Please note any items relating to Committee business are embargoed and should not be made public until after the meeting

A meeting of the **Audit Committee** will be held on **Thursday 1 September 2016 at 9.30 within the Board Room, Conference Centre, King's Cross, Dundee.** Any apologies to be submitted to Lisa Green on ext. 36680, direct dial (01382) 496680 or via email to lisa.green7@nhs.net

AGENDA

ITEM NO.			LEAD OFFICER	REPORT NO AND ACTION REQUIRED
1.	**WELCOME**		S Hay	
2.	**APOLOGIES**		S Hay	
3.	**DECLARATION OF INTERESTS**		S Hay	
4.	**MINUTE OF PREVIOUS MEETING**			
	4.1	Minute of the Audit Committee Open Business - 21 June 2016	S Hay	Attached - For approval
	4.2	Action Points Update	L Bedford	Attached - to note update
	4.3	Workplan 2016/17	L Bedford	Attached – to note update
	4.4	Matters Arising	S Hay	
5.	**AUDIT FOLLOW UP**			
	5.1	Audit Follow Up (AFU) – Full Cycle Update Report	L Bedford	AUDIT68/2016 Attached – to note report
	5.2	Interim Evaluation of Internal Control Framework 2015/16 Audit Report No. T08/16	L Bedford	AUDIT69/2016 Attached – to note report
6.	**FTF/INTERNAL AUDIT**			
	6.1	FTF Audit and Management Services Internal Audit Progress Report	J Lyall	AUDIT67/2016 Attached – to note progress
7.	**UPDATES TO THE NHS TAYSIDE CODE OF CORPORATE GOVERNANCE**		M Dunning	AUDIT61/2016 Attached – to recommend for approval
8.	**BEST VALUE FRAMEWORK 2016/17**		M Dunning	AUDIT70/2016 Attached – for discussion/ approval
9.	**PROPERTY TRANSACTION MANAGEMENT**		L Lyall	AUDIT66/2016 Attached – to note report
10.	**PAYMENT VERIFICATION: FAMILY HEALTH SERVICE (FHS) CONTRACTORS** **Payment Verification – Annual Process Update**		J Haskett	AUDIT62/2016 Attached – to note report
11.	**PAPERS/MINUTES FOR INFORMATION**			
	11.1	Corporate Governance Review Group Action Note – 19 May 2016 (unapproved)	M Dunning	Attached – for information
	11.2	Attendance Record	S Hay	Attached – for information

ITEM NO.		LEAD OFFICER	REPORT NO AND ACTION REQUIRED
11.3	Audit Scotland – External Auditors	L Bedford	Verbal update
11.4	Audit Scotland Reports	L Bedford	For information

- Code of Audit Practice
  http://www.audit-scotland.gov.uk/report/code-of-audit-practice-2016
- Strategy and Annual Action Plan
  http://www.audit-scotland.gov.uk/report/accounts-commission-strategy-and-annual-action-plan-2016-21
- Engagement strategy
  http://www.audit-scotland.gov.uk/report/accounts-commission-engagement-strategy-and-engagement-plan-201617
- Annual Report
  http://www.audit-scotland.gov.uk/report/accounts-commission-annual-report-201516
- Corporate Plan 2016/17 Update
  http://www.audit-scotland.gov.uk/report/corporate-plan-201617-update
- Audit Scotland Annual report
  http://www.audit-scotland.gov.uk/report/accounts-commission-annual-report-201516
- Transparency & Quality
  http://www.audit-scotland.gov.uk/report/transparency-and-quality-annual-report-201516
- Annual Report and accounts 2015/16
  http://www.audit-scotland.gov.uk/report/audit-scotland-annual-report-and-accounts-201516
- Technical Bulletin 2016/2
  http://www.audit-scotland.gov.uk/our-work/technical-guidance#bulletin

12.	**DATE OF NEXT MEETING:** **Thursday 15 December 2016 at 9:30am** in the Board Room, Conference Suite, Kings Cross.	All	For information

RESERVED BUSINESS OF THE COMMITTEE IN ACCORDANCE WITH THE GUIDE TO THE EXEMPTION UNDER THE FREEDOM OF INFORMATION (SCOTLAND) ACT 2002

SO 28.3
Qualified Exemptions and the Public Interest

13. MINUTES OF PREVIOUS MEETINGS

13.1	Minute of the Audit Committee Reserved Business - 21 June 2016	S Hay	Attached – for approval
13.2	Action Points Update	L Bedford	Attached – to note update
13.3	Matters Arising	S Hay	

FOISA 27(1)
Information Intended for Future Publication

14. 14.1	Minute of Audit Committee Open Business - 21 June 2016	S Hay	Attached – for approval

FOISA 33(1)
Commercial Interests and the Economy

15. NHS SCOTLAND COUNTER FRAUD SERVICES

15.1	NHS Scotland Counter Fraud Services and National Fraud Initiative Update	R Mackinnon	AUDIT64/2016 Attached – to note report
15.2	Banking and Treasury Management	R MacKinnon	AUDIT65/2016 Attached – to note report

FOISA 33(1)
Commercial Interests and the Economy

16. PAYMENT VERIFICATION

16.1	Payment Verification: Family Health Service (FHS) Contractors	J Haskett	AUDIT63/2016 Attached – to note report

17. PRIVATE DISCUSSION

Mr S Hay
Chair
September 2016

DISTRIBUTION

MEMBERS	REGULAR ATTENDEES	FOR INFORMATION
Mr D Cross OBE	Mr L Bedford	Prof J Connell
Councillor D Doogan (Vice Chair)	Mr D Colley	Mrs G Costello
Ms L Dunion	Mr B Crosbie	Miss D Howey
Mrs J Golden	Mr G Doherty	Councillor K Lynn
Mr S Hay (Chair)	Ms M Dunning	Ms L McLay
Mr M Hussain	Mr T Gaskin	Mr H Robertson
Councillor G Middleton	Mrs F Gibson	Mrs A Rogers
	Mr B Hudson	Prof A Russell
	Mrs J Lyall	Prof M Smith
	Mr R MacKinnon	Mrs S Tunstall-James
	Mr D Mills	Dr D Walker
	Ms F Mitchell-Knight	
	Mrs H Walker	

Minute NHS Tayside

TAYSIDE NHS BOARD
AUDIT COMMITTEE - OPEN BUSINESS

Minute of the meeting of Tayside NHS Board Audit Committee held at 9.45 a.m. on **Tuesday 21 June 2016** in the Board Room, Conference Suite, King's Cross, Dundee

Present:
Mr D Cross, OBE, Non Executive Member, Tayside NHS Board
Mrs J Golden, Non Executive Member, Tayside NHS Board
Mr S Hay, Non Executive member, Tayside NHS Board (Chair)
Mr M Hussain, Non Executive Member, Tayside NHS Board
Councillor G Middleton, Non Executive Member, Tayside NHS Board

Chair, Chief Executives and Senior Officers
Mr L Bedford, Interim Director of Finance, NHS Tayside
Prof J Connell, Chair, Tayside NHS Board
Mr G Doherty, Director of Human Resources, NHS Tayside
Mr R MacKinnon, Associate Director of Finance - Financial Services & Governance/FLO, NHS Tayside
Ms L McLay, Chief Executive, NHS Tayside

External Auditors
Ms G Collin, Senior Manager, PricewaterhouseCoopers
Mr K Wilson, Senior Manager, PricewaterhouseCoopers

Internal Audit – FTF Audit and Management Services
Mr T Gaskin, Chief Internal Auditor, FTF Audit and Management Services
Mrs J Lyall, Acting Regional Audit Manager, FTF Audit and Management Services

Other Attendees
Miss W Aitchison, Endowment Accountant, NHS Tayside
Mr P Crichton, External Auditor, MMG Archbold (Item 5)
Ms M Dunning, Board Secretary, NHS Tayside
Mr G Finnie, Financial Accountant, NHS Tayside
Miss J Flood, Financial Accountant, NHS Tayside
Mrs F Gibson, Head of Financial Services, NHS Tayside
Mrs L Green, Committee Support Officer, NHS Tayside
Miss D Howey, Head of Committee Administration, NHS Tayside
Mr D Mills, Representative Area Clinical Forum, NHS Tayside
Mr D Taylor, External Auditor, Henderson Loggie (Item 6)

Apologies
Councillor D Doogan, Non Executive Member, Tayside NHS Board
Ms L Dunion, Non Executive Member, Tayside NHS Board
Mrs H Walker, Risk Manager, NHS Tayside

Mr S Hay in the Chair

1. WELCOME **ACTION**

The Committee moved into open business.

2. APOLOGIES

The apologies were noted as above.

3. DECLARATION OF INTERESTS

Mr Hay wished to note his thanks to Mrs Penny Campbell for her valuable and helpful contributions to the Committee prior to her resignation.

4. MINUTE OF PREVIOUS MEETING

4.1 Minute of the Audit Committee Minute – 5 May 2016

The Audit Committee Minute of the meeting held on 5 May 2016 was approved on the motion of Mr D Cross and seconded by Mr M Hussain.

4.2 Action Points Update

Mr MacKinnon spoke to the Action Points Update.

Recording Equipment – It was noted this matter was progressing and discussions with staff side colleagues were ongoing.

External Review of all Mental Health Sites – It was noted a report would be submitted to a future Committee meeting following review by the Principal Architect.

Work Plan Progress Report – It was noted this was an Agenda item.

Workshop for Non Executive Members – It was noted the facilitation of a short workshop for Non Executive Members to address issues regarding access to NHS Mail, Staffnet and Network Devices from various devices had been scheduled for 22 September 2016 and further details would be circulated in due course.

Progress on Internal Audit Report T21/14 Medical Instrumentation and Devices – It was noted that the Head of Instrumentation post had been filled and an update would be given to the Committee at its meeting on 1 September 2016.

Risk Manager attendance at Strategic Risk Management (SRMG) meetings – It was noted Mr Hay would consult with the Chief Executive regarding Risk Managers attendance at SRMG following this Committee meeting.

HSCI Governance Presentation – It was noted the HSCI Governance presentation would be given to Tayside NHS Board at its December 2016 meeting.

NHS Scotland Overview Report and Checklist – It was noted a Board Development Session had been arranged for 22 September 2016.

Adverse Events Management Policy – It was noted this would be an Agenda item at the 1 September 2016 meeting.

