NHS Western Isles
Healthcare Governance & Audit Committee

Board Meeting 22.06.22
Item 12.1.1
Purpose: For Information

Minutes of Meeting
1st December 2021

Via Microsoft Office Teams

Members Present:

Abdul Elghedafi	Non Executive Director
Tim Ingram	Non Executive Director (Chair)
Jocelyn McConnachie	Non Executive Director
Sheena Wright	Non Executive Director

In Attendance:

Debbie Bozkurt	Director of Finance & Procurement
Gordon Jamieson	Chief Executive
Stephanie Hume	AZETS
Fiona MacKenzie	Nurse Director
Cheryl Martin	Secretariat
Frank McAuley	Medical Director
Gill McCannon	NHS Western Isles Chair
Dana Murray	Non Executive Director / Employee Director
Louise Sullivan	Head of Clinical Governance & Professional Practice
Elizabeth Young	AZETS

1. **WELCOME**

Mr Ingram took the Chair welcoming everyone to his first meeting as HGAC Chair especially welcoming Ms Elizabeth Young from AZETS who has taken over from Mr Chris Brown until March 2022. Ms Young introduced herself to the members, noting that she qualified as a Chartered Accountant in 2010 and is a qualified Chartered Internal Auditor. She added that she joined AZETS in 2015. Ms Young advised that if members had any queries outwith the meeting, Ms Bozkurt had her contact details.

Mr Ingram noted that Mrs Dana Murray was attending as an observer.

2. APOLOGIES

The following apologies were noted:
Janice MacKay, Head of Infection Prevention & Control, Decontamination & Cleaning Services
Dave Rigby, Non Executive Director
Maggie Watts, Director of Public Health

3. MINUTES

3.1 Healthcare Governance and Audit Committee Minutes 15th September 2021

There were no requested amendments to the minutes presented.

Decision: The minutes of the meeting of the 15th September 2021 were approved as an accurate record.

3.2 Matters arising

Mrs McCannon queried if the review of bank staff as noted in item 7.1 on page 4 of the minutes had been carried out. Ms Bozkurt advised that she had done a review of bank cover with no issues in the use of bank or agency staff found. She added that the increase in bank and agency usage was due to pressures in service and was not Covid-19 related.

Mrs McCannon queried if there was any progress with the impairment of the £260k eMREC costs and Ms Bozkurt advised that this would be discussed with the Scottish Government as part of the year end procedure.

Mrs McCannon noted that there would be a verbal update for the mortality review at this meeting and re-iterated her previous request for Uist and Barra hospital mortality data to be included in the next report presented to the committee.

3.3 Action points from 23rd June 2021

There were six recommendations on the action points list, three of which were complete and will be removed from the tracker.

The other recommendations were discussed as follows:

Framework for Adverse Events training session – Mrs Sullivan advised that this had been deferred until after the Covid-19 emergency footing has been lifted by the Scottish Government.

Counter Fraud Champion – Mr Ingram advised that Mr Elghedafi had agreed to take on the role of NHS Western Isles Counter Fraud Champion. Ms Bozkurt noted that she would discuss the role and training required with Mr Elghedafi following the meeting.

Non Covid-19 Surgical Site Infections Report – Ms MacKenzie apologised that she had not shared the surgical site infection report with members but noted that there were seven infections recorded during August and September and internal practices had been reviewed and a number of changes made. She assured the members that there have been no further surgical site infections reported to date.

4. DECLARATION OF INTERESTS

Mr Ingram advised that he had recently become a Non Executive Director with David MacBrayne Ltd whose main subsidiary company was CalMac Ferries Ltd.

AUDIT

5. EXTERNAL AUDIT – AUDIT SCOTLAND

There were no papers presented under this item.

