APPROVED 15TH JUNE 2023

SHETLAND NHS BOARD

Minutes of the Meeting of the Audit Committee held at 10:00 on Tuesday 28th March 2023 via Microsoft Teams

Present	
Mr Colin Campbell [CC]	Non-Executive Director (Chair)
Mr Lincoln Carroll [LC]	Non-Executive Director
Mrs Natasha Cornick [NC]	Non-Executive Director
In Attendance	
Mr Colin Marsland [CM]	Director of Finance
Ms Stephanie Hume [SH]	Internal Audit
Ms Elizabeth Young [EY]	Internal Audit
Mr Brian Howarth [BH]	External Audit
Mr Daniel Cunningham [DC]	External Audit
Mr Wojciech Kuzma [WK]	External Audit
Ms Edna Mary Watson [EMW]	Chief Nurse (Corporate) *(items 1-14)*
Ms Michelle Hankin [MH]	Clinical Governance & Risk Team Leader *(items 1-8)*
Mr Joe Higgins [JH]	Non-Executive Director (Whistleblowing Champion)
Mrs Pauline Moncrieff [PM]	Board Business Administrator (minutes)
Mrs Erin Seif	PA to Director of Finance

1. Apologies

Apologies were received from Jane Haswell and Michael Dickson.

2. Declaration(s) of Interest

There were no declarations of interest.

3. Draft Minutes of the Meeting held on 29th November 2022

The draft minutes were approved as an accurate record of the previous meeting.

4. Action Tracker

(189) Datix & Systems Officer Lead to look at ways to streamline the presentation of information within the Strategic Risk Register

EMW reported that the team had prepared draft templates of possible ways to present risk in a more accessible format going forward. A meeting was scheduled with Mr Campbell for early April to review these and it was hoped that by the June meeting the information will be a different format.

(190) Appropriate Departmental learning summaries – inclusion in monthly Clinical Governance and Learning Bulletin

Complete - update included in the Strategic Risk Register item later on the agenda.

(193) Update on progress with the Bank, Agency and Locum onboarding audit action

To be discussed later on the agenda as part of Internal Audit feedback

(195) Exit interview process to be added to Audit Are B3 (Recruitment and Retention)

Complete – previously discussed and agreed.

(197) Audit Committee Business Plan 2023/24 – dates for external audit attendance
Complete - To be discussed and agreed later on the agenda

5. Matters Arising

(8) Strategic Risk Register Report – update on Risk SR07 Mental Health
CC said this will be picked up by the risk team later on the agenda.

6. Strategic Risk Register Report *(Paper AUD 22/34)*

EMW reported that since the last meeting, the risk management team had liaised with both internal and external audit who had assisted in reviewing aspects of the register which needed attention. Key highlights included:

- Only 3 out of the 18 risk descriptors required to be updated to the new format
- Some new controls have been added to the finance risk and also SR01 which relates to national standards. Both internal and external audit had highlighted that SR01 in particular had been out of date.
- There are 2 organisational risks on the register set at 'Tolerate'. These relate to registrations across the range of professions and also the risk of meeting treatment time guarantees during remobilisation.
- SR07 was a strategic risk which was downgraded to directorate level followed by concerns being raised about this being closed without a new risk being brought forward. The Director of CH&SC had presented a new mental health risk for consideration at RMG in early March and after discussion, RMG felt the risk was too broad in nature and required some refinement. The Director of CH&SC is to resubmit to the next RMG.
- No further risks have been closed in this quarter but some changes in the risk scores. SR02 (Finance) is currently the highest risk level being increased to 20 (very high risk) due to the board's reliance on high cost locums in order to cover vacancies in key posts.
- 3 other high risk areas are Planning Contingency relating to the challenge in accessing services now an issue across acute and partnership services; Workforce due to the challenges of recruitment and retention of staff; and Covid Outbreak considered to be high due to vulnerabilities in the services to address any Covid outbreak.
- Changes have been made to risk responses and no new procedures in this quarter but it had been signaled to RMG the desire to review the board's CRAT process in terms of practice within the organisation. There have been 5 CRATs since October and all are still in the stage of their final reports or lessons learnt being drafted.
- The Director of CH&SC has proposed moving all the directorate risks onto the JCAD system used within the local authority. The first report from JCAD was brought to RMG in November which highlighted there were a number of differences between the NHS Datix system and JCAD. The team are seeking clarity on whether there is a structured approach similar to that in the NHS in terms of the frequency of review being based on the actual risk level. The team have concerns around the visibility of the risks whereby all the NHS departmental, organisational and strategic risks will sit on the Datix system and the directorate risks for the partnership will sit on the JCAD system outwith the NHS.