The Committee noted all completed actions.

4.3 Work Plan Update

Mr MacKinnon advised the Committee that the Work Plan had been updated to include the Annual Accounts cycle to June 2017

The Committee

- **Noted the updated to the Work Plan**

4.4 Matters Arising

There were no matters arising.

ENDOWMENT FUNDS

5. Draft Annual Accounts 2015/16 Tayside NHS Board Endowment Funds (AUDIT50/2016)

The Committee welcomed Mr Crichton, External Auditor for MMG Archbold, who was in attendance for this item.

Mr MacKinnon advised the Committee that the report highlighted the responsibilities of the Audit Committee in terms of the Endowment Fund. It was noted that Mr MacKinnon had reviewed the draft accounts and met with the external auditors following completion of the audit.

Mr Crichton advised the Committee this was the first annual accounts carried out under the Financial Reporting Standard (FRS) 102 and the transition in reporting had gone well providing a clean findings report with no areas for concern and any immaterial errors being reported for information only.

Mr Crichton highlighted the minor errors contained within the report as follows:

- the omission of legacies which had been received post year end. This was due to the timing of the receipt of income
- the omission of a number of accruals from the financial statements. This was due to the timing of the cut off in the current year. It was noted the level had been significantly reduced following the introduction of the PECOS system
- the number of old funds remaining unspent. There was an intention to move funds under £2,000 and those dormant for at least 3 years to unrestricted funds, however, this was in the early stages with no application as yet having been made to The Office of the Scottish Charity Register (OSCR)

It was noted there was a reliance on the work of FTF Internal Audit and there were no concerns over controls.

Mr MacKinnon confirmed a report would be submitted to the Board of Trustees, following the summer recess, taking forward proposals in relation to the unspent and dormant funds.

The Committee

- **Considered the draft annual accounts and recommended that the Board of Trustees should adopt the accounts for the year ended 31 March 2016, and that Professor Connell, in his capacity as Chair of the Board of Trustees, and Ms McLay, in her capacity as Trustee, should sign on behalf of the Board of Trustees:**
  - **The report of the Trustees (page 10)**
  - **The statement of Trustee' Responsibilities for the preparation of the Financial Statements (page 11), and**
  - **The Balance Sheet (page 15)**
- **Considered the Audit Findings Report to the Audit Committee from MMG Archbold**
- **Considered the Letter of Representation to MMG Archbold and recommended that it be signed by Professor Connell, in his capacity as Chair of the Board of Trustees, and Ms McLay, in her capacity as Trustee, on behalf of the Board of Trustees.**
- **Considered the Letter of Confirmation to MMG Archbold and recommended that it be signed by Professor Connell, in his capacity as Chair of the Board of Trustees on behalf of the Board of Trustees**

PATIENTS' FUNDS

6. Patients' Funds – External Audit Report (AUDITR49/2016)

The Committee welcomed Mr Taylor, External Auditor for Henderson Loggie, who was in attendance for this item.

Mr MacKinnon advised that the draft Abstract of Receipts and Payments in respect of Patients' Private Funds was presented for consideration by the Committee prior to submission to Tayside NHS Board.

Mr Taylor advised the Committee that this was the first full year audit following the introduction of the new procedures in June 2014.

Mr Taylor informed the Committee that a small number of errors or system weaknesses were found during the review, however, internal controls in most cases were found to be adequate during audit testing. It was noted that in 2014/15 there were 12 minor action points reducing to 6 minor action points in 2015/16 all categorised as priority C, low risk.

The Committee

- **Reviewed the draft Abstract and Receipts and Payments**
- **Noted the draft audit certificate from Henderson Loggie**
- **Considered the Audit Findings Report from Henderson Loggie**

- **Approved the Recommendation that Tayside NHS Board formally adopts the Abstract of Receipts and Payments in respect of Patients' Private Funds for the year ended 31 March 2016, and authorises the Director of Finance and the Chief Executive to sign the Abstract on behalf of Tayside NHS Board along with the draft letter of representation**

7. EXCHEQUER FUNDS

Mr Hay advised the Committee that Items 7.1 to 7.7 concerned the assurances required for the Audit Committee to approve and recommend the draft report Tayside NHS Board – Assurance by Audit Committee which would be considered under Item 7.8

7.1 Review of System of Internal Control (AUDIT47/2016)

Mr Bedford advised that this report was a scene setter in providing the Committee with the framework for the Committee's review of the system of internal control covered in Item's 7.1 – 7.8 on the Agenda and included the draft Governance Statement (GS) at Appendix 1 of the report.

Mr Bedford highlighted some minor errors contained within this version of the GS as follows:

- Page 1 - minor typo in Tayside Health Board heading
- Page 5 - additional sentence within 3rd paragraph
- Page 9 - Enhancement During Leave – Last sentence to read "An electronic solution will be rolled out across....."

It was noted that these amendments had been reflected within the version of the GS included within Item 7.5 Review of System of Internal Control Lead Officer's Statement to Chief Internal Auditor. It was noted the GS included input from, a range of colleagues and both internal and external audit.

Mr Cross noted that the GS had strengthened from previous years, however, queried what procedures were in place for the Audit Committee to monitor the controls mid-point and highlighted the need for forward planning. It was noted that an Interim Review was submitted to the Committee at its meeting in February 2016. Mr Gaskin advised that Internal Audit would be presenting an Interim Review to the Committee in December 2016 which would be available before February 2017. It was noted Mr Bedford would update the Committee of any issues.

The Committee was asked to review the System of Internal Control and to consider the various terms of its assurance report to Tayside NHS Board. This was to be done by considering each of the reports under Item 7 followed by the conclusion included within Item 7.7 and the Assurance Report at Item 7.8.

The Committee

- **Agreed to review the System of Internal Control and to consider and approve the terms of its assurance report to Tayside NHS Board**

7.2 Annual Reports and Assurances by Committees including Best Value Assurances (AUDIT52/2016)

Mr MacKinnon advised the Committee that all Standing Committees of Tayside NHS Board, with the exception of the Audit Committee, the Board of Trustees and the Governance Review Group had approved their Annual Reports prior to 30 May 2016.

It was noted that Appendix 1 of the report included the overall conclusions from each of these Annual Reports and the Best Value Framework Assurance 2015/16 was included as Appendix 2 of the report. The Best Value Framework Assurance 2015/16 was approved by the Committee at its meeting on 5 May 2016 subject to the inclusion of the Integrated Joint Boards (IJBs) in 2016/17.

Mr MacKinnon advised the Committee that the main function of the Audit Committee was to provide assurance to Tayside NHS Board that an appropriate system of internal control was in place. It was noted Mr Bedford had described work taken place under Item 7.1 of the Agenda.

It was noted that the Audit Committee Annual Report 2015/16 was to be considered separately under Item 7.7 on the Agenda.

Mr Gaskin highlighted that the Clinical and Care Governance Committee conclusion on page 2 of the report did not give assurance on accuracy and effectiveness due to the word "tested" being include within the paragraph *"As a result of the work undertaken during the year I can confirm that measures aligned to the Committee's Terms of Reference tested the effectiveness of clinical governance throughout NHS Tayside services during the year".* Mr Gaskin advised that work carried out by Internal Audit highlighted no concerns and this should be reflected in the conclusion.

The Committee

- **Considered the overall conclusion included within each Standing Committee's Annual Report, Board of Trustees and that of the Governance Review Group and the assurances given therein, in reaching a conclusion on the adequacy and effectiveness of Internal Control in the context of its review of the system of internal control**
- **Noted the Best Value Framework Assurance 2015/16 was approved by the Audit Committee at its meeting on 5 May 2016 subject to the inclusion of the IJBs in 2016/17**

7.3 SHARED SERVICES AUDIT REPORTS (AUDIT53/2016)

7.3a Practitioner & Counter Fraud Services – Service Audit Report

Mr MacKinnon advised the Committee the NHS National Services Scotland (NSS) Service Audit of the Practitioner & Counter Fraud Service had been undertaken in accordance with International Standard on Assurance Engagements 3402 (ISAE 3402), "Assurance Reports on Controls at a Service Organisation", issued by the International Auditing and Assurance Standards Board.

It was noted the Service Audit reflected a satisfactory and sound position with fourteen minor control weaknesses identified, a reduction from the sixteen identified the previous year.

The Committee

- **Noted the audit report from the independent Service Auditors**
- **Noted the Introduction by (NSS) Director of Finance and Management Assertion**
- **Noted the management response to the issues arising set out within the action plan**

7.3b National IT Services Contract – Service Audit Report

Mr MacKinnon advised the Committee the NHS National Services Scotland (NSS) Service Audit of the National IT Services Contract had been undertaken in accordance with ISAE 3402, "Assurance Reports on Controls at a Service Organisation", issued by the International Auditing and Assurance Standards Board.

It was noted the Service Audit reflected a satisfactory position with eight minor control weaknesses identified. The Service Audit confirmed all minor actions from 2014/15 had been resolved.

The Committee

- **Noted the executive summary of the report of the Service Auditors**
- **Noted the audit report from the independent Service Auditors**
- **Noted the management responses to the issues arising**

7.3c National Single Instance Financial Services Ledger – Service Audit Report

Mr MacKinnon advised the Committee the NHS National Services Scotland (NSS) Service Audit of the National Single Instance Financial Ledger Services (NSI) had been undertaken in accordance with ISAE 3402, "Assurance Reports on Controls at a Service Organisation", issued by the International Auditing and Assurance Standards Board. It was noted the report was reviewed and approved by the host Board, NHS Ayrshire and Arran, at its Audit Committee meeting on 13 April 2016.

It was noted the Service Audit reflected a satisfactory position with only minor control weaknesses identified and management responses had been reflected within the report.

The Committee

- **Noted the cover letter from the Director of Finance, NHS Ayrshire and Arran**
- **Noted the Service Audit from the NSI independent Service Auditors, PwC**

7.4 FTF Annual Internal Audit Report 2015/16 (BOARD54/2016)

Mr Gaskin advised the Committee that the report provided an audit opinion based on work undertaken throughout the year and built on audit evidence obtained over a five year audit cycle by Internal Audit and noted that many areas had been covered within the Interim Review.

Mr Gaskin highlighted the amount of added value work which had been undertaken, as part of the annual plan and at the request of management. It was noted this work would be included within the Mid Year Review to be presented to the Committee and Tayside NHS Board in February 2017.