6. INTERNAL AUDIT - AZETS

6.1 Financial Management & Reporting

Issue: *The committee was asked to note for assurance the Financial Management & Reporting review, presented by Ms Stephanie Hume, AZETS.*

Discussion: Ms Hume advised that this review concentrated on four control objectives all of which were Grade 2 priority. She added that the organisation reflects good practice in a number of areas including positive feedback from budget holders on the support and guidance provided by management accounts and an appropriate financial reporting framework in place with monitoring reports presented to various committees on a regular basis.

Ms Hume noted that the areas for improvement which would strengthen the control framework were:

- Ensuring that the Scheme of Delegated Authority Matrix is updated to reflect budget holder changes and the Code of Corporate Governance is updated to reflect changes to limits within the Scheme of Delegation;
- Implementing a mechanism to record actions taken by budget holders to address budget variances and provide budget holder training.
- Ensuring that there is ongoing monitoring of the staff capacity issues in the Finance team so that financial monitoring processes are not detrimentally affected;

Mr Ingram advised that as part of the question and answer document there were two questions raised which were responded to by Ms Bozkurt as follows:

1. The Matrix needs to be updated. Will the audit process address the extent to which compliance with the Matrix is being achieved – *The Matrix is updated six to twelve monthly. The Matrix authority is noted by post, which remains unchanged. Delegated authority letters for new or upgraded staff are circulated but this will be done on a more regular basis.*
2. The matter of resources is clearly significant. Are the posts for recruitment new posts, which would require new job descriptions and if so is there, support being provided to speed up this process – *There are minor changes to be made to the job descriptions which does take some time. We would hope to have two jobs out for advert next week. The other two posts require rebanding and would expect to advertise for these early in the New Year.*

Ms Hume advised that NHS Western Isles financial management and reporting procedures were well designed, with an appropriate financial management and reporting framework in place, that reflects the structure of the organisation.

Decision: The committee formally noted the report.

6.2 Expenditure & Creditors

Issue: *The committee was asked to note for assurance the Expenditure & Creditors review, presented by Ms Hume.*

Discussion: Ms Hume advised that NHS Western Isles' expenditure and creditor processes were not fully operating in line with documented processes with a number of issues around supplier maintenance, including new supplier requests, supplier change requests not being adequately evidenced and supplier details not being correctly filed. This constrained the ability to evidence a complete audit trail and conclude on elements of testing over key counter-fraud controls. There was also inconsistencies between the purchase order approvals recorded within the system and the delegated approval levels provided.

Ms Hume added that there were three improvement actions identified in the review, two Grade 2 and one Grade 3 priority, which focuses on supplier maintenance. The finance response was that all issues would be resolved and completed by the end of December 2021.

Ms Hume noted that a number of other areas for improvement were identified including updating the Scheme of Delegation and evidencing Budget Holder budget reviews. These issues were also been noted in the recent Financial Management and Reporting Audit.

Mr Ingram advised that as part of the question and answer document there were two questions raised which were responded to by Ms Bozkurt as follows:

1. How are new starters formally advised of their obligations regarding spending controls – *Yes, see point in the first question. Each new staff member or change of post receive a delegated authority letter, which describes their level of sign off etc. This letter should be signed and return to Finance.*
2. Is there an adequate corporate "Management of Change" process, which should be followed to ensure changes e.g. the personnel and spending controls are implemented – *The Matrix is updated every six to twelve months. The Matrix authority is noted by post, which remains unchanged. Delegated authority letters for new or upgraded staff are circulated but this will be done on a more regular basis.*

Decision: The report was formally noted.

6.3 Sickness Absence

Issue: *The committee was asked to note for assurance the Sickness Absence review, presented by Ms Hume.*

Discussion: Ms Hume advised that NHS Western Isles follow the NHS Scotland Workforce Attendance Policy, which is readily available to all staff, however full compliance to the policy is not carried out. The Board is considering a range of wellbeing initiatives to promote attendance, with some of these more advance than others.

Ms Hume noted that there were three Grade 3 improvement actions identified from this review that would strengthen the control framework and also noted a number of areas of good practice.

