it could be very high risk. It was advised the matrix was a starting point for agreeing risks but during discussion it was agreed that a narrative to explain the reasoning behind risk scores would be beneficial. The Corporate Manager was tasked with reviewing the possibility of including a narrative and providing a further report to Committee. Thereafter the Committee agreed to: i) approve the updated Risk Policy provided in appendix 1 of the report; ii) task the Corporate Manager with reviewing the possibility of including a narrative explaining the reasoning behind risk scores; and iii) note a further report will be presented to Committee in due course.
5.	**STRATEGIC RISK REGISTER – JULY 2018**
	A report by the Chief Officer provided an overview of the current strategic risks, along with a summary of actions which are in place to mitigate those risks, updated as at July 2018. Discussion took place on mitigating actions and what can be done to reduce risk. The Chair stated the register was easier to understand than what was previously presented and asked if all present were of the opinion the correct risks were being reviewed or if there was anything that should be added or removed. During further discussion it was agreed a risk assessment of the General Data Protection Regulation (GDPR) should be undertaken. Thereafter, following further lengthy discussion, the Committee agreed to note:

	i) the updated defined strategic risks for the Integration Joint Board; ii) the updated Strategic Risk Register; and iii) a risk assessment of the GDPR will be undertaken.
6.	**ANNUAL PERFORMANCE REPORT 2017/18**
	A report by the Chief Officer requested the Committee consider and approve the draft Annual Performance Report 2017/18. It was stated that production of the report for publication by 31 July had been challenging as the updated indicators for 2017/18 produced by the Information Services Division for Scotland had not been made available until the beginning of June 2018. Lengthy discussion took place on the content of the report and the need to not only deliver services well but also to capture the information for inclusion in reports such as this. Thereafter the Committee agreed to: i) note the approach taken to produce the 2017/18 Annual Performance Report; and ii) approve the report in appendix 1 of the report for publication by the 31 July 2018.
7.	**PERFORMANCE REMIT**
	Under reference to paragraph 5 of the draft Minute of the Moray Integration Joint Board meeting of 28 June 2018 a report by the Legal Services Manager (Litigation & Licensing), Moray Council, invited the Committee to consider its expanded remit regarding performance. Following consideration and discussion of the information and other needs required in order to provide direction to officers the Committee agreed to note the expanded remit attached as appendix 1 of the report.
8.	**QUARTER 4 (JANUARY – MARCH 2018) PERFORMANCE REPORT**
	A report by the Chief Officer updated the Committee on the performance of the Moray Integration Joint Board (IJB) as at Quarter 4, 2017/18, including: ▪ National core suite indicators and comparison to 32 national IJBs performance (appendix 1 of the report); ▪ Local indicators linked to strategic priorities for Quarter 4 (Jan-Mar 18) (appendix 2 of the report); and ▪ Highlight report on data presented in the National and Local indicators. (appendix 3 of the report). Discussion took place on the performance as noted in the indicators contained within the three appendices to the report. In-depth discussions covered bed capacity and delays in discharging patients. It was stated that delaying discharge may be cultural as it may be thought to be helping the wider family cope, however this is not always in the best interests of the patient. Further work is required to improve and decrease delays.

	It was the opinion of the Committee that it was good to compare Moray with the rest of Scotland however it was felt that comparison with previous local indicator results would allow a greater understanding of improvement and slippage. Thereafter the Committee agreed to note: i) the Red, Amber, Green assessment criteria as noted in paragraph 4.1 of the report; and ii) that local indicators will be included in future for comparison against previous local results.
9.	**INTERNAL AUDIT ANNUAL REPORT 2017/18**
	Under reference to paragraph 5 of the Minute of the meeting of the Moray Integration Joint Board (MIJB) Audit and Risk Committee dated 25 May 2017 a report by the Chief Internal Auditor advised the Committee of the internal audit work undertaken relating to the MIJB for the financial year ended 31 March 2018, and provided an opinion on the adequacy of the internal control systems examined. Committee was advised that from the audit work completed, appropriate governance and risk management arrangements have been established in line with guidance, but in specific areas reviewed some control weaknesses were evident which present opportunities for improvement. It was stated that improvement was an ongoing process and that opportunities had been recognised and were being worked on. Thereafter the Committee agreed to note the audit opinion derived from audit work completed. Ms Tweedie left the meeting during discussion of this item.

MEETING OF MORAY INTEGRATION JOINT BOARD

SPECIAL AUDIT, PERFORMANCE AND RISK COMMITTEE

THURSDAY 26 JULY 2018

ACTION LOG

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY
1.	Risk Policy	Include narrative to explain reasoning behind risk scores. Further report to be presented to Committee.	Sept 2018 Sept2018	Jeanette Netherwood
2.	Strategic Risk Register – July 2018	General Data Protection Regulation risks to be assessed.	Sept 2018	Jeanette Netherwood
3.	Annual Performance Report 2017/18	Publish the 2017/18 Annual Performance Report.	31 July 2018	Jeanette Netherwood
4.	Quarter 4 (January – March 2018) Performance Report	Include local indicators for comparison against previous local results.	Sept 2018	Bruce Woodward

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 27 SEPTEMBER 2018**

SUBJECT: **STRATEGIC RISK REGISTER – SEPTEMBER 2018**

BY: **CHIEF OFFICER**

1. REASON FOR REPORT

1.1 To provide an overview of the current strategic risks, along with a summary of actions which are in place to mitigate those risks, updated as at September 2018.

2. RECOMMENDATION

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

3. BACKGROUND

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

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

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 Risk scores are weighted based on assessment according to their likelihood and corresponding impact as per Section 5 of MIJB Policy. Guidance notes have been prepared for managers to assist with the assessment of risk and scoring and an extract of this is provided in **APPENDIX 2**.

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

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

5. SUMMARY OF IMPLICATIONS

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

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

(b) Policy and Legal

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

There are no legal implications arising from this report.

(c) Financial implications

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

(d) Risk Implications and Mitigation

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

(e) Staffing Implications

There are no 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 has not been completed because there are no service, policy or organisational changes being proposed.

(h) Consultations

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

6. CONCLUSION

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

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

HEALTH AND SOCIAL CARE MORAY STRATEGIC RISK REGISTER

AS AT SEPTEMBER 2018

RISK SUMMARY

1

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

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

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

1	
Description of Risk: *Political:* The Integration Joint Board (IJB) does not function as set out within the Integration Scheme, Strategic Plan and Scheme of Administration and fails to deliver its objectives or expected outcomes.	
Lead: Chief Officer	
Risk Rating: low/medium/high/very high **HIGH**	**Rationale for Risk Rating:** Change in membership of IJB committees following change in Moray Council political balance. Management capacity to fully complement structure could be a potential risk.
Risk Movement: increase/decrease/no change **NO CHANGE**	**Rationale for Risk Appetite:** The MIJB has zero appetite for failure to meet its legal and statutory requirements and functions.
Controls: • Integration Scheme. • Strategic Plan. • Governance arrangements formally documented and approved. • Agreed risk appetite statement. • Performance reporting mechanisms. • Business Management Team being developed.	**Mitigating Actions:** Induction sessions will be held for new IJB members. IJB voting member briefings are held regularly. Conduct and Standards training held for IJB Members July 18 SMT regular meetings and directing managers and teams to focus on priorities. System re-design and transformation.
Assurances: • Audit, Performance and Risk Committee oversight and scrutiny. • Reporting to Board.	**Gaps in assurance:** None known
Current performance: Current milestones being met with the exception of the Annual	**Comments:** Draft Performance Management Framework, aligned to strategic planning and resources has been presented to MIJB (Jan 18).

Performance Report 2017/18 published late, on 20 August 2018.	Framework is under further development and Implementation will be progressed through HSCM Performance meetings. The Framework will continue to be developed as we confirm our new organisational structure and alignment to the new Strategic Plan will be a key focus.

2	
Description of Risk: *Financial:* There is a risk of MIJB financial failure in that the demand for services outstripping available financial resources. Financial pressures being experienced by the funding Partners will directly impact on decision making and prioritisation of MIJB	
Lead: Chief Officer/Chief Financial Officer	
Risk Rating: low/medium/high/very high **VERY HIGH**	**Rationale for Risk Rating:** The impact of funding cuts from both Moray Council and NHS Grampian in previous years are still being endured. Funding cuts from Moray Council have been significant 2017/18 (£1.3m) and 2018/19 (£1.759m Gross). NHS Grampian provided no uplifts for pay and price increases in 2017/18 creating increased pressure. Financial settlements are set to continue on a one year only basis which does not support financial planning Demand on services continues to rise and the IJB has no remaining reserves to be utilised. At the end of Qtr 1 in the 2018/19 financial year the IJB is showing a £1m overspend. The financial forecast at the end of the 6 month period will be key in establishing the full year pressure.
Risk Movement: increase/decrease/no change **NO CHANGE**	**Rationale for Risk Appetite:** MIJB recognises the pressures on the funding partners. However the MIJB also recognises the significant range of statutory services and nationally agreed contracts it is required to deliver on within that finite budget. MIJB has expressed a zero appetite for risk of harm to people.
Controls: Chief Finance Officer appointed - this role is crucial in ensuring sound financial information and supporting sound financial decision making, budget reporting and escalation.	**Mitigating Actions:** Risk remains the MIJB can deliver transformation and efficiencies at the pace required.

Savings Plan presented to MIJB in March 2018. Further Savings have been presented in June 2018 in progression towards a balanced budget for 2018/19.	Financial information is reported regularly to both the MIJB and Senior Management Team. The Chief Officer and Chief Financial Officer (CFO) have engaged in the budget setting processes of both NHS Grampian and Moray Council to outline the significance of reduced funding and the subsequent risk to the partners as part of the risk sharing arrangement that exists. In an attempt to lessen the anticipated overspend – correspondence to all budget managers/holders has been prepared and will be circulated during September 18. Chief Officer and CFO will continue to engage with the partner organisations in respect of the forecast of overspend, corrective action and a recovery plan during 2018/19.
Assurances: MIJB oversight and scrutiny of budget. Reporting through MIJB, NHS Grampian Board and Moray Council.	**Gaps in assurance:** None known
Current performance: Indicative budget for 18/19 was approved to allow services to continue on 29 March 2018 by MIJB members. The indicative budget showed a budget shortfall of £4.5m. A further paper was presented to the board on 28 June 2018 displaying a reduced budget shortfall of £3.3m. The budget currently diplays a shortfall of £3m (as at August 18)	**Comments:** Senior managers to work with Chief Officer and Chief Financial Officer to address the budget shortfall and provide regular update reports to the MIJB, Moray Council and NHS Grampian as part of the risk sharing arrangement in place .

3	
Description of Risk: *Human Resources (People):* Inability to recruit and retain qualified and experienced staff whilst ensuring staff are fully able to manage change resulting from Integration	
Lead: Chief Officer	
Risk Rating: low/medium/high/very high **MEDIUM**	**Rationale for Risk Rating:** Risk assessed as moderate given existing controls. Increasing workload experienced – being managed by effectively recruiting to senior posts.
Risk Movement: increase/decrease/no change **NO CHANGE**	**Rationale for Risk Appetite:** The MIJB has zero appetite for harm happening to people.
Controls: Management structure in place with updates reported to the MIJB. Organisational Development and Workforce Plans have been developed and aligned with service priorities. Continued activity to address specific recruitment and retention issues. Management competencies being developed. Communication Strategy developed and approved in June 2017 with the associated commitments are progressing as anticipated. Incident reporting procedures in place per NHSG and Moray Council arrangements. Council and NHS performance systems in operation with HSCM reporting being further developed.	**Mitigating Actions:** System re-design and transformation. Support has been provided from NHSG with transformation and our co-ordinated working with Dr Grays in a one system – one budget approach. Management Structure continues to be progressed Joint Workforce Planning. Lead Managers are involved in regional and national initiatives to ensure all learning is adopted to improve this position. Lead Managers and Professional Leads are linked to University Planning for intakes and programmes for future workforce development.
Assurances: operational oversight by Moray Workforce Forum and reported to MIJB.	**Gaps in assurance:** joint or single system not yet agreed for incident reporting.
Current performance: iMatter survey undertaken during July 2018 across all operational areas. Action plans to be developed and progressed when results	**Comments:** Regular reporting and management control in place The Workforce plan will be developed and aligned with the strategic

are available. Representation on NHS Grampian's HSE Expert Group and operational H&S meeting established in HSCM Organisational Development Plan presented and approved at MIJB in January 2018.	plan 2019- 2022

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<tr><td colspan="2">4</td></tr>
<tr><td colspan="2">Description of Risk: Regulatory:
Inability to demonstrate effective governance and effective communication with stakeholders.</td></tr>
<tr><td colspan="2">Lead: Chief Officer</td></tr>
<tr><td>Risk Rating: low/medium/high/very high

MEDIUM</td><td>Rationale for Risk Rating:

Locality planning assessed as medium in relation to ability to work at the pace required and current workforce capacity.

