APPROVED – 28TH NOVEMBER 2023

SHETLAND NHS BOARD

Minutes of the Meeting of the Audit and Risk Committee held at 10:00 on Tuesday 26th September 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
Mr Joe Higgins [JH]	Non-Executive Director (Interim Chair of CGC)
In Attendance	
Mr Colin Marsland [CM]	Director of Finance
Mr Brian Chittick [BC]	Chief Executive
Ms Edna Mary Watson [EMW]	Chief Nurse (Corporate)
Ms Elizabeth Young [EY]	Internal Audit
Mrs Pauline Moncrieff [PM]	Board Business Administrator (minutes)
Mrs Erin Seif	PA to Director of Finance

1. Apologies

Apologies were received from Michelle Hankin, Brian Howarth and Stephanie Hume.

2. Declaration(s) of Interest

With regard to the Revised Payment Verification Protocols (item 17), CC declared that he was employed by one of the local ophthalmic contractors although there was no personal financial benefit to be gained from this.

3. Draft Minutes of the Meeting held on 15th June 2023

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

4. Action Tracker

(203-206) To be discussed later on the agenda as part of paper presentations.

5. Matters Arising

There were no matters arising from the draft minutes or Action Tracker.

6. Strategic Risk Register Review *(Paper AUD 22/13)*

EMW reported the key highlights in the report for member's information including:

- Adequacy of controls within strategic risks – from 17 strategic risks, 5 have tested all the controls, 3 had some testing and the remaining 9 have had no testing so far. No detail has been given of the testing, so the team will address this for meetings going forward.
- SR14 (Estates) – a number of issues affect this risk including the condition of the board's estate, environmental audits and the board's ability to meet national targets (eg. net zero). The Chief Exec will revisit this with the Head of Estates.
- SR13 (Access to Services) – the risk score continues to be at a sustained increased rate of 16 both due to challenges within the partnership and the acute services to deliver services.

- SR08 (Workforce) - continues to be a very high risk. Rewording of this risk has been discussed at RMG and agreed that there will be a dedicated discussion at EMT to look at the workforce risk in particular. The CExec and DoF will look at rewording the finance risk.
- SR02 (Finance) - the risk score decreased in Q1 and has been maintained in Q2.
- SR16 (COVID outbreak) - the risk rating has decreased from 16 to 12, but is still maintained within the high risk category due to the fragility of all the mitigating measures.
- No new risks have been added in Q2 this last quarter and for the majority of the risks the rating scores have maintained stationary.
- There were 2 organisational risks discussed at RMG:
  Risk 1001 (NMC registration checks) - the DoN will lead a review by engaging with respective professional leads to ensure the risk reflects maintaining registrations across all professions. This risk will sit within the workforce risk and no longer be a stand-alone risk.

  Risk 654 (Meeting Treatment Time Guarantee during remobilisation – RMG had agreed that all the risks that related to the pandemic, remobilisation or recovery are no longer fit for purpose and require to be reviewed. This work will be done in the coming weeks.
- Organisational risk (Risk 523) was closed which related to the potential for infection with blood borne viruses and in particular regarding visiting clinicians and the challenges to ensure their status was up-to-date whilst travelling during pandemic status.
- Directorate risk (Risk 1510) was closed which related to poor documentation around interim discharge letters. The implementation of the HEPMA system has mitigated this risk with an interim discharge letter process now in place.
- Progress with trial of the Risk Register on the JCAD system (training for the NHS Clinical Governance Team) - there is currently no date identified for training by the local authority risk team on the current system to enable access and oversight of the NHS risks which currently sit on the JCAD system.
- 4 risks remain regarded as having their adequacy of control as inadequate – these relate to the national standards (SR01), workforce (SR08), the COVID outbreak (SR16) and IT failure due to cyber attack (SR17).
- Risk Appetite and Controls – these still required to be reviewed and this will work is planned for the coming months.
- CRAT (Clinical Risk Advisory team) review meetings – an updated report was received at the RMG in September and closed off 2 recent CRAT reports (potential wrong site surgery and the care of a person with mental health issues whilst in the Gilbert Bain Hospital).
- 2 emerging issues – a draft response by the Information Governance team following the Information Commissioner’s letter to NHS Lanarkshire concerning inappropriate use of WhatsApp. RMG will set up a local short life working group in order to provide guidance for staff and look at adding WhatsApp and other instant messaging as an organisational risk.
- Reinforced Autoclaved Aerated Concreate (RAAC) – the CExec had informed RMG that following discussion with Estates, this was not considered to be an area of significant concern for NHS Shetland

