MORAY INTEGRATION JOINT BOARD

AUDIT, PERFORMANCE AND RISK COMMITTEE

Thursday, 30 January 2020

Inkwell Main, Elgin Youth Café

NOTICE IS HEREBY GIVEN that a Meeting of the **Moray Integration Joint Board Audit, Performance and Risk Committee** is to be held in **Inkwell Main, Elgin Youth Café**, **Francis Place, Elgin, IV30 1LQ** on **Thursday, 30 January 2020** at **13:00** to consider the business noted below.

AGENDA

MORAY INTEGRATION JOINT BOARD

AUDIT, PERFORMANCE AND RISK COMMITTEE

MEMBERSHIP

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

NON-VOTING MEMBERS

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

ADVISORS

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

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

MINUTE OF MEETING OF THE MORAY INTEGRATION JOINT BOARD

AUDIT, PERFORMANCE AND RISK COMMITTEE

Thursday, 19 September 2019

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

PRESENT

Ms Tracey Abdy, Mrs Pam Dudek, Councillor Tim Eagle, Mr Sandy Riddell

APOLOGIES

Councillor Louise Laing, Mr Steven Lindsay, Councillor Dennis Robertson, Mr Atholl Scott

IN ATTENDANCE

Ms Jeanette Netherwood, Corporate Manager; Mr Dafydd Lewis, Senior Auditor, Moray Council (substituting for Mr Atholl Scott); Mr Brian Howarth, Audit Director, Audit Scotland; and Mrs Caroline Howie, Moray Council as clerk to the Board.

ALSO PRESENT

Councillor Shona Morrison (ex-officio)

1 Chair of Meeting

The meeting was chaired by Mr Sandy Riddell.

2 Declaration of Member's Interests

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

3 Order of Business

In terms of Standing Order 2.2 the Committee agreed to vary the order of business as set down on the Agenda and take Item 8 'External Auditors Report to Those Charged with Governance' and Item 9 '2018/19 Audited Annual Accounts' at this juncture to allow the Audit Director, Audit Scotland to leave the meeting at the earliest opportunity.

4 External Auditors Report to Those Charged with Governance

A report by the Chief Financial Officer invited Committee to consider the reports to those charged with governance from the Board's External Auditor for the year ended 31 March 2019.

During discussion it was stated that the Committee had an assurance role and that although there was a deficit the Committee was of the opinion that assurances had been given that work was underway to ensure transformation was taking place in an efficient and timely manner.

Thereafter the Committee agree to note the report and the reports from the External Auditor within appendices 1 and 2 of the report.

Councillor Morrison entered the meeting during discussion of this item.

5 2018/19 Audited Annual Accounts

Under reference to paragraph 16 of the Minute of the meeting of the Moray Integration Joint Board dated 27 June 2019 a report by the Chief Financial Officer presented the Audited Annual Accounts for the year ended 31 March 2019.

Following discussion the Committee agreed to approve the Audited Annual Accounts for the financial year 2018/19.

Thereafter Councillor Shona Morrison, Chair of Moray Integration Joint Board, Ms Pam Gowans, Chief Officer and Ms Tracey Abdy, Chief Financial Officer signed the paperwork to confirm the accounts were a true and accurate record.

Councillor Morrison and Mr Howarth left the meeting at this juncture.

6 Minute of Meeting dated 28 March 2019

The Minute of the meeting of the Moray Integration Joint Board Audit, Performance and Risk Committee dated 28 March 2019 was submitted and approved.

7 Action Log of Meeting dated 28 March 2019

The action log of the Moray Integration Joint Board Audit, Performance and Risk Committee dated 28 March 2019 was submitted and it was noted that all actions, apart from the following, had been completed:

Item 2 'Quarter 3 (October - December 2018) Performance Report' - it had not be

possible to provide a report on this occasion and the Committee agreed to defer this to the next meeting.

8 Minute of Meeting dated 25 July 2019

The Minute of the meeting of the Moray Integration Joint Board Audit, Performance and Risk Committee dated 25 July 2019 was submitted and approved.

9 Minute of Meeting dated 1 August 2019

The Minute of the meeting of the Moray Integration Joint Board Audit, Performance and Risk Committee dated 1 August 2019 was submitted and approved.

10 Action Log of meeting dated 1 August 2019

The action log of the Moray Integration Joint Board Audit, Performance and Risk Committee dated 1 August 2019 was submitted and it was noted that all actions had been completed.

11 Order of Business

In terms of Standing Order 2.2 the Board agreed to vary the order of business as set down on the Agenda and take Item 11 'Planned Internal Audit Work for 2019/20' and Item 12 'Strategic Risk Register - September 2019' at this juncture to allow additional time for the officer due to present Item 10 'Quarter 1 (April - June 2019) Performance Report' to arrive at the meeting.

12 Planned Internal Audit Work for 2019-20

A report by the Chief Internal Auditor provided Committee with information on the areas of work to be included in the Internal Audit plan for the remainder of the 2019/20 financial year.

Discussion took place on the work covered by the audits and how the policies and priorities of Moray Council Housing were integrated with the Moray Health and Social Care Partnership.

The Chief Officer advised discussions were planned for September to look strategically at how work would be undertaken to ensure appropriate governance.

Thereafter the Committee agreed to note the contents of the report and the outcomes and assurances expected from each of the selected project areas.

13 Strategic Risk Register - September 2019

Under reference to paragraph 6 of the draft Minute of the meeting dated 28 March 2019 a report by the Chief Officer provided an overview of the current strategic risks, along with a summary of actions which are in place to mitigate those risks, updated as at 1 September 2019.

Discussion took place on the work of the Health and Social Care Moray Resilience Group and it was stated the Group would be undertaking a review of the Business Continuity for the Primary Care contract.

Issues with recruitment and retention of personnel was discussed and the Committee agreed to seek a further report on this to a future meeting.

Thereafter the Committee agreed to:

i. note the updated Strategic Risk Register;

ii. note the action log; and

iii. seek a report to a future Committee on the issues with recruitment and retention of staff.

14 Quarter 1 (April - June 2019) Performance Report

A report by the Chief Financial Officer updated Committee on the performance of the Moray Integration Joint Board as at Quarter 1 (April - June 2019/20).

As the officer due to introduce the report had not arrived the Chief Officer advised she would be able to cover any queries and the Committee agreed to review the report.

The Number of Alcohol Brief Interventions being delivered and capacity of staff to undertake these was discussed.

It was stated that complaints can come in via either the NHS or Moray Council systems however if there were complex complaints that covered both areas these were dealt with by one person leading the investigation to ensure duplication of work was kept to a minimum.

Thereafter the Committee agreed to note the:

i. performance of local indicators for Quarter 1 (April - June 2019) as presented in the summary report at appendix 1 of the report; and

ii. detailed analysis of the local indicators that have been highlighted and actions being undertaken to address poor performance as contained within Section 5 of the report.

15 Delayed Discharges

Under reference to paragraph 5 of the Minute of the meeting dated 28 March 2019 a report by Sean Coady, Head of Service, informed Committee of Health and Social Care Moray (HSCM) performance in regard to Delayed Discharges and the action being undertaken to address the performance within that area.

Discussion took place on steps and solution that may be possible to impact and reduce the number of delayed discharges. It was stated that a focus group would be taking place during October and encouraging steps had already been taken.

During further discussion the Committee agreed a further report on the impact of changes would be beneficial and agreed to seek a report to the meeting scheduled for March 2020.

Thereafter the Committee agreed to note:

i. the performance of HSCM in regard to Delayed Discharges;

ii. the collated comments in appendix 1 of the report, from the workshop on 23 July 2019; and

iii. a progress report will be brought to the Committee on 26 March 2020.

16 Payment Verification Assurance Update

Under reference to paragraph 10 of the Minute of the meeting of 13 December 2018 a report by Sean Coady, Head of Service, provided an update on the review of the Payment Verification Assurance Service provided by National Services Scotland Practitioner Services Divisions, on behalf of NHS Grampian.

As the officer responsible for the report was not in attendance the Committee agreed to defer the report until the meeting scheduled for January 2020.

MEETING OF MORAY INTEGRATION JOINT BOARD

AUDIT, PERFORMANCE AND RISK COMMITTEE

THURSDAY 19 SEPTEMBER 2019

ACTION LOG

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY
1.	Action Log of Meeting dated 28 March 2019	Report on NHS staff sickness absence to be provided in January.	Jan 2020	T Abdy
2.	Strategic Risk Register – September 2019	Further report to be presented in relation to staff recruitment and retention.	Jan 2020	J Netherwood
3.	Delayed Discharges	Further report to be presented on the impact of work being undertaken to reduce delayed discharges.	Mar 2020	Sean Coady
4.	Payment Verification Assurance Update	Report deferred to January 2020.	Jan 2020	Sean Coady

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 30 JANUARY 2020**

SUBJECT: **QUARTER 2 (JULY – SEPTEMBER 2019) PERFORMANCE REPORT**

BY: **CHIEF FINANCIAL OFFICER**

1. REASON FOR REPORT

1.1 To update the Audit, Performance and Risk Committee on the performance of the Moray Integration Joint Board (MIJB) as at Quarter 2 (July – September 2019/20).

2. RECOMMENDATION

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

i) the performance of local indicators for Quarter 2 (July – September 2019) as presented in the summary report at APPENDIX 1; and

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

3. BACKGROUND

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

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

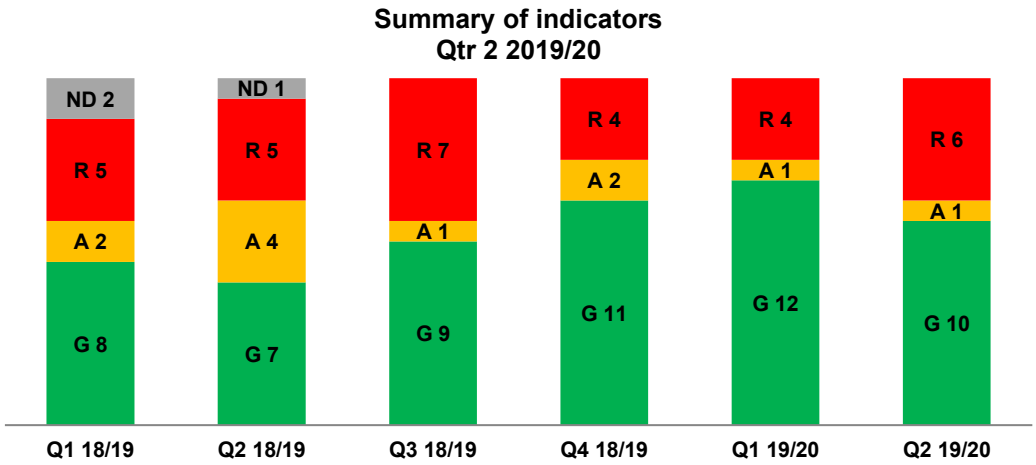
4. KEY MATTERS RELEVANT TO RECOMMENDATION

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

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

4.2 The performance indicators for quarter 2 is attached in **APPENDIX 1.** Moray has 17 local indicators. Ten of the indicators are green, 1 is amber and 6 indicators are showing as red.

Figure 1



4.3 The table below (Figure 2) gives a summary of the historical movement of the RAG status by indicator quarter 1 2018/19.

Figure 2 – RAG History

HSCM Indicator RAG over time									
ID.	**Indicator Description**	**PD***	**Q1 (Apr-Jun 18)**	**Q2 (Jul-Sep 18)**	**Q3 (Oct-Dec 18)**	**Q4 (Jan-Mar 19)**	**Q1 (Apr-Jun 19)**	**Q2 (Jul-Sept 19)**
L07	Rate of emergency occupied bed days for over 65s per 1000 population	▼	A▼	A▼	G▼	G▼	G▼	**G▼**
L08	Emergency Admissions rate per 1000 population for over 65s	▼	G▼	G▲	G▼	G▼	G▼	**G▲**
L09	Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population	▼	A▼	R▲	A -	A▼	G▼	**G -**
L10	Number of Bed Days Occupied by Delayed Discharges per quarter (inc code 9) per 1000 18+ population	▼	R▲	R▲	G▼	G▼	G▼	**G▼**
L11	Number of delayed discharges inc code 9 (Census snapshot, monthly average for quarter)	▼	R▲	G -	G▼	G▼	G▼	**G▼**
L12	A&E Attendance rates per 1000 population (All Ages)	▼	G▼	R▲	G▼	A▲	R▲	**A▲**
L13	A&E Percentage of people seen within 4 hours, within community hospitals	▲	G -	G -	G -	G -	G -	**G -**
L14	Percentage of new dementia diagnoses who receive 1 year post-diagnostic support	▲	ND	G - (2014/15)	G▼ (2015/16)	R▼ (2016/17)	G▲ (2017/18)	**G▲**
L15	Smoking cessation in 40% most deprived after 12 weeks	▲	R▼	G▲	R▼	G▲	G▲	**R▼**
L16	Percentage of clients receiving alcohol treatment within 3 weeks of referral	▲	G▲	G▼	G -	G -	G -	**G -**
L17	Percentage of clients receiving drug treatment within 3 weeks of referral	▲	G -	G▲	G -	G -	G -	**G -**
L18	Number of Alcohol Brief Interventions being delivered	▲	R▼	R	R▼	R▼	R▲	**R▲**
L19A	Number of complaints received and % responded to within 20 working days - NHS	▲	G▲	R▼	R▼	G▲	R▼	**R▲**
L19B	Number of complaints received and % responded to within 20 working days - Council	▲	ND	G -	G -	G -	G -	**R▼**
L20	NHS Sickness Absence % of Hours Lost	▼	R▼	R▼	R▲	G▼	G▲	**G▼**
L21	Council Sickness Absence (% of Calendar Days Lost)	▼	ND	ND	R▲	R▼	A▲	**R▲**
L41	Percentage of patients commencing Psychological Therapy Treatment within 18 weeks of referral	▲	G▲	G▼	R▼	R▼	R▼	**R▲**

* Positive Direction

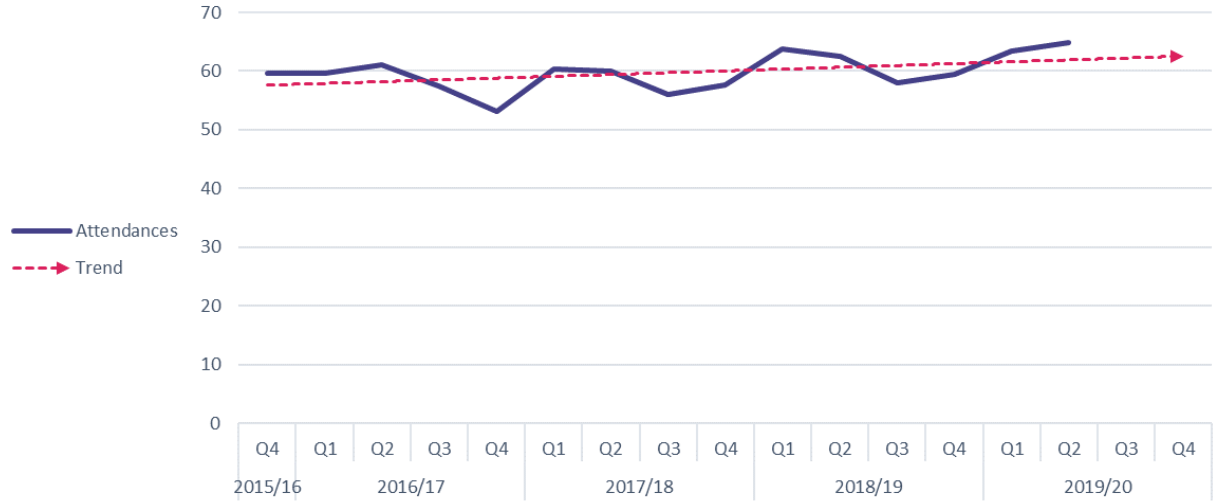
4.4 The target for L11 – Number of delayed discharges including code 9 was reduced from 35 to a more challenging 25 to be more in line with Scottish and comparator performance (for information Code 9 refers to those patients who are delayed for reasons beyond the control of the partnership such as awaiting the Guardianship process to complete, discharge to a specialist facility or for those who an interim move is not possible or appropriate).

4.5 **Section 5** provides exception reporting and supplementary information which explains the background to current performance and management action being undertaken to address the underlying issues.

5. PERFORMANCE ANALYSIS

5.1 **L12 - A&E Attendance rates per 1,000 population (All Ages)** – The attendance rate per 1,000 population was expected to decrease seasonally in Q2 however it has increased and has been increasing since Q3 2018/19. This continues an ongoing increasing trend over the last 3 years.

Figure 3 - A&E Attendance rates per 1000 population (All Ages)



5.1.1 Rates of A&E attendances are higher than would be expected and whilst this increase in attendances is affecting all ages it is particularly noticeable in the 35+ age group. Despite the increasing trend in A&E attendances there is, however, no change in the proportion of emergency admissions from A&E.

5.1.2 11% of attendances were recorded as inappropriate and were redirected. There is an encouraging downward trend in the number of attendances whose conditions are not true accidents or emergencies, but they still make up 21% of all attendances and the need to educate people of the help that can be provided by other professions such as pharmacies, opticians, dentists etc is subject to ongoing promotion by NHS Grampian through their “know who to turn to” communications..

5.1.3 While A&E attendances are increasing in real terms there has been little change in minor injuries however more are being classified as ‘major’ which suggests attendances are increasing in complexity. A High Intensity User (HIU) is someone who attends 5 times or more in a year and there is a particularly large concentration of HIUs in Elgin with all six intermediate zones having rates at or above the 90th Percentile. Two of those six have the highest rate of HIUs in Grampian with 7.7 per 1000 population. There is a strong association with proximity to A&E and people from less affluent areas.

5.2 **L15 - Smoking cessation in 40% most deprived after 12 weeks** – There is a general annual downturn in those accessing Smoking Advice Service in Moray. Aberdeen City, Aberdeenshire and the rest of Scotland follow the same pattern.

Figure 4 - Smoking cessation in 40% most deprived communities after 12 weeks

5.2.1 No specific reasons have been identified for Moray other than there is a reduction in the pool of smokers within the 40% most deprived communities and as a result there are fewer people to come to services. Of those that are left significant numbers are turning to e-cigarettes/vaping devices to help them quit and are not accessing services they traditionally might have.

5.2.2 To increase reach and provide a holistic, person centred approach, the healthpoint and Smoking Advice Service is merging, increasing the reach of smoking advisors in Moray and working alongside the range of support services available which include pharmacies. Advisors are available within the Community (based within GP practices, throughout Moray) and Dr Gray's Hospital, including: pre-assessment, Mental Health and Maternity services. This is a part of wider Partnership working that aims to further embed and sustain the Making every Opportunity Count (MeOC) approach within Health and Social Care and partner organisations. MeOC is a 3-tiered approach and provides practitioners with a range of flexible tools including a DIY MOT self-check, which provides a framework for practitioners to support clients to identify any health and wellbeing concerns they may have.

5.2.3 Once a need is identified practitioners can signpost clients to the most appropriate supporting service which includes smoking cessation. MeOC has been imbedded within Acute/Primary Care; the Community; the Third Sector and Local Authority.

5.2.4 There has been an increase in the number of Pharmacy clients on the national smoking cessation database appearing in the 4 week follow up column. To support community pharmacies a range of smoking cessation work has been undertaken by the Pharmacy and Medicines Directorate across Grampian; Moray input includes:

- Meetings with champions to discuss smoking cessation and the Grampian quit rates; including distribution of tobacco resources to community pharmacy teams.
- Delivery of smoking cessation training (20 attendees).
- Community Pharmacy's encouraged to sign up to Action on Smoking and Health (ASH) Charter.

- Pharmacy visits.
- Recruitment of public health practitioner (tobacco and pharmacy) until March 2020 to support smoking training and development within community pharmacies.

5.3 **L18 - Number of Alcohol Brief Interventions (ABI) being delivered** – In quarter 2 there were 171 ABIs delivered in Moray which is below the target of 259.

5.3.1 The Grampian Alcohol Screening and Brief Intervention Strategy was presented at the Moray Alcohol and Drug Partnership (MADP) and it was agreed that the local health improvement team would lead on developing an action plan. The team have substantially increased the number of staff available to do training. The increase reflects an increase in the numbers delivered in primary care and is reflective of the engagement strategy that has been adopted in Moray.

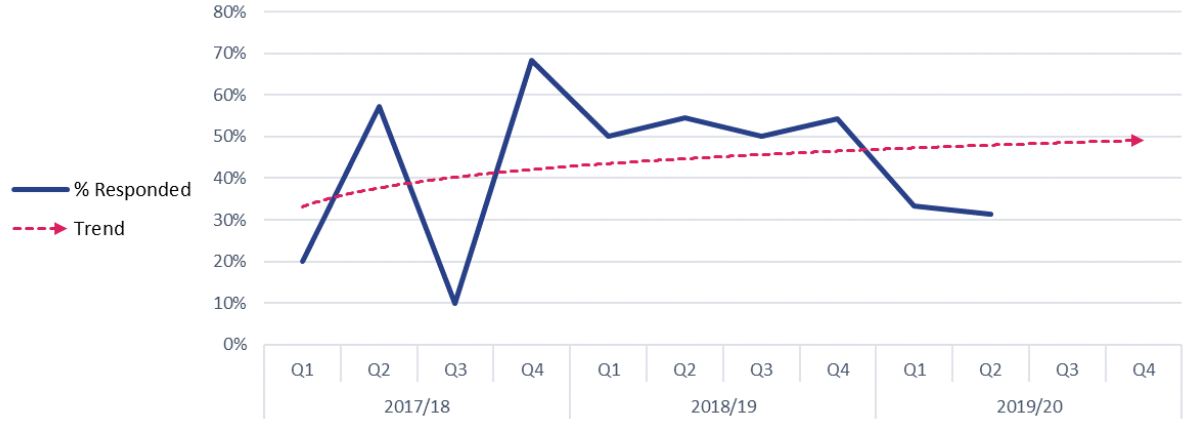
5.3.2 The 4 Area Public Health Co-ordinators (APHCs) have now all been trained in the delivery of ABI. Each of the APHCs are aligned to the 4 localities in Moray and continue to offer bespoke sessions to GP practice staff (including refreshers). Training is also promoted within the community to partner organisations. Two ABI training sessions were delivered in the quarter, one in Linkwood with 10 Participants and another at Moray coast with 10 participants. The participants included nurses, health care assistants, GP's and a Pharmacist.