Performance framework to be further developed from a planning perspective to show the links through operational service delivery to strategic objectives.</td></tr>
<tr><td>Risk Movement: increase/decrease/no change

NO CHANGE</td><td>Rationale for Risk Appetite:

The MIJB has a low risk appetite to failure.</td></tr>
<tr><td>Controls:

Annual Governance statement produced as part of the Annual Accounts 2017/18 and submitted to External Audit by the statutory deadline
Performance reporting mechanisms in place.
Community engagement in place for key projects areas such as Forres.</td><td>Mitigating Actions:

Schedule of Committee meetings and development days in place and taking place.

Good working relationship established with Audit Scotland, the MIJB’s appointed external auditors since 16/17.

The second Annual Performance Report published in August 2018. Lessons learned will be addressed and incorporated into the approach for the production of the 2018/19 Report.</td></tr>
<tr><td>Assurances: Oversight and scrutiny by Clinical and Care Governance Committee, Audit Performance and Risk Committee and MIJB.</td><td>Gaps in assurance: None known</td></tr>
<tr><td>Current performance:
Communications Strategy developed and approved by MIJB in June</td><td>Comments: Regular and ongoing reporting.</td></tr>
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2017. Annual Performance Report 2017/18 published August 2018 Draft Annual Accounts (2017/18) published by the statutory deadline of 30 June. Audited Accounts due for publication 27 September 2018	

5	
Description of Risk: *Environmental:* Inability to deal with unforeseen external emergencies or incidents as a result of inadequate emergency planning and resilience.	
Lead: Chief Officer	
Risk Rating: low/medium/high/very high **MEDIUM**	**Rationale for Risk Rating:** Resilience standards and implementation plan agreed. Business Continuity Plans in place for most services.
Risk Movement: increase/decrease/no change **NO CHANGE**	**Rationale for Risk Appetite:** The MIJB understand the requirement to meet the statutory obligations set out within the Civil Contingencies Act.
Controls: Lead Officer identified working alongside Emergency Planner. Local resilience plan developed. NHS Grampian Resilience Standards Action Plan approved (3 year).	**Mitigating Actions:** Table top exercise for MIJB to be undertaken in Autumn 2018 focusing on business continuity planning. Table top exercises to test winter planning scheduled during September 2018
Assurances: Audit, Performance and Risk Committee and NHS Grampian Civil Contingencies Group oversight and scrutiny.	**Gaps in assurance:** Some progress has been made however further work required to address the targets in the implementation plan that have not been met. NHSG Civil Contingencies Group have highlighted some areas for action in relation to the Resilience standards Training needs to be reviewed and plan for roll out and will be co-ordinated via Moray's Civil Contingencies Group.

6	
Description of Risk: *Reputational:* Risk to MIJB decisions resulting in litigation/judicial review. Expectations from external inspections are not met.	
Lead: Chief Officer	
Risk Rating: low/medium/high/very high **MEDIUM**	**Rationale for Risk Rating:** Considered medium risk due to the reporting arrangements being relatively new and testing required in first full year of operation.
Risk Movement: increase/decrease/no change **NO CHANGE**	**Rationale for Risk Appetite:** The MIJB has some appetite for reputational risk relating to testing change and being innovative. The MIJB has zero appetite for harm happening to people.
Controls: Clinical and Care Governance (CCG) Committee established and has overview of inspection processes and reports. Operational Risk Register being reviewed. Complaints procedure in place	**Mitigating Actions:** This is discussed regularly by the three North East Chief Officers. Additional resource has been allocated to support the analysis of information for presentation to CCG committee
Assurances: Audit, Performanceand Risk and Clinical and Care Governance Sub-Committees oversight and scrutiny.	**Gaps in assurance:** Process for highlighting recurring themes or strategic expectations from external inspections requires further development to ensure Committee has sight of significant issues.
Current performance: External inspection reports are reviewed and actions identified.	**Comments:** Self Directed Support Thematic review has commenced with Care Inspectorate visits planned for October 2018.

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<tr><td colspan="2">7</td></tr>
<tr><td colspan="2">Description of Risk: Operational Continuity and Performance:
Inability to achieve progress in relation to national Health and Wellbeing Outcomes. Performance falls below acceptable level.</td></tr>
<tr><td colspan="2">Lead: Chief Officer</td></tr>
<tr><td>Risk Rating: low/medium/high/very high

MEDIUM</td><td>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 budgetry constraints impact.</td></tr>
<tr><td>Risk Movement: increase/decrease/no change

NO CHANGE</td><td>Rationale for Risk Appetite:

Zero tolerance of harm happening to people as a result of action or inaction.</td></tr>
<tr><td>Controls:
Performance Management reporting framework in place.
Strategic Plan and Implementation Plan developed and approved.
Performance regularly reported to MIJB. Revised Scorecard being developed.
Best practice elements from each body brought together to mitigate risks to MIJB’s objectives and outcomes.
Chief Officer and SMT managing workload pressures as part of budget process.</td><td>Mitigating Actions:

The introduction of significant changes in working practices has the potential to cause major disruption to service delivery.

Unplanned admissions or delayed discharges place additional cost and capacity burdens on the service.</td></tr>
<tr><td>Assurances: Audit, Performance and Risk Committee oversight. Operationally managed by OMT with strategic direction provided by SMT.</td><td>Gaps in assurance: None known</td></tr>
<tr><td>Current performance:
Close monitoring and performance management in place.
The process for production of the Strategic Plan 2019-22 is underway and will facilitate further linkages across operational, Local and National Performance Indicators with progress in delivery of the National Outcomes as a clear focus.</td><td>Comments: Regular and ongoing reporting.

Performance monitoring and reporting under review to identify key performance indicators and appropriate owners.</td></tr>
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8	
Description of Risk: *ICT:* Risk of major disruption in continuity of ICT operations including data security being compromised	
Lead: Chief Officer	
Risk Rating: low/medium/high/very high **LOW**	**Rationale for Risk Rating:** Corporate Information Security policies in place and staff are required to complete training and confirm they have read, understood and accept the terms of use .
Risk Movement: increase/decrease/no change **NO CHANGE**	**Rationale for Risk Appetite:** MIJB has a low tolerance in relation to not meeting requirements.
Controls: Computer Use Policies and HR policies in place for NHS and Moray Council. Business Continuity Plans being updated to fully reflect ICT disruption. PSN accreditation secured. Guidance regularly issued to staff. Guidance on effective data security measures issued to staff.	**Mitigating Actions:** Protocol for access to systems by employees of partner bodies to be developed. Information Management arrangements to be developed and endorsed by MIJB. Integrated Infrastructure Group has been established, with ICT representation from NHSG and Moray Council, to consider and provide solutions to data sharing issues and ICT infrastructure matters.
Assurances: Strict policies and protocols in place with NHS Grampian and Moray Council.	**Gaps in assurance:** None known
Current performance: Training programme to be developed on records management, data protection and related issues for staff working across and between partners.	**Comments:** Data sharing groups for Grampian and Health and Social Care Moray have been established and meetings held. They will have oversight of any issues arising from Data protection and GDPR matters from either Council or NHS systems.

9	
Description of Risk: *Infrastructure:* Requirements for ICT and Property are not prioritised by NHS Grampian and Moray Council.	
Lead: Chief Officer	
Risk Rating: low/medium/high/very high **HIGH**	**Rationale for Risk Rating:** Changes to processes and necessary stakeholder buy-in still bedding in. Moray Council, in predicting a budget deficit for the current financial year have implemented special arrangements to ensure only essential expenditure is incurred. This includes the consideration to the deferring of projects already in the Capital plan. Dedicated project manager on long term sick
Risk Movement: increase/decrease/no change **INCREASED**	**Rationale for Risk Appetite:** Low tolerance in relation to not meeting requirements.
Controls: Chief Officer has regular meetings with partners . Infrastructure Programme Board established with Chief Officer as Senior Responsible Officer/Chief Officer member of CMT	**Mitigating Actions:** Dedicated project Manager in place – monitoring/managing risks of the Programme Membership of the Board reviewed and revised to ensure representation of all existing infrastructure processes and funding opportunities. Process for ensuring infrastructure change/investment requests developed Project Manager linked into other Infrastructure groups within NHSG & Moray Council to ensure level of 'gatekeeping'
Assurances: Infrastructure Programme Board function to provide robust governance and decision-making through collaboration, and reports to Strategic Planning and Commissioning Group.	**Gaps in assurance:** Further work is required on developing the process for approval for projects so that they are progressed timeously. Need to review all existing processes in relation to infrastructure changes/projects/investments and streamline to avoid duplication of effort.

Current performance:	**Comments:**
The board has not met in the past quarter. A meeting will be arranged in the next quarter to review progress.	The development of the processes around the Infrastructure Board and its governance positioning are still a work in progress. Interim Premises, Infrastructure and Digital Development manager appointed as lead with further resource being funded by NHS to take forward transformation projects in the next 12 months.

Extract from Draft MIJB Risk Management Guidance Notes

Likelihood

Likelihood is a measure of probability and cannot therefore be taken as fixed. The following scale is used to analyse the likelihood of a risk.

Score	Category	Description / Frequency			
1	Rare	Less than 5%	1 in 25 years	May occur only in exceptional circumstances	Force Majeure
2	Unlikely	Up to 20%	1 in 10 years	Not expected to occur in normal circumstances	Not known in this activity
3	Possible	Up to 65%	1 in 5 years	Might occur at some time	Has happened elsewhere
4	Likely	Up to 90%	1 in 2 years	Will probably occur at least once	Has happened in the past
5	Almost certain	Over 90%	Within 1 year	Will occur in most circumstances	Imminent/ near miss

Impact

Impact is a measure of the effects felt when a risk occurs. However, defining a 1- 5 scale is not as simple as it is for likelihood, as the impact of a risk can be felt in a variety of ways. Where a risk has an impact in more than one category, e.g. financial, environmental, operational etc., the category with the highest score should be the one recorded. The scale is as follows:

Score	1	2	3	4	5
Category	**Negligible**	**Minor**	**Moderate**	**Major**	**Extreme**
Political	Action or non-action which impacts on a single member		Action or non-action which affects the decision making of the board		Action or non-action which affects ability of the board to discharge its responsibilities
Regulatory	No breach of compliance	Compliance breach – internal remedial action required	Compliance breach – external examination / action	Significant breach – penalties imposed	Serious compliance breach. Penalties and legal action.
Financial	Balanced budget and retention of general reserve	In year fluctuations are managed by corrective actions in year	Highlighted overspending in service areas and corrective actions taken to mitigate. No general reserves.	Inability to deliver services within agreed funding. Preparation and recovery plan required	Funding does not meet requirements. Negotiation and discussion with partners accordingly.
Environmental	No lasting effect on the environment, of short term duration	Short term local effect on the environment or social impact within the local neighbourhood	Serious local discharge of pollutant / community annoyance within Moray area that required remedial action	Long term detrimental environment al or social impact	Extensive long term impacts to environment and community
Reputational	Minor adverse publicity in local media	Some public embarrassment. No damage to reputation	Some adverse publicity. Potential legal implications	Sustained adverse publicity. Major loss of confidence. Legal implications	Highly damaging severe loss of public confidence. Resignation/ removal of senior officers
Information and Communication technology	Temporary incident up to 2 hours to recover to pre-event position	Localised incident. More than one user affected. 2 to 6 hours to recover	Localised incident. Several users affected. Up to a day to recover	Significant incident. Multiple locations or complete service impacted. Between 1 and 5 days to recover	Extreme incident affecting whole organisation. No data use possible. In excess of 5 days to recover pre-event position

Infrastructure					
Human resources	Incident – no obvious harm/injury. Potential impact on individual staff members	Minor injuries or discomfort	Maintenance of safe staffing levels of appropriately trained staff is being delivered through existing staff and locums. Normal service delivery may not be fully maintained.	Insufficient appropriately trained staff to deliver service across more than one location.	Loss of service delivery in one or more areas for a prolonged period of time
Operational continuity and performance	Insignificant disruption to service dealt with by routine operations	Minor disruption to services that might threaten the efficiency or effectiveness, but can be dealt with by service managers	Moderate disruption to service, probably requiring changed ways of operation temporarily	Significant impact and possible withdrawal of service	Significant disruption to or unplanned withdrawal of a service for a prolonged period of time

