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A (M) 16/05 Minutes: 61 - 70

NHS Greater Glasgow and Clyde

Minutes of a Meeting of the Audit Committee held in the Board Room, JB Russell House, Gartnavel Royal Hospital on Tuesday, 13 December 2016 at 9:30am

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PRESENT

Mr A Macleod (Chair)
Mr S Carr
Mr R Finnie
Ms J Forbes
Mr J Matthews
Mrs D McErlean
Ms A Monaghan
Dr R Reid

IN ATTENDANCE

Mr J Brown	NHS Board Chair (until Minute 67)
Mr R Calderwood	Chief Executive (until Minute 67)
Mr M White	Director of Finance
Mr M Gillman	Financial Governance Manager
Mr J Best	Director North Sector, Acute (Minute 67)
Mr W Edwards	Interim Director of eHealth (Minute 66)
Mr B McLean	Fraud Liaison Officer (Minute 68)
Mr P Ramsay	Assistant Director of Finance, Financial Services (Minute 67)
Mr A Barrie	PwC
Ms M Kerr	PwC
Mr K Wilson	PwC
Mr S Elder	PwC
Ms L Maconachie	Audit Scotland
Mr D McConnell	Audit Scotland
Ms L Yule	Audit Scotland

Action by

61. Welcome and apologies

Apologies were intimated on behalf of Dr D Lyons and Cllr M O'Donnell.

Action by

62. Declarations of Interest

No declarations of interest were intimated.

63. Minutes

The minutes of the meeting on 27 September 2016 (A(M)16/04) were approved as a correct record of the meeting, and the note from the Audit Committee Executive Group meeting on 16 November 2016 were noted.

64. Matters Arising/Rolling Action List

Mr Gillman talked through the papers which gave an update on the status of ongoing actions.

Business Continuity – in reference to the contaminated water incident at the RAH, Mr White informed members that feedback was still awaited from Scottish Water. Mr Calderwood advised that the Director of Public Health would be collating the learning arising from the incident; this would include details of how well Business Continuity Plans were adhered to, both by NHSGGC and by Scottish Water. This action would continue to be monitored.

List of audit actions – Mr Gillman gave an overview of the schedule detailing audit actions. He reported that, as this was the first schedule of this type to be prepared, all medium and high audit actions undertaken from April 2014 were detailed, and that completed actions would fall off future reports. Mr Wilson noted that this was a helpful document for PwC and that they would assist them in their follow-up process. Mr Brown also thought it was a useful schedule and highlighted the agreed actions for completion.

Audit Committee Remit – Mr Gillman advised members that the changes discussed at the previous meeting had been incorporated into the remit.

Data Protection Audit action plan – Mr White outlined the progress made towards implementing agreed management actions, and advised that there would be two or three significant pieces of work carried out in 2017. There followed a discussion amongst members around some of the recommendations made in the report, including the clear desk policy and the existence of a separate Sandyford IT system. Mr Macleod requested that progress towards implementing agreed actions should be monitored, and for an update to be provided for to the next meeting.

Director of Finance

Visas and professional registrations – following the previous meeting where, as a result of a visa fraud, members had requested a paper outlining the Board's practice for ensuring all staff were entitled to work (either as a foreigner or in their professional role) and a paper was submitted from HR. Mr Carr said he would like to know what had been done as a result of the visa fraud that had previously come to light. Members discussed the process outlined for checking professional registrations.

Director of Human Resources

Mr Macleod noted that he while he considered that the process was robust, there should be a task delegated to line managers to ensure the process is followed and that staff being employed have appropriate registrations.

Action by

Mr Calderwood advised that there was an exercise underway to communicate with nursing staff to emphasise the importance of maintaining their professional registrations.

Noted

65. Risk Management

Mr White outlined for members a paper setting out options for moving the risk management agenda forward.

Mr Brown acknowledged that this was a positive step forward, it was important to be clear about responsibilities for identifying risk, and that the biggest challenge would be to embed, throughout the organisation, a culture for managing and mitigating risks. Mr Carr commented that the culture for risk starts at the top and it would be useful for the NHS Board members to have more insight into risk. Mr Macleod requested that Mr Hamilton arrange for risk to be the subject of a future Board seminar.

Head of Board Administration

Noted

66. Cyber Security

Mr Edwards gave a presentation to members on the policies and measures in place within NHSGGC to maintain its cyber security, eHealth's action plan over the next six months and the emerging threats to NHS Boards.

Following the presentation, members had a number of questions:

Mr Macleod asked about the internal threats; Mr Edwards advised that, as part of implementation plan, all staff are being targeted to raise awareness of cyber threats.

Dr Reid asked that if, (as an example), Sandyford has its own IT system, what oversight do we have to ensure all legacy systems are adequately protected? Mr Edwards replied that there is a need to produce a comprehensive Information Asset Register (IAR) to ensure that all systems are adequately protected.

Mr Macleod asked what the timescale was for producing an IAR. Mr White said that work needs to be immediate, and we will look to have this in place by the end of March.

Interim Director of eHealth

Mr Carr expressed his view that it would be helpful for Board Members to have a presentation on what an Information Asset Register is and how it would be classified, i.e. priorities etc.