5.3.3 An ABI Action Plan for Moray is being developed in line with the pan Grampian ABI strategy and is currently still in draft and expected to be signed off in early 2020.

5.4 **L19A Number of complaints received and % responded to within 20 working days - NHS** –During the last quarter, a total of **16** complaints were recorded within Datix.

5.4.1 On review of those taking longer than 20 days, it is apparent that this was due to the complexity of the complaint, with multi-disciplinary and more than one service being involved in the investigation. On two occasions the complaint had been assigned to the incorrect manager which incurred a delay in responding. Complainants had been notified of the extended time required for the investigation.

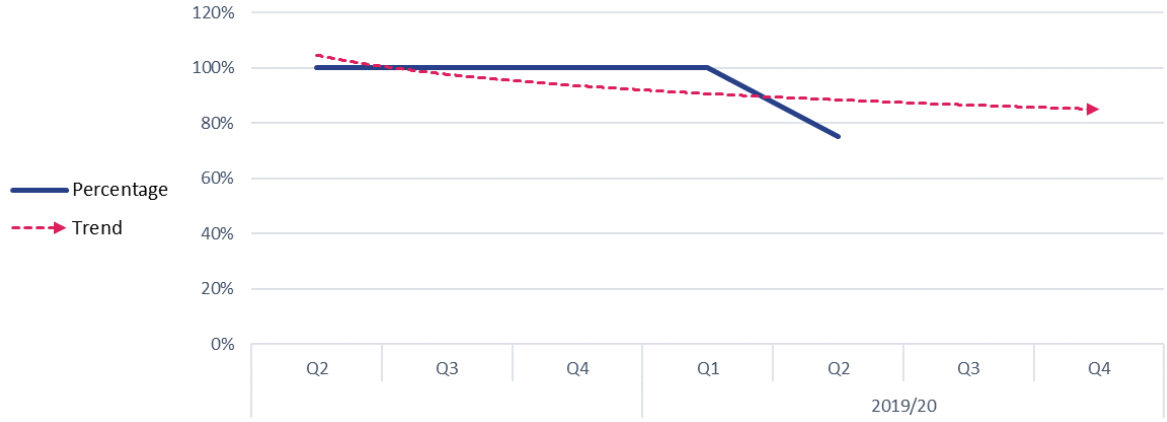
Figure 5 - Number of complaints received and % responded to within 20 working days - NHS



5.5 **L19B Number of complaints received and % responded to within 20 working days - Council** – This has consistently been at 100% for the previous 3 quarters but is now at 75% with 2 out of 8 complaints taking longer than 20 days to respond to: One due to the complexity of the case and the other as due to a management vacancy that has now been addressed. Learning outcomes have been noted from these complaints and actions are underway to mitigate similar future incidents. Detailed analysis of the complaints is reported to the Clinical and Care Governance Committee of the Moray IJB.

5.6 **L21 - Council Sickness Absence (% of Calendar Days Lost)** – Council sickness absence has not improved since commencement of recording this measure. Against the generic Council target of 5.9% this measure has consistently presented at around 8% and in quarter 2 is at its highest level of 8.8%.

Figure 6 - Council Sickness Absence (% of Calendar Days Lost)



5.6.1 Due to the changes in organisation structure there is some work to be undertaken to realign the data from Moray council systems. This will need to be addressed before further analysis per department can be made.

5.6.2 Of the total absences 37% of the days lost were from short term absences however the majority 63% were from long term absences.

5.6.3 Provider Services have experienced a high level of sickness absence and have investigated in more detail as they record absence of Care workers on their Staffplan system. Their recorded average rate of absence across the four main Provider Services departments was 8.9% for the quarter. This is split as follows:

- Short Term Assessment and Reablement Team – 7.5%
- Care at Home – 5.6%
- Day Services – 12.5%
- Challenging and Complex Needs – 10%

5.6.4 This information is being used operationally within Provider Services to:

- Evaluate operational capacity and efficiency
- Logistical planning of resources (workforce)
- Forecasting and future planning in supporting staff

5.7 **L41 – Percentage of patients commencing Psychological Therapy Treatment within 18 weeks of referral** – The adult mental health psychology team have now recruited to a 1.0 whole time equivalent (wte) clinical psychologist and are in the process of confirming a start date. Given the length of time this vacancy has been carried, there are a significant number of people waiting to be seen, which has been identified as a risk for the service. Long term sickness has had an impact on primary care psychology service. There is uncertainty around government funding for the service which is due to end March 2020. At present, there is no indication that any additional funding will be made available beyond that so a decision was made to close the waiting.

5.7.1 Referrals into secondary care are being reviewed and active management of waiting lists is taking place. The primary care service has closed their waiting lists meantime until the position on funding is clarified. The withdrawal of admin support to the psychological primary care team has resulted in inaccurate data reporting as clinical staff are having to prioritise seeing patients over data entry. Psychotherapy has continued to adhere to the 18 week target for seeing patients.

6. SUMMARY OF IMPLICATIONS

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

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

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

(b) Policy and Legal

None directly associated with this report.

(c) Financial implications

None directly associated with this report.

(d) Risk Implications and Mitigation

None directly associated with this report.

(e) Staffing Implications

None directly associated with this report.

(f) Property

None directly associated with this report.

(g) Equalities/Socio Economic Impact

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

(h) Consultations

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

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

7. CONCLUSION

7.1 This report requests the Audit, Performance and Risk Committee comment on performance of local indicators and actions summarised in Section 5.

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

Moray Health and Social Care Partnership: Performance at a Glance Quarter 2 (July to Sept 2019)
Local Indicators

Appendix 1

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

ID.	Indicator Description	Source	Q2 (Jul-Sep 18)	Q3 (Oct-Dec 18)	Q4 (Jan-Mar 19)	Q1 (Apr-Jun 19)	Q2 (Jul-Sep 19)	Target	RAG Status
L07	Rate of emergency occupied bed days for over 65s per 1000 population	NHS	2375	2344	2274	2117	**2097**	2360	G▼
L08	Emergency Admissions rate per 1000 population for over 65s	NHS - PMS	189	187	182	177	**179**	193	G▲
L09	Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population	NHS - PMS	130	130	127	123	**123**	125	G -
L10	Number of Bed Days Occupied by Delayed Discharges per quarter (inc code 9) per 1000 18+ population	NHS	45	41	37	31	**26**	-	G▼
L11	Number of delayed discharges inc code 9 (Census snapshot, monthly average for quarter)	NHS	39	35	32	26	**23**	25*	G▼
L12	A&E Attendance rates per 1000 population (All Ages)	NHS	62.6	58.0	59.4	63.5	**64.9**	-	A▲
L13	A&E Percentage of people seen within 4 hours, within community hospitals	NHS	100.0% (681)	100.0% (564)	100% (563)	100% (647)	**100% (673)**	98%	G -
L14	Percentage of new dementia diagnoses who receive 1 year post-diagnostic support	ISD	Reported Annually	94.9% (2014/15)	90.7% (2015/16)	66.7% (2016/17)	**96.5% (2017/18)**	70%	G▲
L15	Smoking cessation in 40% most deprived after 12 weeks	NHS	20	30	34	23	**Q1 is most recent this is always a qtr behind**	-	R▼
L16	Percentage of clients receiving alcohol treatment within 3 weeks of referral	NHS	100%	100.0%	100.0%	100.0%	**100.0%**	90%	G -
L17	Percentage of clients receiving drug treatment within 3 weeks of referral	NHS	100%	100%	100.0%	100.0%	**100.0%**	90%	G -
L18	Number of Alcohol Brief Interventions being delivered (includes ABIs in priority and wider settings where data can be aligned to HSCP)	NHS	221	166	125	136	**171**	259	R▲
L19A	Number of complaints received and % responded to within 20 working days - NHS	NHS	54.5% (11)	50.0% (18)	54.2% (24)	33% (12)	**31% (16)**	-	R▲
L19B	Number of complaints received and % responded to within 20 working days - Council	SW	100% (6)	100% (6)	100% (3)	100% (5)	**75% (8)**	-	R▼

ID.	Indicator Description	Source	Q2 (Jul-Sep 18)	Q3 (Oct-Dec 18)	Q4 (Jan-Mar 19)	Q1 (Apr-Jun 19)	**Q2 (Jul-Sep 19)**	Target	RAG Status
L20	NHS Sickness Absence % of Hours Lost	NHS	4.6%	4.7%	3.8%	3.9%	**3.8%**	4.0%	G▼
L21	Council Sickness Absence (% of Calendar Days Lost)	SW	8.1%	8.3%	7.4%	7.7%	**8.8%**	5.9%	R▲
L41	Percentage of patients commencing Psychological Therapy Treatment within 18 weeks of referral	NHS	100.0%	80.0%	78.0%	73.0%	**78.0%**	90%	R▲

*** Target adjusted down from 35 to 25**

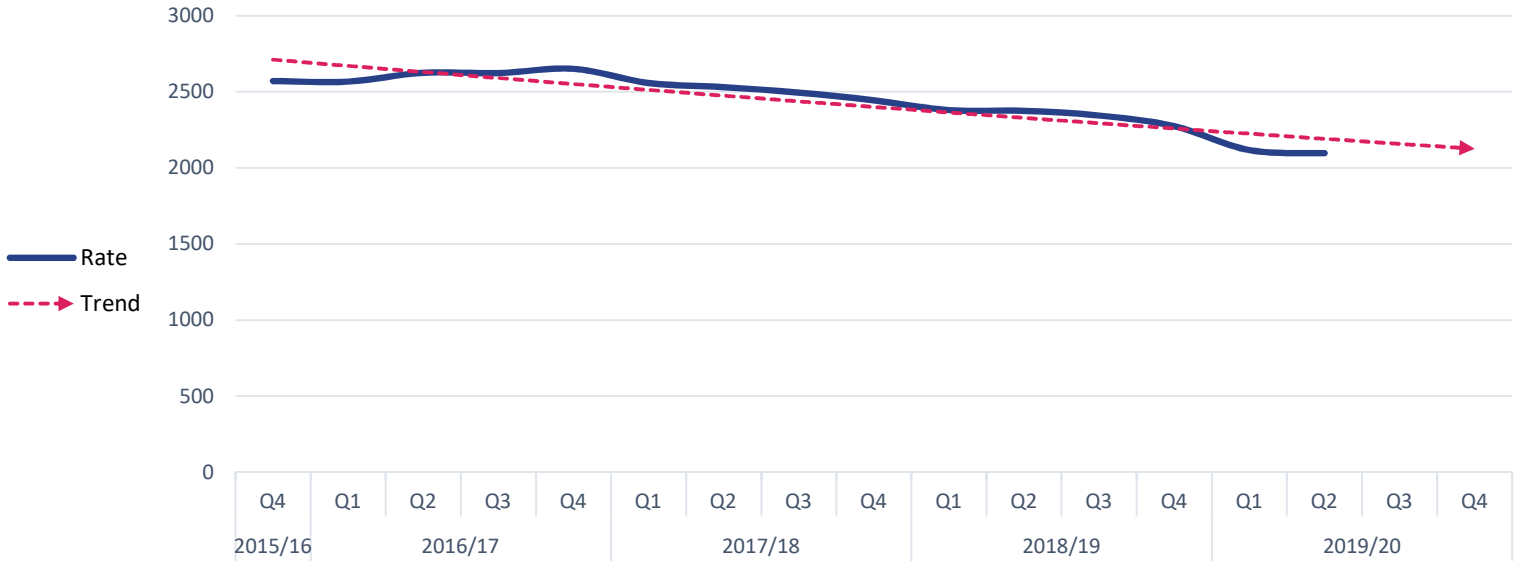
HSCM Indicator RAG over time

ID.	Indicator Description	EPD*	Q1 (Apr-Jun 18)	Q2 (Jul-Sep 18)	Q3 (Oct-Dec 18)	Q4 (Jan-Mar 19)	Q1 (Apr-Jun 19)	Q2 (Jul-Sept 19)
L07	Rate of emergency occupied bed days for over 65s per 1000 population	▼	A▼	A▼	G▼	G▼	G▼	G▼
L08	Emergency Admissions rate per 1000 population for over 65s	▼	G▼	G▲	G▼	G▼	G▼	G▲
L09	Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population	▼	A▼	R▲	A -	A▼	G▼	G -
L10	Number of Bed Days Occupied by Delayed Discharges per quarter (inc code 9) per 1000 18+ population	▼	R▲	R▲	G▼	G▼	G▼	G▼
L11	Number of delayed discharges inc code 9 (Census snapshot, monthly average for quarter)	▼	R▲	G -	G▼	G▼	G▼	G▼
L12	A&E Attendance rates per 1000 population (All Ages)	▼	G▼	R▲	G▼	A▲	R▲	A▲
L13	A&E Percentage of people seen within 4 hours, within community hospitals	▲	G -	G -	G -	G -	G -	G -
L14	Percentage of new dementia diagnoses who receive 1 year post-diagnostic support	▲	ND	G - (2014/15)	G▼ (2015/16)	R▼ (2016/17)	G▲ (2017/18)	G▲
L15	Smoking cessation in 40% most deprived after 12 weeks	▲	R▼	G▲	R▼	G▲	G▲	R▼
L16	Percentage of clients receiving alcohol treatment within 3 weeks of referral	▲	G▲	G▼	G -	G -	G -	G -
L17	Percentage of clients receiving drug treatment within 3 weeks of referral	▲	G -	G▲	G -	G -	G -	G -
L18	Number of Alcohol Brief Interventions being delivered	▲	R▼	R	R▼	R▼	R▲	R▲
L19A	Number of complaints received and % responded to within 20 working days - NHS	▲	G▲	R▼	R▼	G▲	R▼	R▲
L19B	Number of complaints received and % responded to within 20 working days - Council	▲	ND	G -	G -	G -	G -	R▼
L20	NHS Sickness Absence % of Hours Lost	▼	R▼	R▼	R▲	G▼	G▲	G▼
L21	Council Sickness Absence (% of Calendar Days Lost)	▼	ND	ND	R▲	R▼	A▲	R▲
L41	Percentage of patients commencing Psychological Therapy Treatment within 18 weeks of referral	▲	G▲	G▼	R▼	R▼	R▼	R▲

* Expected Positive Direction

L07 **Rate of emergency occupied bed days for over 65s per 1000 population**

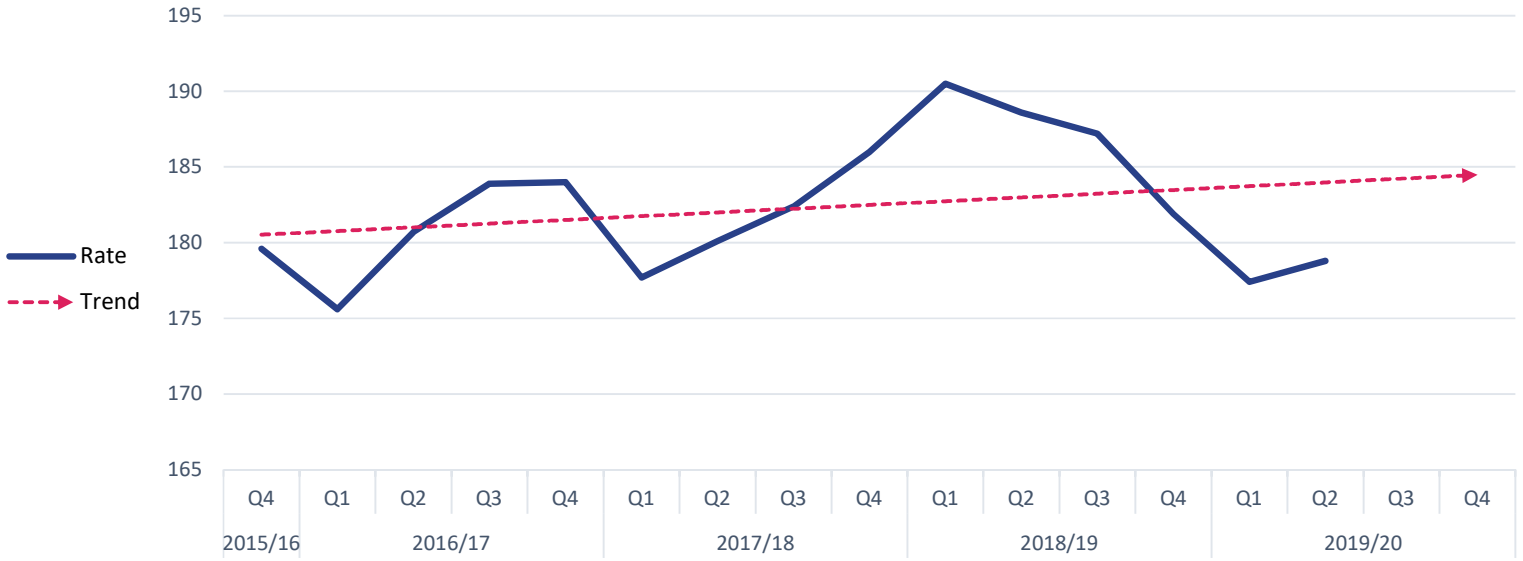
Financial Year		▼
2015/16	Q4	2571
2016/17	Q1	2567
	Q2	2625
	Q3	2623
	Q4	2651
2017/18	Q1	2558
	Q2	2531
	Q3	2495
	Q4	2444
2018/19	Q1	2380
	Q2	2375
	Q3	2344
	Q4	2274
2019/20	Q1	2117
	Q2	2097
	Q3	
	Q4	



There has been a steady reduction in this measure over the past 2 years and this looks to continue on into the forseeable future.

L08 Emergency Admissions rate per 1000 population for over 65s

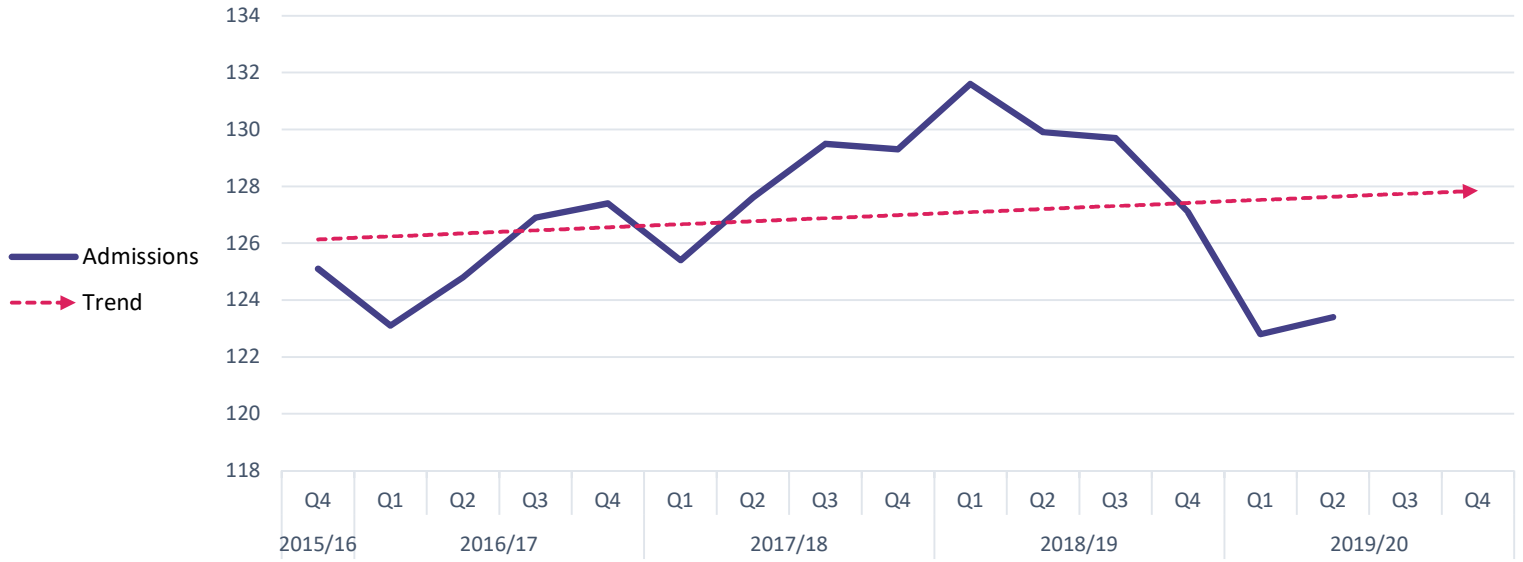
Financial Year		▼
2015/16	Q4	179.6
2016/17	Q1	175.6
	Q2	180.7
	Q3	183.9
	Q4	184.0
2017/18	Q1	177.7
	Q2	180.1
	Q3	182.4
	Q4	186.0
2018/19	Q1	190.5
	Q2	188.6
	Q3	187.2
	Q4	181.9
2019/20	Q1	177.4
	Q2	178.8
	Q3	
	Q4	



While there is an increasing trend in this measure there was a dip in Q1 2019/20 and while the Q2 performance has had an increase it is still lower than any quarter before Q1 in 2 years.

