Audit and Risk Committee - 3 September 2024

Minutes

NHS Orkney
Tuesday, 3 September 2024 at 09:30 BST

Attendance

Present:
Members: Paul Corlass, Debs Crohn, Suzanne Gray, Issy Grieve, Kat Jenkin, Rashpal Khangura, Rachel King, Anna Lamont, Ryan McLaughlin, Rachel Ratter, Laura Skaife-Knight, Jean Stevenson, Jason Taylor, Phil Tydeman

Absent:
Members: Des Creasey

1. Apologies (Presenters: Chair)

   No apologies were recieved.

2. Declaration of Interest (Presenters: Chair)

   I Grieve and J Stevenson declared an interest against item 7, Interim Non-Executive Arrangements.

3. Minute of meeting held on 27 June 2024 (Presenters: Chair)

   The minute of the Audit and Risk Committee meeting held on 27 June 2024 was approved as an accurate record of the meeting.

   3.1. Chairs Assurance Report from meeting on 27 June 2024 (Presenters: Chair)

   The Chairs Assurance report of the Audit and Risk Committee meeting held on 27 June 2024 was noted and approved.

4. Matters arising (Presenters: Chair)

   There were no matters arising.

5. Action Log (Presenters: Chair)

   The action log was reviewed, and corrective action agreed on outstanding issues (see action log for details).

6. Escalation Log

   The action log was reviewed, and corrective action agreed on escalated issues (see escalation log for details).

7. Interim Non-Executive Arrangements (Presenters: Board Chair)

   Julie Colquhoun, on behalf of the Board Chair, presented the report advising as a result of several unexpected and unplanned work/life balance challenges there was an urgent need to make some interim arrangements across the Governance Committees.

It was proposed I Grieve would be the interim Vice-Chair of the Audit and Risk Committee.

Decision / Conclusion

The committee approved and supported the interim non-executive arrangements across the Governance Committee, including I Grieve as Vice-Chair of the Audit and Risk Committee.

8. PATIENT SAFETY, QUALTY AND RISK

8.1. Corporate Risk and Assurance Report (Presenters: Medical Director)

The Head of Patient, Safety and Risk presented the report which provided an overview and update on risk management across NHS Orkney.

During the last reporting period there were no new risks added to the corporate risk register, there were no longer very high risks and two risks had been closed.

Mitigations and actions were underway in relation to the risk around cCube.

The Recovery Director asked whether reduced or changed risks during the period could be reflected in the report.

Members were advised a risk jotter had been progressed in relation to the risk associated with attendance of face to face mandatory training and data quality issues.

The Chief Executive requested that the three top corporate risks were detailed on the cover paper. The committee agreed that the Senior Leadership Team would determine the top risks and feedback through the Chairs Assurance report.

Decision / Conclusion

The committee approved the changes within the refreshed report and noted the evolution the detail available to integrate and gain assurance.

8.2. Risk Management Strategy (Presenters: Head of Patient Safety, Quality and Risk)

The Head of Patient Safety, Quality and Risk presented the report identifying the risk management processes within NHS Orkney.

The proposed risk jotter had been successfully used for four current risks on the corporate risk register with one draft risk rejected and one risk going through the review process at time of writing. Following feedback from users, the Senior Leadership Team and Risk Management Group, the risk jotter had been revised to simplify it and to provide clarity in the owner, the primary and secondary impact; as well as aligning the risks to the corporate strategy and identifying the oversight committees for the risk.

The test of change proposed for the operational risk registers, had not been trialled, the delay reflected issues identified through stakeholder consultation during the initial review of the operational risk registers. This presented an opportunity to consider the current three tier approach or move to a two-tier approach and then review the registers in line with this revised approach. The Risk Management Group recommended to move to a two-tier risk register approach.

The Recovery Director advised that any new investments would need to be considered and evident upon the risk register in relation to the context of the National Financial Affordability Challenge.

Whilst the Chief Executive fully supported the continued use of the risk jotter and the proposed move to the two-tier structure, she raised concern around the level of change requested from staff. Members agreed that Risk Management Strategy updates would continue to be presented to the committee, and that scoping and development work in respect of the operational risk registers could proceed with a view to roll out commencing in the new financial year.

Decision / Conclusion

The committee approved the recommendation made by the Risk Management Forum that scoping and development work in respect of the operational risk registers could proceed with a view to roll out commencing in the new financial year.

Committee approved continued use of the revised risk jotter, and continuing test of change.