The Impact and Likelihood scores can be plotted on the Risk matrix. The total risk score is the aggregate of Likelihood x Impact and is stratified as follows:

Likelihood	**Consequence / Impact**				
	Negligible 1	Minor 2	Moderate 3	Major 4	Extreme 5
Almost Certain 5	Medium	High	High	V High	V High
Likely 4	Medium	Medium	High	High	V High
Possible 3	Low	Medium	Medium	High	High
Unlikely 2	Low	Medium	Medium	Medium	High
Rare 1	Low	Low	Low	Medium	Medium

Scores	**Risk**	**Comment**
1 to 3	Low risk	Acceptable level of risk. These risks have both a low likelihood and a low impact so no additional controls are required. Managers/Risk Owners should continue to monitor risk assessments as the situation may change.
4 to 9	Medium risk	Acceptable level of risk. Risks with high likelihood but a low impact or high impact but very unlikely can be dealt with via normal service processes ie routine, low level preventative measures that do not cost much but have a beneficial cumulative effect. Managers/risk owners should review these risks regularly to ensure assessments are appropriate and effective.
10 to 16	High risk	Risks in this category have the potential to impact significantly on the organisation and therefore action should be taken to reduce, control, mitigate and/or transfer the risk. This may need to be carried out urgently and may involve significant resource. It may not be possible to prevent the risk, but plans should be in place as to how to deal with it if it occurs. Service Managers/SMT and Board members will periodically seek assurance that measures taken are effective and appropriate and that the risks are being appropriately managed. It may be necessary to accept this level of risk.
17 to 25	Very High Risk	Unacceptable level of risk. High likelihood with major/extreme impacts result in risks that are unacceptable and urgent/immediate remedial/corrective action is required. Response Plans will need to be put in place. Managers/Risk owners should review the risks to ensure measures put in place continue to be appropriate and effective. The Board will seek assurance that risks of this level are being effectively managed. It may be necessary to accept opportunities that have an inherent very high risk.

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 27 SEPTEMBER 2018**

SUBJECT: **NHS GRAMPIAN INTERNAL AUDIT REPORT – INTEGRATION JOINT BOARD PERFORMANCE REPORTING AND KEY PERFORMANCE INDICATORS**

BY: **CHIEF FINANCIAL OFFICER**

1. REASON FOR REPORT

1.1 To present the Committee with a summary of findings from a recent NHS Grampian internal audit review carried out by PricewaterhouseCoopers (PwC). The audit assessed the performance reporting and Key Performance Indicator (KPI) processes of the 3 Integration Joint Board's within the Grampian Health Board area.

2. RECOMMENDATION

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

i) considers and notes the findings from the audit, attached at APPENDIX 1; and

ii) notes the management responses to the audit recommendations and timescales outlined in the report at APPENDIX 1.

3. BACKGROUND

3.1 Assurances for the Moray Integration Joint Board (MIJB) are drawn from audit work conducted by the internal auditors of both Moray Council and NHS Grampian. These assurances combined, then inform the overall annual opinion relative to controls assurance that is provided by the Chief Internal Auditor for inclusion with the MIJB's Annual Accounts.

3.2 PwC is contracted to provide internal audit services to NHS Grampian and is accountable solely to NHS Grampian for its work. Since the formation of the MIJB, agreement has been reached between the audited bodies (NHS Grampian, and Aberdeen City, Aberdeenshire and Moray Councils) and their relevant auditors that audit reports can be shared where relevant with the IJB's within the Grampian Health Board area.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The scope of the PwC review was to assess the design and operating effectiveness of the key controls within the KPI reporting process for performance reporting for the 3 IJB's with a focus on:

- Performance Indicators;
- Data Gathering; and
- Performance Reporting

4.2 The review concluded that current processes and controls were well designed and operating effectively and that the MIJB are meeting their reporting obligations. There was also recognition of the control improvement opportunities available to the MIJB, inherent in any new organisation. It was acknowledged that the MIJB is going through continuous development and that processes and controls will continue to progress.

4.3 The report highlights 3 low risk findings in relation to control improvement opportunities, these being:

- 'The survey data used to present National indicators are based on government survey. The population used for this survey is based on a random selection of the public. On reviewing the participants less than 1% are users of the service and therefore the results may not accurately reflect the performance of the IJB and there are no local indicators to accurately show the experiences of users in this format'.

- 'Indicators do not have owners to drive improvement and offer explanation for underperformance'.

- 'The format of the data presented does not accurately reflect performance and can lead to misinterpretation.

4.4 The audit concluded that the performance reporting within the IJB's creates a low risk for NHS Grampian and acknowledgement was given to the development taking place within the IJB's.

5. SUMMARY OF IMPLICATIONS

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

No implications arising directly from this report

(b) Policy and Legal

The work of internal audit aims to provide assurances in terms of good governance and the duty to secure best value in the use of public funds

(c) Financial implications

No implications arising directly from this report.

(d) Risk Implications and Mitigation

The audit highlights 3 low risk findings in relation to the control improvement opportunities. The management comment provided will assist the mitigation of the risks highlighted.

(e) Staffing Implications

No implications arising directly from this report.

(f) Property

No implications arising directly from this report.

(g) Equalities/Socio Economic Impact

No implications arising directly from this report

(h) Consultations

Consultation has taken place with the Chief Internal Auditor for the MIJB and Performance Officers within Health and Social Care Moray. Comments have been incorporated where appropriate.

6. CONCLUSION

6.1 The findings, recommendations and management responses to the audit carried out by PwC on the performance reporting of the MIJB is provided for consideration by the Audit, Performance and Risk Committee.

Author of Report: Tracey Abdy, Chief Financial Officer
Background Papers:
Ref:

Internal Audit Report 2017/2018

IJB Performance Reporting and KPIs

June 2018

Final

NHS Grampian

pwc

Contents

Distribution List

For action	Director of Finance
	IJB Chief Officers
For information	Audit Committee

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

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

1. Executive summary

Report classification	*Trend*	**Total number of findings**				
			Critical	High	Medium	Low	Advisory
Low Risk	N/A – No prior year reviews for comparison	Control design	-	-	-	2	-
		Operating effectiveness	-	-	-	1	-
		Total	**-**	**-**	**-**	**3**	**-**

Summary of findings

The scope of our review was to assess the design and operating effectiveness of the key controls within the Key Performance Indicator (KPI) reporting process for performance reporting by the Integration Joint Boards (IJBs). Our review focused on:

- Performance Indicators;
- Data Gathering;
- Performance Reporting.

Our view is that the current arrangements for performance reporting within the Integration Joint Boards creates a low risk for NHS Grampian (NHSG). The current processes and controls in place are well designed and operating effectively and the IJBs are meeting their reporting obligations. However it should be noted that the IJBs are relatively new and therefore, as with any new process, there are control improvement opportunities that can be identified. The IJBs are going through constant development and processes and controls will continue to develop as the IJBs mature.

In summary we have identified three 'low' risk findings in relation to control improvement opportunities and these result in this report being classified as 'low' risk.

The low findings are as follows:

- The survey data used to present National indicators are based on a government survey. The population used for this survey is based on a random selection of the public. On reviewing the participants less than 1% are users of the service and therefore the results may not accurately reflect the performance of the IJB and there are no local indicators to accurately show the experiences of users in this format.
- Indicators within Moray and Aberdeen City IJB do not have owners to drive improvements and offer explanations for underperformance.

- The format of the data presented does not accurately reflect performance and can lead to misinterpretation within Moray and Aberdeenshire.

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

Management comment

Moray Council

Action 3.01 - Along with the development of the Local PIs we are developing qualitative PIs across the IJB to more accurately reflect the service user experiences. These will be completed alongside the local indicators.

Action 3.02 is under development in Moray with the intention being that indicators will be fully owned by relevant individuals. The time scale for completion is 31 March 2019.

Action 3.03 has been noted. A commitment has been made to review and develop what is reported to the IJB for greater clarity. This is considered continuous improvement at this stage and will be monitored closely. This is also an area of interest for external audit. A Review of Standing Orders and Scheme of Administration report is being presented to the IJB on 28 June 2018 updating the remit of the IJB's Audit and Risk Committee to include greater scrutiny of performance renaming the committee to Audit, Performance and Risk.

Aberdeenshire Council

Aberdeenshire H&SCP welcomes the findings of the audit and is pleased to note that our approach to KPIs and the relationship with the NHS Board is broadly very positive. We note the recommendation under section 3.03 for Aberdeenshire HSCP regarding the presentation of performance against the 'Number of delayed discharges' (L11). Whilst this indicator has a specific target of 35, and the value reported was 38, it was recorded as having been met as it remained within previously agreed tolerances (whereby a score of less than 40 would be within acceptable tolerance levels). We will reassess our locally agreed targets and tolerance levels as part of our current review of our performance framework to ensure these remain valid.

Aberdeen City Council

The ACHSCP Executive Team welcome the findings of this audit and were happy with the involvement that we were able to have. We recognise that as our IJB develops so too will all our processes and controls in terms of how we collect, interpret and present our data. It is imperative that the data we are asked to collect allows us to not only tell the right narrative but also to further develop our services – this is why we highlighted some of the issues with national data from random surveys. We will continue to work with both our partner organisations to ensure we have the good clean data that maximises our ability to meet the health and social care needs of the population of Aberdeen City going forward.

2. Background and scope

Background

Through closer integration of Health and Social Care services, Scottish Ministers aim to improve people's experience of health and care services and the outcomes that the services achieve. To provide a framework for assessing performance, a series of National Health and Wellbeing Outcomes have been developed.

The National Health and Wellbeing Outcomes apply across Local Authorities, Health Boards and IJBs to ensure that all are clear about their accountability for delivery. There are nine national outcomes which focus on areas of service improvement to inform how services are planned to make a difference to the care people are receiving.

Each Integration Authority is required to publish an annual performance report setting out how the outcomes are being met. Progress against a core suite of Key Performance Indicators (KPIs), identified by the Integration Authorities in line with guidance from the Scottish Government, is reported along with narrative giving context on local performance.

Performance Indicators

The Scottish Government has set 23 national KPIs to be reported on by the IJBs. These are in place to show how well the IJBs are performing against the nine national outcomes. The data gathering processes for each of these indicators is also mandated by the Scottish Government and therefore all data captured and processed for these national indicators should be handled and presented in a consistent manner by each IJB.

Additionally, each IJB must set its own local indicators to report on how it is achieving the national outcomes and its own local outcomes. The local KPIs used by all the IJBs are under constant development and will continue to change in order to best show progress being made to achieve outcomes.

Within Aberdeenshire H&SCP each local indicator has an assigned owner. This is the person responsible for driving change and improvements in order to ensure targets are continuously being met.

Data Gathering

There are a number of systems and data sources drawn on by the IJBs in order to inform their performance reporting. These include systems and data hosted and provided local authorities, the health board or external published data such as Government surveys. Each of these systems can provide specific information that can be used by the IJB to present KPI results. As the data is either taken from published data or operational systems there is an audit trail to support the reported performance.

The data is obtained by the health intelligence team at NHS or members of the H&SP at the councils and sent on to the IJB to be prepared and presented for stakeholder review. The data presented shows how the IJB is performing and there are various methods to show how the data compares to targets, prior periods and national averages.

Data is gathered for each KPI at set frequencies ranging from quarterly to every two years. Trends are included within the reports to show how the indicator data has performed over time. The current performance of indicators has been included in appendix 4.

Performance Reporting

There are several reporting requirements of the IJB. Performance is reported a number of times throughout the year to the IJB, NHS Grampian and the respective council. On a monthly basis NHS Grampian holds a Senior Leadership Team meeting. This is an informal meeting to discuss all NHS Grampian operations and includes exception reporting review where NHS targets have not been met in the month. The exception report includes details of all indicators from the IJBs that impact NHS Grampian. All three Chief Officers of the IJBs are present at the meeting and therefore have the opportunity to discuss with the Health Board any matters concerning the IJBs.

Approximately every six weeks each individual IJB meets with NHS Grampian for a Performance Review meeting, although the frequency of these meetings can vary depending on performance and the criticality of issues. These meetings are attended by the Chief Officer of each IJB and the NHS Grampian Director of Finance. The NHS Grampian Head of Performance and a council representative also normally attends. The meeting discussion topics vary depending on the performance of the IJB at the time, and if there are any challenges or issues that have the potential to cause challenges.