Mr Higgins suggested that the finance risk SR02 and the workforce risk SR08 could be combined to reflect that one refers to the failure to recruit to key posts and the other to the resulting financial implications. CM explained although both risks were interlinked, the risk in

SR02 related to the board's ability to meet its statutory obligation to break even and the operational and strategic impact of that - one of the causes of this inability being the locum costs. JH asked if the wording of SR02 could be amended to reflect that failing to recruit posts is not the sole reason for why the board may not deliver a balanced budget. **ACTION: EMW**

LC suggested the workforce risk level should be raised to very high to match the financial risk to reflect the current situation which is not sustainable. LC added that he had shared his concerns regarding the draft Workforce Plan at IJB and at Audit Committee in the past year as he did not feel it gave assurance that there was a robust plan in place or feedback from managers on progress across the board and IJB. **ACTION: EMW**

MH added that risk SR08 did not only focus on the use of locum and supplementary agency staff, but also covers failure to recruit. There are many workforce issues already discussed and senior colleagues are in the early stages of implementing ways to recruit and retain staff.

In response to a question from NC regarding the benefits of IJB risks being on the JCAD system, EMW said that the main benefit would be having all risks in one place and avoiding the need to update on two systems. RMG had expressed concern and it was acknowledged that it would mean there was one layer of the risk management structure sitting on a separate system. The challenge for the NHS would be maintaining an oversight of those risks on JCAD.

NC said it was critical that recording on both systems took place because the Risk Register reporting presented to IJB is much less robust on the local authority side due to the way JCAD works. NC asked that this be fed back to the Director of CH&SC and added that as a member of the NHS Audit Committee, she could not accept the risks be taken off the NHS system and put onto a system that the board have no authority over. **ACTION: EMW**

In response to a question from NC regarding staff viewing the 'read only' information from the Risk Register published on Datix, EMW said she understood that Datix did not enable the team to know that number. EMW informed members that she and MH would soon begin a round of visits to various teams such as mental health, A&E and child development to speak about clinical governance and draw to people's attention that the Datix risk register is openly accessible. MH added that the plan was to provide a general training session covering Datix and risk but also clinical governance and audit. Specialised training packages are being developed to support teams with a view to building the culture of Datix awareness.

In response to comments on the draft Workforce Plan, CM said in Audit Scotland's annual reports on the NHS, they raised concerns over the workforce plans in NHS Scotland at present. As part of national actions to address issues in both nursing and medicine, SGov have set up two working groups to look at these. The Finance & Performance Committee has tasked the management of the recruitment and retention risk to the Staff Governance Committee as an area of concern because it has been highlighted repeatedly in finance reports as a priority risk to the board's financial obligation to break even.

CC said that the workforce risk SR08 was not given the same level of priority, ongoing feedback to the board etc as the finance risk SR02 was given. CC asked that this be formally noted and fed back to RMG adding that it was necessary to find a way of more rigorous perusal of the workforce risk, more regular feedback to the board and other forums due to the considerable financial impact to the board. **ACTION: EMW**

CC added that the focus of the workforce risk SR08 needs to be more on rigorous scrutiny and regular oversight by the board looking holistically in terms of retention as well as recruitment. This should also be fed back to RMG. **ACTION: EMW**

In terms of JCAD, CC said NHS Shetland could not afford to lose oversight of any risks. It was acknowledged that the concept of integrating the 2 systems could be helpful but the board cannot afford to lose any oversight of those risks in the aspiration of combining 2 systems.

LC asked whether the HR team have the resources and the capacity within such a busy team to be able to deliver on this priority which should be considered from an operational level too.

DECISION: the committee agreed to approve the Strategic Risk Register report.