L09 **Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population**

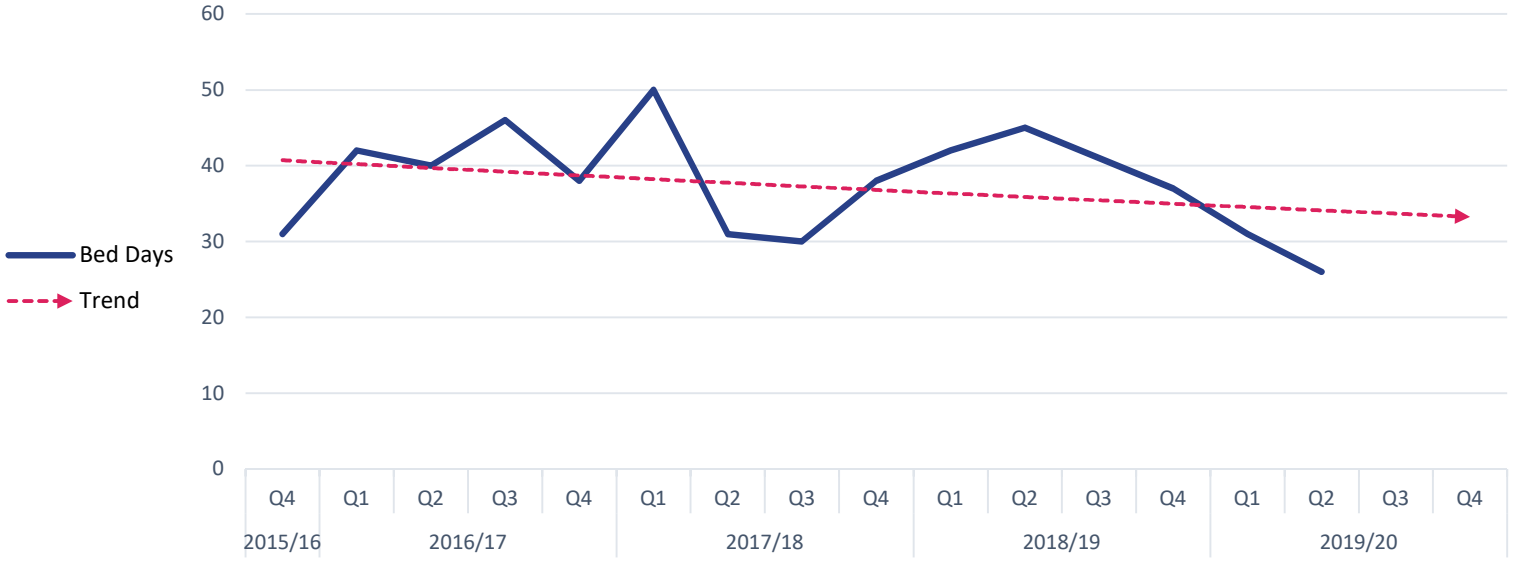
Financial Year		▼
2015/16	Q4	125.1
2016/17	Q1	123.1
	Q2	124.8
	Q3	126.9
	Q4	127.4
2017/18	Q1	125.4
	Q2	127.6
	Q3	129.5
	Q4	129.3
2018/19	Q1	131.6
	Q2	129.9
	Q3	129.7
	Q4	127.1
2019/20	Q1	122.8
	Q2	123.4
	Q3	
	Q4	



While Q1 was the lowest rate per 1,000 in over 3 years there has been a small increase in this measure in Q2. This increase is expected seasonally and the rate is still very much lower than those going back to 2016/17.

L10 Number of Bed Days Occupied by Delayed Discharges per quarter (inc code 9) per 1000 18+ population

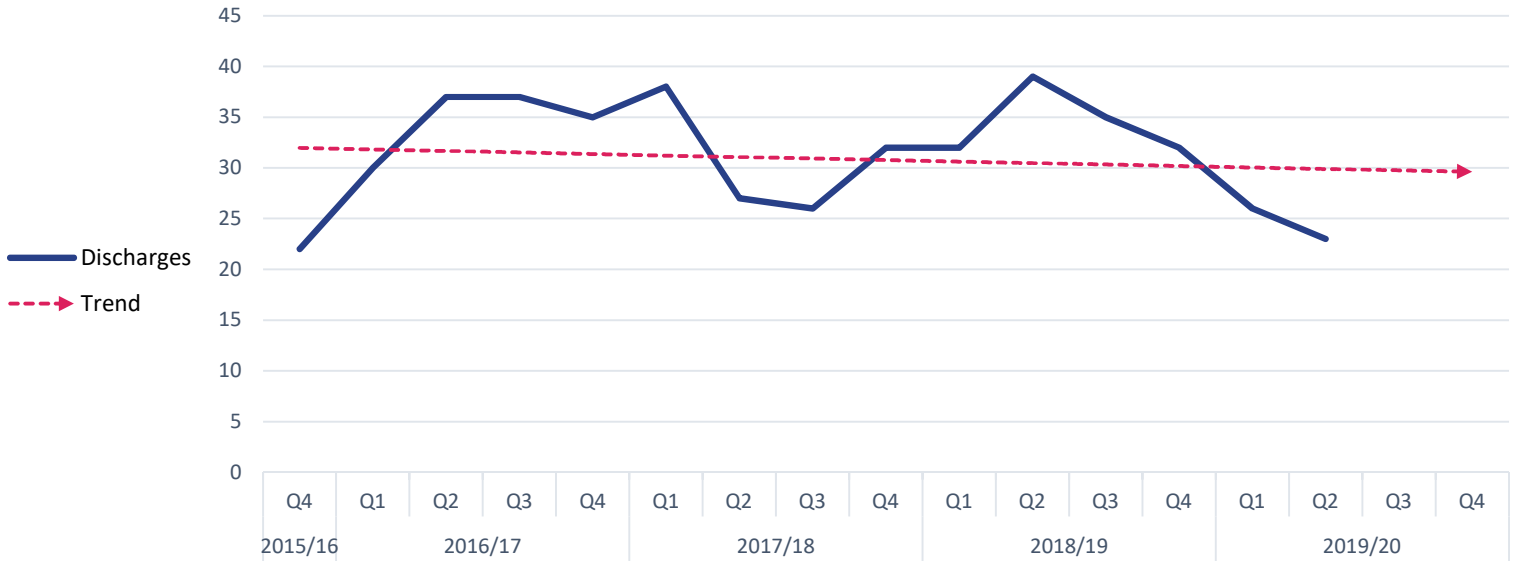
Financial Year		▼
2015/16	Q4	31
2016/17	Q1	42
	Q2	40
	Q3	46
	Q4	38
2017/18	Q1	50
	Q2	31
	Q3	30
	Q4	38
2018/19	Q1	42
	Q2	45
	Q3	41
	Q4	37
2019/20	Q1	31
	Q2	26
	Q3	
	Q4	



There has been a steady reduction in this measure over the past 2 years with Q2 Bed Days Occupied by Delayed Discharge now at its lowest level in 4 years.

L11 Number of delayed discharges inc code 9 (Census snapshot, monthly average for quarter)

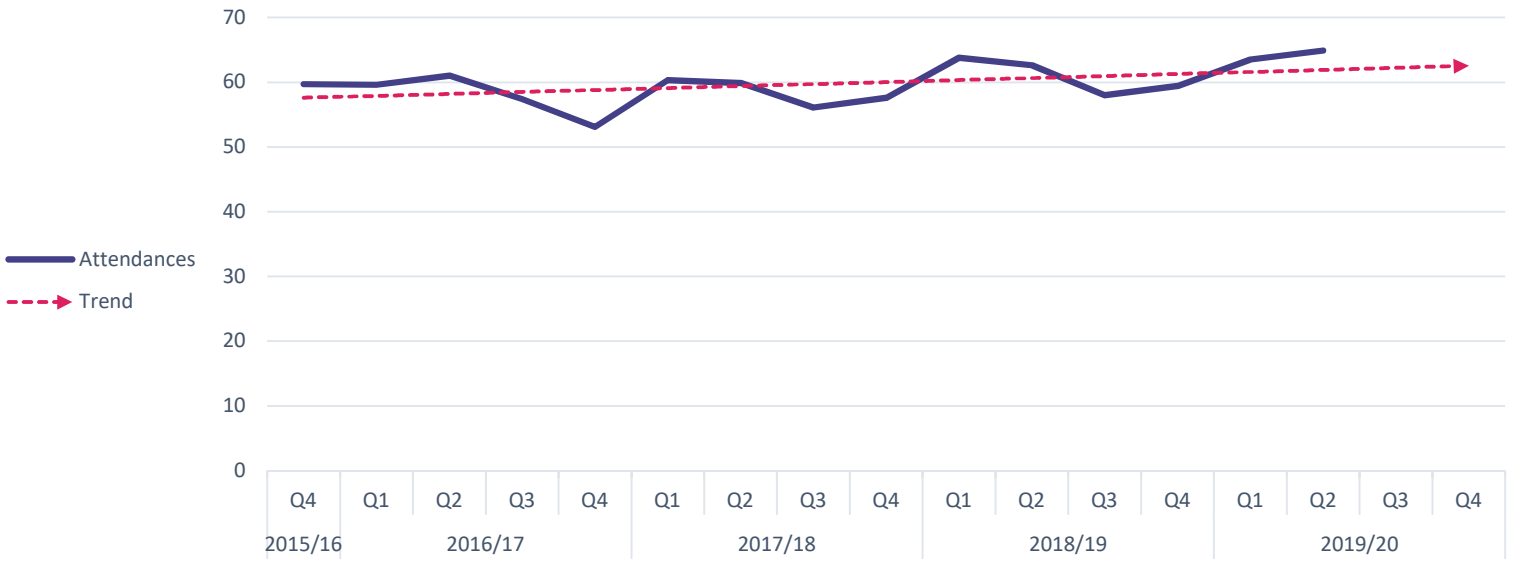
Financial Year		▼
2015/16	Q4	22
2016/17	Q1	30
	Q2	37
	Q3	37
	Q4	35
2017/18	Q1	38
	Q2	27
	Q3	26
	Q4	32
2018/19	Q1	32
	Q2	39
	Q3	35
	Q4	32
2019/20	Q1	26
	Q2	23
	Q3	
	Q4	



There has now been improvement in this measure over the last 5 quarters which is encouraging. The focus on now keeping this measure low.

L12 A&E Attendance rates per 1000 population (All Ages)

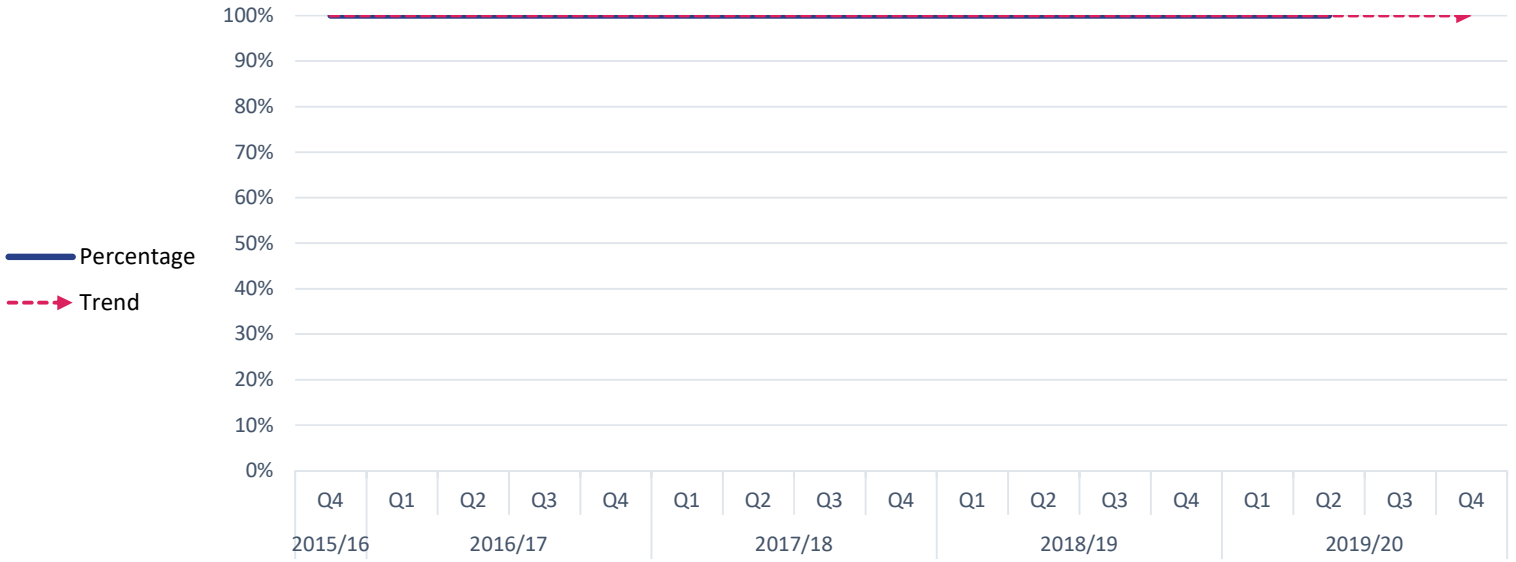
Financial Year		▼
2015/16	Q4	59.7
2016/17	Q1	59.6
	Q2	61.0
	Q3	57.4
	Q4	53.1
2017/18	Q1	60.3
	Q2	59.9
	Q3	56.1
	Q4	57.6
2018/19	Q1	63.8
	Q2	62.6
	Q3	58.0
	Q4	59.4
2019/20	Q1	63.5
	Q2	64.9
	Q3	
	Q4	



The increasing trend in this measure continues. This is discussed in Section 5.1 of the main report.

L13 **A&E Percentage of people seen within 4 hours, within community hospitals**

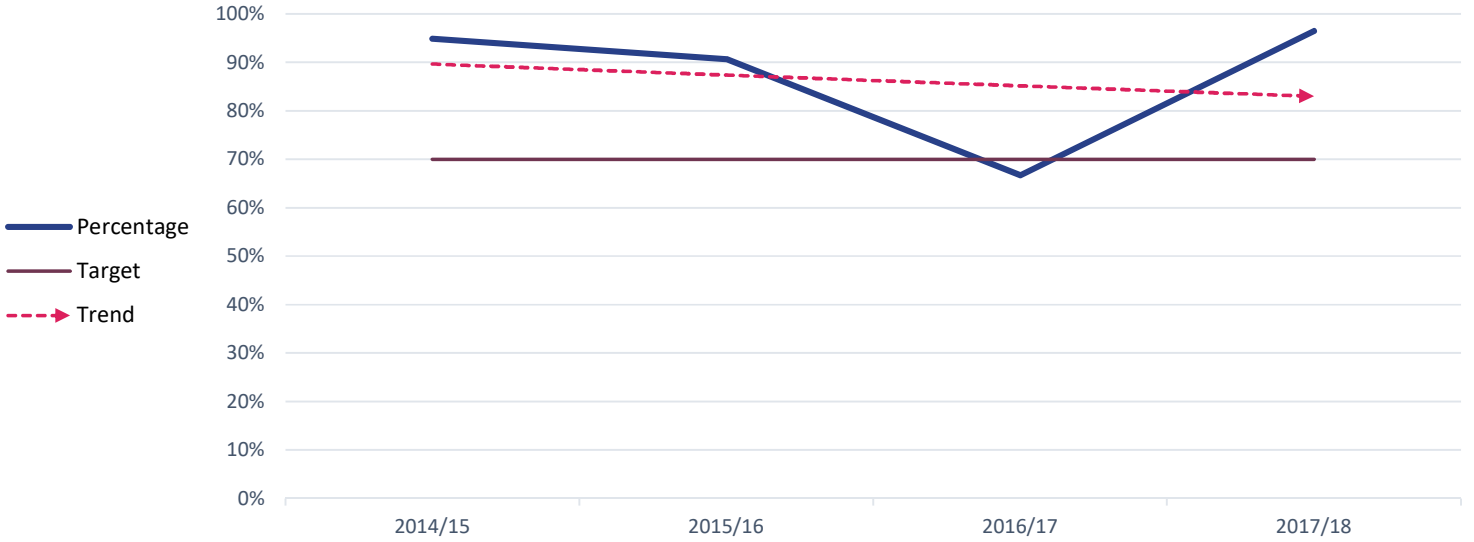
Financial Year		▲
2015/16	Q4	100.0%
2016/17	Q1	100.0%
	Q2	100.0%
	Q3	100.0%
	Q4	100.0%
2017/18	Q1	100.0%
	Q2	100.0%
	Q3	100.0%
	Q4	100.0%
2018/19	Q1	100.0%
	Q2	100.0%
	Q3	100.0%
	Q4	100.0%
2019/20	Q1	100.0%
	Q2	100.0%
	Q3	
	Q4	



This measure is consistently 100%

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

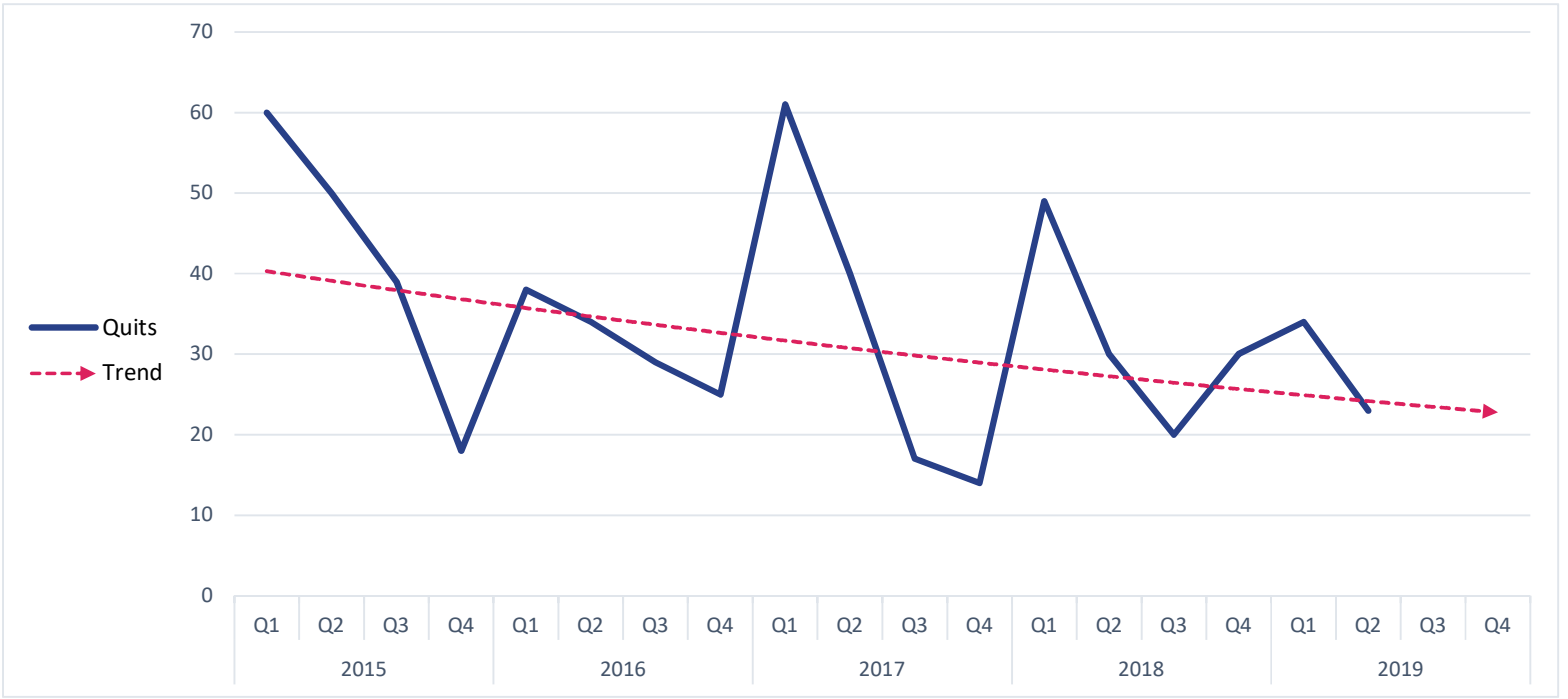
Financial Year	▲	Target
2014/15	94.9%	70%
2015/16	90.7%	70%
2016/17	66.7%	70%
2017/18	96.5%	70%



This measure is a yearly one and while there was a significant dip in performance in 2016/17 the latest figure is now well above target again.