There was a lengthy discussion on the sickness absence risk to both patients and staff and Ms Bozkurt advised that she had been in discussion with the HR Manager regarding training for managers on sickness absence. Mr Jamieson advised that absence management would normally be discussed with management during their monthly performance meeting but due to the pandemic, these meetings have been on hold. He noted that he would welcome any training for management to work within and to apply the policy. Mr Jamieson noted his concerns regarding the use of "unknown cause" being used to record sickness absence as the cause of the employees sickness absence should be discussed with the employee at the initial notification of sickness.

Mr Ingram advised that as part of the question and answer document there were two questions raised the first of which was responded to by Ms Diane MacDonald, HR Manager, the second responded to by Ms Bozkurt as follows:

1. How are managers reminded of the need to address sickness absences and to what extent do we know they are doing so– *Managers have a professional obligation to manage attendance. This is supported in a number of ways:*

   HR monitors and intervenes when an employee hits one of the attendance management triggers. HR have recently introduced long term sickness absence tracking whereby managers are sent details of employees who have been absent over 29 days and are asked to provide information on how they are supporting a return to work.

   Training for managers on managing attendance is planned over the coming months. This will be delivered by HR.

   The Employee Relations Team offer weekly drop in sessions for managers for a variety of HR issues. Attendance management is regularly discussed.

   The HR Manager has recently reviewed all long term absences. The majority of cases are being managed appropriately. There is some evidence of absences being extended due to delays in treatment as a result of the pandemic.

2. Recommendations from auditors to review the risk rating. In the absence of an HRWD will the Director of Finance be responsible for this action. Also will the HR Manager be responsible for completion of the actions in this review and if so will as the HR Manager is new to the role will they be supported in the completion of these recommendations. The sickness absence recording on SSTS is a long standing issue – *The review of the risk rating and the completion of the recommendations will be carried out by the HR Manager in the absence of an HRWD and will be fully supported. The admin of SSTS sits with HR.*

Decision: The committee formally noted the report.

6.4 Progress Report

Issue: *The committee was asked to note for assurance the progress report, presented by Ms Elizabeth Young, AZETS.*

Discussion: Ms Young advised that this report was presented to all HGAC meetings to give a summary of internal audit activity since the last meeting and confirms the reviews planned for the coming quarter. She added that delivery of the plan by the May 2022 meeting was on track.

Decision: The report was formally noted.

6.5 Draft Internal Audit Plan 2022/2023

Issue: *The committee was asked to note for assurance the Draft Internal Audit Plan, presented by Ms Young.*

Discussion: Ms Young advised that this was the committee's first chance to consider the plan for 2022/2023. She added that the plan was oversubscribed, as a number of audits had been included as per management requests.

She asked that the members consider prioritising the audits noted in the plan and perhaps defer those audits, which are less of a concern.

Ms Bozkurt advised that she would be keen to do the IT stock follow up report to ensure that controls are now in place. She noted that there was a problem with pharmacy and theatre stock and could swap the control drugs review for a review of this area.

Mr Jamieson noted that the members should be thoughtful of reviews to be carried out as the Board was still under emergency footing and wondered if pandemic related reviews should be considered. Ms Young advised that they were at present reviewing agency and bank staff during the pandemic at another Health Board and was mindful that the use of agency and bank staff was an issue with most Board areas.

Ms Bozkurt advised that she would discuss the plan in detail with the Ms Young to enable an updated plan to be presented to the next meeting.

Mr Ingram advised that as part of the question and answer document there was one question raised which was responded to by Ms Hume as follows:

1. Within the Audit Plan scope to what extent, if at all, are we covering regulatory compliance, i.e. examining the organisation's identification of compliance obligations and having corresponding compliance assurance processes in place – *Within each review Internal Audit assess whether the organisation has any regulatory obligations to follow a predetermined process. If this is found to be the case, the review will audit the extent to which the organisation is complying with these. Within each of the reviews, we consider the appropriateness of the reporting arrangements within the organisation, including at a governance level and test whether these are being adhered to.*

Decision: The committee formally noted the report.