8.3. Chairs Assurance Report - Risk Management Group (Presenters: Head of Patient Safety, Quality and Risk)

The Head of Patient Safety, Quality and Risk presented the report highlighting:

- A review of the risk management process including training had commenced
- The current system used to manage the local and operational Risk Registers did not meet the needs of the organisation. A paper was submitted to the RMG and option to move to two-tier approach for risk registers recommended
- There was lack of understanding/ training around risks and issues
- Covid inquiries both UK and Scottish continuing
- The Terms of Reference had been reviewed, revised and agreed

The Chair proposed for future reporting to include a sentence summarising the number of risks discussed and recommended for escalation or de-escalation.

Decision / Conclusion
The Audit and Risk Committee noted and took assurance from the report, with the request on risks being fed back to the group chair.

8.4. COVID enquiry Report (Presenters: Corporate Records Manager)

The Head of Patient Safety, Quality and Risk presenting the report advised both the UK and Scottish Covid-19 Inquiries were progressing and seeking information in preparation for hearings.
In February 2023 NHS Orkney submitted, as required, an initial overview of information and documentation held by NHS Orkney and relevant to Module 3, along with narrative around the Board's role in relation to the delivery of Healthcare services, key issues and lessons learnt. A further rule 9 request in relation to this module was received in May 2024, and a response submitted. Rule 9 requests were confidential to each Board or Core Participant until released by the Inquiry team.
The CLO submitted a written closing statement, and a detailed narrative would be published shortly.

Decision / Conclusion
Members noted the update on submissions.

8.5. *Counter Fraud Services Quarterly Report (Presenters: Recovery Director)

Members received the Counter Fraud Services quarterly report dealing with areas of prevention, detection, and investigation of fraud.
The report outlined the number of cases by Board; NHS Orkney had reported no cases in the period. The Recovery director advised that the Senior Financial Accountant would be the nominated lead for CFS going forward.
The Employee Director queried whether there were departments where fraud awareness training was highly recommended or mandatory, and the steps in place in terms of compliance.
The Senior Financial Accountant advised a post meeting note would be provided.

Post meeting note:

Currently the only mandatory fraud training is the cyber security training in Turas, we currently have a 74% compliance rate.

Discussion with CFS have highlighted some other training modules available in Turas and although not mandatory there is training that his highly recommended for finance and procurement staff.

Anti Money Laundering training has also been discussed with CFS; we are awaiting a response from them regarding our queries. The queries relate to mandatory training as well as statutory requirements.

Decision / Conclusion
The Audit and Risk Committee noted the update

9. PERFORMANCE

9.1. Internal Audit Progress Report (Presenters: Internal Auditor)

R King presented the report which provided a summary of internal audit activity since the last meeting, confirming the reviews planned for the next quarter and identifying changes to the annual plan.
Due to a mix of Board resourcing pressures and recently issued national guidance, two key changes to the plan were proposed. The first was to replace the Financial Management and Reporting review with Risk Management work and the second change was to review the Workforce Planning and Strategy. National guidance had been issued with a deadline of June 2025 for the completion and submission of Workforce Strategy to the Scottish Government. Work would therefore focus on the job evaluation process.
The Chief Executive advised that the Scottish Government were content with the change in relation to the Financial Management and Reporting review, as the organisation did not want to duplicate what was already within the Finance Function Root and Branch review.
The Senior Financial Accountant suggested that the deadline for Financial Controls - Income and Expenditure could be moved due to year end capacity and workload.

Decision / Conclusion
Members thanked Azets for the report and recognised the developing close working relationships with NHS Orkney. The committee received assurance on progress against the plan and approved changes to the internal audit plan.

9.2. Internal Audit - Significant Adverse Events (Presenters: Internal Auditor)

R King presented the report which reviewed the processes and procedures in place for the management of significant adverse events. Whilst the organisation had processes and procedures in place that were aligned to national guidance and reflected the current process followed, the main policy was not up to date. Staff involved in the sample of events tested had been appropriately trained.
Three areas of improvement were noted, which related to timescales as set out by the Scottish Government not being adhered to consistently; action plans had not been created within expected timescales following the completion of the investigation report; and monitoring of the SAE process was not sufficient.
Azets acknowledged that the NHS Orkney team involved in the review were new to the organization, and the process and much of the testing covered a time period before they were in post. Work had progressed in particular around action plans.
Members agreed that the Learning from Incidents management action could be closed, as actions had been reframed to SMART objectives, feeding back to the Senior Leadership Team.

