Audit and Risk Committee - 4 March 2025

Minutes

NHS Orkney

Attendance

Members

David Eardley (Azets), Melanie Barnes (Interim Director of Finance), Debs Crohn (Head of Improvement), Suzanne Gray (Senior Financial Accountant), Kat Jenkin (Head of Patient Safety, Quality and Risk), Joanna Kenny (Non-Executive Board Member), Rashpal Khangura (KPMG), Anna Lamont (Medical Director), Ryan McLaughlin (Employee Director), Rachel Ratter (Committee Support), Laura Skaife-Knight (Chief Executive), Keren Somerville (Head of Finance), Jason Taylor (Chair), Phil Tydeman (Director of Improvement).

Guests

Taimoor Alam, KPMG

1. Cover page

2. Apologies (Presenter: Chair)

Apologies received from J Stevenson (J Kenny - Deputy)

3. Declaration of Interest (Presenter: Chair)

There were no declarations of interest raised.

4. Minute of meeting held on 10 December 2024 (Presenter: Chair)

The minute of the Audit and Risk Committee meeting held on 10 December 2024 was approved as an accurate record of the meeting.

4.1. Chairs Assurance Report from meeting on 10 December 2024 (Presenter: Chair)

The Chair's Assurance report of the Audit and Risk Committee meeting held on 10 December 2025 was approved as an accurate record of the meeting.

5. Action Log (Presenter: Chair)

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

6. Risks escalated from other Governance Committees (Presenter: Chair)

Format of the Corporate Risk Register cover paper for / timings of updates

- Risk workshop
- Contact Management Procurement

7. Corporate Risk Register ARC2425 - 75 (Presenter: Medical Director)

The Medical Director presented the report which provided an overview and update on risk management across NHS Orkney. There were 2 risks aligned to the Audit and Risk Committee.

The Chair acknowledged and appreciated the 3-month review cycle for medium risks and 12 months for low risks however queried the alignment with committee meetings to ensure relevant data was presented. The Chief Executive identified the concern as a theme across governance committees and proposed a full Board discussion around risk.

Decision / Conclusion

The committee reviewed and discussed the risks aligned to the committee, and agreed the concern should be discussed in the forthcoming risk workshop.

8. Senior Leadership Tea, Chair's Assurance Reports ARC2425 -74

The Chief Executive presented the SLT Chair's Assurance Reports from the meetings held on 16 December 2024, 8 January, 5 and 14 February 2024 highlighting

- 5 new risks were approved to be added to the Corporate Risk Register
- Closure of outdated version of C-Cube risk agreed – target risk score had been met, and mitigations are complete
- Risk updates: Urgent Cancer waiting times risk had been reduced due to additional work undertaken by the Clinical Governance team. The MRI Scanner risk had been reduced due to confirmation of funding from Scottish Government

The Chair requested that SLT minutes are included at further meetings under the items for noting section.

Decision / Conclusion

The committee welcomed and noted the reports

9. Risk Management Group Chairs Assurance Report and minutes ARC2425 -76

The Head of Patient Safety, Quality and Risk joined the meeting to present the Risk Management Group (RMG) Chair's assurance reports from the meeting held on 12 February 2025 highlighting:

- There had been good attendance with excellent in depth discussions
- The implementation plan for the revised risk management processes continues with a workshop being completed on 6 February. This was well attended with four areas of focus – Education, Communication, Practical Implementation and What Haven't We Thought Of?
- A draft Health and Care Staffing Act Escalation Standard Operating Procedure (SOP) was presented. The SOP was well received but there were some suggestions to make this shorter and more of a 'grab' document for staff. There were meetings about this happening between meetings with the hope to bring this to the next RMG
- The risk jotter presented – Management of Staff Absence, was returned to the author for clarification required
- Robust scrutiny is being applied to risk jotters and discussion of risk, with members actively using the risk matrices to support these discussions. Attendance to meetings continues to be high with active engagement across all attendees. Support with the implementation plan had been high and allowed for sharing of good ideas and different ways of working to be included in the approach

It was agreed that the Director of People and Culture would include detailed information and clarification around risk and risk processes within the managers induction programme.

Decision / Conclusion

The committee welcomed the in-depth discussions held at the RMG and took assurance from the reports.

The Head of Patient Safety, Quality and Risk left the meeting.