Action: Ms Bozkurt to discuss the plan in detail with Ms Young and to enable an updated plan to be presented to the next meeting.

Deadline: Immediate.

7. AUDIT RECOMMENDATIONS TRACKER

7.1 Audit Recommendation Tracker Follow Up Report

Issue: *The committee was asked to note for assurance the Audit Recommendations Tracker Follow up report, presented by Ms Hume.*

Discussion: Ms Hume advised that this review provides their opinion on the status of the actions that management have assessed as closed during the period May 2021 to November 2021. She added that management have continued to keep the number of overdue actions relatively low in comparison to other similar organisations. Despite good progress in completing actions in the period, there has been a small increase in the number of open actions since the last follow up report. It should be noted that eight of the overdue actions are as a result of Covid-19 delays.

Ms Hume noted that two partially completed actions were in relation to the IT stock control audit and Ms Bozkurt advised that she had hoped that NSS would assist with the stock verification but this has not been the case and will need to discuss the way forward with the Director of Public Health. She added that the Procurement Manager has been working with the interim IT Manager in completing a new IT stock procedure document.

Mr Ingram advised that as part of the question and answer document there was one question raised which was responded to by Ms Hume as follows:

1. What is the difference between actions identified as partially complete and those identified as incomplete – *We consider an item to be incomplete if very little or no action has been taken to progress the audit recommendation. We assess an action as being partially complete if the management update suggests work is ongoing to complete the action.*

Decision: The report was formally noted.

7.2 Audit Recommendations Tracker Report

7.2.1 Audit Recommendations Tracker

Issue: *The committee was asked to note for assurance the Audit Recommendations Tracker, presented by Debbie Bozkurt, Director of Finance & Procurement.*

Discussion: Ms Bozkurt advised that there were no new recommendations added to the tracker but there was still a number of actions listed on the tracker, which were overdue or Covid-19 related and she would be working closely with management to complete as many as possible before the next meeting. Mrs McCannon noted that this was a sensible proposition as all members were aware that many areas of the organisation are under pressure and although Covid-19 pressures could not be used as an excuse for delays in completing a recommendation, it could be used as justification for the delay.

Decision:: **The committee formally noted the report.**

FINANCIAL GOVERNANCE

8. INTERNAL REPORTS

8.1 Director of Finance Report on the Financial Position Q2 M6

Issue: *The committee was asked to note for assurance the Financial Position M6 report presented by Ms Bozkurt.*

Discussion: Ms Bozkurt advised that at 30th September 2021 the Board was showing an in year overspend of £1,151k and at year end the Board is showing a breakeven position however, this assumption is high risk and is fully reliant on a number of risks.

Ms Bozkurt advised that in addition to the standard capital planning, the Board has experienced two unexpected significant cost pressures:

- The Western Isles hospital boilers are over 30 years old and following a recent survey all three boilers require immediate replacement. The risks associated with the project have been communicated to Scottish Government as additional capital resource is required to fund this replacement project.
- The creation of the dental hub in Uist and Barra has been discussed for a number of years and in May 2021 the tendering process was completed however bids submitted were 50% higher than expected. Revised tenders were received in September 2021 but costs remain high and the total cost for this project is now £1,320k, leaving a funding gap of £839k. The Scottish Government have confirmed that the gap will be filled via a revenue allocation.

Ms Bozkurt noted that the Board had discussed the requirement for a locally based MRI scanner and the business case had been submitted to the Imaging Executive Board at the Scottish Government and she was awaiting their response. It was noted that there was some opposition in Scottish Government to this request as NHS Shetland had recently raised money to install their MRI scanner and feelings were that NHS Western Isles should do the same. Mr Jamieson noted that this would not be a valid reason for denying NHS Western Isles the funding for this project and he would be contacting colleagues in Scottish Government if funding is not allocated.