Mr Gaskin advised the Committee that Budgetary Control was graded as D, as was reported in the Interim Review. He stated that this was not necessarily due to a failing of systems, however, there was the need to identify measures for improvement to mitigate increased financial risks. Mr Gaskin noted the impact of the introduction of the Transformation Programme Board and the revised Financial Plan following the Interim Review.

Mr Gaskin acknowledged that achievement of the financial plan in the coming year would be challenging although NHS Tayside was travelling in the right direction.

Mr Gaskin thanked Mrs Jocelyn Lyall and Mr Barry Hudson for work carried out in what had been a challenging year.

Mr Hussain raised concerns regarding the C grade applied to Information Security and queried whether an improvement plan was in place. Mr Hussain also sought assurance regarding the drop in the level of grade A's given from 19 in 2014/15 to 7 in 2015/16.

Mr Gaskin advised that guidance DL 2015/17 had been received highlighting a number of recommendations regarding Information Security with a target date of July 2017. It was noted that these recommendations would be addressed with the support of Ms Margaret Dunning. Ms Dunning advised that the Information Security strategic risk had previously been reported to the Finance and Resources Committee. It was noted that following the retiral of the Information Governance Manager and the cancellation of the December Information Governance Committee meeting work had run off course. Ms Dunning advised that the post of Information Governance Manager had recently been filled and an improvement plan was in place to monitor and address the recommendations set out in DL 2015/17 and was confident there would be an improvement to this grade.

Mr Hay thanked Mr Gaskin and his team for the report and work carried out over the course of the year. The Committee was asked to consider and note the report as part of the portfolio of evidence in support of its evaluation of the internal control environment and the GS, and to take into account the Chief Internal Auditor's conclusion included on page 1 of the report that subject to matters highlighted in the report:

- Tayside NHS Board had adequate and effective internal controls in place
- The 2015/16 Internal Audit Plan had been delivered in line with Public Sector Internal Audit Standards

In addition, take into account that FTF Internal Audit had not advised management of any concerns around the following:

- Consistency of the GS with information that we were aware of from Internal Audit work
- The processes adopted in reviewing the adequacy and effectiveness of the system on internal control and how these were reflected
- The format and content of the GS in relation to the relevant guidance
- The disclosure of all relevant issues. Tayside NHS Board had disclosures in the Treatment Time Guarantee, Enhancements During Leave and Finance

There was agreement from the Committee.

The Committee

- **Noted the FTF Internal Audit Report 2015/16**
- **Considered the report as part of the portfolio of evidence provided in support of its evaluation of the internal control environment and the Governance Statement**
- **Took into account the Chief Internal Auditor's conclusion included in page 1 of the report**
- **Took into account that FTF Internal Audit had not advised management of any concerns around the 4 areas noted on page 1 of the report**

7.5 Review of System of Internal Control – Lead Officers Statement to Chief Internal Auditor (AUDIT55/2016)

Mr MacKinnon advised the purpose of the report was to advise the Committee of the content of the letter, included within the report, from the Lead Officer to the Chief Internal Officer. Mr MacKinnon advised the Committee the letter from the Lead Officer provided a progress update around internal control during 2015/16, to allow the Chief Internal Auditor to satisfactorily conclude on Internal Audit's work in this area for NHS Tayside in the financial year 2015/16.

It was noted the following appendices were included within the report:

- Appendix 1 – Extract from Public Finance and Accountability (Scotland) Act 2000 – Responsibilities for Accountable Officer
- Appendix 2 – Draft Governance Statement
- Appendix 3 – Responses received from Executive Directors providing further reassurance on Internal Control

The Committee

- **Noted the contents of the letter which was consistent with the Governance Statement guidance, and in particular the assurances contained within the report including those pertaining to the discharge of the responsibilities of the Chief Executive as the Accountable Officer which significantly contributed to the Audit Committee's overall assessment of the system of internal control within NHS Tayside**

7.6 Annual Report – Patient Exemption Checking (PECS) (AUDIT51/2016)

Mr MacKinnon advised the Committee the report detailed the work of the Counter Fraud Services (CFS) during 2015/16 in checking the propriety of exemptions claimed by patients for charges for ophthalmic and dental work. It was noted the report also identified the amounts recovered and those which had been written off.

The Committee was asked to note the 2015/16 Annual Reporting Package from CFS, level of recoveries made by both NHS Tayside and NHS Scotland during 2015/16 and the level of write offs across the Contractor Groups, which were recorded in the losses form (SFR 18) in the 2015/16 Annual Accounts.

It was noted that CFS had recovered on behalf of NHS Tayside £16,602 for 2015/16 (£2014/15 - £16,614). This represented 5.6% (2014/15 – 5.9%) of the Scotland total. The value of write offs had decreased from £12,798 last year to £12,169 this year, which represented 6.3% (2014/15 – 5.2%) of Scotland total.

The Committee

- **Noted the 2015/16 Annual Reporting Package from Counter Fraud Services**
- **Noted the level of recoveries made by NHS Tayside and NHS Scotland during 2015/16**
- **Noted the reported level of write offs across the Contractor Groups**

7.7 Annual Report of NHS Tayside Audit Committee 2015/16 (AUDIT56/2016)

Mr MacKinnon presented the Audit Committee Annual Report 2015/16 to the Committee for consideration and approval prior to its submission to Tayside NHS Board at its meeting on 23 June 2016.

It was noted the Annual Report was in the normal reporting format and described the purpose and composition of the Committee. The Annual Report detailed the membership, frequency of meetings, schedule of business considered and outcomes.

The Committee

- **Approved the Audit Committee Annual Report 2015/16 for submission to Tayside NHS Board**

7.8 Report to Tayside NHS Board – Assurance to the Committee (AUDIT57/2016)

Mr Hay referred to the review of the System of Internal Control included under Items 7.1 – 7.7 of the Agenda and asked the Committee to consider and approve the terms of its assurance report under Item 7.8 of the Agenda. In order to do this, Mr Hay asked the Committee to consider in turn each of the strands of assurance as follows, and Item 3, Declaration of Interests, during the year at other Audit Committee meetings.

1. The introductory paper for the review of the Systems of Internal Control, and Governance Statement (considered under agenda Item 7.1)
2. The Annual reports and assurances for 2015/16, previously submitted by the Standing and other Committees and summarised for the Audit Committee together with Best Value Assurances (considered under agenda Item 7.2)
3. The assurances provided by Scott-Moncrieff as Service Auditor to NHS National Services Scotland on the payment process operated by the Practitioners Services Division,(considered under agenda Item 7.3a)
4. The assurances provided by Scott-Moncrieff as Service Auditor to NHS National Services Scotland on the services provided by the Atos Origin Alliance,(considered under agenda Item 7.3b)
5. The assurances provided by PricewaterhouseCoopers as Service Auditor to Ayrshire & Arran Health Board on the National Single Instance (NSI) Financial Ledger Services,(considered under agenda Item 7.3c)
6. Internal Audit, plans and reports considered by the Audit Committee during the year and the Annual Report (considered under Item 7.4)
7. The Audit Committee's Lead Officer's Statement to the Chief Internal Auditor regarding assurances on internal control and the Governance statement,(considered under agenda Item 7.5)
8. The Annual Report of Patient Exemption Checking, provided by Counter Fraud Service (considered under Agenda Item 7.6)
9. The Audit Committee's 2015/16 Annual Report (approved by the Committee under agenda Item 7.7)

The Committee

- **Considered all evidence and was satisfied assurance could be given to Tayside NHS Board with regard to the systems of internal control operating within NHS Tayside**
- **Approved the Draft Terms of its Assurance Report to Tayside NHS Board and agreed the draft Governance Statement would be signed by the Chief Executive as part of the Accountability Report in the Annual Report and Accounts**

In Accordance with the Freedom of Information (Scotland) Act Exemption 27(1)

8. Annual Accounts for the Year to 31 March 2016 (BOARD58/2016)

Under the terms of the Public Finance & Accountability (Scotland) Act 2000, Tayside NHS Board is not permitted either to make the Accounts, nor allow copies or extracts thereof, to be made publicly available prior to the Audited Accounts being formally laid before Parliament. The Freedom of Information (Scotland) Act Exemption 27 (1) therefore applies and extracts of this Minute relating to the Accounts can only be made public at that point and time.

Mr Bedford, Interim Director of Finance, presented the Annual Report and Accounts for the year ended 31 March 2016.

In Accordance with the Freedom of Information (Scotland) Act Exemption 27(1)

9. PricewaterhouseCoopers – Annual Report on the 2015/16 Audit to the Board and the Auditor General for Scotland (AUDIT59/2016)

Under the terms of the Public Finance & Accountability (Scotland) Act 2000, Tayside NHS Board is not permitted either to make the Accounts, nor allow copies or extracts thereof, to be made publicly available prior to the Audited Accounts being formally laid before Parliament. The Freedom of Information (Scotland) Act Exemption 27 (1) therefore applies and extracts of this Minute relating to the Accounts can only be made public at that point and time.

The Committee

- **Noted the PricewaterhouseCoopers – Annual Report on the 2015/16 Audit to the Board and the Auditor General for Scotland**

10. Recommendation to the Board of Annual Accounts

Mr Hay advised the Committee that having reviewed the system of internal control, the Annual Report and Accounts and considered the view of the external auditor, the Committee was asked for approval of the recommendations detailed within Item 8, Annual Accounts for the year ended 31 March 2016.

The Committee

- **Approved the recommendation to Tayside NHS Board that the summary of Losses and Special Payments contained in SFR 18.0 and separately included under agenda Item 16 be approved.**
- **Approved the recommendation to Tayside NHS Board, the adoption of the annual accounts.**
- **Approved the recommendation to Tayside NHS Board that authority be granted to sign the documentation specified within Table 1 of the cover report at Item 8, as follows:**
  a. **Performance report (page 9) – Chief Executive**
  b. **Accountability Report (including the Governance Statement) (page 36) – Chief Executive**
  c. **Balance Sheet (page 41) – Chief Executive and Interim Director of Finance**
  d. **Letter of representation to External Auditors – Board Chair and Chief Executive**

11. Notification from Sponsored Body Audit Committees (AUDIT48/2016)

Mr MacKinnon advised the purpose of the report was to inform the Committee of the content of letter received from Scottish Government Health and Social Care Directorate (SGHSCD), attached as Appendix 1 of the report, which intimated the requirement to notify the Health and Wellbeing Audit and Risk Committee of any significant issues of frauds which arose during 2015/16 that were to be considered to be of wider interest.