7. Draft Risk Management Year End Review & 2023/24 Workplan *(Paper AUD 22/35)*

EMW presented the report and highlighted the key points:

- RMG met on 4 occasions (June, Sept, Nov and March) and all meetings have been aligned to the Audit Committee with members receiving the action notes from each meeting.
- The ToR were reviewed and approved by the committee in November 2022.
- The Risk Management Strategy was approved by the board in April and subsequently a quick reference guide has been developed to support managers with both the adding and management of risk in the Datix system using the new approach.
- Each of the board standing committees have received their risks twice a year. Some would like to see their risks at each meeting but only review them twice a year, therefore going forward, it is proposed to provide the strategic risks to each of the board standing committee meetings but still maintain the formal requirement to review them twice a year.
- Lessons learned is a key part of clinical governance and to date NHS Shetland has not done well in terms of achieving documented lessons learned for sharing across the organisation. This is similar to other NHS boards across Scotland who are also reporting a 33-37% return on developing of lessons learned from Datix incidents. However, it is considered possible to provide a more personal service to departments and this will be the focus over the next year to support the development of lessons learned.
- The Significant Adverse Event Reporting audit was conducted by internal audit and is on the agenda today. The verbal feedback and final report was very positive.
- Progress on some actions in the last 12 months had been delayed due to two significant gaps within the team, namely being without the team leader post for 6 months and illness within another key role. The team have rolled forward the issues not addressed into next year's workplan with the aspiration to consolidate last year's intended actions and learning and move forward from there.

CC said that in the last 3 years, the management of risk within the board had consistently improved and was well integrated into all the governance committees. It was now possible to report that NHS Shetland had a robust risk management system. CC extended the committee's appreciation to EMW and the CG team including RMG for their hard work.

MH reported that the Learning Bulletin is used to share lessons learned from a national level and the team found that the bulletin was being used in individual team governance meetings as

a standing item for discussing how national learning is now applicable to their teams. The CG team is also currently reviewing all the clinical governance content for the new intranet and lessons learned will also be included on that page.

DECISION: the committee noted the Draft Risk Management Year End Review & 2023/24 Workplan.

8. Risk Management Group draft Action Note 15th March 2023 *(Verbal update)*

EMW reported that the minutes from the meeting on the 15th March had not yet been typed up so were not available for circulation. The main discussions at that meeting had included

- the Director of CH&SC looking at the JCAD reporting system
- the use of the CRAT was highlighted which is a local name adopted around the significant adverse event review process.
- There is a national review of significant adverse events but this is unlikely to report for 18 months' time so the team feel the review of CRAT should take place locally sooner than that.

MH added that there are two members of the clinical governance team on the national steering groups so whilst developing the board's new process, this will be in line with national work.

Decision: the committee noted the update from the RMG on 15th March 2023.

Internal Audit

9. Internal Audit Progress Report Quarter 3 2022-23 *(Paper AUD 22/36)*

EY said Internal Audit were on track to complete their work in time for the May Audit Committee when they will deliver their annual report. The main points for the committee to note were:

- 5 audits completed to date, 3 of which are presented today
- 2 audits yet to finalise - 1 not yet started (financial sustainability) A draft scope has been issued but not yet had any feedback. IA are looking to get the scope agreed in order to complete work and reported for the May meeting. The second (the Management of Board Performance) was due to the November meeting but has been deferred again till May to allow some discussion around the management responses.

Decision: the committee noted the Internal Audit Progress Report Quarter 3 2022-23

10. Internal Audit Follow-up Report Quarter 3 2022-23 *(Paper AUD 22/37)*

SH presented the report and members noted the following points:

- There were 8 actions carried forward from the review in November
- As of this meeting, there were no actions closed as a result of this follow-up and management had indicated that all 8 were considered partially complete
- Of the 8 actions, 4 of them are grade 3 and IA recommend these are the actions the committee should focus on and push forward to close these off.
- There is one report outstanding from 2021 and IA recommend this should also be focused on.
- Appendix 2 shows there is one report in relation to bank and agency staff where the management have indicated that they are potentially looking to close the action. However, IA did not receive the update until after the paper deadline so were unable to incorporate this information in the paper.

- The review in relation to process efficiencies management also had management suggest removing the action but IA require further follow up with management to understand what that ongoing work would result in.

In response to a question from LC, SH explained that the bank and agency action would not be removed before the next committee meeting and any decision would be explained within the next report - if it was considered effectively no longer applicable or superseded by any other piece of work that was ongoing. This is a grade 2 action but the committee would have the opportunity to agree they are content with the proposal before it was removed.