There is formal reporting to the IJB on a quarterly basis from the Health and Social Care Partnership. Performance reports must be prepared for these meetings and presented to the IJB. Representatives from NHS Grampian are present at these meetings. These board meetings and reports are published on the IJB website.

Each IJB also prepares an annual report. This must be a full reflection of the performance of the IJB in the year and is published on the IJB's public facing website.

All data relied upon by the NHS Grampian reported by the IJB is taken from data obtained from NHS Grampian systems.

Scope and limitations of scope

Our approach focused on the following three areas:

1. **Performance Indicators**
2. **Data Gathering**
3. **Performance Reporting**

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

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

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

3. Detailed current year findings

3.01 Government survey data – control design

Finding
The IJB must use both local and national indicators to show how the health and social care partnership is performing. The national indicators and how the corresponding data is gathered is determined by the Scottish Government. It was noted the information used to show the results of the one of the national indicators tested 'Percentage of people with positive experience of the care provided by their GP practice' was gathered using a national survey. This survey is performed every two years on a sample of the population and part of the survey seeks to understand their views on the health and social care they have received. These questions can be used to show a number of different conclusions and statistics, part of which is if people have had a positive experience with their GP. Due to the random sample, the number of surveys completed by users of Health and Social Care Partnership was extremely low. For example in Aberdeen City less than 1% of those who participated in the survey would have used the Health and Social Care Partnership. This therefore is not the most appropriate measure to show the data for this indicator. As the national indicators may not be truly reflective of the qualitative information of the users of the service Aberdeenshire IJB has prepared its own survey to determine these measures and present them through local indicators. The sample was selected from a population of people receiving two or more Health and Social Care services. This means that although fewer overall surveys are completed, the findings from the survey are more meaningful to the IJB. Moray and Aberdeen City IJB did not have such qualitative local indicators in place although Aberdeen City IJB have expressed an interest in performing a survey of this nature in the future.
Implications
• H&SCP may be drawing conclusions from inappropriate data. • Stakeholders may be misled by indicator results which are not reflective of reality.

Action plan

Finding rating	*Agreed action*	*Responsible person / title*
Low	• Local indicators showing qualitative outcomes will be determined. • Local surveys will be used to accurately reflect the experiences of the H&SCP users.	Aberdeen City IJB Chief Officer and Moray IJB Chief Officer *Target date:* 31 December 2018 *Reference number:*

IJB Performance and Reporting KPIs 2017/18 - 01

3.02 *Roles and responsibilities – control design*

Finding

The data gathering processes are performed by a number of different individuals in each IJB, council and NHS Grampian. A selection of indicators was sampled to ensure that all data gathering processes are assigned to a responsible person. As a result of testing it was noted that with regards to data gathering processes all roles and responsibilities are clear and all relevant individuals are aware of their responsibilities. These individuals are only responsible for gathering the correct data to present the indicators, they do not have responsibility for interpreting the results or driving through improvements.

It was however noted that the IJBs would benefit from each indicator having a responsible person to drive improvements for that indicator and be responsible for any added commentary which may be required by management on these indicators. For example, if the indicator had not been meeting targets.

In Aberdeenshire, a formal list has been compiled, assigning a responsible individual to each indicator. It is these individuals who co-ordinate processes, drive improvements and give reasons where targets have not been met. There are no such lists in Aberdeen City or Moray, although Moray has noted an interest in developing a list of this nature.

Implications

- Targets for indicators may not be met due to lack of clearly assigned ownership for driving improvements or changes.

Action plan

Finding rating	*Agreed action*	*Responsible person / title*
Low	• A formal list of indicator owners will be prepared and maintained within each IJB.	Aberdeen City IJB Chief Officer and Moray IJB Chief Officer *Target date:* 31 March 2019 *Reference number:* IJB Performance and Reporting KPIs 2017/18 - 02

3.03 Presentation of performance results – operating effectiveness

Finding

A sample of indicators was selected in order to assess if the format of reporting was appropriate. The following exceptions were noted in relation to the format of reporting;

- Within Aberdeenshire a sample of five indicators were selected for testing. One of the indicators selected was the 'Number of delayed discharges', the target for this indicator was 35 for the monthly average over the quarter to September 2017. In the quarter two report, the value of this indicator was 38 and it had been noted that the target had been met. The target of 35 should have been the maximum number of delayed discharges and therefore any value greater than 35 would result in the target not being met. Therefore this was incorrectly presented due to error.
- Within Moray a sample of three indicators were selected for testing (a smaller sample was selected in Moray due to the number of indicators used). The report for quarter two was reviewed and for two of the samples there was a significant variance from the previous quarter, 38% and 29%, for bed days and delayed discharges respectively. The indicator is shown with a trend line to show how the indicator has varied over time. It has been noted that despite the significant variance the trend line shows almost a horizontal line. This shows that the axis scales used in preparation of the trend graph is inappropriate to accurately visualise the variances between reporting periods.

No issues were noted with the presentation of performance results in Aberdeen City.

Implications

- Results are not appropriately presented and may mislead stakeholders.

Action plan

Finding rating	*Agreed action*	*Responsible person / title*
Low	• Targets will only be recorded as 'met' when they have been reached. • Where trend lines are used an appropriate scale will be used to accurately reflect variances in trends.	Aberdeenshire IJB Chief Officer and Moray IJB Chief Officer *Target date:* 31 December 2018 *Reference number:* IJB Performance and Reporting KPI's 2017/18 - 03

Appendix 1. Basis of our classifications

Individual finding ratings

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

Report classifications

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

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

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

Appendix 2. Terms of Reference

Background and audit objectives

Through closer integration of Health and Social Care services, Scottish Ministers aim to improve people's experience of health and care services and the outcomes that the services achieve. To provide a framework for assessing performance, a series of National Health and Wellbeing Outcomes have been developed.

The National Health and Wellbeing Outcomes apply across Local Authorities, Health Boards and Integration Authorities to ensure that all are clear about their accountability for delivery. There are nine national outcomes which focus on areas of service improvement to inform how services are planned to make a difference to the care people are receiving.

Each Integration Authority is required to publish an annual performance report setting out how the outcomes are being met. Progress against a core suite of Key Performance Indicators (KPIs), identified by the Integration Authorities in line with guidance from the Scottish Government, is reported along with narrative giving context on local performance.

Scope

We will review the design and operating effectiveness of key controls in place relating to performance management outcomes during the period 1 April 2017 to 31 December 2017. The sub-processes and related control objectives included in this review are:

Sub-Process	Objectives
Performance Indicators	• Performance indicators/statistical measures to report against each of the national outcomes have been set by each of the IJBs. • Roles and responsibilities have clearly been defined to allocate responsibility for data gathering against each of the performance indicators.
Data Gathering	• Systems are in place within each IJB to support data gathering for the indicators that they are responsible for. • There is a demonstrable link between the data gathered and the national outcomes to allow transparent reporting over performance, including trends to demonstrate where improvements in service delivery are being achieved. • The frequency and format of data gathering throughout the year has been agreed.
Performance Reporting	• A timetable of reporting performance has been set and agreed by each IJB. • There is a clear audit trail to support reported performance for the indicators. • NHS Grampian's Accountable Officer is able to derive assurance from the reporting mechanisms that are in place for the IJBs. IJB Performance is considered as part of the monthly NHS Grampian system wide performance management undertaken by the Senior Leadership Team of NHS Grampian.

Limitations of scope

This review will only consider a sample of performance indicators/national outcomes which the Integration Joint Boards are required to report against.

Audit approach

Our audit approach is as follows:

- Obtain an understanding of the key controls in through discussions with key personnel, review of systems documentation and walkthrough tests;
- Identify the key risks of the process;
- Evaluate the design of the controls in place to address the key risks; and
- Test the operating effectiveness of the key controls

Appendix 3. Limitations and responsibilities

Limitations inherent to the internal auditor's work

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

Internal control

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

Future periods

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

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

Responsibilities of management and internal auditors

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

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

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

Appendix 4. Key Performance Indicators

Aberdeen City – National Indicators – May 2018

ISD's latest refresh of this data was December 2017, however please note that data is only updated to the end of the financial year available hence the newest data provided by ISD here is for 2016/17.

Data for the Core Suite of Integration Indicators, NI - 1 to NI - 23 are populated from national data sources and data is issued nationally. Indicators 1 to 10 are outcome indicators based on survey feedback and are updated bi-annually. Data for National Indicators 11 to 23 are derived nationally from organisational/system data and are updated more frequently. Data for indicators 10, 21, 22 and 23 are not yet available.

	Indicator	Title	Previous score 2013/14	Current score 2015/16	Scotland 2015/16	RAG
Outcome indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	96%	96%	94%	G
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	80%	82%	84%	A
	NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	85%	78%	79%	R
	NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	83%	77%	75%	R
	NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	83%	82%	81%	A
	NI - 6	Percentage of people with positive experience of the care provided by their GP practice	87%	86%	87%	A
	NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	83%	80%	84%	A
	NI - 8	Total combined % carers who feel supported to continue in their caring role	44%	42%	41%	A
	NI - 9	Percentage of adults supported at home who agreed they felt safe	79%	83%	84%	G
	NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	NA	NA	NA	

	Indicator	Title	Previous score	Current score	Scotland	RAG
Data indicators	NI - 11	Premature mortality rate per 100,000 persons *(European age-standardised mortality rate per 100,000 for people aged under 75)*	464 2015	460 2016	440	G
	NI - 12	Emergency admission rate (per 100,000 population)	10,189 2015/16	9,974 2016/17	12,294	G
	NI - 13	Emergency bed day rate (per 100,000 population)	117,105 2015/16	110,352 2016/17	125,634	G
	NI - 14	Readmission to hospital within 28 days (per 1,000 population)	89 2015/16	93 2016/17	100	A
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	88% 2015/16	89% 2016/17	87%	G
	NI - 16	Falls rate per 1,000 population aged 65+	19 2015/16	20 2016/17	22	A
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	79% 2015/16	86% 2016/17	84%	G
	NI - 18	Percentage of adults with intensive care needs receiving care at home	53% 2014/15	55% 2015/16	62%	G
	NI - 19	Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)	1,765 2015/16	1,156 2016/17	842	G
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	27% 2015/16	25% 2016/17	25%	G
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	NA	NA	NA	
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	NA	NA	NA	
	NI - 23	Expenditure on end of life care, cost in last 6 months per death	NA	NA	NA	

*** *Please note definitional changes were made to the recording of delayed discharge information from 1 July 2016 onwards. Delays for healthcare reasons and those in non hospital locations (e.g. care homes) are no longer recorded as delayed discharges. In this indicator, no adjustment has been made to account for the definitional changes during the year 2016/17. The changes affected reporting of figures in some areas more than others therefore comparisons before and after July 2016 may not be possible at partnership level. It is estimated that, at Scotland level, the definitional changes account for a reduction of around 4% of bed days across previous months up to June 2016, and a decrease of approximately 1% in the 2016/17 bed day rate for people aged 75+.*

RAG scoring based on the following criteria

If Aberdeen City quarter has improved or stayed the same from previous, then "Green"
If Aberdeen City quarter has worsened by 5% or less of previous quarter, then "Amber"
If Aberdeen City quarter has worsened by more than 5% of previous quarter then "Red"

Aberdeen City – Local Indicators – May 2018

KEY	
I	Improved on previous reporting period by more than 2%
W	Worsened on pervious reporting period by more than 2%

Category	ID.	Indicator Description	Source	Performance Current Reporting Period	Target	Previous Reporting Period	Performance against Last Period	Trend line	Trend Period	Current Period
Responsive	L01	Number of Bed Days Occupied by Delayed Discharges per month (inc code 9) per 1000 18+ population	NHS - EDISON	**8.6**	-	7.7	W		5 Months	Oct-17
	L02	Number of delayed discharges inc code 9 (Monthly Census snapshot)	NHS - EDISON	**50**	-	45	W		5 Months	Oct-17
	L10	% people 65y+ with intensive care needs receiving care at home	SW	**37%**	-	35%	I		4 Quarters	Oct-Dec 17
	L11	Unmet need (hours) for social care	SW	**522**	-	562	I		2 Data Points	Jun-17
	L12	Uptake of self directed support (No. & % out of elligible clients)	SW	**286 (9.99%**	-	233 (7%)	I		2 Data Points	Jun-17
Effective	L03	A&E Attendance rates per 100,000 population (All Ages) (Monthly Average for rolling 12 month period)	NHS	**1707**	-	1693	W		5 Months	Dec-17
	L04	Smoking cessation in 40% most deprived after 12 weeks	NHS	**135**	-	73	I		5 Quarters	Apr-Jun 17
	L05	Number of Alcohol Brief Interventions being delivered	NHS	**587**	-	690	W		5 Quarters	Jul-Sep 17
	L06A	Number of complaints received and % responded to within 20 working days - NHS Aberdeen City	NHS	data available at the moment due to changes in data collection, this indicator should be available with the next up						

Safe	L06A	Number of complaints received and % responded to within 20 working days - NHS Aberdeen City	NHS	data available at the moment due to changes in data collection, this indicator should be available with the next upd						
	L06B	Number of complaints received and % responded to within 20 working days - Aberdeen City Council H&SC	SW	**19 (100%)**	-	26 (92%)	I		4 Quarters	Oct-Dec 17
	L09	Number of new referrals to initial investigation under adult protection	SW	**85**	-	70	V		3 Quarters	Jul-Sep 17
	L13	Adult Services % Posts Vacant	SW	**4.90%**	-	5.01%	I		4 Quarters	Oct-Dec 17
	L14	Number of new community payback orders	SW	**274**	-	240	V		4 Quarters	Oct-Dec 17
	L15	Number of Criminal Justice Social Work reports to court	SW	**405**	-	323	V		4 Quarters	Oct-Dec 17
Well Led	L07	NHS Sickness Absence % of Hours Lost	NHS	**4.7%**	-	4.4%	V		5 Quarters	Jul-Sep 17
	L08	Council Sickness Absence (% of Calendar Days Lost)	SW	No update available						

Aberdeenshire – National Indicators– April 2018

ISD's latest refresh of this data was December 2017, however please note that data is only updated to the end of the financial year available hence the newest data provided by ISD here is for 2016/17.

