NHS Greater Glasgow and Clyde

AR (M) 17/05 Minutes: 53-66

Minutes of the Audit and Risk Committee meeting held in JB Russell House on Tuesday, 12th December 2017

PRESENT

Mr A Macleod (in the Chair)
Mr S Carr (until Minute 63)
Mr R Finnie
Dr D Lyons
Mr J Matthews
Mrs D McErlean

IN ATTENDANCE

Mr J Brown	NHS Board Chair
Ms J Grant	Chief Executive
Dr J Armstrong	Medical Director (for Minute 58)
Mr J Best	Interim Chief Officer, Acute Services Division (until Minute 58)
Dr L de Caestecker	Director of Public Health (until Minute 57)
Mr A Crawford	Head of Clinical Governance (for Minute 64)
Mr W Edwards	Director of eHealth (until Minute 59)
Mr M Gillman	Financial Governance Manager
Mr J Hamilton	Head of Administration
Ms H Jackson	Head of Business & Resources, eHealth
Ms S Johnston	Head of Civil Contingencies (until Minute 57)
Dr M McGuire	Nurse Director (for Minute 58)
Dr M Smith	Lead Associate Medical Director (for Minute 58)
Mr M White	Director of Finance
Ms L Maconachie	Audit Scotland
Mr D McConnell	Audit Scotland
Ms L Yule	Audit Scotland
Ms G Collin	PwC (until Minute 64)
Ms M Kerr	PwC (until Minute 64)
Mr K Wilson	PwC (until Minute 64)

Action by

53. Welcome and Apologies

Apologies for absence were intimated on behalf of Ms J Forbes, Cllr J McColl and Ms A Monaghan.

Mr Macleod referred to the clash of future committee dates with those of the Clinical and Care Governance Committee. Mr Hamilton agreed that the CCG Committee dates would be changed. **Head of Administration**

Noted

Action by

54. Declarations of Interest

No declarations of interest were raised.

Noted

55. Minutes

Mr Brown referred to minute 44, and noted asked about the wording of his comment on the Health and social care integration: managing direction from IJBs review. Following a suggestion by Ms Kerr, it was agreed that the wording should be amended to reflect the point that this review was no longer in the audit plan.

Subject to the above amendment, the minutes of the meeting on 12 September 2017 (A (M) 17/04) were approved as a correct record of the meeting.

The notes from the Audit Committee Executive Group meeting on 30 August 2017 and minutes of the Risk Management Steering Group (RMSG) meeting on 29 August 2017 were also noted.

With regard to the RMSG minutes, Mr Macleod asked that Mr White describe the role of Ms MacRae on the group. Mr White advised members that Ms MacRae had been co-opted onto the RMSG due to her expertise in the field of risk management. Mr Brown asked if the Risk Management Strategy should be reviewed on an annual basis. Mr Macleod suggested that when the committee considers the updated strategy, it should take a view on the required frequency for updating the strategy.

Noted

56. Matters Arising/Rolling Action List

Mr Macleod noted that he had received correspondence from Cllr McColl regarding the action lists, and that he had proposed that in future no actions should be removed from the lists until the committee has had appropriate confirmation that it had been completed. Mr Carr agreed that he considered that it was the role of the committee to approve whether or not an action has been cleared.

Mr Gillman then proceeded to update the committee on the status of ongoing actions on both the rolling actions list and the audit actions update. He reported that five actions were now cleared and that confirmation was awaited for dates for Risk Management and Cyber Security to be included on the Board Seminar timetable. **Head of Administration**

In respect of the list of outstanding audit actions, it was noted that six out of thirteen actions due had been completed, with one long standing action not yet completed, which was the introduction of a barcode tracking system for the central decontamination unit. Mr Brown expressed concern at the length of time that has been taken to implement this action. Ms Grant clarified that there are tracking systems in place, but what was needed was a single system, and that an implementation plan would be reviewed by the CMT. **Director of PPFM**

Mr White was tasked with setting deadlines for all the outstanding actions to be completed. **Director of Finance**

Noted

57. Business Continuity Update

Dr de Caestecker reported to members that good progress has been made in ensuring that there is a comprehensive set of Business Continuity Plans in place across the organisation. The matter is also an item on the agenda of meetings of the Resilience Group.

