Audit and Risk Committee - 10 December 2024

Minutes

NHS Orkney
10/12/2024 09:30GMT

Attendance

Present:

Members: Ryan McLaughlin, Suzanne Gray, Issy Grieve, Kat Jenkin, Rashpal Khangura, Rachel King, Anna Lamont, Rachel Ratter, Laura Skaife-Knight, Brian Steven, Jason Taylor, Phil Tydeman

Guests: J Obrien - Item 8.1, C Coelho - Azets

Absent:

Members: Jean Stevenson

1. Apologies (Presenters: Chair)

   Apologies were received from J Stevenson.

2. Declaration of Interest (Presenters: Chair)

   No declarations of interests were raised.

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

   The minute of the Audit and Risk Committee meeting held on 3 September 2024 was approved as an accurate record of the meeting.

   3.1. Chairs Assurance Report from meeting on 3 September 2024 (Presenters: Chair)

   The Chairs Assurance report of the Audit and Risk Committee meeting held on 3 September 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. Corporate Risk Register (Presenters: Medical Director)

   The Head of Patient Safety, Quality and Risk presented the report which provided an overview and update on risk management across NHS Orkney.
   There were no changes to risk scores since the last report with one additional risk that would be included in the next iteration.
   The Medical Director advised that following committee feedback, work was underway to update cover pages to include narrative around risk movement between meetings. Risks were an on-going review and also discussed at SLT. For clarity around review dates, it was agreed that a key would be included on the cover page to indicate review periods.

The Chair highlighted it had previously been agreed that the top 3 risks identified at SLT would feature on cover paper which it was not. The Chief Executive requested that this was also included on the report to Board.

Decision / Conclusion

The committee reviewed and discussed the risks aligned to the committee.

6.1. SLT Chair's Assurance Report (Presenters: Chief Executive)

The Chief Executive presented the SLT Chair's Assurance Reports from the meetings held on 14 October and 18 November 2024 highlighting:

- 6 new Corporate Risks were proposed, 1 was agreed, 5 were not agreed and went back to the Risk Management Group and 2 were taken forward
- SLT supported the proposed next steps for the Operational Risk Register process and definitions and cleansing of current local and operational risks
- SLT agreed for a new Corporate Risk for addition to the Corporate Risk Register – re: Training compliance/Health and Safety
- SLT agreed to close Risk 349 (Digital records – Health visiting and School Nurse Service) so there was not a duplication of digital risks, though instead to add to OHAC operational risk register
- SLT agreed the new Board Assurance Framework.

The Chair welcomed the detailed reports providing assurance to the committee in respect of scrutiny and discussion of risk by the organisation.

Decision / Conclusion

The committee welcomed and noted the reports.

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

The Head of Patient Safety, Quality and Risk presented the Risk Management Group Chairs Assurance Report highlighting:

- The Island Games Preparedness and Public Protection risk jotters were agreed for escalation to SLT for inclusion on the corporate risk register
- Clarifications/revisions were requested in relation to risk jotter Organisational Policies and Procedures and therefore for resubmission at the next Risk Management Group (RMG)
- There was concern over speed of changes to the risk management process and the need to ensure that the new process was implemented in a robust way
- A survey would be circulated to the organisation to gain insight into current levels of knowledge and where training should be focused
- The group agreed to temporarily increase the frequency of meetings to allow time to discuss the increased number of risk jotters coming through RMG and to allow for more frequent submission of risk jotters

Members thanked the Head of Patient Safety, Quality and Risk for the insightful report and commended the level of work carried out over a short period and the way in which embedded risks were scrutinised. The Chair welcomed the detailed reports providing assurance to the committee in respect of scrutiny and discussion of risk by the organisation.

Decision / Conclusion

The committee welcomed and noted the report.

7. Audit and Risk Committee Annual Review and core documents (Presenters: Chair, Medical Director)

The Chair and Medical Director presented the revised committee Terms of Reference and Business Cycle for review and approval.
The main amendments to the Terms of Reference, Workplan and Business Cycle included:

· Inclusion of oversight of NHS Orkney's Board Assurance Framework
· The addition of ensuring robust arrangements are in place in relation to Business Continuity and Emergency Planning
· Removal of the Litigation report which will be presented via the Finance and Performance report
· The addition of a Scotland National Audit Programme (SNAP) Audit summary
· Inclusion of a Review of Public Health Scotland National Audit Programme reports

Members requested the following amendments were made:

- Governance section - diagram that shows groups that reports to the committee
- Attendance - change Accountable Officer, Director of Finance and Medical Director from should attend to must attend to remain consistent with other committees
- To include guiding principles to remain consistent with other committees
- Update to job titles

Decision / Conclusion
Members approved the Terms of Reference and Business Cycle with the above caveats that would be actioned and virtually circulated to the committee for ratification.