L15 Smoking cessation in 40% most deprived after 12 weeks

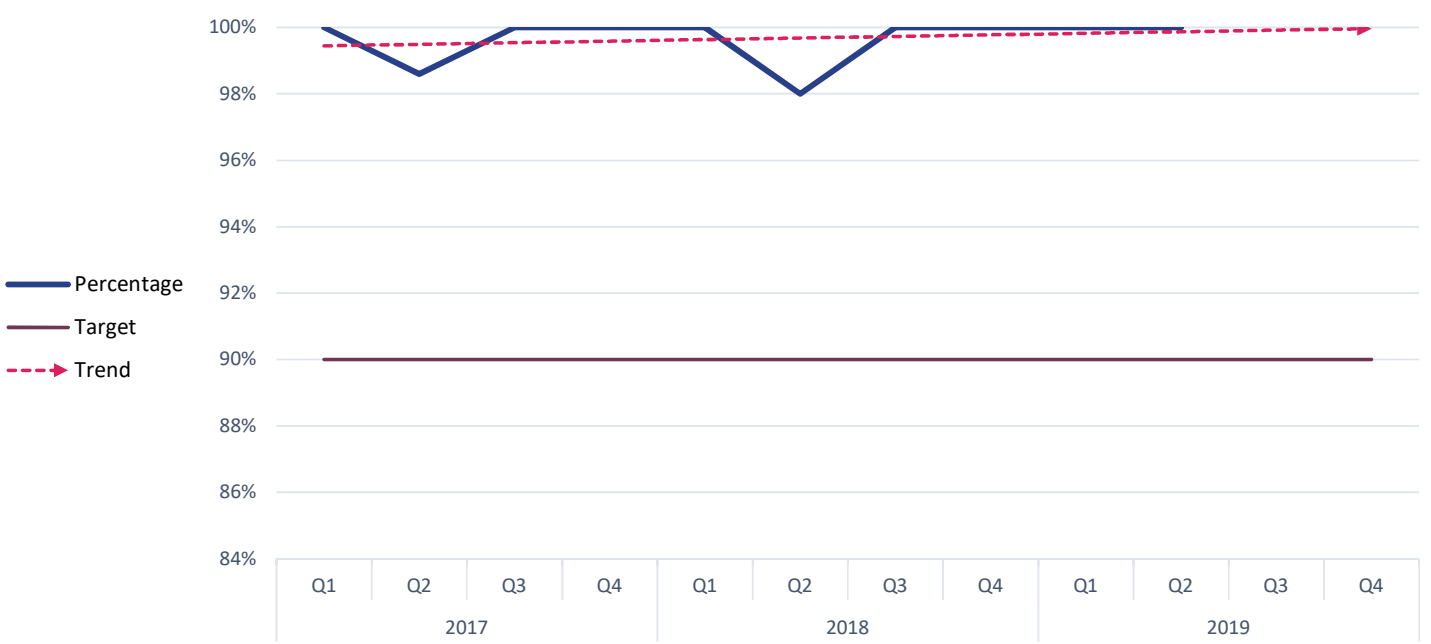
Calendar Year		▲
2015	Q1	60
	Q2	50
	Q3	39
	Q4	18
2016	Q1	38
	Q2	34
	Q3	29
	Q4	25
2017	Q1	61
	Q2	40
	Q3	17
	Q4	14
2018	Q1	49
	Q2	30
	Q3	20
	Q4	30
2019	Q1	34
	Q2	23
	Q3	
	Q4	



While the long term trend is a decreasing one. Q1 2019 was significantly lower than Q1 in all previous years and Q2 is similarly below previous years. See Section 5.2 for further analysis and commentary.

L16 **Percentage of clients receiving alcohol treatment within 3 weeks of referral**

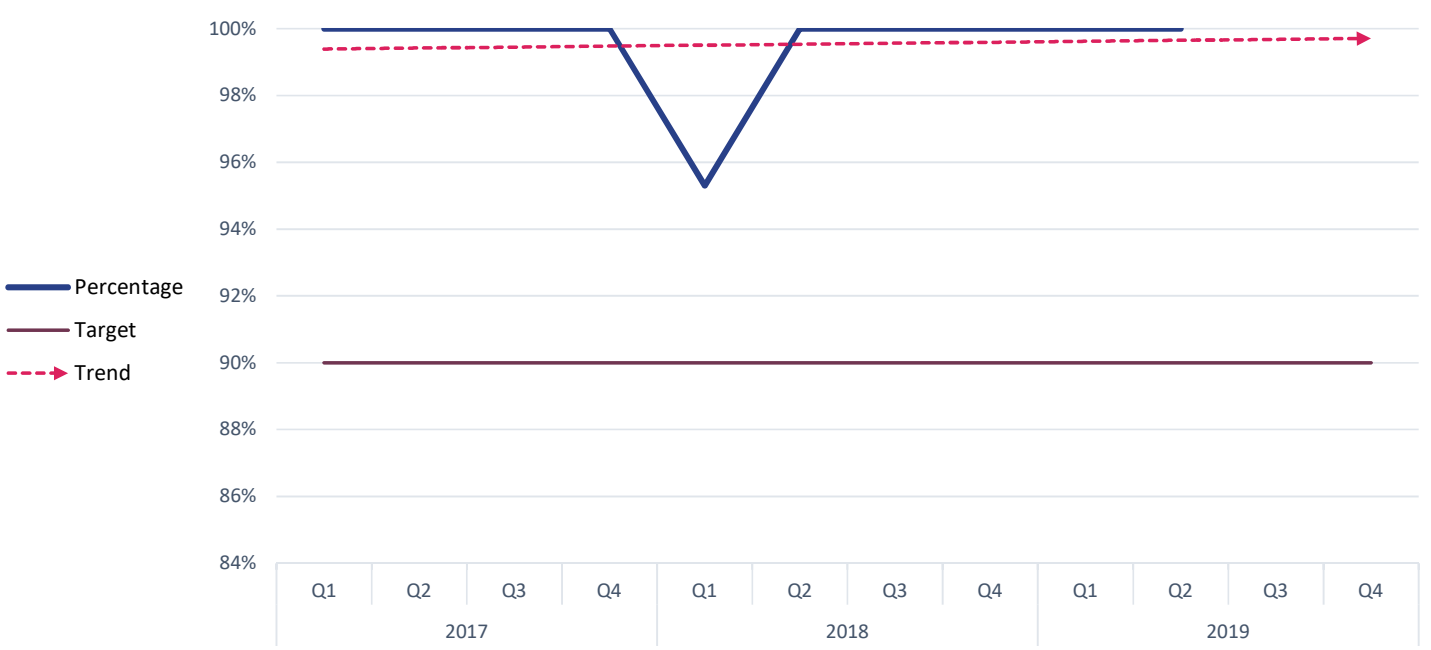
Calendar Year		▲	Target
2015	Q1		
	Q2		
	Q3		
	Q4		
2016	Q1		
	Q2		
	Q3		
	Q4		
2017	Q1	100.0%	90%
	Q2	98.6%	90%
	Q3	100.0%	90%
	Q4	100.0%	90%
2018	Q1	100.0%	90%
	Q2	98.0%	90%
	Q3	100.0%	90%
	Q4	100.0%	90%
2019	Q1	100.0%	90%
	Q2	100.0%	90%
	Q3		90%
	Q4		90%



The latest Quarter reported for this measure is the 4th time it has hit 100% in a row. This is well above the target of 90%.

L17 **Percentage of clients receiving drug treatment within 3 weeks of referral**

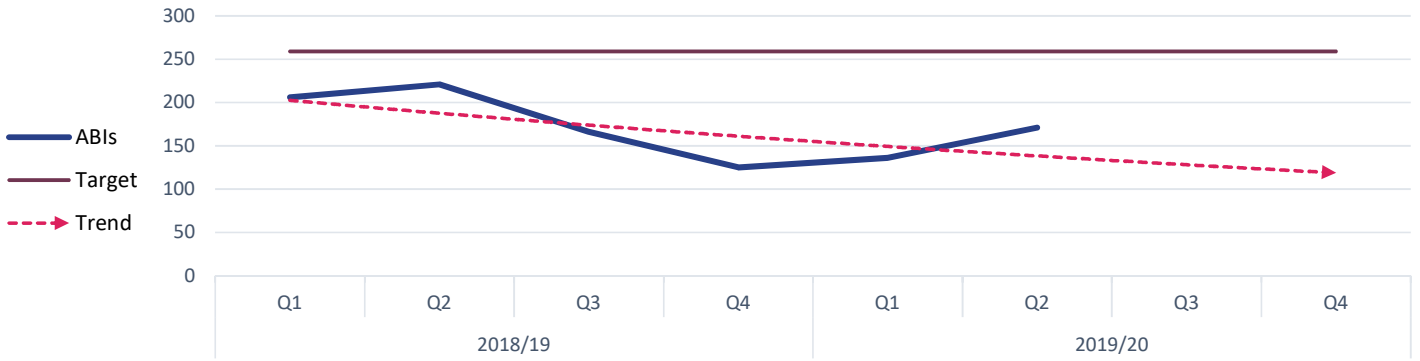
Calendar Year		▲	Target
2015	Q1		
	Q2		
	Q3		
	Q4		
2016	Q1		
	Q2		
	Q3		
	Q4		
2017	Q1	100.0%	90%
	Q2	100.0%	90%
	Q3	100.0%	90%
	Q4	100.0%	90%
2018	Q1	95.3%	90%
	Q2	100.0%	90%
	Q3	100.0%	90%
	Q4	100.0%	90%
2019	Q1	100.0%	90%
	Q2	100.0%	90%
	Q3		90%
	Q4		90%



This measure is consistently 100% and has only dipped once in the last 3 years. In that dip is was 95.3% which was still above the target of 90%.

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

Financial Year		▲	Target
2017/18*	Q1	66	
	Q2	59	
	Q3	106	
	Q4	142	
2018/19	Q1	206	259
	Q2	221	259
	Q3	166	259
	Q4	125	259
2019/20	Q1	136	259
	Q2	171	259
	Q3		259
	Q4		259

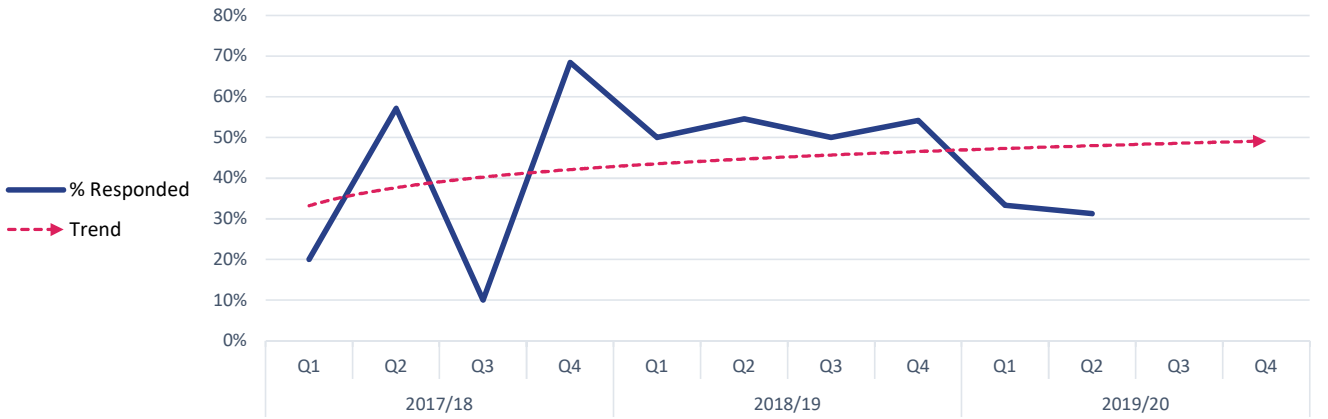


Despite the long term trend showing a reduction in the number of ABIs being delivered in Moray Q1 and Q2 are the first two quarters to have a Q on Q increase. See 5.3 for further analysis and commentary.

* Prior to 2018/19 only ABIs done in GP practices were recorded at partnership level, therefore previous years are not comparable

L19a **Number of complaints received and % responded to within 20 working days - NHS**

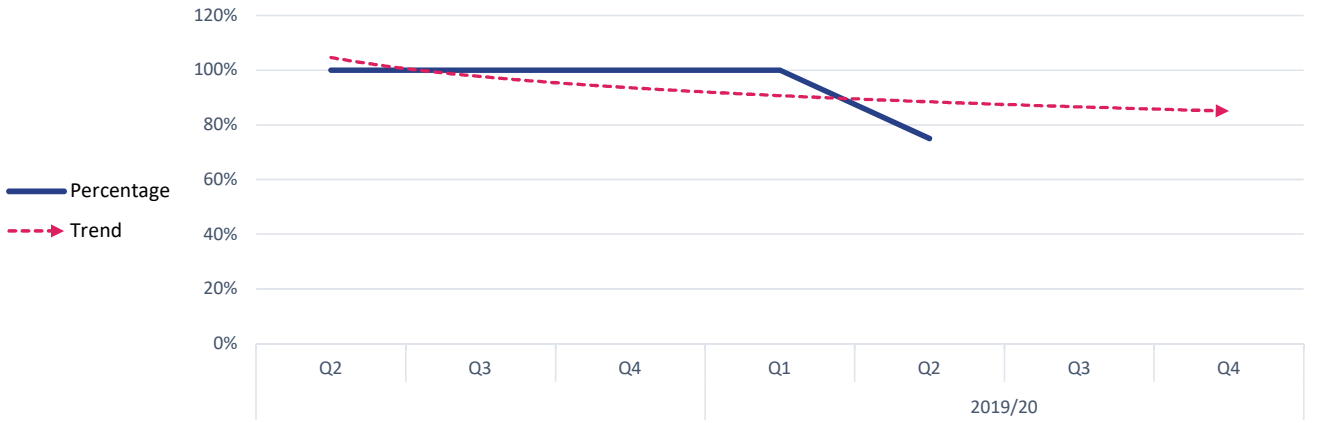
Financial Year	▲	Total number	Done in 20 days	
2017/18	Q1	10	2	20.0%
	Q2	14	8	57.1%
	Q3	10	1	10.0%
	Q4	19	13	68.4%
2018/19	Q1	8	4	50.0%
	Q2	11	6	54.5%
	Q3	18	9	50.0%
	Q4	24	13	54.2%
2019/20	Q1	12	4	33.3%
	Q2	16	5	31.3%
	Q3			
	Q4			



Despite an increasing trend there was a significant drop in performance in this measure in Q1 and this continues in Q2. See 5.4 for further analysis and commentary.

L19a **Number of complaints received and % responded to within 20 working days - NHS**

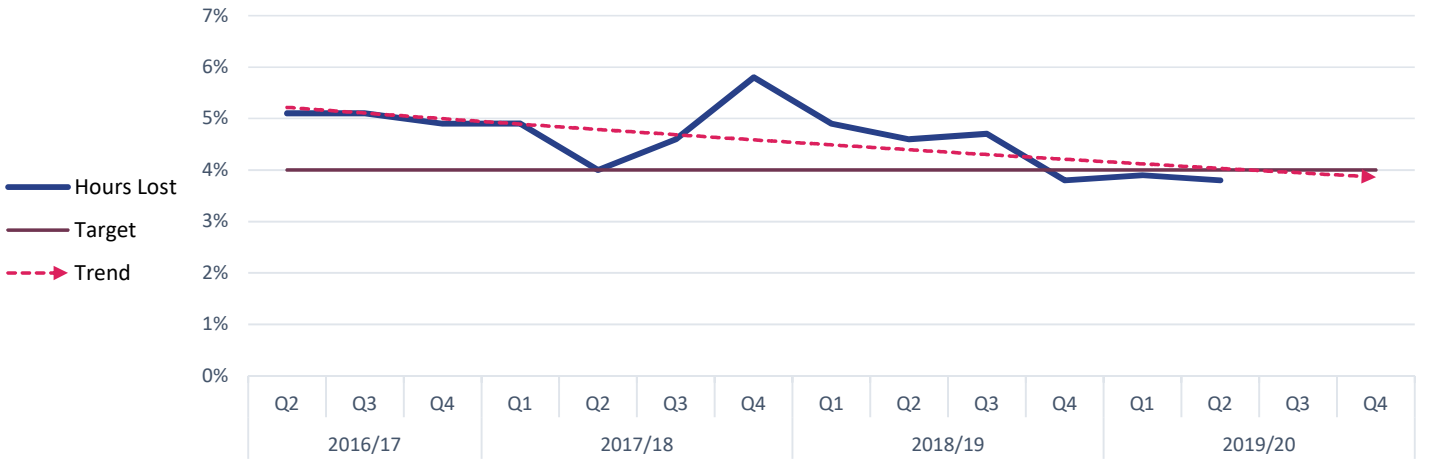
Financial Year	▲	Total number	Done in 20 days	
2017/18				
2018/19				
	Q2	6	6	100.0%
	Q3	6	6	100.0%
	Q4	3	3	100.0%
2019/20	Q1	5	5	100.0%
	Q2	8	6	75.0%
	Q3			
	Q4			



Despite an increasing trend there was a significant drop in performance in this measure in Q1 and this continues in Q2. See 5.4 for further analysis and commentary.

L20 **NHS Sickness Absence % of Hours Lost**

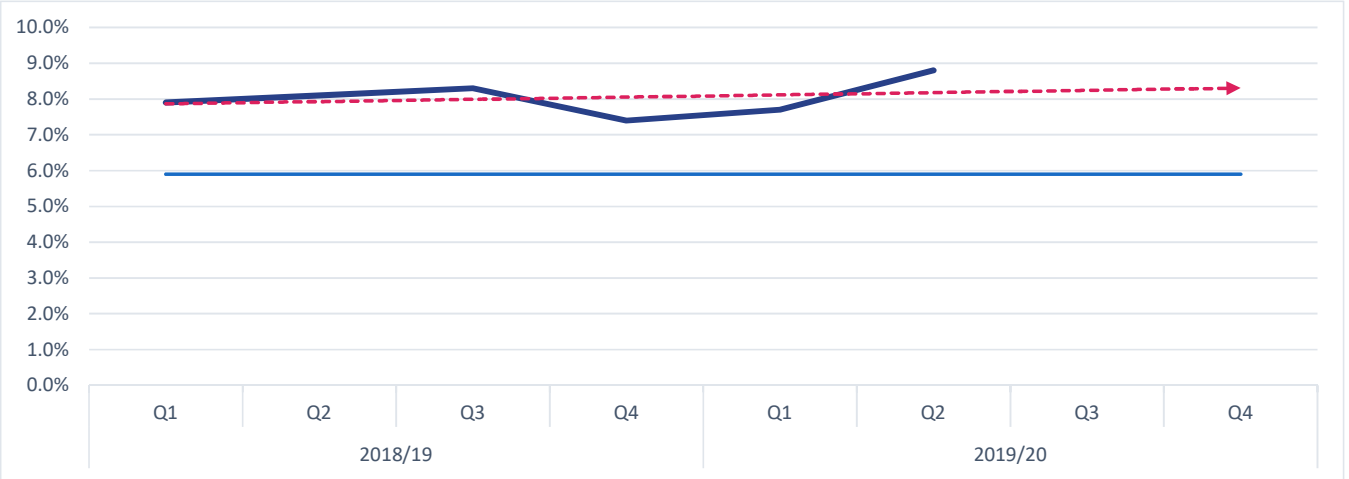
Financial Year		▼	Target
2016/17	Q2	5.1%	4%
	Q3	5.1%	4%
	Q4	4.9%	4%
2017/18	Q1	4.9%	4%
	Q2	4.0%	4%
	Q3	4.6%	4%
	Q4	5.8%	4%
2018/19	Q1	4.9%	4%
	Q2	4.6%	4%
	Q3	4.7%	4%
	Q4	3.8%	4%
2019/20	Q1	3.9%	4%
	Q2	3.8%	4%
	Q3		4%
	Q4		4%



NHS Sickness absence has been improving steadily over the last 3 years and has now hit target three quarters in a row.

L21 **Council Sickness Absence (% of Calendar Days Lost)**

Financial Year		▼	Target
2018/19	Q1	7.9%	5.9%
	Q2	8.1%	5.9%
	Q3	8.3%	5.9%
	Q4	7.4%	5.9%
2019/20	Q1	7.7%	5.9%
	Q2	8.8%	5.9%
	Q3		5.9%
	Q4		5.9%

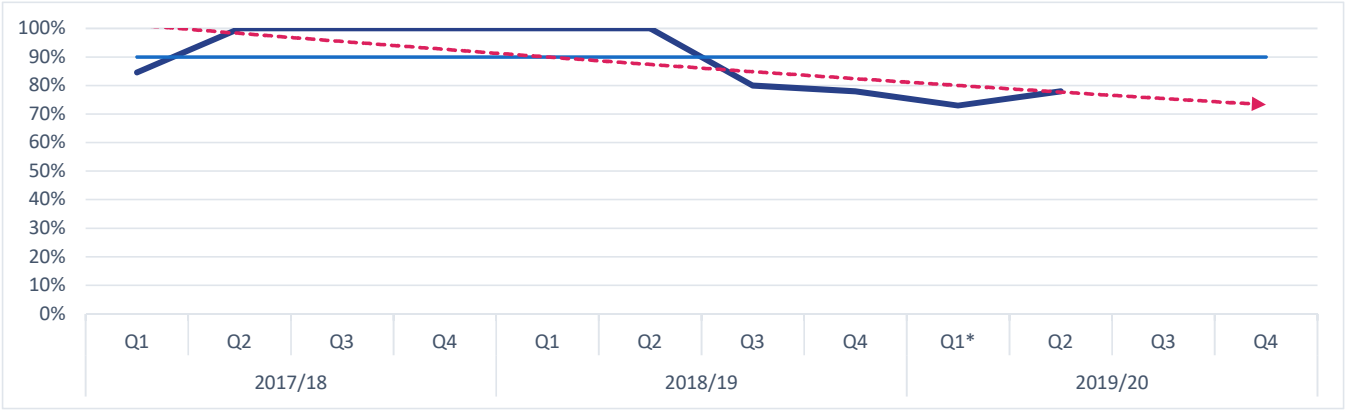


This measure is consistently very high and despite a reducing trend has been acknowledged by the Performance Management Group where actions are being undertaken to improve this.