Data for the Core Suite of Integration Indicators, NI - 1 to NI - 23 are populated from national data sources and data is issued nationally. Indicators 1 to 10 are outcome indicators based on survey feedback and are updated bi-annually. Data for National Indicators 11 to 23 are derived from organisational/system data and are updated quarterly. Data for indicators 10, 21, 22 and 23 are not yet available.

	Indicator	Title	Previous score 2013/14	Current score 2015/16	Scotland 2015/16	RAG
Outcome indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	96%	96%	94%	G
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	83%	88%	84%	G
	NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	81%	80%	79%	A
	NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	78%	82%	75%	G
	NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	82%	83%	81%	G
	NI - 6	Percentage of people with positive experience of the care provided by their GP practice	84%	84%	87%	A
	NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	84%	89%	84%	G
	NI - 8	Total combined % carers who feel supported to continue in their caring role	42%	39%	41%	A
	NI - 9	Percentage of adults supported at home who agreed they felt safe	84%	84%	84%	G
	NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	NA	NA	NA	

	Indicator	Title	Previous score	Current score	Scotland	RAG	
Data indicators	NI - 11	Premature mortality rate per 100,000 persons *(European age-standardised mortality rate per 100,000 for people aged under 75)*	349 2015	331 2016	440	G	
	NI - 12	Emergency admission rate (per 100,000 population)	8,533 2015/16	8,432 2016/17	12,294	G	*
	NI - 13	Emergency bed day rate (per 100,000 population)	87,987 2015/16	90,166 2016/17	125,634	A	*
	NI - 14	Readmission to hospital within 28 days (per 1,000 population)	77 2015/16	79 2016/17	100	G	*
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	89% 2015/16	89% 2016/17	87%	G	
	NI - 16	Falls rate per 1,000 population aged 65+	15 2015/16	15 2016/17	22	G	
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	78% 2015/16	90% 2016/17	84%	G	
	NI - 18	Percentage of adults with intensive care needs receiving care at home	53% 2014/15	53% 2015/16	62%	A	
	NI - 19	Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)	1037 2015/16	677 2016/17	842	G	***
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	22% 2015/16	22% 2016/17	25%	G	
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	NA	NA	NA		
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	NA	NA	NA		
	NI - 23	Expenditure on end of life care, cost in last 6 months per death	NA	NA	NA		

* Data updated or refreshed since last update report

*** Please note definitional changes were made to the recording of delayed discharge information from 1 July 2016 onwards. Delays for healthcare reasons and those in non hospital locations (e.g. care homes) are no longer recorded as delayed discharges. In this indicator, no adjustment has been made to account for the definitional changes during the year 2016/17. The changes affected reporting of figures in some areas more than others therefore comparisons before and after July 2016 may not be possible at partnership level. It is estimated that, at Scotland level, the definitional changes account for a reduction of around 4% of bed days across previous months up to June 2016, and a decrease of approximately 1% in the 2016/17 bed day rate for people aged 75+.

RAG scoring based on the following criteria

If current Aberdeenshire position is better than current Scotland position

- *and Aberdeenshire value has improved or stayed the same then "Green"*
- *and Aberdeenshire value has worsened by 5% or less of previous Aberdeenshire value then "Amber"*
- *and Aberdeenshire value has worsened by more than 5% of previous Aberdeenshire value then "Red"*

If current Aberdeenshire position is worse than current Scotland position

- *and Aberdeenshire value has improved or stayed the same then "Amber"*
- *and Aberdeenshire value has worsened by 5% or less of previous Aberdeenshire value then "Amber"*
- *and Aberdeenshire value has worsened by more than 5% of previous Aberdeenshire value then "Red"*

Aberdeenshire –Local Indicators – April 2018

KEY					
Performance Against Target	✔	No concern. Meeting target	Performance Against Previous Period	I	Improved on previous reporting period by more than 2%
	?	On Review. Not meeting target but within tolerance		S	+/- 2% on previous reporting period
	✖	Of concern. Not meeting target, out-with tolerance. Included in exception report		W	Worsened on pervious reporting period by more than 2%

ID.	Indicator Description	Source	Performance	Target	Previous Period	Against Last Period	Trend line	Trend Period	Current Period
L01	Percentage of Adult Protection Cases screened within 24 hours of notification	Carefirst	✔ 93.0%	85%	83.0%	I		5 Quarters	Oct-Dec 17
L02	Percentage of Adult Protection enquiries that proceed to Investigation	Carefirst	✔ 41.0%	35%	51.0%	W		5 Quarters	Oct-Dec 17
L03	Rapid response service, Home Care Responders Referrals (median minutes between referral and visit)	Carefirst	No target 20	-	20	S		5 Quarters	Oct-Dec 17
L04	Percentage of all clients on SDS pathway	Carefirst	✔ 90.0%	100%	88.0%	I		5 Quarters	Oct-Dec 17
L05	OT Assessments completed within timescales	Carefirst	✖ 87.0%	95.0%	89.0%	W		5 Quarters	Oct-Dec 17
L06	Number of people receiving community alarm and/or telecare	Carefirst	✖ 2757	3100	2736	S		5 Quarters	Oct-Dec 17
L07	Rate of emergency occupied bed days for over 65s per 1000 population	NHS	✔ 2323	2360	2350	S		5 Quarters	Oct-Dec 17
L08	Emergency Admissions rate per 1000 population for over 65s	NHS - PMS	✔ 188	193	189	S		5 Quarters	Oct-Dec 17
L09	Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population	NHS - PMS	✔ 124	125	124	S		5 Quarters	Oct-Dec 17
L10	Number of Bed Days Occupied by Delayed Discharges per quarter (inc code 9) per 1000 18+ population	NHS - EDISON	No target 22.0	-	18.0	W		5 Quarters	Oct-Dec 17
L11	Number of delayed discharges inc code 9 (Census snapshot, monthly average for quarter)	NHS - EDISON	✖ 52	35	38	W		5 Quarters	Oct-Dec 17

ID.	Indicator Description	Source	Performance	Target	Previous Period	Against Last Period	Trend line	Trend Period	Current Period
L12	A&E Attendance rates per 1000 population (All Ages)	NHS	✗ **21.9**	19.3	22.0	S		5 Quarters	Oct-Dec 17
L13	A&E Percentage of people seen within 4 hours, within community hospitals	NHS	✓ **99.8% (8573)**	98.0%	99.8% (9207)	S		5 Quarters	Oct-Dec 17
L14	Percentage of new dementia diagnoses who receive 1 year diagnostic support	ISD	✗ **57.8%**	70%	83.6%	W		3 Financial Years	Apr-Sep 16
L15	Smoking cessation in 40% most deprived after 12 weeks	NHS	No target **113**	-	143	W		5 Quarters	Jul-Sep 17
L16	Percentage of clients receiving alcohol treatment within 3 weeks of referral	NHS	✗ **88.2%**	90%	95.5%	W		5 Quarters	Oct-Dec 17
L17	Percentage of clients receiving drug treatment within 3 weeks of referral	NHS	✗ **89.0%**	90%	78.8%	I		5 Quarters	Oct-Dec 17
L18	Number of Alcohol Brief Interventions being delivered	NHS	✗ **217**	688	225	W		5 Quarters	Oct-Dec 17
L19A	Number of complaints received and % responded to within 20 working days - NHS	NHS	✗ **46.0% (24)**	85%	60.% (25)	W		3 Quarters	Oct-Dec 17
L19B	Number of complaints received and % responded to within 20 working days - Council	SW	✓ **100.0% (14)**	85%	89.% (9)	I		5 Quarters	Oct-Dec 17
L20	NHS Sickness Absence % of Hours Lost	NHS	! **4.9%**	4.0%	4.5%	W		5 Quarters	Oct-Dec 17
L21	Council Sickness Absence (% of Calendar Days Lost)	SW	! **4.6%**	4.0%	5.2%	I		5 Quarters	Oct-Dec 17
L22	Percentage of unpaid carers who feel supported to continue in their caring role	IBP Survey	No target **43%**	No target	39%	I	-	2 Bi-Annual	2017

ID.	Indicator Description	Source	Performance	Target	Previous Period	Against Last Period	Trend line	Trend Period	Current Period
L23	Percentage of unpaid carers who are aware of short break/respite services available locally	IBP Survey	No target 51%	No target	-	-	-	1 Bi-Annual	2017
L24	Percentage of unpaid carers who state they have PoA or other AWI Measures in place	IBP Survey	No target 59%	No target	-	-	-	1 Bi-Annual	2017
L25	Percentage of unpaid carers who have a say in the services that are provided for the person they care for	IBP Survey	No target 65%	No target	-	-	-	1 Bi-Annual	2017
L26	Percentage of unpaid carers satisfied with the quality of services provided for the person they care for	IBP Survey	No target 47%	No target	-	-	-	1 Bi-Annual	2017
L27	Percentage of unpaid carers who feel well informed about the services provided to the person they care for	IBP Survey	No target 46%	No target	-	-	-	1 Bi-Annual	2017
L28	Percentage of service users who are satisfied overall with the social care services they receive	IBP Survey	✓ 85%	85.0%	84%	S	—	2 Bi-Annual	2017
L29	Percentage of service users who are satisfied overall with their involvement in the design of their care	IBP Survey	! 82%	85.0%	84%	W	—	2 Bi-Annual	2017
L30	Percentage of service users who are satisfied with the health services that they receive	IBP Survey	✓ 86%	85.0%	85%	S	—	2 Bi-Annual	2017
L31	Percentage of service users who feel they are treated with respect	IBP Survey	✓ 98%	95.0%	99%	S	—	2 Bi-Annual	2017
L32	Percentage of service users who feel that people doing the assessment listened to what you had to say	IBP Survey	! 91%	95.0%	94%	W	—	2 Bi-Annual	2017
L33	Percentage of service users who are satisfied with the knowledge of people doing the assessment	IBP Survey	! 91%	95.0%	95%	W	—	2 Bi-Annual	2017
L34	Percentage of service users who have an Anticipatory Care Plan in place	IBP Survey	No target 37%	No target	-	-	-	2 Bi-Annual	2017
L35	Percentage of service users who have an Emergency Care Plan in place	IBP Survey	No target 41%	No target	-	-	-	2 Bi-Annual	2017

ID.	Indicator Description	Source	Performance	Target	Previous Period	Against Last Period	Trend line	Trend Period	Current Period
L36	Percentage of service users who had been asked about desired personal outcomes	IBP Survey	No target 89%	No target	-	-	-	2 Bi-Annual	2017
L37	Percentage of service users who are aware that they can grant PoA	IBP Survey	No target 91%	No target	-	-	-	2 Bi-Annual	2017
L38	Percentage of service users who have a PoA in place	IBP Survey	No target 70%	No target	-	-	-	2 Bi-Annual	2017
L39	Percentage of service users who feel that people who identified my social care needs worked together as a team	IBP Survey	! 88%	90.0%	91%	W	—	2 Bi-Annual	2017
L40	Percentage of service users who feel health and care services are well co-ordinated	IBP Survey	No target 86%	No target	-	-	-	2 Bi-Annual	2017

Note indicators shaded in grey have not been updated this quarter, this is due to updated data not being available at time of writing.