Decision / Conclusion
The Committee reviewed the report and accepted the recommendations.

9.3. Internal Audit - Recruitment and Staff Records (Presenters: Internal Auditor)

R King presented the Recruitment and Staff Records Audit which provided good assurance over the arrangements in place around the range of controls in place for the recruitment of staff and staff record keeping.
There were a number of areas for improvement, most notably, updating policies and procedures for the recruitment process to ensure they were kept up to date and accurately reflected the expected process. It was recommended that introducing feedback requests to both successful and unsuccessful candidates would provide assurance that the process was working well.
The Chief Executive thanked everyone involved and acknowledged the areas to be celebrated and where further work was required, and urged that the end -to -end review and the outputs from this audit were aligned to ensure there was one improvement plan. A post meeting note would be provided in relation to the end- to -end HR review timescales.
In response to a query around international recruitment, members were advised that Azets only carried out the specific scope of the audit. The Director of Improvement advised that an in-house review the entire recruitment team would map out the full recruitment process and would ensure national recruits were included.

Decision / Conclusion
The Committee reviewed the report and accepted the recommendations.

9.4. Internal Audit - Health and Safety Risk Assessments (Presenters: Internal Auditor)

R King presented the Health and Safety Risk Assessments Audit which provided good assurance over the new health and safety risk assessment process. Internal Auditors commended efforts made over the past year to roll out the new processes and to ensure health and safety risk assessments were in place across the Health Board.
There were a number of areas which could help strengthen the base which had been established. While risk assessments had been completed across all areas sampled, they were often not tailored specifically enough to the department and therefore actions being taken to address the risks did not overtly and directly coincide with the actions noted within the risk assessment itself. There was also a need to define levels of risk. A number of lower recommendations were also provided to help improve the health and safety risk assessment control environment.
The Employee Director raised concern around issues identified on tailoring risk assessments, whilst a risk assessment may in theory exist, staff were not aware of the mitigations in place as they are not communicated.
The Chair noted the very positive work in the delivery of the control book system and emphasised the importance of on-going support for various departments in terms of maintaining and understanding the post roll out.
The Chief Executive requested that the responsible Executive Lead joined future meetings to allow further discussions to take place.

Decision / Conclusion
The Committee reviewed the report and accepted the recommendations.

9.5. Internal Audit Recommendations (Presenters: Director of Improvement)

The Director of Improvement presented the report advising that 9 of the 18 management actions from the 2022/23 internal audit were complete and closed, 9 actions submitted to Azets for review. There were 2 actions to date on the 2024/25 cycle that had been submitted and approved by Azets.

There had been continued improvement around how evidence was submitted to Azets and in a timely fashion.
With the strengthened governance in place to monitor and support internal audits, it was proposed that a one-off review of an agreed set of recommendations from the 2022-23 audit cycle be taken forward. The 2022-23 cycle was chosen as it represents a materially significant period of time to evaluate the sustainability of those improvements.
The Chair welcomed the reviews and the hard work involved, the importance of continued learning and that the review not be a one off. He proposed a checklist for Senior Leadership Team to consider when proposing the next internal audit plan, to cover organizational requirements / audit area cycle, feedback from governance committes now built into their workplans, and which, if any recommendations from previous years could be reviewed to gain assurance that recommendations had been embedded.

Decision / Conclusion
The Audit and Risk Committee noted the positive update and support for the review as approved in the change to the internal audit plan. The Chief Executive undertook to formulate a checklist for future internal audit planning.

9.6. External Audit Recommendations (Presenters: Recovery Director)

The Recovery Director presented the report advising the Boards external auditors had made a number of recommendations, included within the annual ISA 260 external audit report. These were categorised in priority order, using the risk matrix.
The Board had five external audit recommendations identified during the 2023/24 accounts audit. There was clear ownership of these recommendations within the finance team and an action log had been created, which outlined the progress against the actions. The first action was not due until 30 September 2024 and all actions were on track to be implemented before the suggested deadline.
Members were advised that the Senior Financial Accountant would be the lead and additional processes and controls had been introduced to ensure targets were met.
The Chair welcomed the action tracker, and noting the importance of the recommendations in terms of board de-escalation, that an update on each recommendation be provided on the action tracker at each meeting.

Decision / Conclusion
The Audit and Risk Committee noted the update.