10. PEOPLE

No papers were presented.

11. PATIENT SAFETY, QUALITY AND EXPERIENCE

No papers were presented.

12. PERFORMANCE

12.1. SFI Waiver Report ARC2425 -77 (Presenter: Interim Director of Finance)

The Interim Director of Finance presented the report providing members with an oversight of all SFI waivers that had been approved from April 2023 to March 2025. There had been none received since July 2024.

Decision/Conclusion

Members noted and approved the report.

13. Governance Committee Workplans 2025/26

13.1. Joint Clinical and Care Governance Committee, Finance and Performance Committee, Remuneration Committee, Staff Governance Committee ARC2425 -78 (Presenter: Chair)

The Chair advised that all Governance Committees of the Board review their core documents and Workplans annually to ensure that they were up to date, relevant and meeting current legislation.

Individual Committee Development sessions were held in the last quarter of 2024 where documentation was reviewed, and agreement reached on any changes to the Workplans for 2025/26. These were provided to the committee for assurance that remits were accurately reflected, prior to presentation to the Board for final approval as required in the Model Standing Orders.

- Joint Clinical and Care Governance Committee (JCCGC)
- Finance and Performance Committee (F&P)
- Remuneration Committee
- Staff Governance Committee

Members agreed that the formatting of dates would be tidied up within the F&P Workplan and the two Executive Leads for both the F&P and Audit and Risk Committee would discuss elements that fell under both business cycles to ensure clarity around roles.

Decision / Conclusion

The Audit and Risk Committee endorsed the Governance Workplans for 2025/26 subject to the above caveats.

14. Code of Corporate Governance for Recommendation of Board approval - ARC2425 -79 (Presenter: Head of Improvement)

The Head of Improvement presented the refreshed Code of Corporate Governance for Recommendation of Board approval approval of the amendments and updates to the Code of Corporate Governance 20025/26, noting the Standing Financial Instructions have remained unchanged from Version 17 (2024/25) due to a full review being underway. This work is expected to be completed by the end of Quarter 3 2025/26.

The main changes to the Code during this review have included:

- Amendments to the Governance Committee Terms of Reference following individual Committee reviews
- Changes to purpose and aims to reflect the Corporate Strategy 2024-2028 Strategic Priorities
- Minor changes to job titles, emails addresses and links to reflect current arrangements

The Medical Director highlighted that it was helpful to see the track changes and requested this across all such documents presented to committee / board as appropriate (Action: Head of Improvement)

Decision/Conclusion

The Committee recommended Board approval of the Code of Corporate Governance subject to minor formatting amendments.

15. POTENTIAL

15.1.1. Internal Audit progress report - 81- ARC2425 -80

D Eardley 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. Three reviews had been completed since the previous Audit and Risk Committee in December 2024.

It was proposed that the Risk Management workshop be deferred to May 2025 following confirmation from management that it would not be able to take place during 2024/25.

15.1.2. Internal Audit Reports

15.1.2.1. Financial Controls - Income and Expenditure ARC2425 - 82

D Eardley presented the report which summarised a review of the policies and procedures for income and expenditure and found that while there

there were Standing Financial Instructions in place, there was a lack of supporting policies and procedures across both income and expenditure. Basic finance training had been provided to staff with finance responsibilities as part of induction, but this did not include training on certain, important areas such as budget management.
Ten improvement actions were raised to support management, both in the work which had been initiated and in those areas where focus was needed. Further information was included in the management action plan.
Azets suggested and it was subsequently agreed that the conclusion would be updated to reflect discussions held with the Director of Improvement to clarify the second sentence, to reflect there had been a mix of staff changes and unavailability which had impacted the teams availability over the last 12-18 months. It was acknowledged that management had worked hard to get more robust and responsible over the period and found solutions towards challenges.

Areas of good practice were detailed within the report and a number of areas for improvement were identified which, if addressed, would strengthen NHS Orkney's control framework.

The Chair observed that it could be evidenced that contract procurement management had been looked into and improvement actions were in place which would be fed back to other Governance Committees (in response to items escalated from other committees).

Decision / Conclusion

The Committee reviewed the report and accepted the recommendations and amendment to the conclusion.