Moray – National Indicators – April 2018

ISD's latest refresh of this data was December 2017, however please note that data is only updated to the end of the financial year available hence the newest data provided by ISD here is for 2016/17.

Data for the Core Suite of Integration Indicators, NI - 1 to NI - 23 are populated from national data sources and data is issued nationally. Indicators 1 to 10 are outcome indicators based on survey feedback and are updated bi-annually. Data for National Indicators 11 to 23 are derived from organisational/system data and are updated quarterly. Data for indicators 10, 21, 22 and 23 are not yet available.

	Indicator	Title	Previous score 2013/14	Current score 2015/16	Scotland 2015/16	RAG
Outcome indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	96%	96%	94%	G
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	81%	78%	84%	A
	NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	74%	72%	79%	A
	NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	71%	77%	75%	G
	NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	75%	78%	81%	G
	NI - 6	Percentage of people with positive experience of the care provided by their GP practice	85%	87%	87%	G
	NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	74%	86%	84%	G
	NI - 8	Total combined % carers who feel supported to continue in their caring role	44%	43%	41%	A
	NI - 9	Percentage of adults supported at home who agreed they felt safe	76%	81%	84%	G
	NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	NA	NA	NA	

	Indicator	Title	Previous score	Current score	Scotland	RAG	
Data indicators	NI - 11	Premature mortality rate per 100,000 persons *(European age-standardised mortality rate per 100,000 for people aged under 75)*	399 2015	360 2016	440	G	
	NI - 12	Emergency admission rate (per 100,000 population)	8,673 2015/16	8,734 2016/17	12,294	A	*
	NI - 13	Emergency bed day rate (per 100,000 population)	94,533 2015/16	94,294 2016/17	125,634	G	*
	NI - 14	Readmission to hospital within 28 days (per 1,000 population)	76 2015/16	74 2016/17	99	G	
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	90% 2015/16	90% 2016/17	87%	G	
	NI - 16	Falls rate per 1,000 population aged 65+	17 2015/16	16 2016/17	22	G	*
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	78% 2015/16	78% 2016/17	83%	G	*
	NI - 18	Percentage of adults with intensive care needs receiving care at home	75% 2014/15	67% 2015/16	62%	R	
	NI - 19	Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)	764 2015/16	1,095 2016/17	842	R	***
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	22% 2015/16	21% 2016/17	25%	G	
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	NA	NA	NA		
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	NA	NA	NA		
	NI - 23	Expenditure on end of life care, cost in last 6 months per death	NA	NA	NA		

*** *Please note definitional changes were made to the recording of delayed discharge information from 1 July 2016 onwards. Delays for healthcare reasons and those in non hospital locations (e.g. care homes) are no longer recorded as delayed discharges. In this indicator, no adjustment has been made to account for the definitional changes during the year 2016/17. The changes affected reporting of figures in some areas more than others therefore comparisons before and after July 2016 may not be possible at partnership level. It is estimated that, at Scotland level, the definitional changes account for a reduction of around 4% of bed days across previous months up to June 2016, and a decrease of approximately 1% in the 2016/17 bed day rate for people aged 75+.*

RAG scoring based on the following criteria

If Moray performance has improved or stayed the same then "Green"

If Moray performance has worsened by 5% or less then "Amber"

If Moray performance has worsened by more than 5% then "Red"

Moray –Local Indicators– April 2018

RAG scoring based on the following criteria		
Performance Against Previous Period	G	*If Moray quarter has improved or stayed the same from previous, then "Green"*
	A	*If Moray quarter has worsened by 5% or less of previous quarter, then "Amber"*
	R	*If Moray quarter has worsened by more than 5% of previous Moray quarter then "Red"*

ID.	Indicator Description	Performance Current Quarter	Target	Previous Quarter	Against Previous Quarter	Trend line	Trend Period	Current Quarter
L07	Rate of emergency occupied bed days for over 65s per 1000 population	**2495**	2360	2531	G		5 Quarters	Oct-Dec 17
L08	Emergency Admissions rate per 1000 population for over 65s	**182**	193	180	A		5 Quarters	Oct-Dec 17
L09	Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population	**130**	125	128	A		5 Quarters	Oct-Dec 17
L10	Number of Bed Days Occupied by Delayed Discharges per quarter (inc code 9) per 1000 18+ population	**30**	-	31	G		5 Quarters	Oct-Dec 17
L11	Number of delayed discharges inc code 9 (Census snapshot, monthly average for quarter)	**26**	35	27	G		5 Quarters	Oct-Dec 17
L12	A&E Attendance rates per 1000 population (All Ages)	**56.1**	19.3	59.9	G		5 Quarters	Oct-Dec 17
L13	A&E Percentage of people seen within 4 hours, within community hospitals	**100.0% (595)**	98%	100.0% (729)	G		5 Quarters	Oct-Dec 17
L14	Percentage of new dementia diagnoses who receive 1 year diagnostic support	**75.0%**	70%	90.7%	R		3 Financial Years	Apr-Sep 16

L15	Smoking cessation in 40% most deprived after 12 weeks	**44**	-	60	R		5 quarters	Apr-Jun 17
L16	Percentage of clients receiving alcohol treatment within 3 weeks of referral	**100.0%**	90%	98.6%	G		5 Quarters	Jul-Sep 17
L17	Percentage of clients receiving drug treatment within 3 weeks of referral	**100.0%**	90%	100.0%	G		5 Quarters	Jul-Sep 17
L18	Number of Alcohol Brief Interventions being delivered	**95**	257	65	G		5 Quarters	Oct-Dec 17
L19A	Number of complaints received and % responded to within 20 working days - NHS	**10.0% (10)**	-	57.0% (14)	R		3 Quarters	Oct-Dec 17
L19B	Number of complaints received and % responded to within 20 working days - Council	No data available at the moment, this indicator should be available with the next update						
L20	NHS Sickness Absence % of Hours Lost	**4.6%**	4.0%	4.0%	A		5 Quarters	Oct-Dec 17
L21	Council Sickness Absence (% of Calendar Days Lost)	No data available at the moment, this indicator should be available with the next update						
L41	Percentage of patients commencing Psychological Therapy Treatment within 18 weeks of referral	**61.5%**	90%	100.0%	R		3 Quarters	Oct-Dec 17

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 27 SEPTEMBER 2018**

SUBJECT: **INTERNAL AUDIT PLAN**

BY: **CHIEF INTERNAL AUDITOR**

1. REASON FOR REPORT

1.1 To provide the Moray Integration Joint Board (MIJB) Audit Performance and Risk Committee with information on the proposed internal audit coverage for completion in the current 2018/19 financial year.

2. RECOMMENDATION

2.1 It is recommended that the Committee considers this report and agrees the proposed audit coverage.

3. BACKGROUND

3.1 The Scottish Government Integrated Resources Advisory Group (IRAG) guidance requires each IJB to establish adequate and proportionate internal audit arrangements for the review of risk management, governance and control of delegated resources.

3.2 The guidance recommends that a risk based audit plan should be developed by the Chief Internal Auditor of the IJB and be approved by the IJB or other Committee (in Moray, the Audit, Performance and Risk Committee). Importantly it also notes that the operational delivery of services within the Health Board and local authority on behalf of the IJB will be covered by their respective internal audit arrangements as at present.

3.3 In 2016/17, discussions took place involving Audit Committee Chairs, Chief Officers and Chief Internal Auditors from NHS Grampian and the three north east councils around the provision of audit assurances across the three IJBs and agreement reached in principle that:

- There should be an annual audit plan specific to the Moray IJB and reports on topics included in that plan will be presented to the MIJB

Audit, Performance and Risk Committee to provide assurances on the selected areas.

- NHS Grampian and Moray Council for their own respective interests will agree their own annual audit plans. Audit reports on topics contained within these plans will be reported in the first instance to the relevant audit committees of each organisation. Where these audit reports contain information relevant to the MIJB, these will then be presented to the MIJB Audit, Performance and Risk Committee as an additional source of assurance.

- When all audit plans are finalised consideration will be given to the possibility of sharing audit resources where there is any similarity in the plans.

3.4 The reporting arrangements are working as intended albeit there is an inevitable delay in reporting the same information firstly to the partner body and then to this Committee. Informal discussions between auditors are continuing on matters of common interest however as yet there have been no formal opportunities for sharing audit resources. This remains under consideration.

3.5 Moray Council's Audit and Scrutiny Committee at its meeting on 23 May 2018 approved an audit plan which provided for a total of 80 days input for audit work relating to the MIJB and Social Care (paragraph 5 of the Minute refers). The proposed use of these days has been discussed with the Chief Financial Officer and is as detailed below. While the number of days assigned specifically to the MIJB is relatively small this is consistent with the approach being taken across most IJBs in Scotland, recognising that for now the staff, systems, and processes under direction of the MIJB are with NHS Grampian or Moray Council.

3.6 In selecting audit topics, a full evaluation of the council's resource inputs to the activities directed by the MIJB has been undertaken, with consideration also given to the results of prior year coverage and the impact of planned changes in service delivery. In respect of change, audit interventions are beneficial where they aid the change process, however recommendations can have less impact if they are based on reviews of systems that are under transformation.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The budget in scope broadly amounts to some £52 million, the major elements of this relating to:

- £17m Assessment & Care: recent audit work has covered some £9m from a review of residential care, the remainder relates to home care and respite care and meeting the costs of the Access Teams;
- £15m Provider Services: recent audit work has considered internal home care provision (circa £5 million) and aids and adaptations (£200k). The remainder comprises the Independent Living Service, Learning Disabilities (LD) Care at home, LD Day Care & Supported Housing;

- £10m Commissioning: £2.1m of overall £6m LD contracts partially covered in prior year audit exercise still to be concluded. Self-directed Support also included here which has on going audit involvement. The rest of the budget relates to Mental Health, Older Persons contracts and sheltered housing.
- £7m Specialist Services: Limited recent coverage in this area. Consists of £1m Mental Health staffing, £0.8m Drug & Alcohol, £5m Learning Disabilities Residential Care plus home care and housing support.
- £1m Intermediate Care & Occupational Therapy: mainly staffing costs.
- £2m other - includes staff costs for senior management, strategy and support £700k; other staff costs are apportioned across the above headings.

4.2 The areas considered for audit in 2018/19 relate to:

- **concluding the review on LD**: This is likely to take the form of an interim report recognising that commissioning arrangements will remain under review in the longer term as services are reconfigured.
- **payroll testing**. This will confirm the veracity of employee costs incurred in the delivery of selected service areas and ensure appropriate controls are in place.
- **contributions policy**: A review of a sample of financial assessments for service users to confirm the correct and consistent application of the contributions policy.
- **governance review**: Annual requirement to inform the audit opinion on the governance arrangements linked to SG guidance and best value requirements.
- **self-directed support**: participation in national study and development group.

4.3 In considering the audit coverage, the Audit, Performance and Risk Committee should be aware that the responsibility for developing and maintaining a sound control environment rests with management and not with Internal Audit. Similarly it will be recognised that Internal Audit is not the only scrutiny activity within the MIJB, with services challenged through other mechanisms including external audit and inspection, and separate reporting on clinical and care governance.

5. SUMMARY OF IMPLICATIONS

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

The work of internal audit supports good governance and provides independent assurances to the MIJB on use of its resources.

(b) Policy and Legal

The report has been prepared having regard to IRAG guidance issued by Scottish Government.

(c) Financial implications

There are no financial implications arising directly from this report.

(d) Risk Implications and Mitigation

The work of internal audit provides assurances on the adequacy and effectiveness of the internal control systems established by management in support of service delivery arrangements and use of resources in selected areas. Positive assurances together with recommendations covering areas for improvement mitigate the risk of desired outcomes not being achieved.

(e) Staffing Implications

The delivery of the planned audit coverage can be accommodated within the available internal audit staff resource of the council.

(f) Property

None arising from this report.

(g) Equalities/Socio Economic Impact

None arising from this report.

(h) Consultations

Consultations have taken place with Tracey Abdy, Chief Financial Officer whose comments have been incorporated within the report.

6. CONCLUSION

6.1 The Committee is asked to consider and agree the planned audit coverage for the Moray IJB for 2018/19.

Author of Report: Atholl Scott
Background Papers: Audit working papers
Ref: IJB/aprc/270918

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 27 SEPTEMBER 2018**

SUBJECT: **INTERNAL AUDIT UPDATE**

BY: **CHIEF INTERNAL AUDITOR**

1. REASON FOR REPORT

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

2. RECOMMENDATION

2.1 It is recommended that the Audit, Performance and Risk Committee considers and notes the contents of this update report together with the completed audit reviews.