8. People

8.1. People and Culture Review (Presenters: Director of People and Culture)

The Director of People and Culture presented the report providing the committee with the results of the People and Culture review that was commissioned in October 2024 and an update on next steps following initial discussions with the People and Culture leadership group and wider team.
The review comprised two levels of attention, the first being a focus on things relevant to the whole directorate, and the second being a more detailed assessment of the operating model for Human Resources, Organisational and Learning Development, and Health and Safety.
The overall feedback from the CIPD was that they were struck by the "kindness" of the people they engaged with at NHS Orkney and overall the review was positive.
There were 22 recommendations in the report, a plan and timeline would be created in December and reported through the Improvement Programme Board.
The review used multiple methods to allow maximum participation and the results were shared with the entire team directly, as well as being discussed in small and large group settings.
I Grieve thanked all involved and the helpful breadth covered and welcomed the improvement plans.
The Interim Director of Finance was grateful for the report and would be very happy to help influence or provide observations from elsewhere around what could help finance colleagues.
Members discussed the senior vacancies within the team and the need to be cautious around future advertising and to understand what was required from the team.
The Chief Executive highlighted the requirement around the reference to people over policy and queried what support and intervention was required to move the team focus. Three external review reports and improvement plans would be overseen by the Improvement Board from January 2025.
Members were advised that there had been engagement with NES for support to facilitate discussion shared purpose and ways of working.
Members discussed the significant overlaps in certain areas and the possibility of collaboration.
The Chief Executive advised that the three Heads of Service (Finance, People and Culture and Digital) should be driving the agenda and investigating the commonalities.
Decision / Conclusion

Members were suitably assured from the review undertaken and the plans formulated to take forward.

8.2. Employee Director Proposal - Paper postponed (Presenters: Board Chair)

Item postponed.

9. Patient

10. Performance

10.1. Public Health Scotland Waiting Times Improvement Plan Update (Presenters: Head of Improvement)

The Chief Executive presented the report asking the committee if they were content with the Improvement Plan being overseen by the Planned Care Programme Board, with assurance going to Audit and Risk Committee via the Chair's Assurance Report.
Notable progress had been made to date on delivering the Waiting Times Improvement Plan with over 95% of actions on track or completed. Of the 39 actions, 4 remain off-track/overdue due to several factors, including staff absence, hosted digital systems and changes in staffing. Actions to address these were provided.
The review of the team structure had been built into the Waiting Times Improvement Plan which was overseen by the Planned Care Programme Board. A business case would be developed for the Health Intelligence function, and this would be brought to Senior Leadership Team for discussion in February 2025 as part of the Year 2 Corporate Strategy Delivery plan.
Decision / Conclusion
The committee noted progress on the Public Health Scotland Waiting Times Improvement Plan and accepted the proposal requesting that specific reference to the plan was highlighted in the Chair's Assurance report.

10.2. NHS Orkney Board Assurance Framework (Presenters: Chief Executive)

The Chief Executive presented the new draft NHS Orkney Board Assurance Framework which provided a mechanism for assurance to be monitored throughout the year, placing an emphasis on the need for the Board to be able to demonstrate it had been properly informed about the totality of risks and was assured that adequate controls and assurances were operating effectively to reduce risks to an acceptable level. This would enable oversight of the risks to the delivery of NHS Orkney's Strategic Objectives, as set out in the Corporate Strategy.
Having a Board Assurance Framework provides the structure for evidence to support NHS Orkney's Annual Governance Statement.
Progress would be reported quarterly to the Audit and Risk Committee and will report to SLT also with the Quarterly Corporate Strategy progress updates. The Board would review the complete Assurance Framework annually.
Support for the Board Assurance Framework would be through the Corporate Governance team but would require the active involvement of many across the system, including the Board, to make it work effectively.
Decision / Conclusion
Members scrutinised and approved the draft Board Assurance Framework for onward submission to the Board on 12 December 2024.

11. Potential

11.1. Risk Management Group Terms of Reference (Presenters: Head of Patient Safety, Quality and Risk)

The Head of Patient Safety, Quality and Risk presented the Risk Management Group (RMG) Terms of Reference highlighting the main changes, including increased core membership to reflect services within the organisation.
The Medical Director highlighted the maturity of the group and shift of focus from a discussion forum to formally reporting with a refined scrutiny role with expectations and timescales.
Decision / Conclusion
Members approved the Terms of Reference as recommended by the Risk Management Group.