The Committee was asked to approve the draft response to SGHSCD.

The Committee

- **Approved the terms of the draft response included in Appendix 2 of the report and authorised this to be signed by the Chair of the Audit Committee**

12. Updates to the NHS Tayside Code of Corporate Governance (AUDIT46/2016)

Ms Dunning advised the Committee the purpose of the report was to seek approval of the amendments to the Code of Corporate Governance.

Ms Dunning advised that the amendments and updates were detailed in Appendix 1 of the report. It was noted many of the amendments were minor housekeeping issues along with amendments required as a result of an Internal Audit report.

The Committee

- **Scrutinised the amendments and updates, detailed in Appendix 1, to the Code of Corporate Governance and recommended Tayside NHS Board's approval of these at its meeting on 23 June 2016.**

13. ATTENDANCE RECORD

The Committee

- **Noted the Attendance Record**

14. DATE OF NEXT MEETING

The next meeting of the Audit Committee will take place on Thursday 1 September 2016 at 9:30am in the Board Room, Conference Suite, Kings Cross.

Subject to any amendments recorded in the Minute of the subsequent meeting of the Committee, the foregoing Minute is a correct record of the business proceedings of the meeting of Tayside NHS Board Audit Committee held on 21 June 2016, and approved by the Committee at its meeting held on 1 September 2016.

…….. .....

CHAIR **DATE**

NHS Tayside Audit Committee – 1 September 2016 Open Business
Action Points Update

New Actions arising from meeting on 21 June 2016

MEETING	MINUTE REF.	HEADING	ACTION POINT	RESPONSIBILITY	STATUS
21 June 2016		No action points from this meeting			

Actions carried Over

MEETING	MINUTE REF.	HEADING	ACTION POINT	RESPONSIBILITY	STATUS
5 May 2016	1.	Welcome – Recording Equipment	The Committee to be updated on arising issues regarding the use of recording equipment at Committee meetings	G Doherty	The last Workforce & Governance Forum was postponed due to quoracy. This matter will be discussed at its next meeting.
5 May 2016	4.2	APU – External Review of all Mental Health Sites	Update to the Committee around the external review relating to original build specifications for all Mental Health sites	M Anderson	Update to Strategic Risk Management Group in the first instance followed by update to Audit Committee. External review of Hospital Build Programme and Governance of the Programme for Murray Royal undertaken by Health Facilities Scotland. Update report to Audit Committee December 2016
5 May 2016	5.2	Progress on Internal Audit Report T21/14 Medical Instrumentation and Devices	Further update to the Committee following appointment to the post of Head of Instrumentation	L Smith	Update included within the Full Audit Cycle Follow Up at the September 2016 meeting Head of Instrumentation post has been filled with an update regarding the appointment coming to the December Committee meeting
5 May 2016	8.1	Annual Report of the Strategic Risk Management Group 2015-16	Mr Hay to raise issue of risk managers attendance at SRMG meetings with Chief Executive	S Hay	Mr Hay has been in email consultation with Ms McLay to address this issue

Recurring / longer term actions

MEETING	MINUTE REF.	HEADING	ACTION POINT	RESPONSIBILITY	STATUS
3 September 2015	Item 9	Adverse Events Management Policy	A revised version will be brought back in September 2016.	H Walker	Item deferred to September 2017 to allow for significant areas of work to emerge and be given the appropriate time to conclude and then be incorporated into the revised version of the Policy

Item Number 4.3

AUDIT COMMITTEE

Audit Committee Workplan 2016/17

This workplan outlines the major items the Audit Committee has to consider as part of its schedule of work and the corresponding Best Value Characteristics under the headings of regular reports, annual reports, corporate risk reporting, minutes for information and policies

AUDIT COMMITTEE WORKPLAN 2016/17

	Responsible Officer	Comment	Meeting 5 May 2016	Meeting 21 Jun 2016	Meeting 1 Sept 2016	Meeting 15 Dec 2016	Meeting 16 Mar 2017	Meeting 11 May 2017	Meeting 22 June 2017
REGULAR REPORTS									
Audit Follow Up									
Full Cycle Reports	D Colley				**X**				
Mid Cycle Reports	D Colley		**Item 5.1**					**X**	
Update of AFU Protocol	D Colley	**As & when available**							
Evaluation of AFU Process, FTF Report	B Hudson / J Lyall								
Annual Accounts									
Accounting Policies	F Gibson		**Item 13**						
Annual Accounts Guidance	F Gibson								
Draft Governance Statement	F Gibson		**Item 12**						
Review of Annual Accounts for Exchequer	L Bedford	**Annual**							**X**
Review of Annual Accounts for Endowments	L Bedford	**Annual**		**Item 5**					**X**
Review of Annual Accounts for Patient Funds	L Bedford	**Annual**		**Item 6**					**X**
Losses & Compensation Payments	L Bedford	**Annual**		**Item 16**					**X**

AUDIT COMMITTEE WORKPLAN 2016/17

	Responsible Officer	Comment	Meeting 5 May 2016	Meeting 21 Jun 2016	Meeting 1 Sept 2016	Meeting 15 Dec 2016	Meeting 16 Mar 2017	Meeting 11 May 2017	Meeting 22 June 2017
Risk Management									
Strategic Risk Management Group Annual Report	M Dunning	**Annual**	**Item 8.1**					**X**	
Risk Management Annual Report	H Walker	**Annual**	**Item 8.2**					**X**	
Risk Management Workplan	H Walker	**Annual**	**Item 8.3**					**X**	
Risk Management Strategy **(last presented 3/9/15)**	H Walker	**5 year document**	**-**	**-**	**-**	**-**	**-**		
Clinical Governance & Risk Management Report	H Walker	**Standing Item**							
Risk Management CIPFA Self Assessment and Audit Checklist	H Walker	**Annual**	**Item 8.4**					**X**	
Review of Internal Controls									
Committee Annual Reports & Assurances	R MacKinnon	**Annual**		**Item 7.2**					**X**
Best Value Framework Assurances	R MacKinnon	**Annual**		**Item 7.2**					**X**
Review Framework of Internal Controls & Corporate Governance	L Bedford			**Item 7.1**					**X**
Lead Officer Statement on Governance Statement on Internal Control to Chief Internal Officer	R MacKinnon			**Item 7.5**					**X**
Chief Internal Auditors Annual Report & Assurance Statement	T Gaskin	**Annual**		**Item 7.4**					**X**

AUDIT COMMITTEE WORKPLAN 2016/17

	Responsible Officer	Comment	Meeting 5 May 2016	Meeting 21 Jun 2016	Meeting 1 Sept 2016	Meeting 15 Dec 2016	Meeting 16 Mar 2017	Meeting 11 May 2017	Meeting 22 June 2017
Code of Corporate Governance (COCG)									
Updates to Code of Corporate Governance	M Dunning	**As & when available**		**Item 12**	**X**				
Governance Review Group Annual Report	M Dunning			**Item 7.2**					**X**
Internal Audit									
Internal Audit Action Plan Progress Report	B Hudson	**Standing item**	**Item 6.1**					**X**	
Internal Control Mid Year Review	T Gaskin								
Internal Audit Annual Report (incl report on previous years (Internal Control)	T Gaskin			**Item 7.4**					**X**
Internal Audit Strategy & Annual Plan Interim Review	T Gaskin								
Approval of Internal Audit Strategy and Annual Plan	T Gaskin								
Private Discussions	T Gaskin		**Item 22**	**Item 17**	**X**	**X**	**X**	**X**	**X**
Consideration of T21/14 Medical Equipment and Devices									
Consideration of T17/15 Health Equity									
Consideration of T23A/15 Enhancements During Leave									

AUDIT COMMITTEE WORKPLAN 2016/17

	Responsible Officer	Comment	Meeting 5 May 2016	Meeting 21 Jun 2016	Meeting 1 Sept 2016	Meeting 15 Dec 2016	Meeting 16 Mar 2017	Meeting 11 May 2017	Meeting 22 June 2017
External Audit (PWC/AS)									
Annual Audit Plan **(presented to Committee 4/2/16)**						**X**			
External Audit Plan Progress Report			**Item 7.1**					**X**	
External Audit Interim Report									
Audit Scotland Financial Overview Report	G Meldrum				**X**				
Audit Scotland Annual Report on NHS Scotland	L Bedford					**X**			
Audit Scotland Publications		**As & when available**							
Audit Scotland Technical Bulletins		**quarterly**			**X**	**X**	**X**		
Financial Statements Checklist	R MacKinnon						**X**		
Interim Management Letter							**X**		
Financial Management Services Third Party Assurance	R MacKinnon			**Item 11**					**X**
Report to those charged with Governance on the Audit of NHS Tayside Financial Statements				**Item 9**					**X**
Private Discussions			**Item 22**	**Item 17**	**X**	**X**	**X**	**X**	**X**

AUDIT COMMITTEE WORKPLAN 2016/17

	Responsible Officer	Comment	Meeting 5 May 2016	Meeting 21 Jun 2016	Meeting 1 Sept 2016	Meeting 15 Dec 2016	Meeting 16 Mar 2017	Meeting 11 May 2017	Meeting 22 June 2017
External Audit - Other									
Review of External Auditor – Endowment, Audit Planning Memorandum , Fees & Reporting Arrangements	R MacKinnon								
Review of Audit Plan of Endowment Funds – External Audit Report (MMG Archbold)	P Crichton			**Item 5**					**X**
Review of Audit Plan of Patients' Funds – External Audit Report (Henderson Loggie)	D Taylor			**Item 6**					**X**
Appointment of External Auditors Endowment & Patients Funds & approval of fees	R MacKinnon						**X**		
Other reports									
Property Transactions Monitoring	L Lyall		**Item 14**		**X**			**X**	
Litigation Monitoring	R MacKinnon			**Item 16**					**X**