3. BACKGROUND

3.1 At the meeting of this Committee on 26 July 2018, information was provided in respect of progress made relative to the delivery of the audit plan for 2017/18 (paragraph 9 of the draft Minute refers). This contained a number of outstanding actions that have been progressed as follows

Audit Area	Progress/Update
Review of Change Funds	Completed. No audit work planned in 2018/19 but will review change fund processes again in 2019/20.
Provision of annual assurance opinion	Completed for 2017/18 and current planned work will inform opinion for 2018/19.
Performance reporting	Work completed by Pricewaterhouse Coopers – a separate report is provided on the agenda for this meeting. Will await development of performance management framework in Moray – no audit work planned for 2018/19.

Audit Area	Progress
Commissioning of Services – Learning Disabilities –consideration of current contractual arrangements	This audit was commenced in 2017/18 and has been carried into the current year, progress has been slow but the audit covers an area of change and one which incurs significant costs. An interim report is planned for later this year
Application of Scottish Living Wage	Audit concluded. No further work planned for 2018/19.
Income generation – Application of the Contributions Policy	Carried into audit plan for 2018/19
Self-directed support (SDS) - support the service team in the development and maintenance of suitable processes for awarding and monitoring use of SDS funds.	Completed for 2017/18. Ongoing support will be provided as required during 2018/19
Information Governance Review – how service user data is managed and controlled	Audit completed and reported to Council. Audit report and action plan attached as **Appendix 1.**
Occupational Therapy Stores- the management of purchases and issues to support day to day living at home by individuals with disabilities.	Audit completed and reported to council Audit report and action plan attached as **Appendix 2.**

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 This report concludes the reporting of matters relative to the 2017/18 internal audit plan.

5. SUMMARY OF IMPLICATIONS

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

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

(b) Policy and Legal

Internal audit provides independent assurances in line with IRAG guidance

(c) Financial implications

No direct implications

(d) Risk Implications and Mitigation

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

(e) Staffing Implications

No implications

(f) Property

No implications

(g) Equalities/Socio Economic Impact

No implications

(h) Consultations

Relevant staff are consulted during completion of audit work. There have been no direct consultations in respect of this report.

6. CONCLUSION

6.1 This report provides summary information concluding the reporting of work from the 2017/18 internal audit plan, together with the audit reports covering Social Care – Information Governance and Occupational Therapy Stores.

Author of Report: Atholl Scott
Background Papers: Internal audit files
Ref: MIJB/aprc/270918

Moray Council

Internal Audit Section

APPENDIX 1

Social Care & CareFirst System Information Governance Review

Final Report

DEPARTMENT: **Education and Social Care Department**

SUBJECT: **Social Care & CareFirst System Information Governance Review**

REPORT REF: **17'016**

Table of Contents

1. Executive Summary

The annual internal audit plan for 2017/18 provides for a review to be undertaken of how information relating to social care service users is recorded, accessed and kept up to date. Effective controls in this area are particularly important due to the sensitive nature of much of the information held. In addition, the council has duties under data protection regulations, and breaches of these regulations can result in censure and substantial financial penalties being levied by the Information Commissioner's Office.

This review focused on access controls around the management of case files. This included consideration of who can view, add, amend or delete information, recognising that restricted access has to be balanced with a need for prompt availability of information for those employees who require it for the effective delivery of services.

The council uses a system known as CareFirst to record and manage social care cases for both adult and children's services. CareFirst is a long standing widely used application within the public sector for recording social care data. Most of the service user data is available on CareFirst, with some data retained separately either on a council IT server or in paper files.

With large volumes of data collected by many different officers over an extended period, the holding of all information on a single system has not been possible. This increases the risk that not all information on any one service user will be readily accessible, although Case Recording Procedures have been implemented to provide guidance to officers on how service user data should be recorded and saved.

In terms of issues arising in the course of this audit the main points raised for management consideration and attention relate to:

- Evaluating whether, with improving technology, it is feasible to strengthen case recording procedures such that all data ultimately can be recorded in a single file for each service user.
- Reviewing the access arrangements for CareFirst to limit as far as is practicable access to case files only to those officers who need to see them.
- Improving procedures for auditing who has accessed files and the reason for that access through formal recording of supervisory reviews of system audit logs.

- Strengthening password controls, both the format of the password (using a range of characters, digits, capital letters etc.) and making it a requirement to change passwords periodically.
- Ensuring to the extent possible that the same processes are applied in respect of case files held both for adult services (now directed by Health and Social Care Moray) and for children's services provided by the council.

This audit review is timely given the recent coming in to force of the new General Data Protection Regulation in 2018, and provides management with an opportunity to reflect on current information management practice in services where large volumes of complex and sensitive data are held.

2. Introduction

The annual Internal Audit plan for 2017/18 provides for a review to be undertaken of how information is accessed and recorded within the CareFirst System and other information databases within Education and Social Care Services. In addition the audit also reviewed the different levels of access and electronic controls used to administer the CareFirst System.

3. Audit Scope

The purpose of the audit was to undertake a review of how information is recorded and managed within the various information databases for Adult and Children Services. The audit also reviewed access and the electronic system controls operating within the CareFirst System

4. Summary Assessment

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

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

Our assessment in terms of the design of and compliance with, the system of internal controls for Social Care & CareFirst System Information Governance Review as limited by the scope of audit is set out below:

System Assessment	Testing Assessment
Substantial	Limited

5. Findings

The main issues raised for management consideration are:

5.1 No single database is used for recording all case details as information and observations may be recorded on three different recording systems i.e. CareFirst, Shared Drive and Paper Files.

5.2 CareFirst Information System is an open database where officers are able to view information but only designated officers are authorised to action a particular function e.g. to incur expenditure.

5.3 Limited evidence was found of how the Service has developed an information security management system with the purpose of minimising the risk of a data security breach.

5.4 Health and Social Care Moray has no officer representation on the Information Assurance Group. An officer from Health and Social Care Moray should attend this Group to ensure they can keep the Service regularly updated with any issues concerning information governance systems and practices.

5.5 No reporting is made to the Information Assurance Group of any breaches in information security, Highlighting any weaknesses or incidents in data security would allow these issues to be discussed and improvements suggested to minimise any possible future loss of information.

5.6 Regular reviews on a sample of case files to ensure completeness, accuracy etc. are undertaken by Children's Services and the Criminal Justice Managers. However there has been no similar co-ordinated review undertaken within Adult Services for a number of years.

5.7 The 'Summary on Case File Auditing Process' used for monitoring within Children's Services and Criminal Justice had not been issued for a number of years.

5.8 It was noted that approximately a third of all case reviews requested for review by Children's Services and Criminal Justice Managers had not been undertaken.

5.9 No clear evidence was noted between the results of auditing case files and changes and improvements in systems and practices.

5.10 The restricted case file access allows for an officer to override the access to a sensitive case file. No authorisation is required from a Team Leader before this access is allowed.

5.11 Limited evidence was noted within the exception report produced by the Services' IT Support Section detailing the reasons provided by officers to access a restricted case file.

5.12 The Service's IT Administration officers may access a restricted case file as part of their duties in managing the CareFirst System. However, this access is not recorded within the exception report provided to Managers.

5.13 Limited evidence was noted of any review undertaken by Managers regarding officers who have overridden access controls to view a restricted case file.

5.14 Sensitive or restricted information may also be held for a client on the Shared drive and paper files, however no authorisation requirement or exception report is produced of officers accessing this information.

5.15 No service instructions were noted regarding the use of mobile storage devices e.g. encrypted USB Sticks.

5.16 From discussions with various officers there was a different understanding of the circumstances where a case file within the CareFirst System may be deleted.

5.17 It was noted that IT Administration Support in accordance with the Council Retention Policy can delete Case Files within the CareFirst System without formal authorisation from a Social Care Service Manager or Team Leader.

5.18 A CareFirst File may be deleted however information regarding a Service User may still be recorded and remain within the Shared Drive or Paper File.

5.19 The CareFirst IT Administration Team will monitor details of officers who have not accessed the system, however there is no established time period after which access is automatically suspended.

5.20 A number of categories within the paper file contents index for both Adult and Children Services were found to be no longer relevant.

5.21 It was noted that the Case Recording Procedure within Adult Services has been recently reviewed, but the revised procedures are still in draft and have not been issued.

5.22 No reference is made within the Case Recording Procedure to the Information Security Policy that could assist officers to ensure good information security practices are followed.

5.23 Information Security Policy has not been reviewed since 2009

5.24 No confidentiality agreement has been signed between the Council and OLM Group, the providers of CareFirst.

5.25 Discussions with officers within the services noted variances of where information, observations, correspondences etc. should be saved. It was also found that difficulties could occur in retrieving data due to generic terms used to save information.

5.26 The Information Systems Support Team for the CareFirst System is based within the Community Care Service and not the ICT Section.

6. Recommendations

Risk Ratings for Recommendations						
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Comments	Responsible Officer	Timescale for Implementation
Key Control: Effective Information control systems in operation to protect and secure access to sensitive information.						
5.1	Investigation should be undertaken to explore the possibilities of developing a single case recording system.	High	Yes	Planning to begin upgrade to new version of CareFirst which includes document management. Adult and Children's Services will jointly review their document management requirements with a view of upgrading to the new Care First System for the future recording of all case documents.	Commissioning & Performance Manager Head of Integrated Children's Services	31/07/2020

Risk Ratings for Recommendations						
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Comments	Responsible Officer	Timescale for Implementation
5.2	A review of access rights to CareFirst, Shared Drive and Paper Files should be undertaken with the purpose that officers should only be authorised to view case file information required to undertake their duties.	High	Yes	A review to meet the requirements of both Services will be undertaken, however, implementation may be dependent on the upgrade to the new Care First System.	Commissioning & Performance Manager on behalf of both services	31/12/2018
5.3	The Service should develop a more co-ordinated approach to ensure regular and effective information security practices are communicated across the Service.	Medium	Yes	Regular bulletin for teams.	Commissioning & Performance Manager for both services	31/12/2018

Risk Ratings for Recommendations						
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Comments	Responsible Officer	Timescale for Implementation
5.4	A representative from Health and Social Care Moray should attend the Information Assurance Group.	Medium	Yes	Invite for a representative to join the Information Assurance Group will be issued .to the Integration Joint Board.	Commissioning & Performance Manager	Complete
5.5	Any breaches in information security should be reported to the Information Assurance Group. This would allow the control environment to be reviewed and for recommending improvements to systems.	Medium	Yes	In consultation with the Information Assurance Group (IAG), procedures will be developed across both services for standard reporting of breaches in information security to the IAG.	Commissioning & Performance Manager	31/12/2018

Risk Ratings for Recommendations						
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Comments	Responsible Officer	Timescale for Implementation
5.6	Regular reviews of Case Files to ensure completeness should be undertaken by Adult Services as is currently undertaken within Children's and Criminal Justice Services.	High	Yes	Immediate re-introduction of regular audits of case files within Adult Services. However both Adult and Children Services to explore the possibility of agreeing a uniform case auditing and reporting system.	Head of Adult Services Head of Integrated Children's Services	30/06/2018
5.7	A "Summary Report on Case File Auditing" should be undertaken on a yearly basis.	Medium	Yes	Already actioned through QAPPT and single agency processes. To be reported to Practice Governance Board.	Head of Integrated Children's Services Commissioning & Performance Manager	Implemented 31/08/2018

Risk Ratings for Recommendations						
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Comments	Responsible Officer	Timescale for Implementation
5.8	A reminder should be issued to all Managers and Senior Officers within Children's Services and Criminal Justice of the importance of completing Case File Reviews at the required intervals.	Medium	Yes	Already actioned – quarterly reports coming to ICS	Head of Integrated Children's Services	Implemented
5.9	Service improvements highlighted from case file reviews should result in a documented improvement plan for implementation by the Service.	Medium	Yes	ICS working to improve communication of audit findings through PGG and developing PRISM. To be reported to Practice Governance Board.	Head of Integrated Children's Services Commissioning & Performance Manager	Ongoing 31/08/2018
5.10	Access to restricted case files within the CareFirst System should only be allowed after authority is obtained from a Team Manager.	Medium	Yes	Review process with a view of implementing new authorisation procedures.	Commissioning & Performance Manager	31/12/2018