Discussion

JH referred to adequacy of controls and suggested separating out where there is a genuine absence of a control from the situation where there is a control, but that it is either not entirely within the board's gift, or is fundamentally vulnerable eg. reliance on NHS Grampian.
BC added that the team had been testing the controls which should provide some analysis of where a true gaps exist or whether a position has evolved and the controls are no longer applicable. **ACTION: EMW will follow this up before the next report to the committee**

BC referred members to the previous conversation held at the last Board Development Session regarding risk appetite and suggested that the discussion on the next steps should begin at board level before cascade cross the organisation. BC offered to take this forward with a view to prioritising this with the other standing committees and reaching a consensus on the board's position around risk appetite. **ACTION: BC**

NC asked what the rationale was for lowering the finance risk given that in Q1 there was already a projecting overspend with no clear control in place which would mitigate this.
CM explained that at the beginning of the year the board agreed a budget that made certain assumptions and the issues causing the cost pressures are subject to EMT reviewing the recovery plan to return the board to break-even. The original underlying reason for the finance risk stemmed from efficiency savings and there is a plan in place for this year in terms of delivering these. The in-year risk mitigation is still being developed in relation to the staff sustainability issue. The finance risk was reduced to 12 at the beginning of 2023/24 to take account of the fact that there was a plan to deliver the efficiency savings in this financial year, but not necessarily on a recurrent basis.

BC said this was a risk which is expected to escalate and deescalate as one financial year progresses into another. Other areas of consideration when looking at management of the finance risk include having a robust Annual Delivery Plan which has been approved by SGov, ongoing discussion including with the Chief Operating Officer of NHS Scotland around NHS Shetland's performance. Early conversations have also taken place looking at developing an outward looking sustainability plan (including finance) for the next 1/3/5 years and it is hoped to share this with the board before Christmas.

In response to a question from LC regarding assurance that there is a robust workforce plan in place, BC said workforce planning was one of his priorities as Chief Exec and this must be linked to all aspects of the work on the Strategic Delivery Plan to gain a clear picture of the board's direction of travel and achieving a sustainable workforce model for the next 1/3/5 years. CM added that the management of workforce risk sits with Staff Governance Committee. Workforce planning does not sit solely with the Director of Human Resources because it is a combination of plans for different services taking into account the resources.

CC summarised that in terms of SR08 Workforce, assurance can be taken from the fact that BC has committed to raise this at EMT level. It was agreed that BC would progress this through EMT and provide feedback to the next audit committee meeting. **ACTION: BC**

Members noted that BC is actively working with the Head of Estates to look strategically at balancing priorities (SR14 Estates). The committee voiced disappointment regarding the non-testing of controls and CC requested that RMG take this forward with the risk owners.

Decision: the committee noted the Strategic Risk Register Review.

7. Risk Management Group draft Action Note 5th June 2023 *(Paper AUD 23/14)*
EMW presented the approved notes from the RMG meeting on 5th June which was considered in September.

Risk Management Group draft Action Note 11th September 2023 (verbal update)
EMW said members would receive these at the next meeting but many of the items on that agenda have been picked up in the SRR report. Some key points from the meeting included:

- JCAD access
- Use of WhatsApp
- Review of the workforce and finance risks
- Detailed discussion on reports in relation to the 2 significant incidents on Datix
- Discussion on the organisational challenge of finding staff with the appropriate level of skill and time in order to conduct some Datix investigations. Michelle Hankin has compiled a guide for developing detailed investigation reports which is currently out for comment before going through the final approval process.
- Within the RMG ToR agreed last year, the intention was to have a development session for RMG. This will be following up with the Chief Exec with a view to finalising a date in the coming months.

Decision: the committee noted the update from the meeting of RMG on 11th September 2023.

Internal Audit

8. Internal Audit Progress Report Quarter 1 2023-24 *(Paper AUD 23/15)*
EY commented that all the audits have at least a passing reference to HR, and IA are not planning to conduct an audit in that area at present. Some progress has been made on the ongoing payroll audit, and data has been received from NHS Grampian. Plans are being finalised for on-site audit testing in October. Proposed dates have been submitted for the remaining audits in the plan and assignment plans for those.

Members were asked to note that the plan was quite back-ended into Q3 or Q4 and although IA are working towards having all reports presented to the March committee, there may be some slippage in individual reviews due to capacity within the HR directorate.
BC acknowledged that work on the audit plan is being back-ended and was grateful that IA had shown some flexibility to allow teams to concentrate on the implementation of the Allocate program. This will result in more pressure on IA into Q3 and Q4 and members were asked to be mindful that it may be necessary to consider being flexible on reporting to Audit Committee.