Decision: **The report was formally noted.**

PERFORMANCE

9. ADVERSE EVENTS / RISK

9.1 Corporate Risk Register (CRR)

9.1.1 CRR Dashboard

9.1.2 CRR Detailed Report

Issue: *The committee was asked to note for assurances the Corporate Risk Register report presented by Mrs Louise Sullivan, Head of Clinical Governance & Professional Practice.*

Discussion: Mrs Sullivan advised that the updates to the risks on the register received were as follows:

Risk 004 – Waiting Times – Ongoing risk that the Covid-19 pandemic impact will result in increasing waiting lists and absence due to Covid-19 related reasons.

Change to non recurring funding is required regularly.

Risk 005 – Security – The PRG / Winter Group meeting monthly or as required. Security situation and risk remains stable and unchanged. The pandemic has resulted in a need for increased physical security presence at the Western Isles Hospital and for vaccine storage. Bank security staff recruitment is underway.

Risk 040 – GP OOH – There is a risk of an increasing diminished number of GP's participating in the OOH service. Service change for OOH in Barra is in place.

Risk 045 –Covid-19 – Controls have been updated for pandemic/winter resilience, Covid-19 surge capacity, Covid-19 ventilation capacity, training and supply of PPR, Covid-19 patient management pathways for Uist and Barra Hospital and St Brendan's and mass vaccination.

Risk 047 – Winter 2020-2021 – Respiratory Syncytial Virus (RSV) has been identified as a hazard and additional paediatric pathways and training are in place.

Mr Ingram advised that as part of the question and answer document there were two questions raised which were responded to by Dr McAuley and Mr Jamieson as follows:

1. Risk 040 GP OOH – The risk rating for this was 20 but has been reduced to 16. Can we get clarification on what mitigations have taken place in order to justify this. Also from a governance perspective it would be good practice if this risk was separated into areas – *The Risk related to the Out of Hours GP service has been reduced due to the increased use of NHS24 on Barra and Vatersay and the deployment of contingency support whereby the two Southern centres provide remote OOH support for the Lewis and Harris service.*

   In regards to separating the risk, the OOH service based in St Brendan's and OuAB are fragile and essential as they provide the medical cover for the community hospitals. As we have recently seen travel to and from the islands especially Barra can be significantly disrupted. This risk is 4 x 4 =16. The risk on Lewis and Harris relate to remote support 4 x 2 =8.

2. Should St Brendan's be added in more detail to the risk register in light of the physical / environmental and potential health and safety risk that could be affected given the possibility of a delay of the Barra and Vatersay Community Campus (BVCC) and also in light of the current review of the build – *The way forward for this project will be discussed at the next project board meeting and following this, the Board should take a view on the project. Regardless if the project goes ahead or not the Board is left with a significant risk regarding the existing St Brendan's building. The original Outline Business Case (OBC) explicitly noted the reasoning behind the new build and the question for the Board would be has this risk appetite changed.*

Mrs McCannon advised that she would request that the December Board briefing be moved to Friday 17th December to enable discussion on the BVCC, following the BVCC Project Board meeting on 16th December and consideration of adding this to the Corporate Risk Register.

Decision: **The Corporate Risk Register was formally noted.**
Action: **Mrs Martin to ask the Business Manager to reschedule the Board Briefing to Friday 17th December 2021 to enable discussions on the BVCC.**
Deadline: Immediate.

9.2 Emerging Risks / Significant Issues

There were no emerging risks or significant issues discussed.

9.3 Adverse Event Report

9.3.1 Adverse Events Report from 12th August to 10th November 2021

Issue: *The committee was asked to note for assurances the Adverse Events report presented by Mrs Sullivan.*

Discussion: Mrs Sullivan advised that during the period 12th August to 10th November 2021, there were two hundred and nineteen adverse events reported, ninety six of these had been investigated and approved. Currently there were two hundred and forty two records waiting review.

The risk matrix application for the ninety six approved adverse events was as follows:

- Twenty eight of these risks were graded as negligible,
- Thirty four graded as minor;
- Twenty nine graded as moderate;
- Four graded as major; and
- No records identified as extreme.