In terms of the summary of outstanding actions, CC said unfortunately the responsible manager was not available to attend to give an update on Policies and Procedures, but reading the narrative it appears this is complete. CC asked that CM liaise with Karl Williamson to obtain feedback in order ascertain if this can be closed off. **ACTION: CM**

CC commented that only the first component of the bank agency and locum onboarding audit (review of policies and procedures) appears to be complete despite the original timescale being Nov 2022. Deadlines have since been extended for completion of the remaining components by a year from Nov 22 to Nov 23 and Oct 22 to Oct 23. Members agreed that the responsible manager would be required to attend the June Audit Committee meeting to give substantive feedback on progress. **ACTION: Lorraine Allinson to be invited to the June meeting**

JH added that it was not clear from the information provided what the process was for extending target closure dates and this should be made more specific when looking at the charter.

Decision: the committee noted the Internal Audit Follow-up Report Quarter 3 2022-23

11. Internal Audit Strategic Audit Plan for 2023/24 *(Paper AUD 22/38)*

EY said the plan being presented has reflected the discussion from the November meeting and some subsequent conversations held with management and the committee chair around the audit plan. Members were asked to note at this point in time, although IA had developed a plan for 23/24 the retender process for the contract was ongoing and depending who the board chooses to appoint as IA, the committee may wish to review the plan with the new IA in May.

Appendix 1 lists the 4 audit areas for the year.

1. PMO financial savings review – IA intend to do the first phase this year and a number of days are allocated for next year. This is an area that the chair had some comments on and is something that IA may want to revisit during the year with a new Chief Exec.
2. Recruitment and Retention – this is a very important area reflected by all the earlier discussion around the risks in that area. IA propose to look at exit interviews within the scope of the review and will include that as a specific objective within the detailed scope when it comes to the detail.
3. Review of communications plan - looking at internal and external communications and specifically going to focus on whistleblowing arrangements.
4. An audit of GDPR - an important area for the board in common with all organisations to ensure compliance.

In response to a question from JH regarding the PMO financial services review and the intention to do an audit of the thoroughness of the work undertaken by CGI, EY explained that with the caveat that IA have not agreed the scope for the 2022/23 audit, the review will look at what

happens next in the process and how the departments implement and learn lessons from the process and then take the actions forward.

In response to a suggestion from JH on a review of change management, EY said that IA have been very conscious about doing something around change management and looking at what a PMO function will look like in Shetland moving forward. The Audit Committee and IA need to reflect on this during the year and around what the scope should be framed for a wider change management audit.

With regard to the charter in appendix 4, JH said it was not clear what the process was for the initial proposing and agreement of the recommended remedial actions. The charter should clearly explain the process for agreeing target closure dates and the process for extension of any closure to prevent repeated extensions without updates on progress. EY explained that as IA progress through the audit, they have discussions with the key contacts and the audit sponsors around the findings that are emerging and what might be a sensible way to deal with those. IA agree those within a more formal close out meeting with the sponsor in a 2-way process and IA give advice and guidance around how actions might be tackled but ultimately it is for the audit sponsor and their delegates to decide what and by when - it is owned by management, and should be led by management. EY agreed to make this clearer in the charter which exists to communicate the key points in terms of Azets' approach and way of working.

ACTION: Internal Audit

Members discussed the value of looking at exit interviews as part of the Recruitment and Retention audit. EY informed the committee that Azets are conducting this audit across almost all of its NHS internal audit clients at present. It is clearly an area that every board struggles with albeit in slightly a different guise depending on their size and geography. IA can look to draw in examples of best practice seen elsewhere and from national guidance and can look to include that in so the committee can feel assured it is not missing something that other boards are doing well. **ACTION: Internal Audit**

CC said in terms of the PMO audit, this should remain on the plan in the meantime but the committee will have to review what the focus of the audit is at the time. In the absence of a PMO, this would not be a priority in the next auditing financial year and with the appointment of the new CExec it will become clearer where the focus will lie.

DECISION: the committee noted the Internal Audit Strategic Audit Plan for 2023/24.

12. Internal Audit report 2022/23: Management of Board Performance *(Deferred)*

13. Internal Audit Report: Mental Health Services *(Paper AUD 22/39)*

SH said IA had undertaken a review of the mental health services in 2019 and the audit had reached a number of findings at the time which became a focus for the committee. As part of this year's internal audit plan, IA were asked to re-conduct the audit as an in-depth review of the actions and to understand what had changed and the progress made. SH explained the scope of the review had covered the same areas as in 2019 to ensure the same coverage and the result was that IA had identified just 3 improvement actions:

1. Job planning and appraisal framework for staff - ensure key documents available, updated as per version control plans and any communications on short term exceptions are held in the same location.