AUDIT COMMITTEE WORKPLAN 2016/17

	Responsible Officer	Comment	Meeting 5 May 2016	Meeting 21 Jun 2016	Meeting 1 Sept 2016	Meeting 15 Dec 2016	Meeting 16 Mar 2017	Meeting 11 May 2017	Meeting 22 June 2017
Reserved Business									
Counter Fraud Services (CFS)									
Counter Fraud Services Update	R MacKinnon	**Standing item**	**Item 20.1**		**X**	**X**	**X**	**X**	
National Fraud Initiatives (& Bribery Act) Progress Report	R MacKinnon		**Item 20.1**		**X**			**X**	
Patient Exemption Checking (PECS) Annual Report	R MacKinnon	**Annual**		**Item 7.6**					**X**
Payment Verification									
Payment Verification Update • General Pharmaceutical Svs • General Ophthalmic Svs • General Dental Svs • General Medical Svs	D Colley	**Standing item**	**Item 21.1** **Item 21.2** **Item 21.3**		**X**	**X**	**X**	**X**	
Revision of Payment Verification Protocols	D Colley								
Other Reserved									
Banking and Treasury Management Report	R MacKinnon				**X**				
Annual Reports									
Audit Committee Annual Report	R MacKinnon			**Item 7.7**					**X**
Audit Committee Terms of Reference & Workplan	R MacKinnon		**Item 11**					**X**	
Audit Committee Handbook & Checklist	R MacKinnon						**X**		

AUDIT COMMITTEE WORKPLAN 2016/17

	Responsible Officer	Comment	Meeting 5 May 2016	Meeting 21 Jun 2016	Meeting 1 Sept 2016	Meeting 15 Dec 2016	Meeting 16 Mar 2017	Meeting 11 May 2017	Meeting 22 June 2017
Minutes for Information									
Strategic Risk Management Group	M Dunning	**As & when available**	**Item 9.2 07/04/16**			**X 15/08/16 02/11/16**	**X 02/02/17**		
Governance Review Group	M Dunning	**As & when available**	**Item 9.3 04/03/2016**		**X 19/5/16**	**X 19/08/16**			
Policies to be adopted by the Committee as and when required									
Adverse Event Management Policy	H Walker	**Annually**							
Health and Safety/Risk Management Policies	Policy Managers	**As & when available**							

Please note any items relating to Board business are embargoed and should not be made public until after the meeting

Item Number 5.1

AUDIT68/2016
Audit Committee
1 September 2016

AUDIT FOLLOW UP (AFU) – FULL CYCLE UPDATE REPORT

1. PURPOSE OF THE REPORT

The purpose of this report is to present to the Audit Committee a progress update on the action taken to 30 June, 2016, relating to recommendations made in NHS Tayside Internal/External Audit reports.

2. RECOMMENDATIONS

The Audit Committee is asked to note the findings for this full cycle to June 2016.

3. EXECUTIVE SUMMARY

Audit Follow Up status update requests have been sent out to Responsible Officers for all actions with due dates up to the cut off month of June 2016.

Appendix 1 contains a summary listing of the status of Internal and External Audit higher risk action points, where each audit report listed contains at least one outstanding action which is either status 'C overdue' or status 'E Deferred-not yet due', arising from the follow up carried out this cycle. The 'E' status actions have arisen as a result of requests made by Responsible Officers to revise the due date. The Responsible Officer has provided an explanation of why an extension to the due date has been requested, and this has been accepted by AFU after consultation with Internal Audit or Director of Finance if required.

3.1 Summary of Key Finding – High Risk Action Points

The actions with 'C, overdue' status are included in Appendix 2**,** with details of the Responsible Officer's comment on the status of the action. Where possible, target dates for completion of the actions are included. Each action will continue to be reported within this appendix until fully completed. Requests for extensions to due dates of more than two years old have not been accepted and remain with 'C' overdue status and reported individually until concluded.

3.2 Progress on D Opinion Audits

Appendix 3 provides a progress update of the remaining outstanding actions (priority 2, 3 & 4) included within 'D' opinion audit reports (see audit opinion definitions included in Appendix 4). It should be noted that no revised due date requests from Responsible Officers are accepted. Due dates reflect the original due dates specified in the final issued audit report. Where notified, however, target dates for completion of the actions from Responsible Officers are included for information.

Noted for this cycle:

- **T21/14, Medical Equipment and Devices** (presented in draft to Audit Committee 13 November, 2014) – Three action points remain outstanding, with progress expected following the commencement of the Head of Instrumentation in late September. An update will be provided to the December Audit Committee meeting.

- **T17/15 Health of the Population** (presented to Audit Committee 3 September, 2015). As reported to Audit Committee in May 2016, one minor point remains outstanding, dependant on a national initiative, due for completion this autumn.
- **T23A/15 Enhancements During Leave** (presented to Audit Committee 7 May, 2015). One action point remains outstanding, requiring Staff Governance Committee approval.
- **T06/17 Annual Report of Internal Control Framework** (presented to Audit Committee 21 June, 2016). One action point covering the incomplete recommendations from the Interim Report (presented to Audit Committee February 2016) required a report to Audit Committee.

3.3 Lower Risk Action Points

In accordance with the Audit Follow Up Protocol, the Committee is asked to note that Lower risk (Priority 3 & 4) actions are being monitored in-house.

3.4 Points Subject to National Initiatives and transfers to Datix

The Committee should note that one new action point has been deferred as a result of national initiatives but remains under scrutiny, and no new action points were deferred to the Datix system of Organisational Risk resulting from an inability to complete.

3.5 Current AFU Protocol

The Audit Committee is asked to note that no amendment to the Audit Follow up Protocol is required at this time.

3.6 For ease of reference, a definition of terms used is included at Appendix 4.

4. MEASURES FOR IMPROVEMENT

The focus of AFU is on exception reporting, allowing the Audit Committee to concentrate on the areas of concern.

5. RESOURCE IMPLICATIONS

Financial
There are no direct financial implications arising from this report.

Workforce
There are no direct workforce implications arising from this report.

6. DELEGATION LEVEL

Not applicable

7. RISK ASSESSMENT

Regular Audit Follow Up on action points contained in audit reports provides assurance that the recommendations are being addressed and thereby minimises the impact of a potential deterioration of audit findings.

8. IMPLICATIONS FOR HEALTH

There are no direct implications for health arising from this report.

9. IMPACT ASSESSMENT AND INFORMING, ENGAGING AND CONSULTING

Routine contact is made with responsible officers on the action points they are responsible for.

10. EQUALITY AND DIVERSITY IMPACT ASSESSMENT

Not applicable.

11. TIMETABLE FOR IMPLEMENTATION AND LEAD OFFICER

Two full-cycle and two mid-cycle update reports are reported to four Audit Committee meetings each financial year.

The lead officer for Audit Follow Up is the Finance Governance Accountant.

Derek Colley
Finance Governance Accountant

Lindsay Bedford
Director of Finance

September 2016

NHS TAYSIDE **APPENDIX 1**

AUDIT FOLLOW UP - FULL CYCLE UPDATE REPORT (cut off to June 2016)

Summary of Higher Risk Action Points (Priority 1 & 2), by audit report, with one or more actions not yet completed

Internal Audit Report Year of Issue	Report Number	Assignment Description	Report Category	Report Date of Issue	Total Action Points	.....STATUS CLASSIFICATION.....					See Appendix 2	See Appendix 3	Referred to Internal Audit
						A Actioned	F No longer relevant	B Not yet due - Outwith scope for this cycle	E Deferred - Due date revised	C Overdue			
2013/14	T12/14	Equality & Diversity	C-	27-Jan-14	5	3	1		1		✓		
	T21/14	Medical Equipment & Devices	D-	19-May-14	31	28				3		✓	✓
2014/15	T23A/15	Enhancements during Leave	D-	27-Aug-15	30	29				1		✓	
	T34/15	eHealth Implementation & Training - Learnpro	C	03-Nov-15	2	1			1				
2015/16	T10B/16	Compliance with Law & Regulations	B-	03-Nov-15	2	1			1				
	T13B/16	Follow up of T13B/14 - Risk Maturity	NA	26-Nov-15	3			2	1				
	T31/16	NHS Tayside Health Fund (Endowments)	B	11-May-16	7	2		4	1				
	T36C/16	Department Review - Outpatients	C	03-Feb-16	15	13			1	1	✓		
2016/17	T06/17	Annual Internal Audit Report	A - D	15-Jun-16	4	1		3				✓	

External Audit Report Year of Issue	Report Number	Assignment Description	External Auditor	Report Date of Issue	Total Action Points	.....STATUS CLASSIFICATION.....					See Appendix 2	See Appendix 3	Referred to External Audit
						A Actioned	F No longer relevant	B Not yet due - Outwith scope for this cycle	E Not yet due - Due date revised	C Overdue			
2015/16	CFE 2/16	Endowment Fund	MMG Archbold	Jun-15	1					1		✓	
	CFE 5/16	NHS in Scotland	Audit Scotland	Oct-15	1					1		✓	

NHS TAYSIDE
AUDIT FOLLOW UP - FULL CYCLE UPDATE REPORT

Appendix 2

Overdue 'C' status Higher Risk Action Points (Priority 1 & 2)

Report Ref	Report Title	Responsible Officer	Original due date	Likely completion date	Priority	Action Point No	Agreed Management Action to Audit Recommendation	Comment from Responsible Officer for September 2016 Audit Committee
T12/14	Equality & Diversity	Diversity & Inclusion Manager	Sep-14	Sep-16	2	7	Management are currently considering the systems and process required to monitor and record hate incidents in relation to the protected characteristics: Disability, Gender Reassignment, Race, Religion/belief and Sexual Orientation.	**Comment received 21.10.14:** We would like an extension to our timeline to enable us to complete the further work required. Agreed to review progres**s** April 2015**.** **Comment received 25.5.15:** There is work ongoing and we have met with key partner leads, further meetings needs to take place to help identify the systems and processes needed for HIM<AP across NHS Tayside. Agree to review September 2015. **Comment received 24.8.16:**HIMAP partnership groups are set up within the 3 localities, Angus, Dundee, Perth and Kinross. NHS Tayside HIMAP group is in the process of being revisited and set up, it previously functioned as RIMAP.
T36C/16	Departmental Reviews - Outpatients	Clinical Services manager	Mar-16		2	4	As at November 2015 the Lead Clinician for Gynaecology plans to meet with each Consultant to discuss their revised job plans and the job plan model. It is anticipated that the new model will be run from February 2016 and the DCAQ tool will be run again 6 weeks after implementation of the new system to check if the new job plans are having a positive impact.	**Comment received 5.8.16:** The implementation of Gynaecology job plans has been delayed as a result of two consultants not agreeing to the new plan. In addition a review of the Gynaecology on call Out Of Hours service is required. Once complete the DCAQ will be monitored through the DOIT programme.