L41 **Percentage of patients commencing Psychological Therapy Treatment within 18 weeks of referral (adults only)**

Financial Year		▲	Target
2017/18	Q1	84.6%	90%
	Q2	100.0%	90%
	Q3	100.0%	90%
	Q4	100.0%	90%
2018/19	Q1	100.0%	90%
	Q2	100.0%	90%
	Q3	80.0%	90%
	Q4	78.0%	90%
2019/20	Q1*	73.0%	90%
	Q2	78.0%	90%
	Q3		90%
	Q4		90%

* Q1 figures changed from the Q1 report as an error in calculation was found and now corrected.



Despite an improvement in this measure performance remains below target.

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 30 JANUARY 2020**

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

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 January 2020.

2. RECOMMENDATION

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

i) amendments to the description of risk; and

ii) updated Strategic Risk Register included in APPENDIX 1 and action plan included in APPENDIX 2

3. BACKGROUND

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

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

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

3.4 The action plan attached as **APPENDIX 2** identifies the progress to date and priorities for the next quarter to address the risks identified.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The Strategic Risks have received an initial review to ensure they align to the Moray Partners in Care 2019- 2029 strategic plan which were agreed at Moray Integration Board on 28 November 2019 (para 13 of the minute refers).

4.2 The Transformation boards are being established and will feed into the Strategic Planning and Commissioning Group. As their implementation plans evolve the Strategic Risk Register will be reviewed further to ensure that it reflects any concerns that may impact on the delivery of the objectives set out in the Strategic Plan.

4.3 The Risk Management Framework is under review and the development session in February 2020 will include a workshop to consider MIJB risk appetite in relation to delivery of the Strategic Plan.

5. SUMMARY OF IMPLICATIONS

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

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

(b) Policy and Legal

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

There are no legal implications arising from this report.

(c) Financial implications

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

(d) Risk Implications and Mitigation

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

(e) Staffing Implications

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

(f) Property

There are no property implications arising from this report.

(g) Equalities/Socio Economic Impact

An Equalities Impact Assessment is not required 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 JANUARY 2020

RISK SUMMARY

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

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

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

1		
Description of Risk: *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	**MEDIUM**
Risk Movement:	Increase/ decrease/ no change	**NO CHANGE**
Rationale for Risk Rating:	The strategic plan has been reviewed and new plan launched in December 2019. The draft transformation plan has been reviewed by MJIB and Transformation Boards are in the process of being established to take the strategic aims forward. Membership of IJB committees has been stable and the majority of members have attended several cycles of meetings.	
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 “”Partners in Care” 2019 to 2029 • Governance arrangements formally documented and approved. • Agreed risk appetite statement. • Performance reporting mechanisms. • Consultation with legal representative for all reports to committees and attendance at committee for key reports.	
Mitigating Actions:	Induction sessions are held for new IJB members. IJB voting member briefings are held regularly. Conduct and Standards training held for IJB Members July 18 with updates provided by Legal Services as appropriate. SMT regular meetings and directing managers and teams to focus on priorities. Regular development sessions held with IJB and System Leadership Group Strategic Plan has been developed. New management structure is in place and wider system re-design and transformation governance structures being developed for implementation at the same time. The proposed governance	

	structure for the Transformation Boards will be presented to IJB in January 2020 for consideration
Assurances:	• Audit, Performance and Risk Committee oversight and scrutiny. • Internal Audit function and Reporting • Reporting to Board.
Gaps in assurance:	None known
Current performance:	Scheme of administration is reported when any changes are required. An initial meeting has been held with legal advisors to establish the governance requirements for the review of the integration scheme in relation to the proposed delegation of Children's and Criminal Justice Services. Report presenting the Strategic Plan, Communication Strategy, Organisational Development and Workforce Plans, Peformance Framework and the draft Transformational Plan were presented and approved at MIJB on 28 November 2019 Report on Standards Officer agreed by IJB March 2019
Comments:	Strategic Planning and Commissioning Group approved the generic Terms of Reference and Chairs of the transformation boards at the meeting on 19 December 2019 and these boards will be established by April 2020

2		
Description of Risk: *Financial*	There is a risk of MIJB financial failure in that the demand for services outstrips available financial resources. Financial pressures being experienced both by the funding Partners and Community Planning Partners will directly impact on decision making and prioritisation of MIJB	
Lead:	Chief Officer/Chief Financial Officer	
Risk Rating:	Low/ medium/ high/ very high	**VERY HIGH**
Risk Movement:	Increase/ decrease/ no change	**NO CHANGE**
Rationale for Risk Rating:	Previous funding cuts from Moray Council have been significant 2017/18 (£1.3m) and 2018/19 (£1.759m Gross). The 2019/20 settlement saw additional investment for health and social care. Although this was passed through to the MIJB there remains a significant funding gap as much of the new investment related to new commitments. Financial settlements are set to continue on a one year only basis, which does not support sound financial planning Demand on services continues to rise and the IJB has no remaining reserves to be utilised. At the end of Qtr 4 in the 2018/19 financial year the IJB had an overspend of £1.2m This deficit was requested to be funded by the partners in the agreed proportionate split as per the Integration Scheme. This resulted in NHSG contributing £751k and Moray Council £441k. The recovery plan has been developed and was agreed with the Finance	

	Directors in the partner organisations and presented to the MIJB in November 2018. The Recovery Plan is being monitored and reported to the MIJB. At the end of Quarter 2 the recovery plan is broadly on target to deliver, however, overspending is occurring in other areas. As at month 6 (Q2) the MIJB is forecast an overspend to the end of the year of £1.6m. Whilst the revised financial forecast has not been formally reported to the MIJB, the month 8 position indicates that the forecast overspend is increasing, primarily in relation to national pressures being placed on the Prescribing budget.
Rationale for Risk Appetite:	MIJB recognises the pressures on the funding partners but also recognises the significant range of statutory services and nationally agreed contracts it is required to deliver on within that finite budget. MIJB has expressed a zero appetite for risk of harm to people.
Controls:	Chief Finance Officer appointed - this role is crucial in ensuring sound financial management and supporting financial decision making, budget reporting and escalation. Corrective action has been implemented through correspondence with budget holders and increased scrutiny at senior management level. Recovery Plan agreed and being monitored regularly. Work surrounding further potential for efficiency will support the formulation of the 2020/21 budget. In October 2019, the MIJB approved the Medium Term Financial Framework that aims to support delivery of the Strategic Plan.
Mitigating Actions:	Risk remains of the challenge that the MIJB can deliver transformation and efficiencies at the pace required. Financial information is reported regularly to both the MIJB, Senior Management Team and System Leadership Group. The Chief Officer and Chief Financial Officer (CFO) continue to engage in finance discussions with key personnel of both NHS Grampian and Moray Council. These conversations continue in preparation of the 2020/21 budget setting process to ensure the MIJB perspective is considered as part of the budget setting processes of the Partners. Chief Officer and CFO will continue to engage with the partner organisations in respect of the financial position throughout the year with a focus on the progress of the recovery plan. Cross partnership finance meetings have been put in place on a quarterly basis with partner CEOs, Finance Directors and the Chair/Vice Chair of the IJB. The MIJB is acutely aware of the recurring overspend on its core services. In addition to the Recovery Plan, service reviews are being carried out to ensure services are prioritised in accordance with the Strategic Plan whilst working within the funding allocated.
Assurances:	MIJB oversight and scrutiny of budget. Reporting through MIJB, NHS Grampian Board and Moray Council.
Gaps in assurance:	None known
Current	Budget Outturn for 2018/19 saw an overspend after consideration of strategic funds of £1.2m. This was met by NHSG

performance:	and MC in the agreed proportions of 63% / 37% respectively as per the Integration Scheme. Plans are being progressed in relation to service planning and financial review during 2019/20. The current reported forecast to the end of 2019/20 is £1.6m overspend. This is set to worsen following national pressure on the Prescribing budget.
Comments:	Senior managers to work with Chief Officer and Chief Financial Officer to address the continuing financial challenge and forecast overspend. Through reporting, regular updates will be provided to the MIJB, Moray Council and NHS Grampian as part of the risk sharing arrangement in place.

3		
Description of Risk: *Human Resources (People):*	Inability to recruit and retain qualified and experienced staff to provide safe care, whilst ensuring staff are fully able to manage change resulting from Integration	
Lead:	Chief Officer	
Risk Rating:	Low/ medium/ high/ very high	**HIGH**
Risk Movement:	Increase/ decrease/ no change	**INCREASING**
Rationale for Risk Rating:	Some front line services are experiencing difficulties with recruitment to vacancies requiring specific skills and experience, and this places pressure on existing staff. In particular there is a significant issue around attracting people to work in Care at home teams. Workshops have been held in all localities but to date there has not been the increase in applications that is needed. Some social work services are experiencing high levels of sickness absence and difficulties with recruitment with associated impacts on service delivery. In Mental Health recruitment to a key clinical post was out to advert five times without successful appointment although they have now recruited and will commence beginning of March. The difficulty with recruitment and retention of staff to caring roles is also being experienced by Care Homes and this can lead to an impact on HSCM teams where additional support may be required by the contractors. The impact of budgetary decisions by the Council in relation to reducing staffing levels has reduced levels of support provided in some key areas for Health and Social Care Moray (HSCM), such as ICT, HR, Legal and design. Council services are still determining what elements of service provision need to reduce and we are working with these services to establish our level of support.	

Rationale for Risk Appetite:	The MIJB is acutely aware of the lean management team in place and the strain this can place on the wider system.
Controls:	Management structure in place with updates reported to the MIJB. Organisational Development plan in place and Workforce Plans are being updated to align to the new strategic plan. Continued activity to address specific recruitment and retention issues. The chief social worker has reviewed the situation with managers and has employed a Consultant Practitioner to developoptions for addressing some of the particular issues affecting social work services in Moray. Management competencies continue to be developed through Kings Fund training. Communications Strategy was approved in November 2019 and is being implemented. Incident reporting procedures in place per NHSG and Moray Council arrangements and are reviewed at Clincial Governance and Practice Governance groups. Council and NHS performance systems in operation with HSCM reporting being further developed and information relating to vacancies, turnover and staff absences is integral to this. SMT review vacancies and approve for recruitment
Mitigating Actions:	System re-design and transformation. Support has been provided from NHSG with transformation and our co-ordinated working with Dr Grays in a one system – one budget approach through the Moray Alliance. All Locality Managers are now in post with effect from January 2020. Joint Workforce Planning is being undertaken and the joint workforce forum was re-established in September 2019. Lead Managers are involved in regional and national initiatives to ensure all learning is adopted to improve this position. Lead Managers and Professional Leads are linked to University Planning for intakes and programmes for future workforce development.
Assurances:	Operational oversight by Moray Workforce Forum and reported to MIJB. Organisational Steering Group oversees any potential organisational change
Gaps in assurance:	Joint or single system not yet agreed for incident reporting. Organisational Development Plan and Workforce plan has been updated and was approved by MIJB in November 2019.
Current performance:	iMatter survey undertaken during July 2019 across all operational areas showed improvement in response rate although there are still some teams that require to engage. Managers have worked with teams and developed action plans with 64% completed by the deadline in comparison to 50% in previous year. The Systems Leadership Group will be taking forward the implementation of the Organisational Development.

Comments:	Staffing issues are being owned by the Systems Leadership Group with a view to working collaboratively across the system to seek opportunities to make jobs more attractive where it has proved difficult to recruit.

4		
Description of Risk: *Regulatory:*	Inability to demonstrate effective governance and effective communication and engagement with stakeholders.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**MEDIUM**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Locality planning assessed as medium in relation to ability to work at the pace required and current workforce capacity. Performance framework to be further developed from a planning perspective to show the links through operational service delivery to strategic objectives.	
Rationale for Risk Appetite:	The MIJB has a low risk appetite to failure.	
Controls:	Communication Strategy approved November 2019 Annual Governance statement produced as part of the Annual Accounts 2018/19 and submitted to External Audit by the statutory deadline Performance reporting mechanisms in place and being further developed through performance management group. Community engagement in place for key projects areas such as Forres and Keith with information being made available to stakeholders and the wider public via HSCM website.	
Mitigating Actions:	Schedule of Committee meetings and development days in place and implemented. Good working relationship established with Audit Scotland, the MIJB's appointed external auditors since 16/17. Annual Performance Report for 2018/19 published in August 2019. Lessons learnt from previous years were incorporated into the approach for the production of the report that was published on 2 August 2019 against a target of 31 July 2019. Social media is actively used as a method of engaging with the public, with short videos focussing on particular services being trialled.	
Assurances:	Oversight and scrutiny by Clinical and Care Governance Committee, Audit Performance and Risk Committee and MIJB. Summary reports of minutes of MIJB meetings are submitted to Council committee and NHS Board.	

Gaps in assurance:	A workshop was held on 8 January 2020 to self assess the mechanisms in place for Clinical and Care Governance to identify any areas for improvement and to provide evidence that there is a robust assurance process in place. There was a lot of good discussion and suggestions for improvement put forward. A report of the outcomes and associated actions to streamline the reporting mechanisms and ensure that there is managerial and professional oversight across all professions will be submitted for consideration at Clincial and Care Governance Committee.
Current performance:	Communications Strategy was reviewed approved by IJB November 2019. Annual Performance Report 2018/19 published August 2019. Audited Accounts for 2018/19 were publicised by deadline 30 September 2019
Comments:	NHS Grampian System Leadership Team are developing their framework for governance and HSCM are fully engaging and participating in this process. HSCM are progressing with setting out the Governance framework for their functions across services (ie Health and Safety, Civil Contingencies, Risk Management, Performance Management etc) and linkages with NHS and Council groups to facilitate communication flows. PwC Internal Audit of Health Governance completed

5		
Description of Risk: *Environmental:*	Inability to cope with unforeseen external emergencies or incidents as a result of inadequate emergency and resilience planning.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**HIGH**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Resilience standards and implementation plan agreed however progress is behind target. National Government has advised that work does not need to continue in relation to impacts of a potential no deal exit from Europe. The new Emergency Planning officer started in the Council on 25 November and links have been established. Progress has been slow in some areas to updating HSCM Business Impact Analysis (BIA) and Business Continuity Plans (BCP). This has been identified as a priority area and managers are working to complete the outstanding work. Once this is completed they BIA will be collated and the system wide understanding of the critical functions will be	

	establish the system wide understanding of the critical functions that will underpin all emergency and distruptive incident planning.
Rationale for Risk Appetite:	The MIJB understand the requirement to meet the statutory obligations set out within the Civil Contingencies Act. Some services are experiencing pressures resulting in business continuity arrangements being invoked, such as Homecare services in Forres and Cullen, Care at Home Reablement Team (START) (increased demand and high levels of staff sickness last week)
Controls:	Winter/Surge Plan updated and has been tested alongside NHSG plans for winter and officers have participated in exercises. HSCM Civil Contingencies group established and meeting regularly to address priority subjects. NHS Grampian Resilience Standards Action Plan approved (3 year). Business Continuity Plans in place for most services although overdue a review in some areas .
Mitigating Actions:	Outstanding BIA/BCP have been escalated to System leadership group for actioning and progress is being made. Information from the updated BIA/BCP has informed elements of the Winter Plan (Surge plan). A Friday huddle has been implemented to gather the status of services across the whole system to provide information and contact details to the Senior Manager on Call (SMOC) over the weekend. NHS Grampian have amended their approach to Pandemic preparation so HSCM Pandemic plan requires redrafing and testing Practitioner group established for Moray with representation from HSCM, Dr Grays, Moray Council and NHSG to discuss matters arising from the Local Resilience Forum and within our respective organisations. In addition it will provide a forum for discussion of the linkages between organisational response plans to ensure there are no gaps or over reliance on particular local resources. Briefing for Mass Casualties Plan held by NSHG Civil Contingencies Unit for HSCM managers on 10 September 2019. Officers have attended a Business Continuity Workshop, Winter Plan cross Grampian exercise and training in writing contingency plans
Assurances:	Audit, Performance and Risk Committee and NHS Grampian Civil Contingencies Group oversight and scrutiny.
Gaps in	Some table top exercises have been completed but a programme requires to be set out for 2020

assurance:	Progress has been made however further work is required to address the targets in the implementation plan that have not been met and the Resilience standards as identified by the NHSG Civil Contingencies Group. Pandemic flu plans require to be progressed
Current performance:	Many services have business continuity arrangements and some are overdue for an update. Work is progressing to collate a critical functions list for agreement by System Leadership Group that will inform planning arrangements going forward. Annual report on progress against NHS resilience standards has been completed and submitted to APR committee in January 2020 for review.
Comments:	The HSCM Civil Contingencies group will schedule and review progress in achieving the NHSG resilience standards, reporting updates to System Leadership Group.

6		
Description of Risk: *Reputational*	Risk to MIJB decisions resulting in litigation/judicial review. Expectations from external inspections are not met.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**MEDIUM**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Considered medium risk due to the reporting arrangements being relatively new	
Rationale for Risk Appetite:	The MIJB has some appetite for reputational risk relating to testing change and being innovative. The MIJB has zero appetite for harm happening to people.	
Controls:	Clinical and Care Governance (CCG) Committee established and future reporting requirements identified High and Very High operational risks are reviewed by System Leadership Group monthly and a review of all risks will be undertaken as part of the risk management framework. Complaints and compliments procedures in place and monitored. Clinical incidents and risks are being reviewed on a weekly basis to ensure processes are followed appropriately and consistently and responses are recorded in a timely manner. Adverse events and duty of candour procedures in place and being actioned where appropriate and summary reports submitted to CCG committee. Reports from external inspections reported to appropriate operational groups and by exception to SMT for subsequent reporting to CCG or Audit Performance and Risk Committee as appropriate.	
Mitigating Actions:	This risk is discussed regularly by the three North East Chief Officers. Additional resource has been allocated to support the analysis of information for presentation to CCG committee Process for sign off and monitoring actions arising from Internal and External audits has been agreed	
Assurances:	Audit, Performance and Risk and Clinical and Care Governance Sub-Committees oversight and scrutiny.	
Gaps in assurance:	Process for highlighting recurring themes or strategic expectations from external inspections requires further development to ensure Committee has sight of significant issues.	
Current	External inspection reports are reviewed and actions arising are allocated to officers for taking forward.	

performance:	A summary of inspections was included in the Annual Performance report for 2018/19
Comments:	No major concerns have been identified for HSCM services in any audits or inspections this year.

7		
Description of Risk: *Operational Continuity and Performance:*	Inability to achieve progress in relation to national Health and Wellbeing Outcomes. Performance of services falls below acceptable level.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**HIGH**
Risk Movement:	increase/decrease/no change	**INCREASING**
Rationale for Risk Rating:	Potential impacts to the wide range of services in NHS Grampian and Moray Council commissioned by the MIJB arising from reductions in available staff resources as budgetary constraints impact. Unplanned admissions or delayed discharges place additional cost and capacity burdens on the service. Due to the high level of demand for beds being experience across NHS Grampian acute services and the challenges in providing staff to care for people at home, there is a significant increase in the level of delayed discharges.	
Rationale for Risk Appetite:	Zero tolerance of harm happening to people as a result of action or inaction.	
Controls:	Performance Management reporting framework. 2019 to 2029 “Partners in Care” Strategic Plan approved and Transformation Plan being developed. Performance regularly reported to MIJB. Revised Scorecard being developed to align to the new strategic priorities. Best practice elements from each body brought together to mitigate risks to MIJB’s objectives and outcomes. Chief Officer and SMT managing workload pressures as part of budget process.	
Mitigating Actions:	Service managers monitor performance regularly with their teams and escalate any issues to the Performance Management Group for further discussion to provide wider support, developing shared ownership and a greater	

	understanding across the whole system. Performance Management Group are reviewing key performance indicators across HSCM services to align with the revised strategic plan. Risks identified through review of performance information will be reported to System Leadership Group for consideration and mitigation or further escalation.
Assurances:	Audit, Performance and Risk Committee oversight. Operationally managed by service managers, receiving reports from Performance management group (which has a specific focus on performance). Strategic direction provided by Systems Leadership Group.
Gaps in assurance:	Development work is underway to establish clear links to performance that describe the changes proposed by actions identified in the new Strategic Plan
Current performance:	A key area of focus where performance data is below target relates to Delayed discharges. Due to the extreme situation being experienced across NHS Grampian and HSCPs daily cross system huddles are being held to focus on reducing the delays. Innovative thinking is being actively encouraged by managers and teams to try to come up with new solutions to facilitate people being able to return home with appropriate support as soon as appropriate. All managers have been notified of the issue and are working collaboratively to resolve it.
Comments:	Regular and ongoing reporting. Work is progressing with development of performance monitoring and reporting of key performance indicators for locality managers. Performance support staff are meeting with managers to review their existing arrangements to ensure that arrangements are in line with the new Performance Management Framework. Development of the Ministerial Steering Group indicators and links to local indicators that underpin them is also underway and will be reported to the Board in March 2020.