In response to a question from JH regarding the title of audit ref B3 (no longer including recruitment), EY explained that this decision had been made after lengthy discussion with senior managers where it was felt that in order to complete this work in a number of days was a challenge and that potentially a deep dive into retention would be likely to yield more benefit.

CC reported that the Joint Audit Committee and Governance Chairs meeting which is traditionally held in May, is planned to be absorbed into the Finance & Performance Committee meeting, but the plan is to keep the May date pencilled into the Audit Committee diary in order to receive the reports due late in Q4.

DECISION: the committee noted the Internal Audit Progress Report Quarter 1 2023/23

9. Internal Audit Follow-Up Quarter 1 2023-24 *(Paper AUD 23/16)*

EY reported that no actions were closed in Q1, but highlighted that overall the number of actions remains relatively low compared to where it had been historically. Updates had been received for all the outstanding actions (in Appendix 2) and revised time scales indicate that all overdue actions will be completed by the end of the calendar year and potentially some before the next audit committee. This is a very positive picture if this progress can be maintained.

BC informed members that recruitment was underway to appoint some business management support to assist with bank and induction in the acute setting. It was acknowledged that this may take a period of time to have an impact but it highlights that managers have taken IA feedback seriously in the context of resourcing the task and the actions required to sustain the change moving forward.

JH asked if the board saw fit to put in place an agile governance approach due to the competing pressures, how confident were members that these revised timescales could be met.
BC replied that members needed to feel confident that the responses fed back were achievable, to review progress at the next Audit Committee meeting and continue to monitor going forward. BC acknowledged that some will be closed off but that others may require an extension but colleagues have assured IA that they are working towards these deadlines.

CC noted there had been progress to some extent with all outstanding actions so members should feel hopeful that deadlines can be met.

BC suggested that going forward, the name of the accountable executive lead on the audit be added to the summary of outstanding actions (in addition to the action owner).

ACTION: IA to add to Appendix 2 in future

With regard to Mental Health Services, EMW said several actions were described as being assessed as complete upon evidence being provided. EMW asked what IA require in order to be able to help support the closure of these actions. EY agreed to pick this up separately outwith the meeting. **ACTION: EY to follow up with Clinical Governance Team**

DECISION: the committee noted the Internal Audit Follow-Up Report Quarter 1 2023/23

10. Internal Audit Annual Plan update *(Paper AUD 23/17)*

EY presented the paper which provides members with an update of the 2 changes to the plan, namely the removal of the recruitment aspect of the audit and the addition of the IT stock audit which were both discussed at the previous meeting. CM explained that any changes to the Audit Plan must be agreed by the Audit Committee to maintain ownership with the committee.

CC commented that the intended first training session for the Audit Committee is on cybersecurity and will be open up to the entire board and as part of the agreement, NHS Highland, NHS Western Isles and NHS Orkney audit committee will also be invited to attend.

DECISION: the committee agreed the Internal Audit Annual Plan update

Audit Scotland Reports

11. Audit Scotland Adult Mental Health *(Paper AUD 23/18)*

CM explained that all reports issued by Audit Scotland that affect NHS are brought to the Audit Committee for information and attention. Audit Scotland have looked into mental health

services and have raised some concerns around the expenditure total set by SGov not being met and also issues regarding access and the way forward in respect of mental health services.

Members discussed the report and agreed it focused on services and money and not enough on partnership working, early intervention and the holistic elements of mental wellbeing.

LC said that the report highlights the issues nationwide, and the committee understand the pressures that local mental health services are under with the additional concern about how communities are coping post Covid. One way to improve the experience of users of the service would be for the NHS and IJB to engage with communities around how they want services delivered locally to best support them. The mental health support for young people should be a priority particularly those transitioning into the adult service.

JH stated that SGov do not measure the outcomes of those receiving care within the mental health service and asked if NHS Shetland was in the position to do so and quantify the level of care delivered to patients within the service locally.
BC reported that from a service perspective, the mental health team were encouraged to conduct some focus group work to discuss the quality of services, for example eating disorders. It was also hoped that they would be able to undertake a patient survey around quality work. The Good Mental Health for All project (which is funded by IJB) will capture much of the service delivery measurement information and be able to assist planning the service going forward. The establishment of some local performance management measurements in order to support the project moving forward are being planned.

NC described the recent IJB seminar where a presentation was given on the Good Mental Health for All project and members could feel assured that the creation of the Mental Health Strategy is evidence based and also links into the work of the Shetland Trauma Strategy.