2. Action plans – implement a standard action plan template focussing on the effectiveness of the actions being taken and future learning and identifying the actions to addressing the risk related to issues.
3. Governance and oversight – ensure that governance and assurance reporting is adequately documented within all mental health services related to ToR. Once completed, management should reflect on where there is any overlap or clarity on distinction between oversight and assurance needed.

Appendix A outlines all the recommendations raised as part of the 2019 audit and provides members with an update on which are complete or partially complete (only 2 are partially complete and the remainder have all been addressed).

LC commented that in terms of the oversight, it was helpful that he and NC were both involved with NHS and with the IJB as this enabled them to feed back to either party as appropriate. One of the challenges for the mental health team in terms of planning is the dependence on locum staff which is also a huge financial burden for the board.

Members agreed that the report was a useful way of illustrating how the service was coming full circle by conducting a deep dive into the 2019 audit recommendations and showing the start of performance improving. The committee congratulated the Mental Health team on all their hard work taking on the huge challenge and transforming their service which is a really positive step.

CC said that Brian Chittick deserved to be acknowledged for his energy and focus in achieving such an impressive improvement and the committee could feel assured that there has been major progress and that the risk is considerably lower than 2 years previously.

DECISION: the committee noted the Internal Audit Report: Mental Health Services.

14. Internal Audit Report: Significant Adverse Events *(Paper AUD 22/40)*

SH reported that IA had conducted a review of the whole process in relation to significant adverse events. The paper outlined the 5 control objectives used as part of the review:

- Whether it is clear within the organisation what constitutes significant adverse events
- Whether staff are clear on roles and responsibilities
- Whether Datix is being completed in an appropriate manner
- Whether decisions related to the management of the actual event themselves are risk based and transparent
- Whether the management of adverse events is completed in a timely manner with obviously lessons learned identified

SH explained the scope of the review and the findings. There had been only 1 significant adverse event within the last 12 within NHS Shetland and IA reported that this had been handled well. IA did not identify any improvement actions.

In response to a question from NC on how common it was to receive a ‘clean’ audit report, EY said it was very rare for IA to find no recommendation and this result was a very good outcome for NHS Shetland.

Members agreed this result should be highlighted and celebrated as an organisation and the staff in the clinical governance team should be congratulated for their hard work. CC said the best way to communicate this could be discussed at an informal board members meeting.

ACTION: the members of the Audit Committee

EMW added that the team were very pleased to see the outcome of the audit showing that there were no weaknesses within the system and it shows that when the board do have a significant adverse event that the process does work, it was followed according to the timeframes etc. All the learning from this event was fed back into the system through the appropriate channels.

[11:20 EMW left the meeting]

DECISION: the committee noted the Internal Audit Report: Significant Adverse Events

Audit Scotland Report

15. Audit Scotland: NHS in Scotland 2022 Annual Report *(Paper AUD 22/41)*

CM presented the report which had been published earlier in the year and shared with members by email in advance. One of the key messages raised by Audit Scotland is that workforce capacity remains the biggest risk to the recovery of NHS services and due to financial pressures, there is the need to prioritise what boards can do. NHS Shetland's Workforce Plan should be looked at in the context of the board's financial resources and priorities agreed. This issue impacts the services provided by both the NHS and the IJB.

BH extended an offer to the committee for a member of the EA central team to attend in order to provide some further insight into the findings in the report (and further national reports in the future) if this would be helpful.

BH suggested that across the public sector currently there was a sense that there was an issue around whether in many places there existed the workforce to deliver the services that the public had been used to. There was a need for a national debate across all occupations about where organisations want the priorities to be and where to perhaps accept there is not the same need going forward.

CC accepted the offer of a presentation by EA (perhaps at a Board Development Session) in order for members to gain more insight. **ACTION: External Audit**

Decision: the committee noted the Audit Scotland: NHS in Scotland 2022 Annual Report.

External Audit

16. External Audit Plan for 2022-23 Accounts *(Paper AUD 22/42)*

BH presented the plan and highlighted the key areas for member's attention.