She added that three of the four events graded as major related to surgical site infections and one related to s SAB infection. There was one RIDDOR adverse event relating to a staff member fall in the hospital grounds reported to the Health and Safety Executive.

Mrs Sullivan noted that no adverse event required a Significant Adverse Event Review and none met the Duty of Candour criteria.

The top three reporting categories for this period were slips, trips or falls, medication and infection control relating to wound / surgical site infections.

Mrs McCannon queried if there could be more information provided for those events in the review bay and Mrs Sullivan noted that although a number have not had the risk matrix applied they are being reviewed so this can be done.

Mrs Sullivan noted that she had been approached by Healthcare Improvement Scotland (HIS) regarding general awareness training for all staff and further training for investigating staff.

Mr Ingram advised that as part of the question and answer document there were two questions raised which were responded to by Mrs Sullivan and Ms MacKenzie as follows:

1. What is the respective significance of the various wrong drug administration and wrong drug prescribed incidents and are there any common root causes – *All of the wrong drug administered and wrong drug prescribed incidents have been fully investigated and all had Category 3, near miss level of harm assigned to them. The majority of prescribing incidents reported occur at the time of admission during the clerking process. A common root cause for both wrong drug administration and prescription is human error. The Risk Manager has collated a report from the system from the last 12 months for all medication incidents with a view to extract learning. There are some excellent examples of improvement / actions, which have been carried out and recorded on the system in response to medication incidents.*
2. Out of the 242 waiting to be reviewed how many are of concern given that there has been no risk matrix applied. How is compliance being encouraged given the service pressures and potential risks that may occur. Theatre resumed service in September following a rise in SSIs how is this service being monitored – *If any SAE is of real concern it is escalated through the structure. The Risk Manager, Head of Clinical Governance and Professional Practice and the Nurse Director meet on a fortnightly basis to discuss processes and any concerns. The Risk Manager is looking to simplify the form to report for example medication errors, falls and incidents were there has been no harm incurred. Despite high numbers there is significant learning being identified which is encouraging. Compliance is being encouraged on a weekly basis and at every opportunity. The HAIRT reports are completed on a bi-monthly basis through to September. Post IMT IPC have been in Theatre for audits on a weekly basis and continue to do so. Regarding the need for increased surveillance they have implemented weekly IPCT meetings with ICD, Medical Director, Theatre Management, Consultants, Senior Nurse, Surgical Ward Manager and Antimicrobial Pharmacist to monitor SSIs and ensure any issues are identified and promptly dealt with e.g. this more recent spike in SSIs appeared to be linked to prophylactic antibiotics which has been addressed.*

Decision: The committee formally noted the report.

9.4 EU Withdrawal in Scotland

Mr Jamieson advised that to date there had been no significant impact on services or procurement of goods following the withdrawal from the EU.

10. QUALITY / SAFETY

10.1 Mortality Review Report

Issue: *The committee was asked to note for assurances the Mortality Review verbal update presented by Mrs Sullivan.*

Discussion: Mrs Sullivan apologised that a written report was not being presented to this committee. She noted that the report has been completed but has to be checked before being circulated. Mr Ingram requested that the report be circulated to members once completed rather than waiting until the next meeting.

Mrs McCannon noted that there had been some discussion that these reviews would be completed via Datix and Mrs Sullivan noted that this had been the case but she was disappointed with what Datix had to offer for reporting on this and may have to look at adapting our own modules.

Dr McAuley advised that in depth monthly mortality and morbidity meetings which include Uist and Barra Hospital are held. He added that he and the Nurse Director are informed of all deaths in the Western Isles although notification of off island deaths are less likely to be received.