Following a brief discussion on the delivery of the testing exercises, Mr Macleod recognised the significant progress made in this area.

Noted

58. Internal Audit Reports

Ms Kerr highlighted for members that two of the internal audit reviews being reported to the committee were classified as "high risk" – Waiting Times Management and Suicide Risk Assessment.

Waiting Times Management
Ms Kerr described for members the scope of the review and the findings they were reporting. The overall objective of this review was to evaluate the design and operating effectiveness of key controls in place with regards to waiting times management. The key objectives considered were: the governance and reporting, capacity planning and managing demand in respect of waiting times management. She advised that their review had identified one high risk finding, three medium risk findings and one low risk finding.

- **High risk** - Absence of project management discipline has led to a lack of clarity on project objectives and benefits, timescales and milestones, resource inputs and monitoring arrangements. Without such rigour and project management discipline there is a risk that the project will not be effectively executed.
- **Medium risk -** Effectiveness of capacity planning exercise. PwC identified that the current process for identifying capacity, demand and potential productivity gains is based on historic actuals rather than genuine capacity. Workshops were held to consider productivity gains and they considered the gap between historic actuals and waiting list numbers. However, PwC would expect that the approach to identify the gap would start with actual capacity (i.e. available clinic and theatre slots) which is built up based on actual known resource, as opposed to actuals delivered.
- **Medium risk -** Quality of action tracking process. PwC found that the action tracking process in place is insufficient to ensure that meaningful actions are identified, monitored and delivered.
- **Medium risk -** Long term capacity and demand assessments. The current focus of the programme of demand and capacity gap assessment and improvement is on seeking immediate and timely solutions to critical short term demand gaps, addressing the issue of current longest waiters first. In order to perform a truly effective capacity and demand assessment, which would allow for longer term solutions to be implemented, management must consider long term trends.

Management actions to address the findings were agreed, with target dates of between January and March 2018 for the implementation of the actions.

Mr Best advised members that management had accepted the findings of the review, and in response, had now seconded a General Manager to run the waiting times process and carry out a further exercise on tidying waiting lists. A planned care programme has been established and management is looking at utilisation and job plans to enable them to reach acceptable utilisation levels. He also noted that we were rolling out patient focussed bookings.

Mr Finnie asked how best non-executive board members should hold management to account and ensure that the Acute Services Committee considers this report. Mr Macleod recognised that reports may be pertinent to other committees of the board. He considered that this report should therefore be referred to the Acute Services Committee.

Financial Governance Manager

Action by

Suicide Risk Assessment

Ms Kerr advised members that this review had been requested by the Medical Director in order to assess any gaps in our risk protocols. The scope of the review focussed on the following areas in relation to suicide risk assessment: risk assessment framework; risk assessment process; joint working and transition process; and staff training.

PwC found that whilst there are risk assessment tools in place which have been tailored for specific service needs, these were not being completed in practice in accordance with the requirements of the Board's policies. Whilst the appropriate clinical care may have been provided in these cases, in numerous instances there was a lack of evidence that the appropriate considerations were made. They also found that there are gaps in the coordination of suicide risk assessment across service areas in NHS Greater Glasgow and Clyde, and that board suicide prevention guidelines covered adult mental health services only, rather than including CAMHS, Acute and Primary Care services. Specifically, PwC identified one high and two medium risk findings:

High Risk - Risk assessment procedures are not operating in practice. PwC looked at the execution of the three risk assessment tools operating across NHSGGC and found that in a significant number of instances, across all three tools, risk assessments were not completed in accordance with the governing policies in place.