10. POTENTIAL

10.1. Litigation 6-monthly Report (2/2) (Presenters: Head of Patient Safety Quality and Risk)

The Head of Patient Safety Quality and Risk presented the report updating members on current litigation cases overseen and managed by the Central Legal Office.
Members were advised that there was two open claims. The paper contained further details and estimated settlement costs.
NHS Orkney were members of the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) which allowed the Board to claim for costs above the threshold of £25,000.
The Chair queried whether there was learning from litigation in terms of highlighting the cost to staff.
Post meeting note from the Head of Patient Safety Quality and Risk: *Currently there is no mechanism for the sharing of learning lessons around costs associated with litigation with our*

workforce. Lessons learnt are focused on the recommendations from incidents / serious adverse event reviews and patient feedback. As we continue to develop ways to share learning we will consider the cost of litigation as part of this.

Decision / Conclusion
The Audit and Risk Committee noted the report.

10.2. Property Transaction Monitoring Annual Compliance Report- Paper not received. (Presenters: Director of Improvement)

The Director of Improvement provided a verbal update advising that there was no evidence to show that a previous internal audit had been undertaken or results had been reported to the Scottish Government Health and Social Care Directorate.
A letter was sent to the Deputy Director of Health, Infrastructure and Suitability and the Scottish Government to ascertain the obligation and requirement.

Decision / Conclusion
The Audit and Risk Committee noted the verbal update, and that a paper would be submitted for the next meeting.

10.3. Patient Exemption Checking – Annual Reporting Package 2023/24 - Paper not received. (Presenters: Recovery Director)

The Recovery Director provided a verbal update advising that the information required was difficult to obtain due to challenges whereby previous work had been completed in isolation. Members were advised the Senior Financial Accountant would be the lead and ensure the relevant assurance was provided in future.

Decision / Conclusion
The Audit and Risk Committee noted the verbal update.

10.4. PHS Waiting Times Review Improvement Plan Update (Presenters: Head of Improvement)

The Head of Improvement presented the report to provide assurance and progress of the Public Health Scotland Waiting Times Improvement Plan.
There had been notable improvements made. The plan considered by the Audit and Risk Committee in May 2024, contained 40 actions which had been reduced to 39. Of the 39 actions, 16 remained off-track/overdue due to several factors including staff absence, hosted digital systems and changes in staffing. Actions to address this were detailed within this paper. The Chair welcomed frequency of the action owner meetings and noted the track care recommendations.

Decision / Conclusion
The Audit and Risk Committee noted the progress and the status of actions and recovery plans in relation to the PHS Waiting Times Improvement plan and agreed the revised completion date for digital actions to be changed to 31 March 2025,

10.5. National Fraud Initiative - Paper not received. (Presenters: Recovery Director)

The Recovery Director advised that the National Fraud Initiative (NFI) was a bi-yearly exercise, the deadline for submission of information for 2024/25 was the 5 October 2024. He advised that the team had been compliant but reactive. Clarification was sought on the requirements and a post meeting note including deadlines would be provided.

Post meeting note:

NFI exercise timetable and update on the status of the exercise has been drafted and included for noting at 10th December 2024 ARC meeting.

R Khangura advised that external audit along side Audit Scotland were to assess the organisations NFI arrangements as part of the 2023/24 end of year report. The assessment read as Amber and the two points that were identified as weaknesses were around regular reporting to the committee on the NFI process. The other was in relation to capacity constraints.

Decision / Conclusion
The Audit and Risk Committee noted the verbal update.

11. Place

11.1. No items at this meeting

12. Items to be included on the Chairs Assurance Report (Presenters: All)

- Approving Interim Non-Executive Director arrangements
- Approving the continuation of the Risk Management Framework in terms of the Corporate Risk Register and the proposals to scope up the two-tier system
- RMG and SLT chairs assurance report to be provided to the committee for triangulation of risks considered (corporate and operational)
- Approved revisions to the internal audit plan, and review of previous recommendations
- Checklist for future internal audit planning
- Receiving three internal audits
- Submission deadlines in respect of committee papers
- Update on PHS waiting times review improvement plan

13. Any Other Competent Business (Presenters: All)

14. Items for Information and Noting Only

14.1. Audit Scotland Reports

14.1.1. Technical Bulletin

Technical Bulletin 2024/2 (audit.scot)

14.2. Reporting Timetable for 2024/25

Members noted the timetable.

14.3. Record of Attendance

Members noted the attendance.