15.1.2.2. Strategic Planning ARC2425 -83

D Eardley presented the report which reviewed the controls and processes put in place with regards to strategy to ensure there was a clear direction and robust method for implementation of this strategy in the coming years. It was acknowledged that NHS Orkney was operating in a challenging environment with both internal and external factors placing significant pressure on the health board.

While the controls and processes followed were generally robust, there were some areas for improvement which NHS Orkney should work to implement such as SMART specificity of KPIs. This would ensure continued improvement and a more robust process to stand up against a very challenging operating environment.

Areas of good practice was summarised including regular engagement between NHS Orkney and the IJB. This was reflected in the alignment of both their strategic plans and as the Chief Officer for IJB was a member of NHS Orkney's Senior Leadership Team.

Decision / Conclusion

The Committee reviewed the report and accepted the recommendations

15.1.2.3. NHS Orkney Internal Audit Sustainability Follow Up Review

D Eardley presented the report advising in accordance with the 2024/25 Internal Audit Plan, a focussed review of eight historical internal audit actions had been carried out. These were selected by the Director of improvement in discussion with the Corporate Leadership Team and approved by the Senior Leadership Team (SLT) in August 2024, recognising these reflected known areas of challenge for the Health Board. The review had included liaising with action owners to determine the extent to which the actions had in fact been fully implemented and confirming if currently embedded in NHS Orkney processes.

Overall it was found that some controls were in place and/or had been further developed, such as the creation of a new Clinical Governance reporting structure and monitoring arrangements for the shared strategic objectives between NHS Orkney and the IJB.

There were a number of areas in which actions had not been completed. This included the creation of a SMART action plan for the priorities contained within the clinical strategy, work to approve and implement a new treatment time guarantee breach letter, the development of a set of key metrics to be used to monitor and report against SLA progress, consistent reporting on Adult Support Protection performance statistics and a lack of consensus between the NHS Orkney Board and the Integration Joint Board (IJB) as to what constitutes a significant variance that should be escalated to the Board.

Members agreed that it would be beneficial to include the Sustainability Follow Up Review within the Internal Audit 3 year cycle plan.

Decision / Conclusion

The Committee reviewed the report and accepted the recommendations

15.2. Internal Audit Recommendations

15.2.1. Internal Audit Recommendations ARC2425 -85 (Presenter: Director of Improvement)

The Director of Improvement presented the report advising there were a number of areas in which actions had not been completed. This included the creation of a SMART action plan for the priorities contained within the clinical strategy, work to approve and implement a new treatment time guarantee breach letter, the development of a set of key metrics to be used to monitor and report against SLA progress, consistent reporting on Adult Support Protection performance statistics and a lack of consensus between the NHS Orkney Board and the Integration Joint Board (IJB) as to what constitutes a significant variance that should be escalated to the Board.

Members were advised of 13 management actions had been closed and 10 with agreed revised dates for completion from 2023/24, and the closure of 9 management actions in line with original timescales from 2024/25.

Members were advised of a new approach to the 2025/26 audit planning cycle, comprising a reduction to five audits with enhanced executive input, greater specificity of ask, and an expectation of best practice comparators.

It was requested and agreed that the 2023/24 tracker and full 2024/25 would be provided as an appendix at the next meeting.

Decision / Conclusion

The Audit and Risk Committee noted the update and approved the extension to the timelines as requested.

15.2.2. Draft Internal Audit Plan 2025/26- 81- ARC2425 -8/10

Members received the internal audit plan, highlighting specifically the 2025/26 proposed programme based on risk and audit needs assessment as at December 2024. In response to a management request the plan would undertake a deeper dive into a focused range of areas.

The plan had also been cross-referenced to the NHS Orkney risk register as at September 2024.

The Medical Director requested that the Caldicott Guardian was included within the Information Governance section of the plan.

The Chair noted the importance of agreeing a timeframe for the risk management workshop and requested follow up with the Medical Director, Head of Improvement and the Board Chair.

It was also requested that the scope of audits was presented and approved to the committee prior to the commencement of the audits. It was agreed a further discussion would be held regarding best practice regarding how the committee would receive the scope to ensure it would not caused a pause in the progress of delivery of the programme.

Decision / Conclusion

The Audit and Risk Committee received the progress report and endorsed the proposal suggested to defer the Risk Management report to 2025/26 and approved the draft Internal Audit Plan 2025/26 with the above caveats. It was agreed that the Internal Audit Sustainability Follow Up Review would be built into the plan's 3 year cycle.