Medium Risk - Lack of co-ordinated framework to govern suicide prevention. A review of suicide risk assessment arrangements in place found that the framework which governs the format, nature and extent of suicide risk assessment covered adult mental health patients only.

Medium Risk - Absence of a robust approach to mental health training. PwC reviewed the current arrangements in place in relation to staff training on suicide prevention and found that there was no clear framework in place to support this (as distinct from use of risk assessment tools, where training is provided). There were a number of inconsistencies relating to the nature and extent of training received across key staff groups, and there was no documented approach to ensuring that each group is in receipt of the appropriate training.

Management actions to address the findings were agreed, with target dates of between March and April 2018 for the implementation of the actions.

Dr Smith outlined the actions that would be undertaken. Management recognised that the use of risk assessment tools was not fully compliant with policy in the audits conducted in CAMHS and ED, two areas that have not so far had the benefit of SPSP support. Performance needed to be improved, and a suite of measures including training, prompts to policy awareness and audit will be introduced.

As part of the revision of risk management policy, management recognised that an overarching framework of Suicide Prevention Guidance needed to be developed to bring together all relevant policies into one coherent document. That is now available online through Staffnet. The document did not expressly reference risk management in CAMHS and Acute settings, and that oversight would be corrected.

Management accepted the criticism of suicide prevention training made in the review. This was previously subject to a HEAT target and Scottish Government support for training materials, both of which have now lapsed. A working group to reinstate appropriate training has been established.

It is the Board's view that pathways are in place to guide the management of suicidal behaviour in ED, but it was accepted there was scope to improve the clarity and availability of that guidance.

Dr Lyons suggested that the Clinical and Care Governance Committee would be the appropriate group for this report. Mr Macleod agreed and asked that the report should be considered by the CCG to ensure that the management actions are taken forward.

Financial Governance Manager

Ms Kerr continued to highlight the key points from the remaining reviews that had been completed in the period:

- Cyber security: phase 2 – risk n/a
- Delayed discharge – medium risk
- Temporary staffing: nursing – medium risk
- Key financial controls: accounts payable – low risk
- Key financial controls: fixed assets – low risk

Cyber security – Ms Kerr described how this review performed a baseline assessment of controls across three selected domains of cyber maturity: Connections, People and Crisis. The PwC cyber maturity assessment methodology was used to examine controls. A mature approach recognises that cyber security is an institutional risk requiring engagement across an organisation.

NHS Greater Glasgow and Clyde has assessed current average cyber security maturity at 2.5 whilst setting average target maturity at 2.7 across the domains discussed. Both 'People' and 'Connections' domains were reported to have the same current maturity scores. The domain reported as being least mature was 'Crisis'. The Crisis domain seeks to understand the organisation's ability to deal with security incidents, business continuity and major incident response. From an organisation wide perspective, it was noted that while NHS Greater Glasgow and Clyde perform annual exercises to discuss and plan incident response to threat scenarios, simulation exercises are not performed to test the effectiveness of such plans. Increased participation by relevant third parties in these exercises would enhance maturity. Similarly, while penetration testing is performed and a vulnerability assessment has taken place, increased maturity can be achieved through the continued development of formal internal monitoring and detective capability. Mr Edwards noted, however, that whilst 'Crisis' appeared less mature, eHealth has robust plans in place to increase maturity.

Mr Brown enquired as to what assurances he could take from the report, as it was not graded in the normal fashion. Ms Kerr advised that the full report gives all the information to allow assurance to be taken from the review. Mr Edwards added that PwC's methodology places NHSGGC ahead of peer organisations and shows that we are in a strong place.