8	
Description of	

Risk: *ICT*	Inability to progress with delivery of Strategic Objectives and Transformation projects as a result of inability to resolve data sharing and data security requirements.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**MEDIUM**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
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.	
Rationale for Risk Appetite:	MIJB has a low tolerance in relation to not meeting requirements.	
Controls:	Computer Use Policies and HR policies in place for NHS and Moray Council and staff are required (through and automated process) to confirm they have read these every 6 months PSN accreditation secured by Moray Council Guidance regularly issued to staff. Guidance on effective data security measures issued to staff.	
Mitigating Actions:	Integrated Infrastructure Group established, with ICT representation from NHSG and Moray Council, to consider and provide solutions to data sharing issues and ICT infrastructure matters. Linkages to Infrastructure board and Information sharing groups have been established albeit these meetings are not taking place regularly. Data sharing groups for Grampian and Health and Social Care Moray have been established and meetings are held regularly. They will have oversight of any issues arising from Data protection and GDPR matters from either Council or NHS systems.	
Assurances:	Strict policies and protocols in place with NHS Grampian and Moray Council.	
Gaps in assurance:	Protocol for access to systems by employees of partner bodies to be documented. Information Management arrangements to be developed and endorsed by MIJB. Process of identification of issue and submission to data sharing group requires to be reinforced to ensure matters are progressed.	
Current performance:	Training programme to be developed on records management, data protection and related issues for staff working across and between partners.	
Comments:	Where national systems are involved it may not be possible to identify a solution however the issues will be able to be raised at the appropriate level via the Grampian Data Sharing Group where all three partnerships are represented.	

9		
Description of Risk: *Infrastructure*	Requirements for support services are not prioritised by NHS Grampian and Moray Council.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**HIGH**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Changes to processes and necessary stakeholder buy-in still bedding in. Moray Council is undertaking a Property review of office and depot accommodation and the potential impact for HSCM services requires consideration. The output was anticipated in October 2019 however due to changes with roles and responsbilities within the Council it is not yet clear when the outcomes will be available for consultation. ICT infrastructure service plans in NHS Grampian and Moray Council are not visible to HSCM and development of communication and engagement process is required. 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. Premises, Infrastructure and Digital Manager in place to provide additional leadership in relation to major infrastructure projects.	
Rationale for Risk Appetite:	Low tolerance in relation to not meeting requirements.	
Controls:	Chief Officer has regular meetings with partners Infrastructure Programme Board established with Chief Officer as Senior Responsible Officer/Chief Officer member of CMT. Process for submission of projects to the infrastructure board has approved and implemented to ensure appropriate oversight of all projects underway in HSCM.	
Mitigating Actions:	Dedicated project Manager in place – monitoring/managing risks of the Programme Membership of the Board reviewed and revised to ensure representation of all existing infrastructure processes and funding opportunities.	

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

Strategic Risk – Action Log

APPENDIX 2

Risk	Action required	Lead	Target	Comment
1. The Integration Joint Board (IJB) does not function as set out within the Integration Scheme, Strategic Plan and Scheme of Administration and fails to deliver its objectives or expected outcomes.	Develop to final approved Performance Management Framework (PMF), aligned to the new Strategic Plan will be a key focus.	Chief Financial Officer	Revised date ~~27 June 2019~~ 31/10/2019	**Completed -** PMF approved at MIJB 28 November 2019 **In progress** - Work is underway to develop the transformation plan underpinned by performance information.
	Review of integration scheme in relation to the proposed delegation of Children's and Criminal Justice Services	Chief Officer	31/3/2021	**In progress**
2. Inability to recruit and retain qualified and experienced staff whilst ensuring staff are fully able to manage change resulting from Integration	Update Organisational Development Plan (presented to MIJB in January 2018) and present to MIJB	Chief Officer	~~30 June 2019~~ 31/10/2019	**Completed** - Management restructure is complete and staff are in post. OD plan was approved by MIJB 28 November 2019. This will be developed and integrated into teams by Systems Leadership Group.
	The Workforce plan will be developed and aligned with the strategic plan 2019- 2022	Chief Officer	~~September~~ 31/10/2019	**In progress** - The outline Workforce Plan was approved by MIJB 28 November 2019. Workforce requirements will be further developed as the locality manager role and the transformation boards priorities become more defined so workforce is aligned appropriately.
	Services experiencing staffing resource issues due to sickness absence or vacancies are escalating matters to Heads of Service for action	SLG/ Heads of Services	ongoing	**In progress** - This is a complex problem impacting on several areas in the system. System Leadership Group have discussed the issues relating to Care at home staff and Mental Health services. Further analysis of information is being undertaken and will be presented to SLG

				for review.
3. **Inability to demonstrate effective governance and effective communication with stakeholders.**	Programme of future reports for Clinical and Care Governance Committee to be developed	Professional Lead for Clinical Governance / Heads of Service	31/3/20	**Completed** - Schedule of reports has been set for Clinical Governance Group with exception reporting to Clinical and Care Governance committee. **In progress –** following the workshop on Clinical Care Governance on 8 January a report on the output will be submitted to CCG Committee in February 2020.
	Communications Strategy developed and approved by MIJB in June 2017 – to be reviewed and updated	Chief Officer	~~June 2019~~ 31/10/19	**Completed** Communiction & Engagement strategy was approved by MIJB 28 November 2019.
	Governance Frameworks documented and communicated for:- • Clinical Governance • Health and Safety • Risk management • Performance management • Civil Contingencies	Corporate Manager	 28/2/19 31/3/19 31/10/19 31/10/19 31/3/20	**In Progress** Clinical Governance and Health and Safety Risk Management and Performance management frameworks have been documented. Civil Contingencies is progressing but requires input from partner organisations. This is being progressed through the local resilience group with representation from Moray Council, Dr Grays, NHSG and HSCM, which has been delayed due to vacancies in the Council but is now active.
4. **Inability to deal with unforeseen external emergencies or incidents as a result of inadequate emergency planning**	Programme of implementation of table top exercises for business continuity to be established and implemented	HSCM Civil Contingencies Group (CCG)	25/2/20	Table top on electricity outage completed**.** **In progress** - Programme of table tops to be submitted to HSCM Civil Contingencies group 25 February 2020.

and resilience.	Staff training programme to be scheduled	Corporate Manager	31/1/20	Programme to be scheduled in partnership with NHS Civil Contingencies Unit and Moray Council.
	Completion of major infectious disease/pandemic plans	Corporate Manager / HSCM CCG	~~30/4/19~~ 31/1/20	**Overdue** Discussion held with colleagues in Aberdeen City and Aberdeenshire to ensure consistent approach. Delay due to Scottish Government issue of draft guidance which has raised queries but feedback has been co-ordinated by NHSG. Services information regarding critical functions is required to populate the plan and action is underway to complete by end of month..
5. Risk to MIJB decisions resulting in litigation/judicial review. Expectations from external inspections are not met.	Process for sign off and monitoring actions arising from Internal and External audits is being set out as part of the HSCM governance arrangements.	Corporate manager / Chief Internal Auditor	ongoing	Any identified shared learning from audits is taken to System Leadership Group.
6. Inability to achieve progress in relation to national Health and Wellbeing Outcomes. Performance of services falls below acceptable level.	Development work will be undertaken to establishing clear links to performance that describe the changes proposed by actions identified in the new Strategic Plan	Chief Financial Officer / Corporate manager / Service Managers	30/6/20	**In progress** Performance support team will be working with managers to progress in line with the Strategic Plan and Transformation plan development.

7.	**Risk of major disruption in continuity of ICT operations, including data security, being compromised**	Protocol for access to systems by employees of partner bodies to be developed.	~~30/10/2019~~ 31/3/20	**Overdue** Existing staff are able to access systems where appropriate, the protocol requires to be documented for implementation for new staff or where services are developing and require additional access to systems.

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 30 JANUARY 2020**

SUBJECT: **INTERNAL AUDIT UPDATE**

BY: **CHIEF INTERNAL AUDITOR**

1. REASON FOR REPORT

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

2. RECOMMENDATION

2.1 The Audit, Performance and Risk Committee is asked to:

i) consider progress against the audit plan to date, noting that while some projects have been taken forward, there is further work required to bring these to a formal conclusion; and

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

3. REPORT

3.1 Audit Planning

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

3.1.2 Planned audit activity for the MIJB was agreed at the meeting of this committee on 19 September 2019 (para 12 of the draft Minute refers). The plan had limited inputs relative to the scale of the MIJB's responsibility to direct elements of social care within the council and defined activities delivered by the NHS. This was appropriate given that both the council and NHS continue to have their own separate and distinct internal audit arrangements.

3.1.3 It was envisaged at the outset that there would be opportunities for closer working between audit teams from the two bodies. This has been explored but only limited progress made, as outlined at para 3.7 below. Nationally, Audit Scotland has recently reported that 'the pace of health and social care integration has been too slow and there is limited evidence to suggest any significant shift in spending from health to social care https://www.audit-scotland.gov.uk/uploads/docs/report/2019/nr_191217_local_government_finance.pdf On that basis the evolution of audit arrangements is likely also to take time.

3.1.4 The PSIAS nevertheless requires the Chief Internal Auditor to provide a written report to support the Annual Governance Statement published with the MIJB Annual accounts. This report should include an opinion of the overall adequacy and effectiveness of the control environment in which the MIJB operates. In practical terms, this has been and will continue to be secured by consideration of the systems of control framework of the council, with a focus on how it manages its main financial systems, and seeking similar assurances from the Internal Auditor for NHS Grampian.

Self Directed Support

3.1.5 Although not an audit project per se, a contribution to development work in social care is secured by having a member of the audit team sitting on the working group that looks at this area. With self directed support a principal driver of change in the care sector, participation in this group keeps internal audit up-to-date with developments taking place. The auditor also provides an internal control perspective on updates to policies and procedures and advice on individual care packages where administrative issues arise.

3.1.6 A recent Audit Scotland report assessing the impact of self directed support (SDS) in reshaping care across Scotland referenced the report by the Care Inspectorate, the Thematic Inspection of SDS across six partnerships carried out in 2018/19. Nationally, the findings reported were:

- Most of the supported people and staff met were very positive about SDS and the principles and values of personalisation. In practice however, more needed to be done to inform, empower and enable people to fully participate.
- In situations where SDS was effectively implemented, supported people found it transformational and experienced positive personal outcomes. However, effective SDS was not accessible to all.
- Discussions and decisions about options, choice and control were not routinely documented in case records.
- Partnerships were not consistently collecting, aggregating, analysing or reporting on personal outcomes. This was making it difficult to evaluate progress in SDS and to drive improvement.

3.1.7 Moray was one of six partnerships that received an SDS review by the Care Inspectorate to inform the national findings, and it received 'good' evaluations in all but one of seven areas covered in the inspection. The findings from this inspection were reported to the Clinical and Care Governance Committee on 28 November 2019 (para 7 of the draft Minute refers). It is intended that Internal Audit will continue to be represented on the SDS working group.

3.2 Specific topics in the Audit plan

3.2.1 The audit work for the MIJB referred to in the audit plan for 2019 /20 covered the following area within social care:

- Adaptations governance
- Care Homes /Residential Nursing (excluding assessment criteria) and
- Equipment

3.3 Adaptations Governance

3.3.1 The adaptations governance audit has considered the use of budgets provided by both social care and the housing service. Work has been undertaken to ascertain the process adopted from referral through to the completion of the adaptations necessary. The audit fieldwork has been completed and the file requires audit manager review prior to the draft audit report being issued to service management.

3.4 Care Homes/Residential Nursing (excluding assessment criteria)

3.4.1 This audit has not been progressed and a terms of reference has still to be agreed. It is hoped that some work on this can be scheduled ahead of the financial year end, on the basis that a suitable terms of reference can be confirmed.

3.5 Equipment

3.5.1 An audit of equipment has been completed that focused on the systems and procedures of the Occupational Therapy equipment store based in Pinefield, Elgin. An audit report has been prepared and issued in draft to the service manager for comment. A number of recommendations have been made to strengthen current systems and processes in place. A response is awaited at the time of drafting this report.

3.6 Learning Disabilities

3.6.1 Internal audit work on learning disabilities was commenced and deferred in 2018 to enable the service to progress plans to undertake a comprehensive review of service provision; in particular involving a review of long standing contracts in place with external service providers. The intention remains to evaluate progress in due course of planned changes and progress achieved. Timing of this will be agreed with service management.

3.7 Joint working

3.7.1 A discussion took place with internal auditors for Aberdeen City and Aberdeenshire Councils (who provide services to their respective IJBs) and with PriceWaterhouseCoopers (PwC) the appointed internal auditors of NHS Grampian regarding a planned audit of business continuity. This audit mainly related to primary care providers with reference to the role of the health and social care partners in the event of service failure. It was noted that those primary care providers who participated in the audit had some form of business continuity plans in place, however, only nine of 20 providers

sampled responded to the audit request for information. Business continuity arrangements in the council are being revisited at the present time to ensure they remain up to date and it is envisaged there will be liason with Health and Social Care Moray regarding elements of social care.

3.8 Ad hoc works

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

4. SUMMARY OF IMPLICATIONS

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

Not directly applicable.

(b) Policy and Legal

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

(c) Financial Implications

No implications directly arising from this report.

(d) Risk Implications

While limited progress has been made at this stage with delivery of the audit plan, there is still time to complete or take forward outstanding projects; in any event this will not impact on the ability to provide assurances on the control environment, which will continue to be drawn from the partner bodies.

(e) Staffing Implications

No implications

(**f) Property**

No implications.

(g) Equalities/ Socio Economic Impacts

An Equalities Impact Assessment is not required as there are no changes or policy or procedures as a direct result of this report.

(h) Consultations

There have been no consultations undertaken in respect of this report.

5. CONCLUSION

5.1 This report provides information on progress re projects included in the audit plan.

Author of Report:	Atholl Scott, Chief Internal Auditor
Background Papers:	Internal Audit Plan
Ref:	mijb/ap&rc/30012020

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 30 JANUARY 2020**

SUBJECT: **PUBLIC SECTOR INTERNAL AUDIT STANDARDS – EXTERNAL QUALITY ASSESSMENT OF INTERNAL AUDIT**

BY: **CHIEF INTERNAL AUDITOR**

1. REASON FOR REPORT

1.1 To provide the Moray Integration Joint Board (MIJB) Audit, Performance and Risk Committee with details of an external quality assessment undertaken on the council's internal audit service.

2. RECOMMENDATION

2.1 It is recommended that the Audit, Performance and Risk Committee considers and notes the report and the action plan prepared to address the issues raised in the external quality assessment of internal audit.

3. BACKGROUND

3.1 The Local Authority Accounts (Scotland) Regulations 2014 at paragraph 7 require that 'a local authority must operate a professional and objective internal auditing service in accordance with recognised standards and practices in relation to internal auditing'.

3.2 The recognised standards adopted by all public bodies are the Public Sector Internal Audit Standards, (PSIAS) developed by standard setters including the Chartered Institute of Public Finance and Accountancy (CIPFA) and the Chartered Institute of Internal Auditors. The standards include a requirement for an External Quality Assessment (EQA) of internal audit once every five years, and for the findings to be considered at a meeting of a council committee. The information is also relevant to the internal audit work conducted for the MIJB.

3.3 Through the Scottish Local Authorities Chief Internal Auditors' Group which the council participates in, and in line with the Standards, it was agreed that the EQA requirement could be met through a peer review process. This required each Chief Internal Auditor to undertake an assessment at another council and receive an assessment in return. It was agreed by the group that to avoid any potential conflicts of interest reviews would not be carried out at

or by a neighbouring authority. Fife Council was selected to undertake the assessment of Moray Council.

3.4 The assessment involved the Audit Manager and an Auditor from Fife and took place over two days in early February 2019. It involved the review of a portfolio of evidence, interviews with the Chair of the Audit and Scrutiny Committee, the Chief Executive, and the Corporate Director (Corporate Services) responsible for internal audit, as well as discussions and file reviews involving all staff in the audit team. A copy of the report detailing the audit findings together with an action plan containing recommendations is provided as **APPENDIX 1**.

3.5 The inspection was thorough and the report gives a useful external perspective of how the service performs as well as providing advice on areas where compliance with the standards can be strengthened. There are a couple of areas highlighted around audit planning where there is a need to do more to evidence the basis for selection of planned audit topics otherwise for the most part the recommendations will be readily implemented subject to time being made available to do so. Overall the positive comments around Moray Council audit working paper and reporting processes were welcomed as an endorsement of the combined efforts of all staff in the team.

3.6 In the interim, work has been done to progress some of the recommendations made, namely:

- The Chief Auditor appraisal has been signed off by the Depute Chief Executive (post title recently amended from previous Corporate Director (Corporate Services)) and Chief Executive of the council
- Audit staff have been required to confirm in writing their understanding of ethics and the need to maintain high ethical standards in the course of their work
- The job description has been updated for the Chief Auditor post
- Employee Review and Development Programme forms (appraisals) have been updated for all audit staff.
- The council's anti-fraud policy has been updated and approved.
- The council's internal audit manual is being updated to reflect latest auditing standards
- The Chief Auditor now has access to agendas for Senior Management Team meetings within the council and can attend as required.

3.7 Other recommendations will be taken forward as time permits with a focus being given in particular to assurance mapping. This should aid audit planning/selection of audit topics in future years.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 Participation in the EQA process provides an independent assessment of Internal Audit's application of the standards expected of public sector internal audit. The provision of this report to the recipients of internal audit services provides transparency around the results of the assessment and of the actions proposed to secure service improvement.

5. SUMMARY OF IMPLICATIONS

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

No direct implications.

(b) Policy and Legal

Completion and reporting results of the external review secures compliance with the relevant statutory requirements and auditing standards.

(c) Financial implications

No implications.

(d) Risk Implications and Mitigation

The findings from the independent review of internal audit mitigate the risk that the service operates without regard to the applicable professional standards.

(e) Staffing Implications

None

(f) Property

None

(g) Equalities/Socio Economic Impact

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

(h) Consultations

This report has been discussed with the Chief Financial Officer of the IJB, any comments have been considered in writing the report.

6. CONCLUSION

6.1 This report provides the Audit, Performance and Risk Committee with a summary of findings arising from an external quality assessment of Moray Council's internal audit service.

Author of Report:	Atholl Scott, Chief Internal Auditor
Background Papers:	Public Sector Internal Audit Standards Self-Assessment Evaluation
Ref:	ijb/ap&rc/30012020

SCOTTISH LOCAL AUTHORITIES
Chief Internal Auditors' Group

Appendix 1

Moray Council

EXTERNAL QUALITY ASSESSMENT

OF THE

INTERNAL AUDIT SERVICE

Final Report

5 April 2019

Index and Report Distribution List

Date of Visit	**5 – 6 February 2019**
Draft Report Issued	**26 February 2019**
Management Response Received	**2 April 2019**
Final Report Issued	**5 April 2019**

Draft Issued to:	**Atholl Scott, Internal Audit Manager**
Final Issued to	**Atholl Scott, Internal Audit Manager**
	Stakeholder Interviewees: Roddy Burns, Chief Executive, Denise Whitworth, Corporate Director (Corporate Services) Councillor Marc Macrae, Chair, Audit and Scrutiny Committee

1. EXECUTIVE SUMMARY

1.1 Introduction

The Public Sector Internal Audit Standards 2013 (PSIAS) require that an independent external quality assessment of compliance against the PSIAS (EQA) should be undertaken at least once every 5 years. This report has been prepared following a review of compliance with the PSIAS and the International Professional Practices Framework (IPPF) on which the PSIAS has been based. The purpose of this report is to provide an overview of Moray Council's arrangements for the operation and management of its Internal Audit service.

In terms of the PSIAS, the Internal Audit Manager performs the function of the Chief Audit Executive (CAE) and this terminology is referred to throughout this report. The PSIAS also refers to "the Board", for the purpose of this report the Board is the Audit and Scrutiny Committee of Moray Council.

The report details the findings from the EQA undertaken in February 2019, by the Service Manager, Audit & Risk Management of Fife Council.

1.2 Scope and Limitations

The methodology for this EQA, takes the form of a validated self-assessment. As such we have undertaken the following work in arriving at our opinion:

- review of the latest self-assessment and supporting evidence provided by the Chief Audit Executive (CAE);
- canvassed the opinions of key stakeholders such as Chair of the Audit and Scrutiny Committee and members of the Council's Corporate Management Team;
- undertook a series of tests using a standard checklist and undertook a review of guidance and process documents and a sample of files.

We have not undertaken any specific work to assess the effectiveness of the Council's Audit and Scrutiny Committee. Our view as to the extent of compliance with the PSIAS cannot be taken as any assurance on the strength of the control environment within Moray Council.

1.3 Areas of Good Practice Identified

- Good overall level of compliance with PSIAS and IPPF;
- The Internal Audit Charter is clear, concise and easy to follow. The purpose, authority and responsibility of Internal Audit, Senior Management and the Board is appropriately set out;
- Functional and administrative reporting lines for the CAE are appropriate;
- The Internal Audit team is appropriately qualified and experienced. It was acknowledged by key stakeholders that the team was knowledgeable and professional. All members of the team are aware of the professional and ethical standards required;
- Working papers system is effective for recording the Internal Audit work and reaching conclusions;
- Reports are concise and easy to follow.

1.4 Conclusion and Main Findings

The overall conclusion is arrived at following completion of the comprehensive EQA Checklist and based on the work we have undertaken, it is our opinion that the Internal Audit Service ***generally conforms*** with the PSIAS. 4 of the 13 Assessment areas 'Fully Conforms', 7 'Generally Conforms' and 2 'Partially Conforms'. Our review has highlighted a few areas where improvements can be made, these being:

- The PSIAS requires reports to the Audit Committee to be submitted directly by the CAE. The reports are presented in the name of the Corporate Director, although the CAE is recorded as the author of the report.
- While Internal Audit staff are clearly aware of the Code of Ethics and do notify of potential conflicts of interest, there are no formal processes in place to evidence this.
- Informal processes have developed for planning and recording of training, and employee development records are not up-to-date. Formal processes should be put in place to evidence these areas and the documentation updated.
- The Fraud Policy and the Audit Manual have not been reviewed recently.
- Work programmes are not approved at set up, or if adjustments are made during the audit, meaning there is no evidence of agreement to proceed.
- There is a lack of evidence of how the audits are selected, and no mechanism to record reliance placed on other sources of assurance.
- The PSIAS 2400.2 requires that audit reports state that the audit has been 'conducted in accordance with PSIAS'. This is not currently included in audit reports.
- The PSIAS requires the CAE to present reports to the Board on the internal audit activity's performance relative to its Audit Plan and other matters. Performance measures are not reported to Audit and Scrutiny Committee during the year or in the Annual Report. Performance reporting is to Policy and Resources Committee as part of the Corporate Services performance management framework.