Interim Director of eHealth/ Head of Board Administration

Action by

Mr Matthews said that the key to cyber security is frontline staff, and asked if there was an example of how management was changing cultures. Mr Edwards replied that eHealth are drip feeding sets of key messages around cyber security to groups of users, e.g. GPs.

Dr Reid enquired about the scheduled downtime and whether there was an impact regarding access to clinical records; Mr Edwards advised that the downtime is planned in conjunction with Clinical Directors, and was scheduled, on a rolling basis, between 6am and 8am.

Mr Brown expressed concern on a number of matters –

- are we managing information security?
- that we don't know what our information assets are;
- if patching is not up to date, how do we know systems are secure?
- how does information governance link in to the NHS Board?
- do we have a proper threat assessment?

Mr White said that management is working on these issues and are trying to define and resolve problems.

Mr Brown asked when will there be a remediation plan, and when will patching be brought up to date? Mr Edwards advised that a plan for patching would be prepared in next 4 weeks (i.e. by mid January), and that he needed to have a clear understanding of what patching to what servers is required.

Mr Macleod said that it was clear that Audit and Risk Committee members wanted clarity on scale of problem, and requested that Mr Edwards should prepare an update and share with himself and Mr White at the earliest opportunity.

Interim Director of eHealth

Mr Brown suggested that there should be a Board Seminar on cyber security, a Board Champion for Information Governance appointed and training for the Board on information security

Interim Director of eHealth/ Head of Board Administration

Dr Reid asked if clinical information is securely held: Mr Edwards responded that there was no evidence to suggest clinical information is insecure, and that regular network penetration testing is carried out.

Mr Wilson commented that this was a high risk area and that the Board required robust controls.

Mr Macleod brought the discussion to a close by noting that the reason for bringing the matter of cyber security to the table was reinforce its importance; he agreed with Mr Brown that the topic should be a future board seminar item. He also requested an update be brought back to the next Audit and Risk Committee meeting

Interim Director of eHealth

Action by

67. Internal Audit

Ms Kerr presented PwC's activity report which summarised progress towards completing the 2016/17 internal audit plan during the period to 6 December 2016. She highlighted that six reviews had been completed during the period and were now reported to the Audit Committee. Of the six, one review, Waiting Times was rated as high risk and, as a consequence, Mr Best was in attendance to describe the management actions that would be undertaken in response to the audit findings. There was, in addition, one medium a four low risk reports.

Waiting Times/TTG – high risk

Ms Kerr advised members that scope of this review was to review and evaluate the control design and operation of the key controls within NHSGGC to achieve the required targets, and provide an assessment of their effectiveness in managing the risks around this process. This audit built on the work that was undertaken during 2014/15 and also reviewed the steps taken to address the weaknesses identified and reported on and included reviewing the evidence to support the independent monthly audit process.

PwC found that NHSGGC works proactively and has very detailed, timely and granular information which is available to those who make the operational and management decisions to manage waiting and treatment times. The dashboard that has been developed gives greater visibility to all stakeholders of the target performance. The data held within the dashboard is fed from TrakCare and is updated on a daily basis. Various filters are available such as speciality, care provider, procedure and waiting time.

However, as at August 2016 there was a continued deterioration in performance against targets. Examples of this include a reduction from 88.1% in June 2016 to 80.7% in the 62 day referral to treatment target for cancer patients, the A&E 4 hour waiting target achievement falling from 94.3% in June 2016 to 92.6% and attainment of both in-patient and out-patient 12 week treatment time guarantee targets falling.

The main weakness which PwC raised as a high rated risk finding is in respect of action plans which are required to address waiting list issues. They did not consider that there was sufficient evidence that recovery plans are being prepared by the local Sector teams with any consistency or rigour, and recommended that recovery plans should be developed to address issues which have a direct impact on performance against waiting time targets. They also did not find evidence that agreed and targeted actions were being taken which have clear outcomes, to defined timescales and with responsibility for the action clearly identified. As a result of this they were not able to determine if these issues are being addressed and if the outcome is as expected.

Mr Calderwood accepted PwC's comments as fair, and said that management was using its best endeavours to meet targets. He added that we are reprofiling, from the bottom up, what we are able to deliver, and, therefore, rather than producing a recovery plan we are looking to produce a capacity plan.

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Mr Best also pointed out that while planning around demand and capacity, we also need to take account of skills/resources that we have in place, and cited the example that it has taken eighteen months to recruit two urologists. He also stated that the development of a capacity plan would be based on safe clinical practice.

Mr Finnie commented that if the Board's policy is not to address waiting time delays by way of action plans, then the main issue was whether government targets were realistic and achievable.

Mr Matthews queried if we are asking PwC to look at the right things, as we know already that we are missing targets. Ms Kerr replied that the report was not high risk due to missing targets, but was around the setting of plans and the lack of evidence that agreed processes are being adhered to.

Mr Brown asked Mr Best if there would be performance profile prepared for each target for the rest of the year. Mr Best responded that there is a cancer plan for the rest of the year, and that we are working closely with the Scottish Government on this. There is also a treatment time guarantee plan for the rest of the year.