- Audit Scotland have been appointed External Auditor for the next 5 years to NHS Shetland.
- Communication of fraud or suspected fraud
- Key risks within the audit planning (Exhibit 2) – EA are required to recognise the risk of management override by the international auditing standards so have designed procedures looking at management manipulation of results as part of its standard planning process.
- (Exhibit 2) Accruals recognition and completeness of expenditure

- Revised International Standard on Auditing includes a requirement for EA look more at ICT arrangements across the systems.
- Wider Scope and Best Value – EA are gathering baseline data on climate change this year across the public sector as the basis of informing national reporting.
- (Exhibit 3) Sign off and plan for the timetable of accounts 2022/23 – the plan is to present to the Audit Committee on 15 June and at the board on 22 June in order to sign off NHS Shetland's accounts for the current year.
- The significant increase in the audit fee this year is a reflection of the current audit market and follows the procurement round which takes place every 5 years (6years was the delay this time due to covid).

With regard to wider scope and best value, JH asked if there would be any value in considering how NHS Shetland has recently has gone about bidding for money in terms of using resources to improve outcomes. BH agreed it could be very helpful to understand the reasons why bids for various grants and other monies are perhaps falling through the net and the board was not being successful. BH said he was reluctant to promise EA could look at this as additional work in 2023/24, but would take this suggestion away and EA will consider it for future. **ACTION: EA**

CM added that the majority of the allocations the board receives are set by SGov usually according to its NRAC share. This is similar to what happens in local government also. CM offered to provide more detail to JH in their upcoming meeting. **ACTION: CM**

DECISION: the committee noted the External Audit Plan for 2022/23 Accounts.

Standing Items

17. Audit Committee Business Plan 2023-24 *(Paper AUD 22/43)*

CM explained that the Business Plan had been changed since it was agreed in November to move the work of risk into the core part of the business along with some further minor changes. The committee is asked to agree when the private meeting with IA and EA should take place (currently in November) and is suggested it take place in March on a recurrent basis.

CC suggested it should be March but members will discuss in the private session of the meeting and feed back. **ACTION: CC**

DECISION: the committee agreed proposed the Business Plan 2023/24.

Other Items

18. National Fraud Initiative in Scotland 2022-23 update *(Paper AUD 22/44)*

CM explained the National Fraud Initiative is a public sector data matching exercise to prevent and detect fraud by sharing information to reduce the likelihood that the public sector is subject to fraud. As part of the exercise, NHS Shetland are sent a number of issues to look at which are highlighted from the analysis of our data. The finance team have considered that data and reviewed the issues with regard to risk and fraud. As identified, there were 2 duplicate payments and the money has been recovered from the relevant suppliers.

There are a number of people who appear on the list because they are employees and classed as suppliers to the board due to the fact that they also own property in Shetland which is leased to the board. There is no issues with fraud found from the assessment and the boards processes work well.

Risk always exists and the board advertise risk and fraud awareness, for example cybersecurity training which was available to all staff as part of cyber Scotland week recently.

All staff complete fraud courses as part of the statutory and mandatory training and NHS Shetland is the only board in Scotland which includes this as mandatory training. It is considered very useful training for staff in both professional and personal life and is part of trying to create a culture in the organisation of zero tolerance to fraud and cybersecurity.

DECISION: the committee noted the National Fraud Initiative in Scotland 2022-23 update.

19. Audit Committee Self-Assessment Annual Performance Report 22/23

(Paper AUD 22/45)

CM said that as part of the board's annual process for reviewing its assurance and governance, the Audit Committee is asked to produce a report which outlines its role and performance. The version of the report presented today will be updated to take account of the attendance at the March meeting and any outcomes from that meeting. At present, the report is indicating that members believe that they have performed their obligations and duties under the terms of reference and there are no material issues that they require to flag to the accountable officers as part of the annual accounts process. The audit committee receives the reports of all the governance committees at the May meeting so that when reviewing the annual accounts assurance certificates, members are aware of the statements made.

ACTION: PM to update with attendance from March 2023 meeting.

DECISION: the committee agreed the Annual Self-Assessment Performance Report.

20. Audit Committee Terms of Reference *(Paper AUD 22/46)*

CM explained the board's Corporate Governance Handbook requires the committee to annually review its Terms of Reference. One of the key changes is the recommendation is the update the title of the committee to Audit and Risk Committee.

DECISION: the committee approved the Audit Committee Terms of Reference.

21. Any Other Competent Business - There was no other competent business.

22. Date of next meeting

- Joint Audit & Governance Committee Chairs meeting on **Tuesday 23rd May at 10:00am** by Microsoft Teams.
- Audit Committee Meeting is **Thursday 15th June 2023 at 10:00am** by Microsoft Teams.

[The meeting concluded at 11:45 followed by..]

23. Private meeting between Audit Committee Member and Auditors