Risk Ratings for Recommendations						
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Comments	Responsible Officer	Timescale for Implementation
5.11	Clear description should be detailed of why access is required by an officer to a Restricted Case File.	Medium	Yes	As 5.10	Commissioning & Performance Manager	31/12/2018
5.12	Access by any officer including IT Officers and Support should be clearly recorded within the Restricted Case File Access Report.	High	Yes	Investigate feasibility for amendment to report. Agreed in principle- Any access by officers out with SWS should be scrutinised by a senior member of SWS.	Commissioning & Performance Manager	30/06/2018
5.13	Evidence should be retained to confirm restricted Case File access report has been reviewed by a Senior Manager.	Low	Yes	Agreed in principle- Will review report distribution list and guidance across both Services. Closely linked to 5.10-5.13 above	Commissioning & Performance Manager Head of Integrated Children's Services	30/06/2018

Risk Ratings for Recommendations						
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Comments	Responsible Officer	Timescale for Implementation
5.14	Authorisation should also be obtained from a senior manager of any access required to a restricted case file when information is stored within the Shared Drive or Paper File.	Medium	Yes	Review current process and investigate viability of new processes.	Commissioning & Performance Manager Strategy Officer	31/12/2018
5.15	The Service should develop clear guidelines regarding the use of mobile storage devices e.g. encrypted USB sticks.	Medium	Yes	Guidance will be issued to all officers incorporating Corporate Information Security Policies. Also be incorporated into 5.3 using corporate guidance. ICS has issued recent guidance circulated from GDPR officer.	Commissioning & Performance Manager	31/12/2018

Risk Ratings for Recommendations						
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Comments	Responsible Officer	Timescale for Implementation
5.16	CareFirst Case Files should be deleted in accordance with the Council Document Retention Policy. Deletion of any case files should only be actioned after authority of a senior manager within the Service is obtained.	High	Yes	Procedures in both Services include a requirement for a Senior Manager to delete a file. Any files highlighted for deletion by System Support will also require the authority of a Social Work Manager.	Commissioning & Performance Manager Head of Integrated Children's Services	30/06/2018
5.17	Information held within the Shared Drive and Paper File should be deleted and destroyed at the same time as deleting the case file within CareFirst.	Medium	Yes	Procedures within both Services include this requirement. Ongoing review undertaken to ensure compliance.	Commissioning & Performance Manager Head of Integrated Children's Services	30/06/2018

Risk Ratings for Recommendations						
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Comments	Responsible Officer	Timescale for Implementation
5.18	Access rights to the CareFirst System should be suspended where an officer has not accessed the system for a period of 3 months. Any reinstatement of access should require the authorisation of a Team or Service Manager.	Medium	Yes	Agreed - System Support will retain evidence of Service/ Team Manager authorisation for reinstatement of officer access to CareFirst. Review of compliance to be undertaken	Commissioning & Performance Manager Commissioning & Performance Manager	Implemented August 2018
5.19	The revised Case Recording Procedures within Adult Services, currently in draft, should be agreed and issued.	Medium	Yes	Already actioned.	Performance Officer.	Implemented

Risk Ratings for Recommendations						
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Comments	Responsible Officer	Timescale for Implementation
5.20	Reference should be made to the Information Security Policy within the Case Recording Procedure to ensure officers have a greater awareness of good information management practices.	Low	Yes	Implemented within Adult Services. Review recording policies to ensure reference to ISP within Children Services	Head of Community Care Head of Integrated Children's Services	31/12/18
5.21	The category index used for paper files should be reviewed and amended accordingly to reflect current information recording requirements.	Low	Yes	Short term working group from both adult & children's services to agree recording requirements.	Commissioning & Performance Manager	31/12/2018

Risk Ratings for Recommendations						
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Comments	Responsible Officer	Timescale for Implementation
5.22	The Information Security Policy should be reviewed and updated as required.	Medium	Yes	A review of the Corporate Information Security Policy will be included within the ICT Infrastructure Security Projects for 2018/19.	ICT Infrastructure Manager	31/03/2019
5.23	Documented assurance should be obtained from the CareFirst Software Supplier of the requirement for confidentiality of personal information when technical access is required for updates etc.	Medium	Yes	To follow up with Software Supplier	Information Systems Officer	30/09/2018
5.24	Consideration should be given to providing all officers with regular briefing sessions regarding the recording, saving etc. of service user information.	Medium	Yes	Annual staff briefing Regular bulletin (see also 5.3)	Head of Integrated Children's Services Commissioning & Performance Manager	31/12/2018

Risk Ratings for Recommendations						
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Comments	Responsible Officer	Timescale for Implementation
5.25	Consideration should be given in partnership with the ICT Applications Manager whether the Information Systems Team within the Community Care Service should be moved to be under the line management of the Corporate ICT Section.	Low	Yes	Investigate advantages/ disadvantages of this recommendation.	Head of Integrated Children's Services Commissioning & Performance Manager Joint Head of HR and ICT	31/03/2019

Moray Council

Internal Audit Section

APPENDIX 2

Occupational Therapy Stores

Final Report

Moray Council

Internal Audit Section

DEPARTMENT: **Education and Social Care**

SUBJECT: **Occupational Therapy Stores**

REPORT REF: **19'003**

Table of Contents

1. Executive Summary

The annual Internal Audit plan for 2017/18 provided for a review to verify the stock valuation of equipment held at the financial year end for a number of Council Services. This report relates specifically to the Occupational Therapy (OT) Store.

Occupational Therapy stocks comprise aids and adaptations issued to service users to help with various daily tasks including cooking, dressing and bathing. The individual items of equipment held can vary in value from a few pounds to upwards of £1,000 for certain type of hoists, specialised seating etc. The total stock value as at 31st March 2018 amounted to some £110,000.

The audit involved a number of tests to confirm the accuracy of the reported stock valuation, including the checking of records for pricing purposes and the physical verification of items held in store. Once agreed, the final stock valuation is passed to Accountancy Services for inclusion within the Council's Annual Accounts.

Further to the review and testing undertaken, the following points were noted:-

- A review of the initial valuation report provided detailing the total stock value noted a number of errors. These required to be corrected arithmetically and due to incorrect product pricing of recycled equipment.

- The purchase price for products bought a number of years ago could not always be verified to the actual invoice with a lack of suitable audit trails to track items back to date of purchase.

- No regular reviews are undertaken of equipment with regard to slow moving or obsolete stock. A yearly check of all equipment should be undertaken to make sure any equipment not issued for a defined period is assessed for consideration of write off.

- At the time of writing this report a new Stores Management System was about to go live. Internal Audit have received a brief overview of this system and have highlighted a number of concerns regarding the procedures for purchasing of stock, treatment of recyclable equipment, stock valuation etc. Management should consider these issues to ensure the new system fully addresses these and the other matters arising during the audit.

2. Introduction

Internal Audit at each financial year end verifies the stocks held by a number of services including roads and lighting, housing as well as Occupational Therapy. This work involves audit testing to ensure the accuracy of records and the physical verification of items held within each store.

3. Audit Scope

The purpose of the audit was to verify the accuracy of the final stock value for Occupational Therapy equipment held at the financial year end. Occupational Therapy Stock relates to aids and adaptations equipment that is issued to service users to help with daily tasks such as cooking, dressing and bathing.

4. Summary Assessment

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

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

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

System Assessment	Testing Assessment
Limited	Limited

5. Findings

The main issues raised for management consideration are:

5.1 Arithmetical errors were noted in the stock valuation spreadsheet submitted to Internal Audit for verification. In particular it was found that the spreadsheet contained numerous pricing errors relating to individual stock items that required to be corrected.

5.2 Errors were also noted in the valuation of recycled stock items. Examples were found where some recycled stock items had been brought back into stock at the original purchase price.

5.3 OT Stores equipment is not physically stored against a clearly marked product/ bin code. The physically storage of stock items should be held in a logical sequence, thus ensuring equipment can be more easily accessed, controlled and managed.

5.4 It was found that recyclable and new equipment are not stored separately. As currently there is a separation in the valuation of new and recyclable items, there should also be a clear physical separation between the two categories of stocks.

5.5 It was not possible to verify individual prices for equipment with an overall stock value of £20,000. This equipment related to purchases made before 2013. The valuation of any item of equipment should always be evidenced to the original purchase price.

.

5.6 No detailed procedure exists for the review of slow moving or obsolete stock. The £20,000 of stock previously identified had been purchased prior to 2013. This equipment should be reviewed and written off if no longer required. If any of these items are still suitable for re-issue a valuation from the supplying company should be obtained.

5.7` No regular stock takes are undertaken of the equipment stored within OT Stores during the year. Regular stock checks would ensure any variances between stock records and the equipment held can be investigated and resolved promptly and not left unresolved until the financial year end.

5.8 It was noted a new stores system is being introduced that should allow for greater control regarding the purchase, issue and management of the OT Stores. However prior to the system going live a number of key controls and principles need to be resolved e.g. unit stock valuation, treatment of recycled goods, management reports detailing stock valuation etc. .

6. Recommendations

Risk Ratings for Recommendations						
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Comments	Responsible Officer	Timescale for Implementation
Key Control: Effective systems exist for the correct valuation of Occupational Therapy Equipment						
5.1	Effective systems and procedures should exist to ensure accurate stock valuation reports.	High	Yes	Health and Social Care Moray have now implemented the ELMS2 System provided by Ethitec. The system will provided all stock valuation reports moving forward however the system will be reliant on data input. A CMP has been conducted and new infrastructure implemented in the Store, including the addition of a Store Person and appropriate administration staff.	Provider Services Manager	30/09/2018

Risk Ratings for Recommendations						
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Comments	Responsible Officer	Timescale for Implementation
5.2	Equipment should be physically stored against their clearly marked bin/ product code reference.	Medium	Yes	A barcoding system has been acquired as part of the implementation of ELMS2 and this will separately mark every item with a value of £15 or more. All stock will be clearly stored in an area where the product is clearly marked and accessible.	Independent Living Team Manager Store Person	31/08/2018 30/09/2018
5.3	New and recyclable equipment should be stored separately.	Medium	Yes	As a result of a CMP, a new management structure has been implemented. A new Store Person will be appointed and additional administration staff appointed.	Provider Services Manager	30/09/2018

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
				A cleaner driver post will also be implemented to ensure separation (mainly due to infection control) Protocols are being developed internally to ensure that all stock is stored appropriately. All stock will be clearly identifiable as part of the ELMS2 system.	Independent Living Team Manager	31/08/2018
5.4	Valuation of any item of equipment should be evidenced to the original purchase invoice.	High	Yes	Processes will be carried out throughout August (including a report to the Operational Management Team) to ensure that all items in the Store can be evidenced to the original	Provider Services Manager	30/09/2018

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
				purchase invoice. An exit strategy will be implemented if any items are found not to meet the basic criteria		
5.5	Procedures should be developed to ensure that all equipment is reviewed every year to ensure any obsolete equipment no longer required is destroyed or sold.	Medium	Yes	A process is being developed with the Health and Social Care Moray Operational Management Team. A protocol will be developed which the Store management will follow in order to ensure that no obsolete products are held at the Store. A protocol will be developed with the OT Budget Manager to identify when a product becomes obsolete.	Provider Services Manager Independent Living Team Manager	30/09/2018 31/08/2018

Risk Ratings for Recommendations						
High	Key controls absent, not being operated as designed or could be improved. Urgent attention required.	Medium	Less critically important controls absent, not being operated as designed or could be improved.		Low	Lower level controls absent, not being operated as designed or could be improved.
No.	Audit Recommendation	Priority	Accepted (Yes/ No)	Comments	Responsible Officer	Timescale for Implementation
5.6	Regular stock checks should be undertaken between stock records and the items held at OT Stores.	Medium	Yes	A pathway will be implemented in the Store to include regular stock checks. As of September 2018, stock checks will be implemented on a quarterly basis. Any issues or concerns will be addressed in July, October and January to ensure that the annual Stock Audit in March functions smoothly. The senior management group will manage risk/issues and a risk assessment and issues log will be implemented. This will be a key agenda item on the Independent Living Service Monthly	Independent Living Team Manager Provider Services Manager	31/08/2018 30/09/2018

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
				Meeting in July, October, January and April. Auditors will be invited to these meetings to ensure a healthy relationship and to allow any escalation of problems in an efficient manner.		
5.7	A number of key operating functions e.g. stock valuation report, need to be agreed regarding new Occupational Stores System.	High	Yes	The new system has just been implemented and a User Group continues to monitor and manage progress. The project lead will liaise with the Independent Living Service Manager to ensure clarity is provided in all functions of the new system.	Independent Living Team Manager	30/09/2018

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
				A report will go to the Infrastructure Board detailing the outcome once fully implemented.	Provider Services Manager	30/09/2018