Mr Brown said that he was reassured that management are responding to the matter.

Key Financial Controls, Payroll and Expenses – medium risk

Ms Kerr described this report for members. The overall objective of this review was to evaluate the design and operation of the key payroll controls in place over the period from April to September 2016.

The sub-processes, and related control objectives included in this review were:

- control environment;
- time recording – standing data maintenance;
- payroll calculations and payroll payments;
- payment of bank staff;
- expense claims; and
- ledger updates.

A number of findings had been raised in the previous year's review in relation to the allocation and processing of bank shifts worked. PwC were aware that an interface between the Bank Staff Management System (BSMS) and the Scottish Standard Time System (SSTS) is being created. This was scheduled to be in operation in October 2016, however, this since been pushed back to February 2017 to ensure that all necessary implementation testing has been performed. PwC identified that the following two medium risk findings remained open from their 2015/16 payroll review.

1. Transfer of data from BSMS to SSTS – whilst awaiting the implementation of the interface between BSMS and SSTS, reliance is still placed on manual input of data to SSTS.

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2. Selection of staff in BSMS – staff are not booked to bank shifts using a unique identifier (pay number) which presents the risk that the wrong staff member is paid.

In addition, during this year's review, a further medium risk finding was identified. This related to the authorisation of bank shifts where PwC identified that certain staff have functionality to schedule and approve their own shift.

Management have agreed with the findings of the report, and the responsible managers have already commenced work to ensure that actions are completed.

Mr Brown asked why was the report not high risk, given the high value of payments made to bank staff, and was also surprised that the reconciliation could not be evidenced. Ms Kerr answered that there were compensating controls which pick up errors, and Mr Ramsay described the processes and validation checks which are in place. He advised that ward managers are sighted on shifts that have been worked, and are therefore able to query any anomalies. Mr Ramsay also noted that the BSMS system was about to be replaced, and that the new system would upload more easily to SSTS.

Low risk reports

There was also a brief discussion on the four low risk reports:

- Key Financial Controls – Accounts Payable
- Key Financial Controls – General Ledger
- Performance Monitoring and Reporting in Acute Services
- Complaints Handling Procedures

Mr Macleod considered that the Performance Monitoring and Reporting report should also be referred to the Acute Services Committee.

Financial Governance Manager/Head of Board Administration

Noted

68. Fraud Report

Mr McLean highlighted for members the report summarising progress in the on-going investigations of fraud as at the end of November 2016. Two new cases of suspected fraud had been added to the fraud register during the period and eight cases closed - there were currently eight open cases.

Mr McLean reported that NHSGGC and NHS Counter Fraud Services (CFS) had supported International Fraud Awareness Week in November 2016 at the Queen Elizabeth University Hospital and Royal Alexandra Hospital where the Board's Fraud Liaison Officer (FLO) and CFS staff had promoted the Board's Fraud Policy and general fraud awareness. The events were well received and around 450 questionnaires were completed; these are being analysed by CFS.

Mr Macleod asked if there were any trends emerging from the questionnaires; Mr McLean replied that there were none so far, but the results would be provided to the Board in due course.

During September 2016 the FLO, Head of Financial Governance, a number of Heads of People and Change and Learning and Education staff had attended a workshop on investigative interviewing techniques run by CFS. Mr McLean

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advised members that NHSGGC staff have been trained on taking over the workshop content and this is being incorporated into ongoing training packages available to NHSGGC HR staff and other managers.

He also reported that the biennial data matching exercise to identify fraud in public sector bodies, the National Fraud Initiative, was underway for 2016/17. NHSGGC has submitted payroll and accounts payable data to the Cabinet Office, and processed data matches are anticipated at the end of January 2017 with follow-up/investigation of the matches commencing thereafter. Regular updates on progress will be provided to the Audit and Risk Committee.

Dr Reid enquired about overseas patient fraud; Mr McLean advised that it could be difficult to make recoveries from such patients who are admitted via A&E. Mr White added that the Home Office Border Agency are notified of patients who have left the country without paying, and they will not be permitted to re-enter.

Noted

69. NHS in Scotland 2016

Mr McConnell referred to the NHS in Scotland 2016 report. He advised members that the report was compiled from the external audit reports of all NHS Boards in Scotland. He added that the key points were around financial balance and service targets. Mr Macleod said that he thought it was helpful that the report highlights those issues to the Scottish Government.

Mr Gillman advised that he had issued Audit Scotland's questionnaire, which accompanied the report, to the non-executive board members to help them in their role of overseeing the board's performance. He informed the committee that six board members had responded, and he highlighted the key points that arose.

There followed some discussion around the questionnaire. Mr Finnie and Mr Carr expressed a view that the questionnaire didn't recognise that non-executive directors are unable to effect change where the board must adhere to government policy. Mr Macleod did, however, consider that it served to highlight issues and to help to better inform communication to board members

Noted

70. Date of Next Meeting

The next meeting will be held on Tuesday 14th March 2017 at 9:30am.

The meeting concluded at 12:55pm.