11.2. Operational Risk Register (Presenters: Medical Director)

The Head of Patient Safety, Quality and Risk presented the report advising the work to revise the risk management processes continued. Following the agreement to move to a two-tier risk register process the next stage was to agree how this would work and what this would look like for the organisation. The Risk Management Group (RMG) had worked to set out a clear process for standing up, managing and standing down operational risk registers, ensuring that the governance processes around this are robust and provide assurance to the organisation that risk is being managed effectively, the paper setting out the proposal for this
There would be two organisation wide operational risk registers named Acute and OHAC (Orkney Health and Care). Acute would be the default register for risks that don't clearly sit on either and risks that the organisation cannot mitigate against but needs to be aware of.
RMG agreed the proposal that all risks that had not been reviewed within a year would be closed.
The Chair observed the positive direction of travel and assurance would be provided to committee via the RMG Chair's Assurance report.
The Chief Executive echoed the Chair however noted the volume of change and the need to check the organisations understanding of the level of detail required.
Decision / Conclusion
Members recommended approval to the Board

11.3. Internal Audit

11.3.1. 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.
Decision / Conclusion
The committee received assurance on progress against the plan and approved changes to the internal audit plan.

11.3.2. Internal Audit Reports

11.3.3. Job Evaluation Process Report (Presenters: Internal Audit)

C Coelho presented the report which summarised a review of the job evaluation process to assess how NHS Orkney was ensuring this in line with the NHS Scotland Job Evaluation Policy, the Agenda for Change Job Evaluation Handbook, and related best practice guidance.
The organisation had strong controls in place for the job evaluation process. Clear and comprehensive policies and procedures were in place, and these aligned to national guidance. Staff involved in the job matching process had been provided with adequate training and there was a clear and appropriate governance structure in place for the process, developed in accordance with the national guidance on governance for job evaluation and confirmed that this was operating in practice.

The testing identified that a notable proportion of job matched were not complete in line with timescales outlined in NHS Orkney procedures. The cause was due to long term absence, complexities and capacity challenges.
The Director of Improvement commended the work of the team and that the cycle had been adapted to include job evaluation and queried difference in the understanding between re-evaluation of changed jobs and the changed posts. He highlighted that benchmark data showed that the organisation was one band higher than most other health boards therefore how was it known when 70% of changes around increased banding were above the national average and how was that risk was managed.
The Interim Director of Finance noted the large number of re-grading for a small organisation and requested future reports include national good practice.
The Chief Executive emphasised that whilst the report was a good news story in terms of process, listening to staff it did not match their experiences leading to frustration and retention issues.
The Chair noted that this was not the first internal audit report that highlighted a disconnection with other internal reports therefore further work was required around scoping in the future. The Director of Improvement agreed that in-depth work was required with regards to the scoping process.
The Chief Executive requested that the lead executive for each report attends for the item at future meetings. Moving forward one cohesive approach was requested for fullness and an authentic account of reality.

Decision / Conclusion

The Committee reviewed the report and accepted the recommendations, noting that the wider topic of audit scoping would be discussed at SLT as part of forthcoming internal audit planning work.

11.4. Property Transaction Monitoring Annual Compliance Report (Presenters: Director of Improvement)

The Director of Improvement presented the report advising that NHS bodies were required to conduct property transactions in accordance with guidance in the NHS Scotland Property Transactions Handbook. The manual stated that an annual internal audit was to take place and assurance was provided that this review has been carried out and the Scottish Government notified in terms of the requirement.
An internal audit review of property transactions had been carried out by the Head of Estates and it had been confirmed in the previous twelve months, no properties had been purchased, leased or exchanged. Guidance was sought as to completing a specific template or form; however SGHSD advised an e-mail noting a nil return was sufficient. This was actioned with an email sent to Scottish Government on 13 November 2024 confirming NHS Orkney's position.

Decision / Conclusion

Members noted the information provided.

11.5. External Audit

11.5.1. Draft External Audit Plan 2024/25 (Presenters: External Audit)

R Khangura provided a verbal update summarising the progress of the draft External Audit Plan 2024/25, a full plan would be presented at the next committee meeting.

Decision / Conclusion

Members noted the positive progress made in relation to the draft plan.

11.6. Internal and External Audit Recommendations

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

The Director of Improvement presented the report advising the status of internal audit recommendations from 2023-24, and 2024-25.
For 2023/24 there was the closure of 11 management actions, 10 with revised dates for Azets review, and 2 pending review by Azets.
For 2024/25 there was the closure of 6 management actions and 4 pending review by Azets.
The 2025/26 audit planning cycle comprised of eight audits and work to review these with the potential to reduce the number of audits with more in-depth analysis.
The Chair noted the progress and hard work in dealing with recommendations for 2023/24 and 2024/25 and the planning led through SLT.
The Chief Executive commended the progress and thanked the Director of Improvement for his fantastic leadership. Members were advised that the Head of Improvement would take over the leadership of internal audit.
Decision / Conclusion
Members noted the status and update of the actions and approved the amended timescales.