A detailed evaluation of each 'Standard' can be seen in Appendix A of the report.

2. FEEDBACK AND EQA FINDINGS

2.1 Purpose, Authority and Responsibility – Action Plan reference 3.1

The PSIAS 1000.2 requires the CAE to periodically review the internal audit charter and present it to senior management and the board for approval. The internal audit charter contents were discussed with the Corporate Director, Corporate Services, prior to submission to the Audit and Scrutiny Committee (ASC), but were not communicated to other members of the Corporate Management Team (CMT).

2.2 Organisational Independence – Action Plan reference 3.2, 3.3 and 3.4

The PSIAS 1100.1 requires the CAE to present to the Audit Committee on the internal audit activity's performance relative to its Audit Plan and other matters. Reporting on audit activity is not included in the Annual Report, and while progress against plan is notified in the Report on the Work of the Internal Audit Section, this does not include performance measures. Performance reporting is to Policy and Resources Committee as part of the Corporate Services performance management framework.

The PSIAS 1100.1 requires reports from the CAE to be submitted to the Audit Committee directly by the CAE. Moray Council protocol requires all reports to Committee to be presented by a Director or Head of Service, therefore, while the CAE is the author of the reports, they are submitted to ASC in the name of the Corporate Director, Corporate Services.

The PSIAS 1100.4 suggests that the CAE's performance appraisals may include feedback from the Chief Executive and the Chair of the Board. Performance appraisals with the line manager do not currently include such feedback.

2.3 Individual Objectivity – Action Plan reference 3.5

The PSIAS 1100.6 requires that adequate arrangements are in place to inform individual auditors of their responsibilities in relation to potential conflicts of interest and promote impartial and unbiased behaviours. While it is accepted that staff notify of perceived conflicts of interest informally and are aware of the need to comply with the Code of Ethics and the Council's Code of Conduct for Employees, there is no formal process for reminding audit staff of their obligations in this regard.

2.4 Proficiency – Action Plan reference 3.6

The PSIAS 1200.5 requires confirmation that up-to-date job descriptions exist that reflect roles and responsibilities and that person specifications define the required qualifications, competencies, skills, experience and personal attributes. An up-to-date job description was available for the auditor role, but the CAE and Senior Auditor roles require updating.

2.5 Continuing Professional Development – Action Plan reference 3.7

The PSIAS 1200.10 requires that audit staff participate in a programme of continual professional development. There are no standard training plans, recording of training is not consistent, and records are not up-to-date.

2.6 Planning and Co-ordination – Action Plan reference 3.8 and 3.9

The PSIAS 2000.2 requires the Audit Plan to be developed using an appropriate methodology. The approach is outlined in the Audit Plan report to ASC, but the use

of an audit planning checklist may be beneficial in evidencing the areas considered in producing the Audit Plan.

The PSIAS 2000.3 requires the risk-based Action Plan to take account of other sources of assurance and suggests this is likely to be evidenced by an assurance mapping exercise. No Assurance map is currently in place, but there are plans to look at assurance sources in 2018/19.

2.7 Policies and Procedures – Action Plan reference 3.10

The PSIAS 2000.12 requires internal audit policies, procedures and guidance documents to be up-to-date and reviewed regularly. The Fraud Policy and the audit manual require updating.

2.8 Engagement Planning – Action Plan reference 3.11 and 3.12

The PSIAS 2200.4 and 2200.5 require work programmes to be approved prior to the commencement of the engagement, and when any adjustments are subsequently made to the work programme. Approval is not currently formally documented.

The PSIAS 2200.6 requires, for audit engagements for parties outside the organisation, a documented agreement detailing roles and responsibilities of internal audit and the client and operational arrangements, such as access to engagement records, distribution of reports etc. No Service Level Agreement is in place and no reference is made to external bodies in the Internal Audit Charter.

2.9 Communicating Results of Engagements – Action Plan reference 3.13

The PSIAS 2400.7 suggests that audit reports should state that the engagement has been conducted in conformance with the PSIAS. Audit reports do not refer to the PSIAS.

2.10 Risk Management – Action Plan reference 3.14

We were able to confirm that the Internal Audit function is highly regarded and respected throughout the Council. It would enhance Internal Audit's planning and risk management if the Chief Audit Executive was able to attend the meetings of the Senior Management Team.

We would like to thank all staff and Members of Moray Council for the co-operation and goodwill we received during our review.

Avril Cunningham, FCCA MIIA
Service Manager, Audit and Risk Management Services
Fife Council

26 February 2019

3. ACTION PLAN

Ref. No.	Recommendation	Priority	Management Comment	Manager Responsible	Date to be Completed
3.1	The CAE should discuss any future updates of the internal audit charter with all members of CMT prior to submission to ASC for approval.	2	Agreed; in the past the charter has been discussed with the Corporate Director (Corporate Services) and in future will be taken through CMT	CAE	Dec 2019
3.2	The CAE should report on performance against the audit plan in the Annual Audit Report and provide ASC regularly with the results of key performance indicators.	2	Agreed, this can be incorporated into future reports to the Audit and Scrutiny Committee. Presently IA performance reporting is to Policy and Resources Committee along with other Corporate Services teams	CAE	Jun 2019
3.3	Audit reports should be submitted to ASC directly by the CAE.	2	Not agreed, currently council Financial Regulations require the Corporate Director (Corporate Services) to secure the provision of an internal audit service for the council. Also there are no provisions in the Scheme of Delegation to the Internal Audit Manager for a departure from current policy that requires committee reports to be issued in the name of a director or head of service. This will be reviewed again when the constitutional documents are next due for updating.	Corporate Director (Corporate Services)/CAE	By March 2020

3.4	Consideration should be given to seeking feedback from the Chief Executive and the Chair of the ASC for future CAE appraisals	3	Agreed, this will be done when the next appraisal (as part of the Employee Review and Development Programme) of the CAE is undertaken	Corporate Director (Corporate Services)/CAE	Sep 2019
3.5	The processes for documenting potential conflicts of interest and for retaining evidence of auditor knowledge of, and compliance with, the Code of Ethics should be formalised.	2	Agreed, this will be straight forward to implement and provide evidence that staff acknowledge the need to adhere to the audit code of ethics alongside professional codes and the council's code of conduct for employees	CAE	Apr 2019
3.6	Job descriptions for CAE and Senior Auditor posts should be up-dated.	3	Agreed, low priority but should be updated to reflect any changes in the roles	CAE	Nov 2019
3.7	A formal approach to planning and recording training should be put in place, and Employee Development Review Forms updated.	2	Agreed, a central training record will be developed –staff hold their own CPD records and to date this has not been seen as a priority	CAE	May 2019
3.8	An Audit Planning Checklist should be used to evidence the areas considered for inclusion in the Audit Plan.	2	Agreed, audit plans are derived from various sources as described in the audit plan report presented to Committee annually. The checklist will detail the sources consulted when determining items for inclusion in the plan	CAE	For 2020/21 plan
3.9	An Assurance Map should be developed to document the approach to using other sources of assurance.	2	Agreed, this would be a useful exercise to bring together the sources of assurance the internal audit team may be able to place reliance on and it is proposed this is developed over the next year	CAE	For 2020/21 plan

3.10	The Fraud Policy and the Audit Manual should be updated, and thereafter regular reviews scheduled.	2	Agreed, the Fraud policy is being updated and the audit manual will be refreshed to reference changes to practice following purchase of new audit software	CAE	Jun 2019 Dec 2019
3.11	Work Programmes should be approved prior to commencement of the audit, and if any adjustments are made during the audit.	2	Agreed in part, for established and recurring audit areas e.g. schools where the parameters of the audit are known in advance. In other areas the audit scope may be developed as the audit progresses depending on initial findings There is currently a dialogue around this which will be recorded in our systems.	CAE	May 2019
3.12	In the absence of a separate documented agreement, reference should be made to engagements for parties outside the organisation in the Moray Council Internal Audit Charter.	3	Agreed, this links to 3.1 above and reference to the MIJB and GVJB will be added into charter on its next update	CAE	Dec 2019
3.13	Audit reports should state that the engagement has been 'conducted in accordance with PSIAS'.	2	Agreed, this will now be added, given the results of this EQA review.	CAE	Apr 2019
3.14	The CAE should routinely attend the Senior Management Team meetings.	3	Agreed in part, this is an added demand on CAE time and having access to the meeting agendas and attending where appropriate is the preferred option.	Corporate Director (Corporate Services)/CAE	Apr 2019

Key to Grading of Recommendations
Priority: 1 – Critical, 2 – Requires addressing, 3 – Good Practice, 4 – Value for Money

SUMMARY OF CONFORMANCE WITH THE PSIAS – Appendix A

Reference	Assessment Area	Fully Conforms	Generally Conforms	Partially Conforms	Does Not Conform
Section A	Definition of Internal Auditing		✓		
Section B	Code of Ethics	✓			
Section C	Attribute Standards				
1000	Purpose, Authority and Responsibility	✓			
1100	Independence and Objectivity		✓		
1200	Proficiency and Due Professional Care			⚠	
1300	Quality Assurance and Improvement Programme			⚠	
Section D	Performance Standards				
2000	Managing the internal Audit Activity		✓		
2100	Nature of Work	✓			
2200	Engagement Planning		✓		
2300	Performing the Engagement	✓			
2400	Communicating Results		✓		
2500	Monitoring Progress		✓		
2600	Communicating the Acceptance of Risks		✓		

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 30 JANUARY 2020**

SUBJECT: **CIVIL CONTINGENCIES – RESILIENCE STANDARDS PROGRESS**

BY: **CORPORATE MANAGER**

1. REASON FOR REPORT

1.1. To inform the Audit, Performance and Risk Committee of Health and Social Care Moray's progress against NHS Grampian's Resilience Improvement Plan 2019-2021 and provide an overview of the work of the Health and Social Care Moray (HSCM) Civil Contingencies Group.

2. RECOMMENDATION

2.1. It is recommended that the Audit, Performance and Risk (APR) Committee consider and note the :

i) contents of this report alongside the HSCM Civil Contingencies Group Action Plan (APPENDIX 1);

ii) outcome of the Primary Care Business Continuity external audit by PriceWaterhouseCoopers at APPENDIX 2; and

iii) progress to date and request an annual assurance report from the HSCM Civil Contingencies Group.

3. BACKGROUND

3.1. In May 2016 Scottish Government Health Resilience Unit (SGHRU) published the NHS Scotland Standards for Organisational Resilience (the Standards): this was subsequently updated and revised and a second edition published in May 2018.

3.2. The stated purpose of the Standards is to "support NHS Boards to enhance their resilience and have a shared purpose in relation to health and care services preparedness in the context of duties under the Civil Contingencies Act 2004".

3.3. Each Standard, of which there are 41, sets out:

- A statement of an expected level of resilience practice

- A rational/basis for the Standard (set within the context of statutory duties under the Civil Contingencies Act 2004 and other key legislation and guidance
- A series of indicators/measures of what should be in place, or achieved, within/by the Health Board.

3.4. Changes introduced in the 2018 second edition of the Standards included:
- Amendments to the wording of specific Standards
- New indicators within certain Standards,
- It also made explicit the role of the Health and Social Care Partnerships in resilience and their link to Primary Care and General Practice.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. The HSCM Civil Contingencies Group, comprising of representatives from each service area, meet monthly to develop and monitor progress on testing and exercising of plans, identify training needs, monitor and manage risks through the escalation process, progress actions, share good practice and development in relation to planning and response to risk with service areas. The group reports to the NHS Grampian Civil Contingencies Group on a quarterly basis.

4.2. A weekly 'Friday Huddle' has been established to provide managers with information from across the health and social care system to support those going on call ahead of the weekend. Feedback from managers supports the weekly meeting as it raises awareness of the pressures in Grampian Medical Emergency Department (GMED), Dr Gray's Hospital and HSCM.

4.3. The Moray Resilience Group provides a forum for HSCM, Dr Gray's Hospital, Moray Council and NHS Grampian colleagues, with a responsibility for resilience, emergency planning or business continuity to discuss and where appropriate develop common procedures or plans to address risks and threats in Moray.

4.4. The action plan (**APPENDIX 1**) is in place to support NHS Grampian's Resilience Improvement Plan, close the gaps and address areas of improvement in Moray, with assurance processes around these. The plan, overseen by HSCM Civil Contingencies group on behalf of the Chief Officer, is linked to each Standard and self-assessment level against each Standard is detailed. Please see below table for criteria for scoring the self-assessment.

Level 1 – Planning	**Level 2 – Implementing**
• Benchmarking against 'Action' undertaken and analysed • Planning arrangements have been initiated • Local improvement plan to meet standard developed and forms integral part of Health Board's Resilience Committee's work plan.	• Resilience Committee / Resilience Exec Lead tasked to progress 'Action' • Implementation plan and methodology agreed • Collating appropriate information to monitor delivery of 'Action' • Some evidence of 'Action' being delivered.
Level 3 – Monitoring	**Level 4 – Reviewing**

• 'Action' implemented consistently and geographically across Health Board • Agreed process in place and being reviewed over time • Associated learning and improvement planning in place to ensure delivery of standard.	• 'Action' has been mainstreamed into existing services • Quality assurance and performance management established to review 'Action' on an on-going basis.

4.5. The following actions have been prioritised for 2019-21: these are predicated on the ongoing maintenance of actions already achieved, identified risks and continuance of the supporting resilience processes and practice in place across the health and social care system:

- Business continuity plans (BCP), service business impact analysis (BIA) and recovery plans to be in place across Moray.
- Critical functions list to be finalised and agreed.
- Training gaps identified and documented.
- Actions to mitigate risks at HIGH and VERY HIGH on the Civil Contingencies risk register
- Embed business continuity across health and social care system through education and training.

4.6. NHS Grampian are exploring the introduction of an electronic system to support business continuity management across NHS Grampian and partnerships. In addition, partners will be collaborating on developing a consistent approach to BIA, and BCP templates which, once agreed, will be rolled out across the system.

4.7. NHS Grampian commissioned PriceWaterhouseCoopers to carry out an audit of Business Continuity in Primary Care and the final report is attached at **APPENDIX 2**. As GP practices are private businesses that contract with partnerships, there is no specific requirement for them to submit completed BCP to partnerships. HSCM plans to work in partnership with local GP Practices to identify common critical functions for the system, and put in place measures to protect them.

5. SUMMARY OF IMPLICATIONS

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

This report forms part of the governance arrangements of Moray Integration Joint Board; good governance arrangements will support the Board to fulfil its objectives.

(b) Policy and Legal

The Civil Contingencies Act 2004 outlines a single framework for civil protection in the UK. Part 1 of the Act established a clear set of roles and responsibilities for specified organisations involved in emergency preparedness and response at local level (known as Category 1 responders). NHS Grampian is a Category 1 responder.

Sector resilience and preparedness is the responsibility of the Chief Officer. The Corporate Manager is responsible for acting as the point of contact for Moray and for driving forward all matters relating to civil contingencies and resilience within Moray, supported by HSCM Civil Contingencies Group and Moray Resilience Group.

(c) Financial implications

There are no financial implications associated with this report.

(d) Risk Implications and Mitigation

HSCM Civil Contingencies Risk Register is routinely monitored by the HSCM Civil Contingencies Group with risks escalated to the senior management team as appropriate.

(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 Equality Impact Assessment is not needed as there is no change to policy or procedure.

(h) Consultations

Consultation on this report has taken place with the Chief Officer, Chief Financial Officer and Caroline Howie, Committee Services Officer, Moray Council, who are in agreement with the content of this report as regards their responsibilities.

6. CONCLUSION

6.1. This report summarises the actions that are being progressed to ensure that HSCM meets the appropriate standards and establishes robust contingency arrangements to ensure critical functions can be maintained during disruptive incidents. Progress is being made but there are some areas that require urgent attention and these are being prioritised by senior management.

Author of Report: Isla Whyte, Interim Support Manager
Background Papers: with author
Ref:

Moray Civil Contingencies Improvement Action Plan

incorporating EXTRACT of PRIORITIES FOR YEAR 1 (MORAY) - NHS Grampian Improvement Plan Against Resilience Standards 2019-2021

Last Updated: 14.01.20

ID	Description	Linked to	Self Assess Level (see criteria on next page)	Requirement	RAG Status	Action Required	Evidence	Owner	Expected Completion Date
1	Governance	Standard 3	4	Civil Contingencies Group (or equivalent) in place for each sector, and actively meeting	G	Draft Terms of Reference to be approved	Terms of Reference agreed, meeting dates agreed. Reviewed annually	HSCM Civil Contingencies Group	31-Jan-21
2	Governance	Standard 2	2	Workplan in place to include training, review of plans, sector based exercising and participation in NHSG programme of exercising	A	Rolling programme of work to be developed.	Annual work plan agreed and in place.	HSCM Civil Contingencies Group	28-Feb-20
3	Business Continuity	Standard 7,8	2	HSCM to have up-to-date, effective Business Continuity (BC) / contingency plans for all prioritised services and functions. HSCM to have an overarching BC Plan with agreed list of critical functions/services.	R	Service Managers to review and provide up to date BCPs and BIAs by 31 July 2019	Critical functions and overarching BC plan in place and agreed by Systems Leadership Group (SLG)	Systems Leadership Group	31/07/2019 revised date 31-Mar-20
4	Specific needs of Children in MI & BC planning	Standard 10	2	The specific needs of children and young people to be addressed in all relevant Major Incident and Business Continuity plans, and ensure that its responses / interventions are sensitive to their needs	A	Sectors to develop model for engagement of Children's social work services in Resilience Groups	Engagement of Children's social work services in resilience planning	Systems Leadership Group	tbc
5	Command Control and Coordination - Major Incident / BC response	Standard 11	2	Sector arrangements to be agreed and tested.	R	Meeting required to discuss roles and responsibilities of senior staff in hours and out of hours. Training needs to be identified ie loggist / control room lead.	Documented roles and responsibilities. Incident Management Team identified. Control Room arrangements documented. List of staff trained held locally ie loggists.	HSCM Civil Contingencies Group	31-Jan-20

6	Major Incident / BC Response - Control Room	Standard 11	2	Staff identified and trained: - Loggists - Control Room Manager	A	Staff to be identified to attend training.	Central list of trained staff held. Training programme in place and communicated via SLG and HSCM Civil Contingencies Group	Corporate Manager / SLG	31-Jan-20
7	Pandemic Influenza	Standard 16	2	NHS Board shall develop and review its Pandemic Influenza Plan jointly with local partnerships and RRP, and seek their endorsement. A joint multi-agency plan shall be developed, if one does not already exist.	A	Completion, sign off and circulation of Grampian Health and Social Care system MID/Pandemic Response plan.	MID/Pandemic Flu response plan detailing integrated health system response to MID/Pan Flu, and setting out links to RP response	HSCM Civil Contingencies Group	31-Mar-20
8	Pandemic Influenza	Standard 17	2	Link with NHSG Board in exercising Pandemic Flu plan every 3 years	A	Grampian wide health and social care system pandemic tabletop exercise.	Exercise documentation and records of attendees. Post exercise report with lessons learned.	HSCM Civil Contingencies Group	TBA
9	Governance	Standard 5	3	Sector risks to be recorded, monitored and escalated where necessary	G	Draft Risk Register to be presented to HSCM Civil Contingencies Group for approval.	Risk Register in place and maintained with actions to mitigate risks in place. System in place to escalate those risks deemed High or Very High to SLG where necessary.	HSCM Civil Contingencies Group	01-Dec-19
10	Information Security and ICT Resilience	Standard 31	2	BIA/Recovery plans reviewed for IT and Communications	A	Define list of critical ICT requirements and advise NHSG Ehealth and Moray Council accordingly.	BIAs updated and held centrally. Critical functions list agreed. NHS eHealth and Moray Council informed of requirements.	Systems Leadership Group	tbc

11	Supply Chain Resilience	Standard 39	2	BIA/Recovery plans reviewed for suppliers	A	Define list of critical suppliers and ensure risk assessment mitigation measures are in place. NHSG Board to be informed.	BIAs updated and held centrally. Critical functions list agreed. Risk assessment completed with actions to mitigate detailed.	Systems Leadership Group	tbc
12	Winter Plan	Standard 18	4	Sectors shall have robust Winter Plans and implement a range of actions to enhance resilience during winter period.	G	Continue to attend cross system meetings to learn from previous experience and ensure progress against action plan.	Winter plan in place and action plan in place. Part of Grampian's year-round planning cycle and participation in joint planning, table top exercises and debrief exercises.	Systems Leadership Group	Ongoing
13	Major Incident /Resilience Plans	Standard 9	2	NHS Board shall have Major Incident or resilience plans that reflect its emergency preparedness. Sectors to sign off plan. Through HSCP, GP / Primary Care made aware of their role in the Major Incident Plan and expectations of them.	A	Take final NHS Board plan to SLG and HSCM CC Group for discussion and sign off.	Grampian plan signed off and partnership working with primary care in place.	Systems Leadership Group	tbc
14	Training		1	Training gaps identified: - who needs to be trained and in what course / session	A	A locally delivered Civil Contingencies programme of training courses for HSCM managers and staff to be identified and implemented	NHSG Civil Contingencies Unit (CCU) training programme in place and dates communicated to SLG	CCU / Corporate Manager	31-Jan-20

NHSS STANDARDS FOR ORGANISATIONAL RESILIENCE

ASSESSMENT & IMPROVEMENT PLAN – BENCHMARKING CRITERIA

PLANNING (1)	IMPLEMENTING (2)	MONITORING (3)	REVIEWING (4)
Level 1 - Planning	**Level 2 - Implementing**	**Level 3 - Monitoring**	**Level 4 - Reviewing**
Benchmarking against 'action' undertaken and analysed	Resilience Committee / Resilience Exec Lead tasked to progress 'action'	Action' implemented consistently and geographically across Health Board	Action' has been mainstreamed into existing services
Planning arrangements have been initiated	Implementation plan and methodology agreed	Agreed process in place and being reviewed over time	Quality assurance and performance management established to review 'action' on an on-going basis
local improvement plan to meet standards developed and forms integral part of Health Board's Resilience Committee's work plan	Collating appropriate information to monitor delivery of 'action'	Associated learning and improvement planning in place to ensure delivery of standard	
	Some evidence of 'action' being delivered		

Business Continuity Management within HSCPs and Primary Care

NHS Grampian
November 2019

Click to launch

pwc

Contents

Distribution list

For action: Martin Allan (Business Manager, Aberdeen City Health and Social Care Partnership)
Jeanette Netherwood (Corporate Manager, Health & Social Care Moray)
Emma King (Head of Locality, Aberdeen Central)
Sean Cody (Community Health Services Manager)

For information: Sandra Ross (Sandra Ross, Chief Officer - Aberdeen City Health and Social Care Partnership)
Pamela Gowans (Chief Officer - Health and Social Care Moray)

Executive summary

Report classification

Medium Risk

Total number of findings

	Critical	High	Medium	Low	Advisory
Control design					
Operating effectiveness			3		
Total			**3**		

Executive summary

Headlines

Audit approach

This review was undertaken as part of the 2019/20 Internal Audit Plan, as approved by the Audit Committee in March 2019. The focus of the review was to consider the extent to which the Aberdeen City Health and Social Care Partnership and Health and Social Care Moray (the HSCPs) have defined, communicated and monitored business continuity management arrangements for primary care providers (PCPs). We also gave consideration to the business continuity management arrangements that are in place at HSCP level specifically, to respond in the event that primary care providers are unable to deliver core services.