Decision: **The report was formally noted.**

11. INFECTION PREVENTION AND CONTROL

Issue: *The committee was asked to note for assurance purposes the Healthcare Associated Infection Reporting Template reports presented by Ms Fiona MacKenzie, Nurse Director.*

Discussion: Ms MacKenzie advised that for the period April to September 2021 there were a total of two Staphylococcus Aureus Blood stream (SAB) infections reported, three Clostridium Difficile Infections (CDI) and one Surgical Site infection (SSI) reported. She added that this was the beginning of the outbreak and the next report will show all incidents reported.

Ms MacKenzie advised that she would answer any questions, there were no questions raised.

Decision: **The committee formally noted the report.**

12. COMPLAINTS

12.1 Complaints and Feedback Annual Report 2020/2021

Issue: *The committee was asked to note for assurance purposes the Complaints and Feedback Annual report presented by Ms Bozkurt.*

Discussion: Ms Bozkurt advised that this was the Complaints and Feedback Annual Report for 2020/2021 which is presented to the SPSO and Scottish Government. She added that the report was self explanatory and would take any questions. There were no questions raised at the meeting.

Mr Ingram advised that as part of the question and answer document there was one question raised which were responded to by Ms Bozkurt as follows:

1. Of the complaints that have been reported as upheld, what are the key lessons coming out of these incidents – *Each complaint will have a number of key lessons and learning and these are now reported in the complaints tracker.*

Decision: **The report was formally noted.**

12.2 Complaints Summary Report July to September 2021

12.2.1 Complaints Summary Full Report

Issue: *The committee was asked to note for assurance purposes the Complaints Summary report presented by Ms Bozkurt.*

Discussion: Ms Bozkurt advised that there were fifteen complaints received in the period 1st July to 30th September 2021 all of which were investigated as Stage 2 complaints, resolved in twenty working days. Of the total investigated the main issues raised related to clinical treatment, staff attitude and behaviour and staff communication. The staff group which received the highest number of complaints was medical consultants and psychiatrists with nine complaints each. Nine of the fifteen complaints were not upheld, one was fully upheld and five were partially upheld.

Ms Bozkurt advised that all of the complaints included in the service improvement tracker have been given the status of ongoing. This will change for the next meeting as the investigating manager will be contacted to give an update similar to that of the audit recommendations tracker.

Mr Ingram advised that as part of the question and answer document there were two questions raised which were responded to by Ms Bozkurt and Dr McAuley as follows:

1. There are a large number still outstanding, or ongoing how is this being monitored to prevent issues occurring again, particularly in relation to service improvement – Implementing the new complaints service improvement tracker will allow the executive team to be able to monitor outstanding actions that are under their remit. We are expecting that this will bed down within a few months and work as the audit recommendation tracker does.
2. Who will take this forward and what is in palce to improve some of the issues raised that relate to consultants / doctors – I as the Medical Director have site of all complaints relating to medical staff. These are logged onto the complaints system as they can be shared as part of the appraisal process.

Decision: **The committee formally noted the reports.**

13. CORPORATE GOVERNANCE

13.1 HGAC Self Assessment, Terms of Reference and Work Plan

13.1.1 HGAC Self Assessment

13.1.2 HGAC Terms of Reference

Issue: *The committee was asked to approve the HGAC Self Assessment and Terms of Reference presented by Ms Bozkurt.*

Discussion: Ms Bozkurt informed the members that the responses in the self assessment were unchanged from the previous year, although she was aware that none of the members had financial experience and will change this. She added that cosmetic changes had been made to the Terms of Reference as per the executive summary and requested that both documents were approved.

Decision: **The committee formally approved the HGAC Self Assessment and TOR.**

13.1.3 HGAC Work Plan

Issue: *The committee was asked to note for discussion the HGAC Work Plan presented by Ms Bozkurt.*

Discussion: Ms Bozkurt advised that the Work Plan was presented for discussion and if members could email Mrs Martin with any comments or amendments they have before the next meeting where it will be presented for approval.