11.6.2. External Audit Recommendations (Presenters: Interim Director of Finance)

The Interim Director of Finance 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. Members had been advised there had been a delay in the implementation of journal segregation recommendation and there remained 2 outstanding actions from 2022/23. Despite the noted slippage all actions are still on target to be completed by 31 March 2025.
Decision / Conclusion
The Audit and Risk Committee noted the update.

11.6.3. Board Governance committee feedback for internal audit planning (Presenters: Chair)

The Chair provided a summary of the internal audit planning proposals from the other governance committees to potentially feature on the internal audit plan as follows:
Finance - The Interim Director of Finance will discuss finance elements at SLT
Remuneration Committee - nothing for the next financial year
JCCGC - Public Protection Framework and Winter Planning identifying ways to improve the process
Staff Governance Committee - staff records - ensuring appropriate documents are in place for clinicians to carry out work in the organisation
The items would be brought to SLT for further discussion.
Decision / Conclusion
The Audit and Risk Committee noted the update.

11.6.4. Standing Financial Instruction Annual Waiver Report - Late paper - yet to be issued (Presenters: Interim Director of Finance)

The Interim Director of Finance apologised that the paper had not met the deadline, and would be presented at the next meeting. He provided members with a verbal oversight of all Standing Financial Instruction waivers that had been approved from April 2023
Five exemptions were reviewed by Procurement and subsequently approved by the Interim Director of Finance.

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

11.6.5. Counter Fraud Services Quarterly Report (Presenters: Interim Director of Finance)

Members had received the Counter Fraud Services quarterly report up to 30 September 2024, dealing with areas of prevention, detection, and investigation of fraud.
The report outlined the number of cases by Board; NHS Orkney had reported 1 case in the period. Members were advised this was due to a Freedom of Information request and the case was noted against all boards that had been requested to provide information. The case would be closed off for next quarter.
It was agreed that the Senior Financial Accountant would write to Audit Scotland / Counter Fraud Services highlighting concerns raised by the committee in terms of identifying a case against NHS Orkney in relation to information requested for a Freedom of Information request and how this could impact the Scottish National figure if a number of Boards are contacted to provide information and also to highlight the cause of unnecessary anxiety.
Decision / Conclusion
Members noted the quarterly report.

11.7. Patient Exemption Checking – Annual Reporting Package 2023/24 (Presenters: Interim Director of Finance , (Senior Financial Accountant))

Members had received the reports which detailed the outcomes of the Patient Exemption Checking Programme undertaken by the NHS Scotland Counter Fraud Services Patient Claims Teams during 2023/24 and Quarter 1 and 2 of 2024/25.
Total recoveries made in 2023/24 were £3,296, write offs for the year were minimal at only £14.12. There were 14,431 cases carried forward into 2024/25.
Recoveries for 2024/25 had reached £2,728 with write offs totalling £273.92 as of 30 September 2024 with a carry forward of 16,429 cases.
Decision / Conclusion
The Audit and Risk noted the summary of case recoveries and write-offs, and agreed in future to roll reporting of the data into the CFS quarterly report.

11.8. National Fraud Initiative (Presenters: Interim Director of Finance , (Senior Financial Accountant))

Members had received an update the National Fraud Initiative 2024/25 matching exercise. The data set uploads were completed in October, there would be no further work to be completed until the data analysis had been completed and the matches released.
Members discussed that the Fraud Training rates were low for the finance team on the Turas module and were advised work was underway in obtaining further training modules to strengthen training.
Decision / Conclusion
Members noted the report.

12. Place

12.1. No items at this meeting

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

CFS Fraud report action
Internal Audit recommendation progress
Job Evaluation report
Governance committee internal audit feedback
BAF onward to board
RMG TOR approved
Recommendation of approval of the Operational Risk Register proposal
Change to the PHS improvement plan
Triangulation provided - SLT and RMG in terms of risk register
Reflection of meeting
Welcomed increased attendance which enabled in-depth discussions
Noted that members were effectively scrutinising papers and identifying gaps for further investigation

14. Any Other Competent Business (Presenters: All)

15. Items for Information and Noting Only

15.1. Audit Scotland Reports

15.2. Senior Leadership Team Minutes

Members noted the minutes.

15.3. Reporting Timetable for 2024/25

Members noted the timetable.

15.4. Record of Attendance

Members noted the attendance.