To examine consistency of business continuity management (BCM) across primary care providers (PCPs) in the Grampian region, we carried out a series of walkthroughs with personnel charged with undertaking BCM at a sample of PCPs within the Health and Social Care Moray and Aberdeen City HSCP locales. These walkthroughs involved enquiry of staff on their business continuity planning, staff training and on support they have had from the HSCPs on implementation and delivery of effective BCM planning. We also inspected BCM plans and relevant support materials in place at each of the sampled providers.

Key findings

Responsibilities for performing BCM have not been clearly defined between PCPs and HSCPs since the inception of the partnership. As a consequence, efforts by the HSCP to support PCPs in reviewing and providing feedback on BCM arrangements has been limited. Across our sample of PCPs, we noted that business continuity plans are in place but are not necessarily aligned with templates used by the HSCPs that have been previously produced by NHS Grampian. Roles and responsibilities relating to business continuity had been communicated by the HSCPs to GP practices at which we carried out our review, but not to the pharmacies, ophthalmologists and dental practices sampled. A template for business continuity plans was provided to some GPs in our sample by NHS Grampian several years ago, varying between 2011 and 2015. In addition to this a Business Impact Assessment (BIA) form has been sent out to some, but not all, PCPs in July 2019. Overall, management at the practices which formed our audit sample demonstrated awareness in BCM practices but a consistent theme was a lack of formal training provided to staff in the area.

During the course of our review we noted 3 medium rated findings. These were as follows:

- Lack of oversight of business continuity management at Primary Care Providers
- Business continuity management Plans at Primary Care Providers are not reviewed on a regular basis
- Business continuity plans are not periodically tested at primary care providers.

Good practice noted

We noted good practice in business continuity incident testing at Integrated Joint Board level. Both HSCPs have carried out three live testing scenarios in the last 18 months in order to ensure staff are sufficiently prepared in the event of a critical incident or a significant disruption to services. For each of the exercises that has been run by the HSCPs, a debrief and mock post-incident review is used to capture lessons learned and incorporate refinements to the BCP.

In addition to this, although the format of business continuity plans that we inspected were not all aligned with the NHS Grampian BCM templates adopted by the HSCPs, there was generally a high standard of documentation at the nine of twenty Primary Care Providers that responded to our audit enquiry. Plans incorporated the roles of all members of staff and the responsibilities of practices to the wider health community. All BCM templates sampled included an incident flowchart, which instructs staff on the necessary steps to take in the events of specific incidents which may impact business continuity.

Executive summary

Management comments

Aberdeen City Health and Social Care Partnership

Aberdeen City Health and Social Care Partnership want to fully engage in cross system partnership working. This includes NHS Grampian primary care providers and independents and will work closely with all to develop a consistent approach to business continuity planning in the City. We will engage with all relevant parties, exercising plans to encourage all participants to see where their role fits into the wider City response

Health and Social Care Moray

Responsibilities for Business continuity have not been clearly defined between NHS Grampian and the Health and Social Care Partnerships with regard to determination of critical functions and therefore that has led to a lack of clarity for Primary Care Providers.

Background and scope

Background

The objectives of the review were to examine how governance of the primary care providers by the HSCPs ensures that the roles and responsibilities of the PCPs in delivering effective business continuity planning are upheld. We reviewed a sample of 20 primary care providers across Health and Social Care Moray and Aberdeen City HSCP regions and assessed the availability and quality of key business continuity management documentation, as well as user training and other measures adopted to communicate policy within the PCPs. Our sample included GP Practices, Dental Surgeries, Pharmacies and Ophthalmologists which together make up the primary care providers.

Process Governance

There is no formal arrangement relating to BCM between HSCPs and PCPs, partially due to a lack of contractual obligation on the part of PCPs to maintain and provide business continuity management documentation. Roles and responsibilities for staff relating to BCM were outlined in a Business Continuity Detailed Recovery Plan Template which was circulated to some PCPs (principally GP Services) in 2011. Management at these sites have retained and updated this template on an ad hoc basis. For other types of PCPs, namely dental practices and pharmacies, business continuity management was administered solely by the property owner or practice manager, independent of HSCP Guidelines. However in our audit we noted that this did not appear to have a detrimental effect on the quality of the business continuity planning that was in place. Staff at primary care providers are not provided with training in business continuity management.

Business Impact Analysis

Business Impact Analysis (BIA) templates were provided to some PCPs in August 2019 but these have not been consistently rolled out across all PCPs, and the roll out has not been supported with a detailed communications and support plan. In response to this, the PCPs in our sample that had received BIA templates had transferred existing business continuity plans into the template. Practice managers are responsible for maintaining and updating both BCM plans and BIAs, as well as making staff aware of where they can access the plans that are in place. We examined the list of potential threats that were defined within business continuity plans at each of the primary care providers for consistency and determined that the were consistent across the practices. Due to the fact that some BCPs have not been reviewed for several years, it is possible that there are some potential threats that have not been identified.

Business continuity plans and testing

All of the primary care providers in our sample that responded provided a thorough Business Continuity Plan which detailed individual staff roles and responsibilities as well as references to anticipated communications with authorities. Continuity plans that were inspected covered all threats which have been identified by the HSCPs as being threats to critical processes, including but not limited to; contaminated patients, chemical incidents, incapacity of staff, major accidents, terrorism, supply chain shortages, pandemic flu, loss of gas or water supplies, telephone and IT failures. Business continuity plans are updated on an ad hoc basis at the discretion of the practice manager. There is no secondary review of changes made to plans. Staff at each PCP are aware of how to access the relevant plans although are not provided with formal training in actioning BCPs.

Background and scope

HSCP oversight of primary care service provision

Both HSCPs have contingency plans in place to maintain services in the event that specific primary care providers are unable to continue to provide services. The business continuity policy which details the strategies behind this contingency planning was coordinated by the NHS Grampian Head of Civil Contingencies on behalf of the partnerships and last updated in 2017. Business continuity plans at IJB level are subject to live testing scenarios on a regular basis, 3 of which have been carried out in the last 18 months. Findings from these tests are captured and subsequently built into updated business continuity plans. Our audit included a review of documentation detailing these tests and the results that arose from staff responses. Currently, the HSCPs do not formally review business continuity plans at primary care providers. A copy of the plans at each PCP is requested on an annual basis but this is not enforced.

Scope and limitations of scope

For this review, we inspected business continuity planning at HSCP level through interviews with senior members of staff responsible for business continuity and examined plans in place, alongside documentation relating to business continuity tests carried out in the last 3 years and policies and procedures that are communicated to Primary Care Providers. In addition to this we carried out an inspection of BCM practices, policies and documentation across a sample of 20 primary care providers across Moray and Aberdeen City local authority areas.

As part of our review, we enquired at each of our sampled Primary Care Providers whether there had been any threats or incidents relating to Business Continuity in the last 36 months, none were noted.

This review considered BCM processes only in respect of primary care services. Other operations performed by NHS Grampian or the HSCPs were out of scope. While this review considered the availability and content of business continuity management information from privately operated primary care providers as part of our approach, we did not assure specific activities performed by these primary care providers to prepare materials, train staff in how to apply materials and test their effectiveness. The review specifically excluded the Aberdeenshire Health and Social Care Partnership and associated Integrated Joint Board due to a similar scope of work that was recently performed by their Internal Audit function.

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.

Current year findings

1 Lack of oversight of BCM Policies at Primary Care Providers

Operating effectiveness

Finding rating

Rating	Medium

Finding and root cause

While we note that there is no contractual requirement for PCP's to prepare and share BCM materials, for the HSPCs to discharge Civil Contingencies Act requirements, PCP oversight is required. HSPCs have not actively set expectations with Primary Care Providers in relation to Business Continuity Management, and roles and responsibilities for performing BCM activity between the HSCPs and the PCPs are not well defined. As a result, the HSCPs do not have clear visibility over the quality of BCM arrangements at PCPs in their region.

We assessed the impact of this through a sample of twenty PCPs. Of the nine respondents:

- only the six GP services had been provided with up to date business continuity planning templates, and as a result the Pharmacy and two Dental Practices that responded have defined their own documentation requirements.
- the six GP surgeries submit business continuity plans to the HSCPs on an annual basis for review, but this is not in place for the three non-GP PCPs.
- feedback is not being provided to GPs that submit their business continuity plans.
- PCPs are not aware of BCM resources to support them in preparing for, or responding to, a business continuity incident.

We did note that Health and Social Care Moray recently offered a workshop for PCP managers on BCM but there was little appetite for the event.

Potential implications

There is a risk that as a result of not setting expectations as to the extent and quality of BCM which is supported through regular feedback, BCM is not practiced to a uniform standard across the PCPs. This could lead to a disparity in services available to the public in the event of a business continuity incident, or an inability to restore services within a reasonable time frame, and could result in reputational damage or government censure.

Recommendation

The partnerships need to work with PCPs to explain the responsibilities of each party for business continuity and how oversight of this at the PCP level is going to be administered by the partnerships. In the short term, the HSCPs should create an identified point of contact or hold drop in sessions on a quarterly basis which combine BCM with other oversight activities relating to provision of primary care. BCM materials should be reviewed by the partnerships to ensure that plans exist for all threats which disrupt critical processes, and feedback and best practices should be shared.

Current year findings

1 Lack of oversight of BCM Policies at Primary Care Providers

Operating effectiveness

Finding rating

Rating	Medium

Management action plan

Responsible person/title:

Martin Allan, Jeanette Netherwood

Target date: April 20th, 2020

Aberdeen City Health and Social Care Partnership

The NHS Grampian Civil Contingencies Unit is currently looking to streamline the BCP process to create a uniform template. They will engage with PCP's across the Partnership on the template, explaining the importance of business continuity planning as well as what a robust BCP can do for organisations when required to use them. A meeting of the Practice Managers (as well as other PCP's) will be called to undertake this engagement.

A session with the NHS 2C Practices will first be held on February 20th followed by a wider cross Partnership workshop with all providers on April 20th 2020.

The Business Support Team within the Partnership will be the single point of contact (generic e-mail address). The "writing a BCP" training course on the 11th of November will also be expanded to include reps from PCP's

NHS Grampian is also currently looking at an IT based solution, through web-based software. After completing a 12 stage BIA, the software generates a bespoke BCP, allowing the organisation to have easily accessible, standardised plans.

Health and Social Care Moray

Health and Social Care Moray will work with NHS Grampian Civil Contingencies Unit and other HSCPs to determine the critical functions that impact across whole system and where PCP are involved in delivery of these functions we shall ensure clear communication of roles, responsibilities and expectations and if there are any areas requiring assistance we shall work collaboratively to resolve the issues. Work commences on this at the workshop on 11 November with NHS Grampian Civil Contingencies Unit and timescales will be determined thereafter.

Current year findings

2 Business continuity plans at Primary Care Providers are not reviewed on a regular basis

Operating effectiveness

Finding rating

Rating	Medium

Finding and root cause

In line with Finding 1, there is no formal expectation set by the HSCPs that business continuity plans are periodically reviewed and updated for changes in the business or its environment in a formal manner.

We investigated the impact of this through a sample of twenty PCP. Of the nine respondents:

- none have carried out a formal review and update of practice business continuity management plans in the last 12 months.
- At four of the six responding GP Services (where the business continuity template had originally been provided by NHS Grampian), there has been no update to business continuity planning documentation since the template had originally been completed following its issue in 2011.
- The pharmacy and two dental practice respondents provided business continuity plans that had been updated on an ad hoc basis for a number of years but had not been formally reviewed by either the practice manager or the HSCPs during this time.

Potential implications

If business continuity plans are not reviewed and updated regularly, changes to critical functions or requirements at primary care providers may not be not identified, leading to an ineffective responses. There is a risk that scenarios culminating in incidents are not complete based on the latest industry and political developments (e.g. the impact of Brexit) or are not critically evaluated for their impact on process requirements. Further, there may not be a defined response to incidents experienced or that current responses in the plans are outdated in terms of technology, process or roles.

From an HSCP perspective, if plans are not being scrutinised locally on a regular basis, limited assurance exists that arrangements are sufficient.

Recommendation

Business continuity plans should be reviewed and updated on an annual basis with any changes communicated to staff. A copy of the plan should continue to be sent to the HSCPs for centralised review each year.

Current year findings

2 Business continuity plans at Primary Care Providers are not reviewed on a regular basis

Operating effectiveness

Management action plan

Aberdeen City Health and Social Care Partnership

A single point of contact generic e-mail address will be used to collate the BCP's and that the Partnership's Civil Contingencies BCP Sub Group undertake the review. In terms of timeline, the PCP's will use the revised templates and workshop to submit a revised BCP.

Health and Social Care Moray

We shall work with our PCPs to ensure that they provide assurance that they can meet the expectations of continuation of the identified critical functions and shall review their arrangements annually whilst providing opportunities for them to take part in table top exercises to test their arrangements.

Responsible person/title:

Martin Allan, Jeanette Netherwood

Target date: May 2020

Finding rating

Rating	Medium

Current year findings

3 Business continuity plans are not periodically tested at PCPs

Operating effectiveness

Finding rating

Rating	Medium

Finding and root cause

In line with Finding 1, there is no formal expectation set by the HSCPs that business continuity plans are periodically tested. None of the nine respondents in our sample of 20 PCPs stated that they carry out periodic testing of any scenarios detailed in their business continuity plans. Staff receive no formal training in implementing the BCMs and are, in almost all cases, made aware of the existence of the document but not required to read it. As a result, it is unlikely that staff are familiar with their responsibilities under different business continuity scenarios as defined in the plans.

We did note that from an HSCP perspective, plans are regularly tested and the results inform the continuous improvement of the business continuity arrangements.

Potential implications

There is a risk that PCP staff using business continuity plans in a live incident are not familiar with their responsibilities and do not perform them effectively.

A failure to carry out periodic testing of procedures could create a situation where issues with plans are only identified in the event of an actual incident or threat. The broader impact of this is a delay in critical services being re-established in the event of an incident.

Recommendation

PCPs should be required to carry out annual testing of business continuity plans through tests involving staff employed at the practice. Findings from these tests should be documented and built into plan improvements on a regular basis. All staff should receive training in BCM to some extent upon joining and should be provided with updated copies of business continuity plans whenever there are any alterations or improvements made to the procedures.

Current year findings

3 Business continuity plans are not periodically tested at PCPs

Operating effectiveness

Finding rating

Rating	Medium

Management action plan

Aberdeen City Health and Social Care Partnership

A Partnership wide exercise (including Primary Care) will be facilitated by both Aberdeen City Council's Emergency Planning Officer and NHS Grampian's Civil Contingencies Unit to test the preparedness of the Partnership in an incident-as discussed with Emergency Planning Officer. The Partnership has taken part in Aberdeen City Council and NHS Grampian run exercises, however a Partnership specific exercise will focus attention on the preparedness of Primary Care within a wider Partnership wide system. The exercise will be held in the first quarter of 2020.

Health and Social Care Moray

PCP will be provided with guidance on the expectations from Health and Social Care Moray with regard to critical functions and we will encourage participation at table top tests and training events. A programme of events will be circulated to PCPs for 2020/21 and a workshop will be carried out to focus on activation, response and communication processes with PCPs.

Responsible person/title:

Martin Allan, Jeanette Netherwood

Target date: 31 March 2020

Appendices

Appendix A: Basis of our classifications

Individual finding ratings

Critical

A finding that could have a:

- **Critical** impact on operational 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

Appendix A: Basis of our classifications

Individual finding ratings

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	Option A	Option B	Points
	Low risk	Satisfactory	6 points or less
	Medium risk	Satisfactory with exceptions	7 – 15 points
	High risk	Needs improvement	16 – 39 points
	Critical risk	Unsatisfactory	40 points and over

Appendix B: Terms of reference

Scope

NHS Grampian recognises the risk associated with business continuity programme governance (rated medium), business continuity testing (rated medium) and business continuity training (rated high) through the civil contingencies risk register. As part of this review we will consider NHS Grampian's assessment of inherent and residual risk (taking into account relevant controls) to ensure effective visibility of the risk to the Executive and Trustees.
The sub-processes, risks and related control objectives included in this review are:

Sub Process	Objectives	Risks
Process governance	Roles and responsibilities for business continuity management have been clearly defined and communicated by the IJB to primary care providers. Policies and procedures have been developed for primary care provider use, are accessible to end users and are periodically reviewed. Primary care providers receive training in how to apply IJB BCM policy. Compliance with policy (including the proportion of primary care providers maintaining business continuity plans) is tracked and monitored by the IJB.	Due to poor governance, key BCM activity is not performed or is performed inconsistently by primary care providers. Primary care providers are not aware of BCM resources to support them in preparing for, or responding to, a business continuity incident.
Business impact analysis	Business impact analysis assessments are performed across all primary care providers periodically. Standards and guidance are provided by the IJB to assist functional areas in performing BIA, which is structured to include personnel, physical premises, third party, IT and communication, and medication requirements. Primary care provider processes are classified according to their level of criticality, and recovery point and time objectives are defined for each process performed. Completed BIAs prepared by primary care providers are reviewed by the IJB to ensure consistency and completeness A list of potential threats is defined and considered by the primary care provider for their potential impact on requirements supporting critical processes. This list includes pandemic influenza, seasonal illness, and potential supply chain disruption due to Brexit.	Critical functions or requirements at primary care providers are not identified, leading to an ineffective response to business continuity incidents. Scenarios leading to business continuity incidents are not complete, or are not fully and critically evaluated for their impact on process requirements. This means that there is not a defined response to incidents experienced or that it is not applicable.

Appendix B: Terms of reference

Sub Process	Objectives	Risks
Business continuity plans	At a primary care provider level, business continuity plans exist for all threats which disrupt critical processes, as determined by the BIA, and provided detailed steps for restoring business-critical requirements. Roles and responsibilities are defined within the primary care provider BCP, including authority to declare or end a business continuity event. Staff at the primary care provider are trained in how to access and use the relevant BCP. BCPs are periodically refreshed and reviewed in line with the update of BIAs.	BCPs are not used by primary care provider staff during a business continuity incident. BCPs that exist are not aligned with incidents experienced.
Business continuity testing	BCPs are periodically tested by primary care providers in line with the criticality of the potential continuity event, according to a defined test script. Testing involves participation at all levels of the organisation, including third parties where appropriate. The results of testing are captured and incorporated into a BCP improvement plan.	Improvements identified through testing the BCP are not built into the next iteration of the plan. Primary care provider staff using BCP in a live incident are not familiar with their responsibilities and do not perform them effectively.
Business continuity incidents	For all business continuity incidents experienced by the primary care provider, post-incident review is used to capture lessons learned and incorporate refinements to the BCP.	Adverse results from continuity events are repeated.
IJB oversight of primary care service provision	Business impact analysis has been performed by the IJB for the event that individual or multiple primary care providers are unable to provide core health services. Contingency plans exist to define how the IJB will identify that primary care providers cannot provide services, and how service to the public will be restored. Plans are tested and refreshed based on lessons learned through testing or continuity events experienced.	The IJB is unable to restore service within a reasonable time frame, leading to reputational damage or government censure.

Appendix C: Limitations and responsibilities

Limitations inherent to the internal auditor's work

We have undertaken this review 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 changes; 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 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.

Thank you

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