NHS TAYSIDE

AUDIT FOLLOW UP - FULL CYCLE UPDATE REPORT - TO JUNE 2016 **APPENDIX 3**

Close monitoring of the status of all Action Points within 'D' Opinion Internal Audit Reports.

All incomplete Action Points (Overdue and within orginal due dates)

Report Ref	Report Title	Responsible Officer	Report Category	Original Due Date	Expected completion Date	Priority	Action Point No	Agreed Management Action to Audit Recommendation	Comment from Responsible Officer
T21/14	Medical Equipment and Devices	Head of Medical Physics	D-	May-15	Jun-16	2	5b	The Head of Instrumentation should present a follow up paper to the MEMG advising them of the current position of all points within the action plan of T21/14. 2) An equipment co-ordinator will be appointed	**Comments received 14.4.16:** Mrs Smith advised that interviews for the vacant position of Head of Instrumentation will take place in June. A report on interim measures to be presented at May Audit Committee. **Comment Received 23.8.16:** Head of Instrumentatioon has been appointed externally with a commencement date of 26th September. A progress report on the 3 outstanding audit actions will be provided to the Audit Committee scheduled for December
T21/14	Medical Equipment and Devices	Head of Medical Physics	D-	Jun-15	Jun-16	2	14	Nurses in Charge of ward areas should be reminded of their role in ensuring that the equipment under their control is checked as per protocols.	
T21/14	Medical Equipment and Devices	Head of Medical Physics	D-	Jun-15	Jun-16	2	17	Prior to contract renewal, user departments should be contacted regarding the quality and frequency of service they have received from 3rd parties. Any issues raised by these departments should be discussed with the supplier before the contract is renewed.	
T17/15	Health of the Population-Health Equity Risk	Director of Public Health	D	Jan-16	Sep-16	3	10	Future iterations of both the Health Equity BAF as well as the Health Equity Strategy should reflect any conclusions of national reviews. Documents will be revised	**Comment Received 14.4.16**: National Review was published in February with detailed recommendations to be published in Autumn 2016 (This point is a low priority item and therefore does not feature in Appendix 1)
T23A/15	Enhancements During Leave	Director of HR	D-	Oct-15	Feb-16	2	1	A system has been proposed to review HR Policy/Terms and Conditions matters in line with best practice learning from the Health and Safety Critical System Checklist.	**Comments received 19.8.16:** Pilot will be reported to Staff Governance Committee for approval.
T06/17	Annual Internal Audit Report	Chief Executive	A-D	Sep-16		1	1	The Audit Committee should receive a detailed report setting out the Board's response to key Internal recommendations made in the Interim Report, presented to Audit Committee 1 Feb 2016.	The recommendations will be reviewed, with a response to be presented to the Audit Committee at its September meeting.

Report Ref	Report Title	Responsible Officer	Author	Original Due Date	Expected completion Date		Action Point No	Agreed Management Action to Audit Recommendation	Comment from Responsible Officer
CFE 2/16	Endowment Fund	Associate Director of Finance - Financial Services & Governance	MMG Archbold	Jun-15			4.2	A number of old funds remain unspent. Reserves policy would benefit from a timeframe for spending of old balances.	**Comment received 17.8.16:** This still remains an issue. The intention now is where appropriate to move those under £500 to unrestricted funds, however a large volume remain and there is a significant number of older funds with no movement in excess of £500. This matter is currently under the consideration of Endowment Advisory Group.
CFE 5/16	NHS Scotland Overview Report	Board secretary	Audit Scotland	Mar-16	Sep-16		1	A Non Executive's meeting or Board Development session around the self assessment checklist to be arranged for all Non Executice Directors	**Comment received 19.8.16:** Audit Scotland Checklist to be forwarded to Non Executives for completion. Resuklts will be collated and shared with Chairman and Non Executives to consider actions.

APPENDIX 4

AUDIT FOLLOW UP

DEFINITION OF TERMS

1. INTERNAL AUDIT OPINIONS AND PRIORITIES

Audit Opinions

Audit opinions are defined as follows:-

A	Good	Meets control objectives
B	Broadly Satisfactory	Meets control objectives with minor weaknesses present.
C	Adequate	System has weaknesses that do not threaten the achievement of control objectives.
D	Inadequate	System has weaknesses that could prevent it achieving control objectives
E	Unsatisfactory	System may meet business objectives but has weaknesses that are likely to prevent it from achieving them.
F	Unacceptable	System cannot meet control objectives.

Audit Priorities

The priorities relating to Internal Audit recommendations within the Action Plan are defined as follows:-

***Priority* 1 recommendations** relate to critical issues, which will feature in the auditors' evaluation of the Statement on Internal Control. These are significant matters relating to factors critical to the success of the organisation. The weakness may also give rise to material loss or error or seriously impact on the reputation of the organisation and require urgent attention by a Director.

Priority 2 recommendations relate to important issues that require the attention of senior management and may also give rise to material financial loss or error.

***Priority* 3 recommendations** are usually matters that can be corrected through line management action or improvements to the efficiency and effectiveness of controls.

***Priority* 4 recommendations** - these are recommendations that improve the efficiency and effectiveness of controls operated mainly at supervisory level. The weaknesses highlighted do not affect the ability of the controls to meet their objectives in any significant way.

2. EXTERNAL AUDIT PRIORITIES

Some External Audit reports do not include any audit priority ratings for action points. For Audit Follow Up purposes, it has been assumed that for these external audit action points, they are of higher priority.

3. AUDIT FOLLOW UP – ACTION POINT STATUS

The status of action points included in follow up audit reports are classified as follows:-

A	Actioned	Recommendation fully implemented.
B	Not Yet Due	Date for implementation is still in the future.
C	Outstanding	Recommendation overdue and not completed.
E	Not Yet Due	Agreement reached for the Date for implementation to be extended beyond the original Due date
F	No Longer Relevant	Intended course of action is redundant.

Item Number 5.2

Please note any items relating to Board business are embargoed and should not be made public until after the meeting

AUDIT69/2016
Audit Committee
1 September 2016

INTERIM EVALUATION OF INTERNAL CONTROL FRAMEWORK 2015/16
AUDIT REPORT NO. T08/16

1. PURPOSE

To provide the Audit Committee with an update with regard to the implementation of the Audit Recommendations as a consequence of Internal Audit Report T08/16, Interim Evaluation of Internal Control Framework.

2. RECOMMENDATION

The Committee is requested to note the current position.

3. EXECUTIVE SUMMARY

Appendix 1 provides an update on the status of the audit recommendations and the consequent management actions arising from the Interim Evaluation of Internal Control Framework presented to the Audit Committee by the Chief Internal Auditor at its meeting in February 2016.

A further update will be provided at the Audit Committee scheduled for December 2016.

4. MEASURES FOR IMPROVEMENT

Each audit report includes an action plan that contains prioritised actions, associated lead officers and timescales. Progress on implementation of agreed actions is monitored through the NHS Tayside Audit Follow System and is reported regularly to the Audit Committee.

5. RESOURCE IMPLICATIONS

Financial and resource implications as a consequence of each recommendation are identified.

6. DELEGATION LIMIT

The responsible Directors for actioning the audit recommendations are identified within the Appendix.

7. RISK ASSESSMENT

The work of Internal Audit and the assurances provided by the Chief Internal Auditor in relation to internal control is one of the key assurance sources taken into account when the Chief Executive undertakes the annual review of internal controls, and forms part of the consideration of the Audit Committee and Board, prior to finalising the Governance Statement.

8. IMPLICATIONS FOR HEALTH

There are no direct implications for health.

9. TIMETABLE FOR IMPLEMENTATION AND LEAD OFFICER

The Lead Officer for each action is identified within the Appendix.

10. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

The Lead Officers have been consulted in drawing together this update.

Lindsay Bedford
Director of Finance

September 2016

Appendix 1

Ref.	Finding	Audit Recommendation	Priority	Management Response/ Action	Action by/ Date	Update
1. a	NHS Tayside has recognised that traditional approaches to making efficiencies are producing declining savings and that new thinking will be needed in 2015/16 and beyond to ensure services are sustainable. To facilitate this, a Strategic Transformation Programme Board has been introduced. The Strategic Transformation Programme Board will provide scrutiny and challenge to ensure the achievement of six workstreams and targets and future delivery of financial balance.	Tayside NHS Board should review the Terms of Reference and reporting lines of the Strategic Transformation Programme Board in detail so that it can be confident that it has full governance oversight of progress with the Transformation workstreams and is devoting an appropriate level of focus to this fundamental programme.	**2**	The Strategic Transformation Board reviewed the Terms of Reference at its meeting on 21 January 2016 and the Terms of Reference will be presented to the Board for approval at its meeting on 29 January 2016.	Chief Executive 29 January 2016	ToR approved by Board on 29 January (Item 10).
	The achievement of workstream objectives on time will be fundamental to the recovery of the financial position and achievement of performance targets but will necessitate an accelerated pace of change.	The Board should also receive assurance that the workstreams have the capacity to implement the required changes within the necessary timescales.	**2**	The Board will receive a report at its meeting on 29 January 2016.	Chief Executive 29 January 2016	The Transformation Programme Board has been provided with an assessment of the resources required to progress the workstream programmes and the actions that have been taken to identify individuals who can support the programmes. The remaining gaps in the required resources are to be progressed recognising the importance placed on the workstream programme by the Board. Additional support has recently been announced by NSS.