Delayed discharge – Ms Kerr advised members that the key finding of this report was that, in order to drive tangible and sustainable improvement against delayed discharge targets, a more detailed, data-driven and targeted approach must be taken in order to identify and change underlying root causes at a granular, departmental and patient-pathway level. This approach should be based on available delayed discharge data, lost bed days data and any additional understanding that can be gained on detailed underlying root causes for delay. Actions should then be targeted towards the areas which present the poorest performance. By doing this, the Board will be better equipped to create and prioritise meaningful actions. PwC did acknowledge that the challenges in improving delayed discharge performance are complex, multi-faceted and variable across the six HSCPs. Differences in patient populations, demographics, the number of stakeholders involved, and other external factors render a single, consistent approach ineffective.

Specifically they identified four medium risk findings:

- Targeted delayed discharge reduction
- Use of delayed discharge funding
- Unscheduled care action plans
- Operational collaboration

Management has accepted the findings in the review and will progress the agreed actions.

Mr Brown said that he recognised the risk to patients, but the cost of delayed discharges was approximately £5m - £6m; he asked if the IJBs were spending enough in this area, or if they were building reserves. Ms Kerr answered that the NHS Board has a lack of visibility around how IJBs spend their resources. Ms Grant added that IJBs have been asked to look at their financial position, and that she and Mr White would look at how IJBs are using their resources.

Director of Finance

Action by

Mr Matthews asked what control the NHS Board has over funds that go to IJBs. Mr White advised that dedicated funding is monitored, but general funding was integrated. Dr Lyons noted that, in his experience, IJB non-execs do challenge officers on the issue of reserves. He also considered that the review highlighted that delayed discharge was not just a financial matter, but a patient focussed matter. Mr Brown suggested that IJB funding should be a board seminar topic.

Head of Administration

Temporary staffing: nursing - Ms Kerr highlighted the key points form this review; over the past 12 months the Board has initiated a series of actions to consider the use of temporary staffing across nursing and midwifery. At present the focus is on reducing the level of agency use. Whilst in the longer term it is the objective that reliance on bank staff will be reduced, it has been acknowledged that bank staff will always be required as a contingency across the health service. The Board has in place policies and processes to manage the use of temporary staff and follows national guidelines when it comes to workforce planning. Work has been done over the last six months by management to examine rostering and the underlying factors that impact the use of temporary staffing. A number of initiatives are underway to improve and help teams with rostering, sickness absence, enhanced observations and recruitment. The findings and recommendations raised within this report demonstrate that the root cause of the issues is the need to set consistent minimum standards for approving the use of agency requests, for managing and monitoring complaints and to ensure proper on-boarding of agency staff. PwC identified two medium risk findings (and one low risk finding).

- Agency staff on boarding and complaints management (medium risk) – the operational protocol does not specify the minimum standards for briefing agency staff to ensure that they are aware of NHSGGC policies and standards.
- Consistency of approval for agency staff (medium risk) – there was no consistent process within sectors/directorates in relation to minimum approvals required internally before requesting Premium Rate Agency staff through the staff bank. Staff bank will not process an agency request unless the chief nurse is copied in except for Mental Health requests where this is delegated to the service manager. The operational protocol does not specify agreed minimum standards.

Management accepted the findings of the review and will progress agreed actions where practical and reasonable to do so, specifically in relation to the on boarding of agency staff. Dr McGuire noted that agencies are required to have standards in place, and any breaches would be referred to the NMC.

Ms Kerr concluded her report by giving an overview of the findings in the two key financial controls reviews – accounts payable and fixed assets – both of which were low risk.

Noted

59. General Data Protection Regulation

Mr Edwards gave a presentation to the committee to inform them of the requirements of the new data protection regulations that would be coming into force in May 2018. Mr Edwards also advised that an Information Asset Register was being prepared; Mr Macleod requested an update for the next meeting.

Director of eHealth

There followed a discussion on the presentation; Mr Macleod was reassured that this was not a huge resource issue for the board. Mr White noted that the impact would be quantified over the coming months. Mr Macleod recognised that work was ongoing, but it would be useful for the committee to get some more detail when the plan is clearer.