Final National Information Security (NIS) Audit Report ARC2425 -87 (Presenter: Head of Improvement)

The Head of Improvement presented the report, summarising that as a result of the increased focus of the Short Life Working Group and work completed to date in 2024, NHS Orkney met an additional 13% of controls, increasing the compliance rate to 50%, in line with the target set in the Corporate Strategy delivery plan for 2024/25.

Auditors recognised significant improvements had been made since the last audit and there was a clear development plan in place for improvements, with a

clear vision and plan for the future to ensure continuous, year-on-year improvements could be made.
Members were advised whilst there was much to be proud of, there was still a way to go to ensure full compliance with the NIS regulations as 4 areas remain rated red.

The Committee recognised and congratulated the great progress made and were assured mechanisms would be put in place to ensure progress continued. The Chief Executive described the work as exemplar due to good planning and prioritisation, integration, good governance and strong leadership and how it could be used throughout the organisation as best practice.

Responding to comments in the report that highlighted resource concerns, the Chief Executive and Head of Improvement both articulated their view that the digital team were not an under resourced team and evidence, resource and engagement was required from the organisation as a whole.

Decision / Conclusion

Members noted the update and welcomed hard work and progress and future steps to increase level of compliance.

15.2.3. Annual Accounts – Key Estimates and Judgements (Presenter: Interim Director of Finance)

The Senior Financial Accountant presented the report seeking approval of the key estimates and judgements used for the 24/25 annual accounts.

Two new elements were added to the estimates, assumptions and judgements that have a significant risk of a causing material adjustment to the carrying amounts of assets and liabilities within the financial statements within the next financial year. These were Band 5 to 6 Nurses Review and NPD Contract Irrecoverable VAT on Utilities Accrual.

Decision / Conclusion

Members approved the report.

15.2.4. Counter Fraud Services (CFS) Quarter 3 Report ARC2425 -89 (Presenter: Interim Director of Finance)

Members had received the Counter Fraud Services quarterly report up to December 2024, dealing with areas of prevention, detection, and investigation of fraud.

The report outlined the number of cases by Board; NHS Orkney had reported 0 case in the period.

Following a conversation with Audit Scotland it was confirmed there was no alternative system to record freedom of request enquiries (as per action log) but it was agreed this would be reviewed in the future.

The Chief Executive queried whether NHS Orkney had been issued the Employee Awareness Survey as the Board was not featured on the table of survey responses to Board. An action was raised to query with CFS.

Decision / Conclusion
Members noted the quarterly report.

15.2.5. External Audit Recommendations ARC2425 -86 (Presenter: Interim Director of Finance)

The Interim Director of Finance presented the report.

The external audit recommendations were reviewed, and updates included in the report.

Members were advised there had been a delay in the implementation of journal segregation recommendation and there remained 2 outstanding actions from 2022/23.

Decision / Conclusion

The Audit and Risk Committee noted the update and welcomed the clarity of the tracker.

15.2.6. External Audit

15.2.7. Draft External Annual Audit Plan 2024/25 - 84

Annual Audit Plan 2023/24 ARC2324-62

KPMG colleagues presented the report which provided the initial considerations of the audit for the year ending 31 March 2025.
KPMG had commenced their audit planning and risk assessment procedures and had identified the following risks on which they would focus on:

- Valuation of land and buildings
- Fraud risk - expenditure recognition
- Fraud risk - revenue recognition rebuttal
- Management override of controls

The wider-scope areas were briefly defined and the areas of focus and current position with the Risk Assessment work.

Decision / Conclusion
The Audit and Risk Committee noted the workplan for 2025/26.

16. PLACE

16.1. No papers presented.

17. Items to be included on the Chairs Assurance Report (Presenter: Chair)

- Corporate Risk Cover Paper/ Development Session
- SFI Waiver approved
- Assurance from committee work plans
- Recommendation of approval to Board of CCG
- Updates re internal/external recs - refreshed approach to internal audit
- Received audit report
- Received external audit plan

18. Any Other Competent Business (Presenter: Chair)

19. Items for Information and Noting Only

19.1. Audit Scotland Reports
19.2. Reporting Timetable for 2025/26
19.3. Record of Attendance