Ref.	Finding	Audit Recommendation	**Priority**	Management Response/ Action	Action by/ Date	Update
2.	The Board has received no formal output on the review of the organisation's strategic planning infrastructure to ensure that it was fit for purpose. The 25 June 2015 Board was informed that there was no dedicated planning function within NHS Tayside and that the draft Clinical Services Strategy had been put together in a very short timescale. A Director of Health and Care Strategy has now been appointed.	The process for implementation of the revised strategic planning arrangements, including the workstreams, should be completed and reported to Board. As with the Strategic Transformation Programme referred to above (and finance below), the Board should review the resources and capacity available to deliver the required improvements.	**2**	The Chief Executive is reviewing the corporate structure to ensure all areas are covered in relevant portfolios.	Chief Executive 30 April 2016	The Chief Executive has implemented a new corporate structure having been previously considered by the Remuneration Committee. The structures to support the new Director arrangements are presently being developed with the intention of securing a structure that is both fir for purpose and an adequacy of resource.
	In the context of a financial overspend, performance on key targets has not been remediated and performance on TTG, a statutory obligation requiring disclosure in the 2014/15 accounts, has worsened significantly.	The Board should consider whether Performance Reports should contain more details in relation to the areas in which performance is not acceptable, action being taken to address these and the effectiveness of actions taken to date.	**2**	Performance reporting is being reviewed to address the issues highlighted in this report.	Director of Acute Services/ Medical Director – Operational Unit 30 June 2016	Two papers were presented to the June Board on waiting times – one with the detail of the 2015/16 performance and the second detailing plans for 2016/17 which demonstrate that even with investment NHS Tayside will not deliver against targets. The reasons for this are fully explained in the report.
3.	Internal Audit T16/15 recommended that the SRMG ensured it complies with the requirement in its Terms of Reference to 'Agree and prioritise the strategic risks that will form the organisations Strategic Risk Profile ...through exercises such as horizon scanning, receipt of legislation, journal articles to ensure NHS Tayside addresses new and emerging risk management issues'.	Given the changing risk environment and following the recommendations of Annex F of the Audit Committee Handbook, we would recommend that the Board undertake a regular horizon-scanning exercise to ensure the BAF includes all fundamental risks.	**2**	The Board Secretary has highlighted Horizon Scanning at the workshops with the standing committees. It has also been agreed that Horizon Scanning will be standing item on the Strategic Risk Management Committee.	Board Secretary 31 March 2016	Complete. Standing agenda item for Strategic Risk Management Group.

Ref.	Finding	Audit Recommendation	**Priority**	Management Response/ Action	Action by/ Date	Update
4.	Internal Audit T16/15 recommended that the SRMG ensured it complies with the requirement in its Terms of Reference to '*Agree and prioritise the strategic risks that will form the organisations Strategic Risk Profile ...through exercises such as horizon scanning, receipt of legislation, journal articles to ensure NHS Tayside addresses new and emerging risk management issues'*.	Given the changing risk environment and following the recommendations of Annex F of the Audit Committee Handbook, we would recommend that the Board undertake a regular horizon-scanning exercise to ensure the BAF includes all fundamental risks.	**2**	The Board Secretary has highlighted Horizon Scanning at the workshops with the standing committees. It has also been agreed that Horizon Scanning will be standing item on the Strategic Risk Management Committee.	Board Secretary 31 March 2016	Complete. Standing agenda item for Strategic Risk Management Group.
5.	In approving the revised Best Value Framework 2015/16, Board members noted some areas where assurance might not be in place and accepted that in some years, Standing Committees may not be able to evidence or demonstrate all of the Best Value characteristics assigned to them. We identified areas where the F&R Committee in particular had not fully considered key Best Value Characteristics.	Whilst it is acceptable that not all areas may be evidenced, each Committee should ensure that it does understand the characteristics assigned to it, which ones it can verify and is comfortable that those elements which cannot be demonstrated are not fundamental.	**3**	The Board Secretary revised and reissued guidance regarding Best Value to all Board Members and this has been circulated to all Board Members.	Board Secretary 31 January 2016	Complete. Guidance issued in November 2015 (guidance dated October). Note Audit Committee comments on 5 May 2016 re. changes required to framework, particularly re IJBs.

Ref.	Finding	Audit Recommendation	Priority	Management Response/ Action	Action by/ Date	Update
6.	The 3 December 2015 Audit Scotland report on HSCI commented on the risks posed by the complex governance and accountability arrangements under HSCI, workforce issues and relating to funding and integrated budgets. The report makes a number of recommendations to help stakeholders, including NHS Boards, address these issues.	The 3 December 2015 Audit Scotland report on HSCI should be presented to Tayside NHS Board to prompt consideration of risks and any necessary actions to be taken i.e. the HSCI BAF should be considered in the light of the Audit Scotland report.	**2** **2**	A report is being prepared for the Clinical and Care Governance Committee to measure the position on HSCI arrangements against the recommendations of the Audit Scotland report.	Director of Primary and Community Care Chief Officers 29 February 2016 and ongoing	The majority of the recommendations were related to the HSCPs and Scottish Government. The HSCI arrangements for Tayside incorporated many of the aspects highlighted. Due diligence work has been effectively undertaken on the allocation of resources and governance frameworks are in place.
	At the October 2015 Board meeting, the HSCI strategic risk rating was downgraded from amber to yellow and current progress was assessed as 'On target' based on the timetable in place. Whilst a project plan for IJB compliance with legislation and guidance by April 2016 is in place and is monitored by the Partnership Collaborative, there is no highlight or exception reporting to Board that would flag up any risks to achievement e.g. overdue actions.	The BAF should also be reviewed to ensure that risks to achievement are monitored appropriately.	**2**	The Board Assurance Framework and Risk profile for HSCI will be continuously reviewed and reported through the Strategic Risk management Group and in regular reporting through the NHS Board and Committees.	Director of Primary and Community Care Board Secretary Chief Officers 29 February 2016 and ongoing	Agreement on detail of performance frameworks and clinical and care governance arrangements to be finalised. The initial BAF and strategic risk was focussed on the establishment of the HSCPs across Tayside and has been completed. The risk is now being re-set to reflect the remaining governance and performance aspect and to ensure delivery of the outcomes
		The Board should also explore its shared understanding of governance under the new arrangements, possibly through the use of various scenarios which could draw out particular aspects of assurance, strategy and control.		The Board will undertake a scenario planning exercise to test wider governance arrangements as previously undertaken as part of the Clinical and care Governance Framework arrangements.	Director of Primary and Community Care Board Secretary Chief Officer 29 February 2016 and ongoing	Internal Audit provided scenarios 11 February 2017. Board has agreed to receive a further paper on HSCI which may resolve these issues but no date known as yet.

Ref.	Finding	Audit Recommendation	Priority	Management Response/ Action	Action by/ Date	Update
7.	The LDP approval letter states that the Board is expected to monitor the local impact that the NHS is making in community planning and the role senior leaders are playing, particularly in the shift towards prevention, early intervention and tackling inequalities. The Board has not received any reports on Single Outcome Agreements and their performance management nor was this area of work included in the CHP Workplans before their dissolution and thus was not delegated elsewhere.	Although the focus is currently on HSCI, the Board should give consideration how NHS Tayside's contribution to the wider community planning agenda should be managed.	**3**	The monitoring and review of the SOAs and Community Planning is undertaken as part of the review of the Local Development Plan (LDP). The reporting is scheduled for financial year end and will fulfil the requirements of the LDP letter.	Director of Primary and Community Care Director of Public Health Director of Health and Care Strategy 30 April 2016	An agenda note to August board meeting proposes a development session to refresh the approach to Community Planning and SOA
8.	The analysis of expenditure shows that staffing issues are having a significant impact on NHS Tayside's financial position, particularly the level of supplementary spend. These issues relate to risks assigned to, and considered by the Staff Governance Committee. However, in line with national guidance, the work of the SGC has been primarily focused on the Staff Governance Standard. The move to more frequent reporting on the relevant BAFs will be important and should provide the opportunity for the SGC to consider the balance of its workload and reflect on whether there is sufficient focus given to these areas particularly the suitability and implementation	The SGC should consider its remit, workplan and agenda so that key workforce issues are being addressed and mitigating actions are in place and working effectively. In particular, it should ensure that the Workforce Plan and Staff Governance Action Plan support the Boards achievement of its operational and Strategic objectives, and are being progressed. Consideration should also be given to ways of ensuring that both the F&R Committee and the Staff Governance Committee can provide their own perspective on these important drivers of cost and performance, without duplicating effort.	**2**	A review has commenced of the Staff Governance Committee work plan. This will more clearly focus the work of the Committee on key performance indicators, including agreed workforce cost and outcome measures, as reflected in associated changes in the F&R Committee terms of reference.	Director of Human Resources 30 June 2016.	Work ongoing. Paper to Staff Governance Committee at its meeting in September 2016

	of the workforce plan.					
Ref.	Finding	Audit Recommendation	**Priority**	Management Response/ Action	Action by/ Date	Update
9.	The Staff Governance Monitoring Report was noted by the SGC on 20 October 2015 when the Committee highlighted that the action plan did not provide details as to where the organisation currently sat within the Standards. It was noted that this was a working document which would evolve over the coming years and data in relation to Standards would be forthcoming.	Whilst the SGC noted that the Staff Governance Action Plan 2015-17 6 monthly Progress Report is a working document which would evolve over the coming years and data in relation to Standards would be forthcoming, management should ensure that the report provides clear data on achievement of targets within timescales and Key Performance Indicators (KPIs).	**2**	Staff Governance Action Plan key performance indicators and data measures will form part of the Staff Governance Committee work plan, as monitored and actioned by the Local Partnership Foras.	Director of Human Resources 30 June 2016	Work ongoing. Paper to Staff Governance Committee at its meeting in September 2016
10.	A report to the December 2015 Remuneration Committee on the Non Executive review of portfolios highlighted concerns about the operation of the appraisal process which, taken together with the findings of T23A/16, did not provide clear evidence that the expectations of Remuneration Committee members or the requirements of the circular relating to management pay have been met in full.	The Remuneration Committee should ensure that it has a clear understanding of the process to be followed in awarding senior managers pay including the timing of review by members, approval by the Remuneration Committee and submission to the NPMC. The deliberations of the Committee should fully reflect the need to ensure that any superior ratings are supported by appropriate evidence.	**2** **2**	The Executive & Senior Manager appraisal system is currently subject to full redesign, including moving away from use of annual portfolio evidence to a continuous cycle of evidenced performance review. Process to be agreed by the Remuneration Committee in February 2016. As above.	Director of Human Resources 30 June 2016 Director of Human Resources 30 June 2016	New process agreed and signed off by the Scottish Government. New process agreed and signed off by the Scottish Government.