CC suggested that the board should consider issuing a press release in response to recent negative news stories in the local media concerning waiting times for some mental health services. These stories have an unfair adverse effect on staff morale when it is through their hard work that waiting times are improving.

DECISION: the committee noted the Audit Scotland Adult Mental Health report

12. Audit Scotland Fraud and Irregularity Annual Report 2022/23 *(Paper AUD 23/19)*
CM explained the report looks at the fraud issues which external auditors have uncovered during the external audit process in 2022/23. The level of fraud identified in the report is a fraction of the true sum in the public sector which is expected to be significantly greater. The report enables organisations to learn from the case studies and to ensure that, in respect of their own services, fraud can be identified and does not exist.

In response to a question from JH, CM reported that the finance team are reviewing how the board compares against the 5 recommendations set out in the report. The board continues to make staff aware of fraud, especially to their own situation and the goal is to develop an anti-fraud culture within the organisation. NHS Shetland has the highest rate of employee participation in the fraud NES standard and CM has a meeting soon with CFS regarding the board's performance against its audit standards against fraud.

The Fraud Prevention Strategy is due to be updated this year but the board has processes in place to try to prevent fraud without being complacent.

DECISION: the committee noted the Audit Scotland Fraud and Irregularity Annual Report 22/23

External Audit

13. (no papers)

Standing Items

14. Counter Fraud Services Annual Report 2022/23 *(Paper AUD 23/20)*

CM presented the report which outlines the work of Counter Fraud Services who are the main agents who support all 22 health boards in respect to the responsibilities around fraud.
The report highlights that NHS Shetland have had no incidences of fraud reported in 2022/23.
The board was subject to being party to a case of fraud but in reality NHS Shetland was not the organisation being defrauded. The board has a duty to ensure that staff have the appropriate training and generally uptake is high.

In response to a question from CC regarding fraud awareness training for staff available on Turas, CM explained there were a number of courses available and the fraud induction course is one of the mandatory courses for the organisation. The fraud awareness course is currently second highest in terms of staff participation (behind child protection) but is below the 100% target. Completion of statutory and mandatory training is one of the topics for review by the Staff Governance Committee.

BC commented that he was pleased to see the level of fraud was so low but wondered if one reason for this might in part be due to less Covid activity being reflected in the data.
CM added that not all fraud is reported plus it was not possible to capture every incidence of fraud because it was difficult to evidence and boards themselves are not permitted to use counter surveillance.

DECISION: the committee noted the Counter Fraud Services Annual Report 2022/23

15. Audit Committee Business Plan 2023-24 *(Paper AUD 23/21)*

CM invited comments from members on any changes to the business plan for the remainder of the year. The business plan for 2024/25 will be presented to the committee in November in terms of planning for next year as part of the continuous business cycle.

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

15. Pharmaceutical Services Payment Verification Annual Report 2022-23

(Paper AUD 23/22)

CM explained that as agreed by Audit Committee previously, the GMS and pharmacy verification report is presented as an annual summary report (as opposed to quarterly).
GMS no longer conduct an audit in Shetland annually because 8 out of 10 of the practices are run by the board. Independent practices should be reviewed by GMS every second year.

In terms of independent pharmacies, analytical data is collected by PSD which is produced in

quarterly reports and shared with the Director of Pharmacy and Director of Finance. When available, both also attend a meeting with PSD to discuss the reports.

The main point for the committee to note is that there are currently no material issues being raised by PSD which they are investigating. Some national issues exist which are under investigation and which NHS Shetland is part of, but none locally.

Members noted that part of the process of looking at verification protocols for all primary care contractor services is being looked at and the revised protocols (including ophthalmic, dental and pharmaceutical services) will be subject to the new verification process coming into place to ensure all services are compliant with the terms of the new contract.

JH referred to the recommendation in the report that boards should conduct some degree of their own verification checking, and asked if this was already being done or if additional resource would be required to carry this out. CM explained that all the verification checks are primarily done by NSS with support from the board when conducting site visits to pharmacists, dentists and opticians. The new protocols should place no additional resource expectations on the board with most of the additional work sitting with NSS to update verification checks and taking account of issues. There is no plan to change the frequency of site visits and GMS conduct these very infrequently due to the number of independent practices in Shetland and it is the board's responsibility to look at salaried practices.

DECISION: the committee noted the Pharmaceutical Services Payment Verification Annual Report 2022-23

<u>Other Items</u>

16. Revised Payment Verification Protocols (NHS Circular DL(2023)24

The committee noted the circular.

17. Any Other Business

There was no further business.

18. Date of next meeting is **Tuesday 28th November 2023 at 10:00am** by Microsoft Teams.

[The meeting concluded at 11:35]