Director of eHealth

Noted

Action by

60. Audit Scotland Draft Annual Plan

Mr McConnell presented the Audit Scotland audit plan for 2017/18, and highlighted the key audit risks which require specific audit testing. He also advised that the fee for the audit had yet to be confirmed, but he expected a reduction of approximately 4% from 2016/17. Mr McConnell noted that the plan was largely similar year on year and across other boards.

Noted

61. NHS in Scotland 2017 Report

Mr McConnell referred to the NHS in Scotland 2017 report, which had been 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 the report didn't highlight any new issues, and most of the actions related to the Scottish Government.

Mr White advised that the report had been debated at the national Directors of Finance meeting, and that Scottish Government officials would appearing at the Parliamentary Audit Committee to speak to the report.

Mr Macleod requested an update on the board's actions on this report at the next committee meeting. **Director of Finance**

Noted

62. Fraud Report

There was a report of the Fraud Liaison Officer asking the committee to note the current fraud cases.

Mr Gillman highlighted for members that at the end of October 2017 there were thirteen ongoing cases of fraud being investigated.

Noted

63. Risk Management Update

There was a report of the Director of Finance asking the committee to note the progress with the risk management programme and approve the Corporate Risk Register.

Mr White described the process for the short and medium term actions being taken to develop and improve risk management. He also mentioned the co-opting of Claire MacRae onto the Risk Management Steering Group.

Noted

Mr White then led members through the updated Corporate Risk Register (CRR), highlighting that the scores, controls and actions of the risks on the register had been reviewed and updated by the Corporate Management Team. He added that there were additional possible risks that would be considered by the Risk management Steering Group for inclusion on the CRR. These were in respect of Brexit and the implications for staffing and procurement, the new General Data Protection Regulation, the removal of Microsoft Office support and the alignment of regional planning with the local transformational change programme. **RMSG**

Mr Finnie commented that much progress had been made with the CRR, and that he would like to see timings shown to achieve target scores. Mr Macleod stated that there would be more involvement in the scrutiny of risks by the relevant governance committees. He added that members are given more assurance that the CRR is considered by the CMT. Mr Brown

was also now reassured that risk management was becoming part of the culture.

Mr Brown also enquired why, on risk 2054 – waiting times, the score after mitigating actions was the same as before the actions. Mr White responded by saying that this was because even after the additional measures were in place, the waiting time targets were still expected to be breached.

Approved

64. Datix Annual Report

Mr Crawford presented a report which provided an update on the progress made to Datix, including service improvement, project development and areas of re-engineering business processes.

He highlighted that this had been another year of progress. There were examples where the way the core modules are used had been revised or developed, along with other examples of innovative and bespoke use of Datix to support organisational learning. Mr Crawford was encouraged by these examples where it is evident collaborations are being built up to better design the use of Datix. This is not just about the Datix environment but also focuses on building processes to ensure this information is being made known and applied to improve healthcare.

Mr Crawford also informed members that the contract with Datix had been extended to May 2018. In response to a question from Mr Macleod about maintaining continuity, Mr Crawford informed the committee that, as there was no other viable supplier, he will be looking at using a waiver to tender to renew the contract.

Noted

65. Tender for Internal Audit Service

Mr White asked members to approve the process for tendering for the provision of an internal audit service. He described that his objective was to continue to procure as a group, but with NHSGGC maintaining control over the process. After discussions with procurement colleagues it had been decided that the tender would be offered in lots – one lot for NHSGGC and one lot for NHSA&A, NWTC and NHS24, with bidders being able to bid for either or both lots. The intention was to achieve value for money and a quality service.

The process would involve each board scoring bids individually, followed by an interview panel comprising representation from all four boards.

Director of Finance

Approved

66. Dates of Future Meetings

The following dates were noted for future meetings:

- Tuesday 13th March 2018, 9:30am
- Tuesday 5th June 2018, 1:00pm
- Tuesday 19th June 2018, 9:30am
- Tuesday 11th September 2018, 9:30am
- Tuesday 11th December 2018, 9:30am

The meeting ended at 1:00pm