Decision: **The Work Plan was formally noted.**

Action: **Members to email Mrs Martin with any amendments to the Work Plan before the next meeting.**

Deadline: 31st January 2022

FOR INFORMATION

8. INTERNAL REPORTS

8.2 Fraud Liaison Officer's Report

8.2.1 Counter Fraud Action Plan

8.2.2 Anti-Fraud, Bribery & Corruption Policy

Mr Ingram advised that as part of the question and answer document there were two questions raised in connection with the Anti-Fraud, Bribery and Corruption Policy which was responded to by Ms Bozkurt as follows:

1. The anti-fraud, bribery and corruption policy does not appear to cover fraud which may be perpetrated by a Non Executive Member of the Board presumably this should be included and the policy position made clear – *Non Executive Directors are covered by the Code of Corporate Practice Section H Code of Conduct of Members of the Board of NHS Western Isles. Part 2 of the Ethical Standards in Public Life etc. (Scotland) Act 2000 sets out the provisions for dealing with alleged breaches of this Code of Conduct and where appropriate the sanctions that shall be applied if the Standards Commission finds that there has been a breach of the Code.*

2. The policy makes no mention of any rights of appeal, which presumably do exist and therefore should be incorporated – *The majority of anti-fraud cases go through internal disciplinary processes and the right to appeal an internal process is documented in the Conduct Policy, which describes the internal disciplinary processes including the appeal stage.*

8.2.3 CFS Quarterly Report September 2021
8.2.4 Rolling Covid-19 Intelligence Alert No 58
8.2.5 Counter Fraud Intelligence Alerts
8.2.5.1 02-2021/2022 – Mandate Fraud
8.2.5.2 03-2021/2022 – Medical Practice Invoice Fraud
8.2.5.3 04-2021/2022 – Email Scam
8.2.5.4 05-2021/2022 – Corporate Impersonation Fraud
8.2.5.5 06-2021/2022 – Whale Phishing Emails

10. QUALITY / SAFETY

10.2 Medical Appraisal & Revalidation Annual Report

14. NATIONAL AUDIT / SCOTTISH GOVERNMENT REPORTS

14.1 Audit Scotland Covid-19 Vaccination Programme September 2021

14.2 The 2020/21 Audit of NHS National Services Scotland Response to Covid-19 Pandemic October 2021

Decision: All reports and minutes were presented for information. There were no questions raised at the meeting and they were all formally noted.

15. ANY OTHER COMPETENT BUSINESS

There was no competent business raised.

16. EVALUATION

Do any members have any comments for the Chair in relation to future improvements required to any aspects of this meeting?

	YES	NO	COMMENTS
I was satisfied that the agenda items presented covered the current significant areas in Health.	✓		
There was sufficient time to review the papers between receipt and the meeting date.	✓		
There was sufficient time allocated to all agenda items.	✓		
The Executive Summaries were an accurate reflection of the full report.	✓		The members commended those involved for a high quality of executive summaries presented.

	YES	NO	COMMENTS
I was satisfied with the Q&A paper			
I was able to reach a satisfactory conclusion from the information presented on each item.	✓		The members did note the absence of the mortality review.
I was able to contribute to the discussions and had my views considered.	✓		
The HGAC discharged its duty in respect of • Proper Scrutiny • Relevant Questioning • Constructive Challenging	 ✓ ✓ ✓		
Significant Issues to be raised with the Board	✓		The issues surrounding the Barra and Vatersay Community Campus should be raised at the next available Board meeting.

17. DATE AND TIME OF THE 2022 MEETINGS

All meetings are held via Microsoft Teams

Date	Time
16th February 2022	10.00am (members meeting 9.00am, members and auditors 9.30am)
18th May 2022	10.00am (members meeting 9.00am, members and auditors 9.30am)
22nd June 2022	9.00am (Annual Accounts Approval Meeting)
14th September 2022	10.00am (members meeting 9.30am)
1st December 2021	10.00am (members meeting 9.30am)

The Chair concluded the meeting at 1.10pm, thanked everyone for their attendance and contribution and wished everyone a Merry Christmas and Happy New Year.