Ref.	Finding	Audit Recommendation	Priority	Management Response/ Action	Action by/ Date	Update
11.	The Audit Scotland 'NHS in Scotland 2015' report provided a 'Checklist for Non Executive Directors' designed to help Non-Executive Directors with their role in overseeing the performance of NHS Boards. The Board is facing severe financial pressures, partly as a result of issues which fall within the purview of the F&R Committee but were not clearly identified at the time. Not all Best value Characteristics assigned to the Committee appear to have been fulfilled and the Committee has not received assurance that the External Audit recommendation in relation to budgetary control has been fulfilled by the NHS Tayside financial framework 2016/17-2020/21.	Given the significance of the financial risks facing the Board, we would recommend that the F&R Committee undertake a review of its remit, reporting arrangements and operations, taking into account recent events, the contents of the finance section of the Audit Scotland checklist, this report, the forthcoming update on previous Internal Audit recommendations and the Committee's own duties under NHS Tayside's Best Value Framework. The F&R Committee should receive specific assurance on how the External Audit recommendation has been fulfilled. Consideration should be given to a process for ensuring that reports received by the Audit Committee where relevant to the remit of a Standing Committee, are referred for action/monitoring and reporting back.	**2** **2** **2**	*A review of the remit, reporting arrangements and operation of the F&R Committee will be undertaken.* *The checklist provided within the Audit Scotland "NHS in Scotland 2015" for Non Executive Directors will also be reflected upon as part of the review.* *A report on the response to the External Audit recommendation will be brought before the F&R Committee.* *Audit reports will be scrutinised for relevance to the remit of other Standing Committees and reported thereon.*	Interim Director of Finance 30 June 2016 Interim Director of Finance 30 June 2016 Interim Director of Finance 31 March 2016 Interim Director of Finance 30 April 2016	Discussions progressed with Chairs of both Audit Committee and Finance & Resources (F&R) Committee. Paper to be prepared for November F&R. The Audit Scotland Checklist has been circulated to all Non Executive Directors, the completion of which will inform a Board Development Event. A desktop event is set for September. The External Audit recommendation was enacted through the Financial Framework 2016/17 – 2020/21 approved by the Board in March 2016. The Framework sought to recognise a range of legacy issues and areas of pressure with the consequent impact on efficiency savings. Agreed will be included in review of F&R Committee and incorporated within revised Internal Audit reporting protocol

Ref.	Finding	Audit Recommendation	Priority	Management Response/ Action	Action by/ Date	Update
12.	NHS Tayside has now commissioned a comprehensive, high level, benchmarking review which concluded that NHS Tayside is spending beyond its means in almost all areas. The F&R Committee has the remit to keep under review arrangements and provide an annual opinion to the Board with regard to the arrangements for securing economy, efficiency and effectiveness in the use of resources. The workplan for the committee does not provide for any items of business to address this work and its annual reports did not identify any issues with NHS Tayside's cost base.	As part of the review of its operations recommended above, the F&R Committee should consider the level and extent of information it requires to be able to conclude effectively on this fundamental issue of concern for NHS Tayside.	**2**	This will be considered as part of the review of the F&R Committee .	Interim Director of Finance 30 June 2016	Discussions progressed with Chairs of both Audit Committee and Finance & Resources (F&R) Committee. Paper to be prepared for November F&R.
13.	Two similar property transactions were originally included in the 2014/15 accounts. One was removed at the request of the External Auditors, the other was not. The accrual for EDL appears to have significantly under-estimated the final cost.	The Audit Committee should receive assurances from Interim Director of Finance and the Board's External Auditors on revised processes which will ensure that the 2015/16 accounts present a complete reflection of the financial position of the Board at that time. Early advice should be sought on the accounting treatment of these issues.	**2** **3**	The relevant assurances will be provided. Discussion will be held with External Audit on any identified issue.	Interim Director of Finance 30 June 2016 Interim Director of Finance 31 March 2016	Assurances provided by both Interim Director of Finance and External Audit as part of Annual Accounts process. Discussions held with External Audit on all property transactions

Ref.	Finding	Audit Recommendation	Priority	Management Response/ Action	Action by/ Date	Update
14.	At the April and September 2015 F&R Committee meetings non-executive members requested enhancements to the financial reporting process and it has been acknowledged that there is a need to monitor financial performance differently. In difficult circumstances, it is possible that the use of specialist and sometimes arcane language may obscure the underlying realities and mitigate against a full understanding of the issues. Whilst it is important that the message is communicated in a way that does not cause unnecessary wider concern, it is equally important that the Board ensures that members have a full accurate and concise report on which to base their conclusions on the realities of NHS Tayside's financial position, associated risks and the opportunities for remedial action. The risk of EDL payments exceeding the provision within the Strategic Financial Plan was not included in the list of reported financial risks this year, although it had been included previously.	The review should assess all aspects of finance reports to ensure that they are fully understood by all Committee members and provide a clear and unequivocal view of the financial position and impending issues and risks. The F&R Committee and other Committees should ensure that any new risks identified during the year are added to the finance report risk section so that they can be monitored and mitigated. There should be an explanation for any risks being removed which should be considered and approved by the F&R Committee. .	**2** **3**	Discussion has already advanced with the Deputy Chairman and Audit Committee Chair on enhancements to the financial reporting process. This process will continue. New risks will be identified and reported on within the report submitted to Committee.	Interim Director of Finance 31 March 2016 Interim Director of Finance 29 February 2016	Revised Corporate Financial Report developed for 2016/17, that will continue to evolve, with the intention of providing a report that provides a clear view of the financial position and impending issues and risks Risks have been considered since February 2016 but further work required

Ref.	Finding	Audit Recommendation	**Priority**	Management Response/ Action	Action by/ Date	Update
15.	For many years, NHS Tayside has struggled to deliver recurrent savings. However, the efficiency savings section of the finance reports does not identify whether savings are recurring or non-recurring.	The efficiency savings element of the financial reports should be specifically reviewed; savings should be overtly classified as recurring or non-recurring.	**3**	The Efficiency Savings element of the financial report will be developed to report on both recurring and non recurring savings.	Interim Director of Finance 29 February 2016	The reporting structure at Group level continues to identify Current Year and Full Year savings. This will be collated into a Tayside position. With initiatives for 2016/17 now more informed, this will be an integral part of future Corporate Finance Reporting to Committee.
16.	Key staff have been lost from the finance team, compounding an overall reduction in senior finance officers in recent years. No formal restructuring of the finance department has yet taken place, nor has there been a comprehensive review of resources and structure.	An exercise should be undertaken to assess the current capability of the Finance Department to determine whether the Department has the resources required, configured in the best way to meet the significant financial challenges faced by NHS Tayside.	**2**	A review is presently underway to consider a revised staffing structure and the outcome will be reported to the appropriate Standing Committee.	Interim Director of Finance 31 March 2016	As a consequence of the appointments to the revised corporate structure of the Board the Director of Finance has a proposed structure that has been discussed with the Director team. The Finance Function is presently recruiting to a number of key posts through an alternative approach having been unsuccessful through the traditional approach.

Ref.	Finding	Audit Recommendation	Priority	Management Response/ Action	Action by/ Date	Update
17.	In a year in which capital disposals will be fundamental to the Board's financial recovery, a 2015/16 PAMS has not been presented to the F&R Committee.	The F&R Committee should have to have an overarching role of monitoring of all capital issues with clear lines of reporting from any sub-groups established to focus on specific issues.	**2**	The governance arrangements with regard to the reporting and monitoring of capital issues will be refreshed in order to provide the level of assurance the Board requires.	Interim Director of Finance 30 April 2016	The remit for strategic capital planning now rests with the Director of Finance. The overarching governance structure is now being considered recognising the remit of Capital Scrutiny Group and the inherent requirement for a prioritisation process.
	Since May 2014, no updated version of the PAMS has been presented to Board or F&R Committee. Although monitoring of the PAMS is within the remit of the F&R Committee and its workplan includes a 6 monthly Property Strategy update, there has been no monitoring by the F&R Committee, although there was discussion at the Capital Scrutiny Group. There is also a Property Strategy Group but this has no formal remit, does not report into the finance governance structures and has met only twice so far this year). During the year, the Board was informed that £90m was required to maintain the Ninewells infrastructure; this did not feature within the PAMS or the Capital plan.	The F&R Committee should receive regular, comprehensive capital reports encompassing the delivery of the PAMS and associated KPIs, backlog maintenance, disposals and capital spend.	**3**	In conjunction with the detailed report currently presented on the in year capital position, a 6 monthly report will be brought on the Property Strategy encompassing the PAMS and associated KPIs, backlog maintenance and disposals.	Interim Director of Finance 30 April 2016	The PAMS update report was considered by F&R in August 2016.

Ref.	Finding	Audit Recommendation	Priority	Management Response/ Action	Action by/ Date	Update
18.	A draft of the eHealth Delivery Plan was considered by the Area Business IM&T Committee in November 2015, however further changes were requested. It is planned that the plan will be approved at its January meeting.	The eHealth Plan should be approved by the Area Business IM&T Committee as a matter of priority, and then formally approved by the Finance and Resource Committee as stated in its annual work plan.	**2**	The eHealth Plan has now been approved by the Area Business IM&T on 13 Jan 2016. The Plan required a refresh around governance structures and a finance update. The refreshed version will be presented to the F&R Committee in February 2016.	Director of eHealth 29 February 2016	The eHealth Delivery Plan was presented to the Finance and Resource Committee on 18 February 2016.
	Part of the NHSScotland Information Security Policy Framework is ensuring that the eHealth Delivery Plan conforms to the Framework. We can see no reference to the Framework in the current draft of the eHealth Delivery Plan.	Future iterations of the eHealth Delivery Plan, and preferably prior to final approval, should reflect the requirements and/or make reference to the NHSScotland Information Security Policy Framework, as stated in DL(2015)17.	**2**	The requirements of the NHSScotland Information Security Policy Framework will be referenced into the summary of the eHealth Delivery Plan, which will be presented to the F & R Committee in February 2016.	Director of eHealth 29 February 2016	Reference to the requirement is within the version of the eHealth Delivery Plan presented to the F and R Committee on 18 Feb 2016. .
19.	There is currently no reference in the CoCG for eHealth in the Standing Orders of NHS Tayside. eHealth is reported through the Area IM&T Committee and its minutes are presented to the F&R Committee. The F&R Committee has in its annual work plan the requirement to consider and make recommendations to the Board with regard to the eHealth Delivery Plan.	NHS Tayside should consider formalising the governance arrangements for eHealth within the Standing Orders of the Board.	**2**	The remit of the Finance and Resources Committee will be updated to detail that eHealth will report through the Finance and Resources Committee and the Finance and Resources Committee should approve the eHealth Delivery Plan.	Board Secretary 31 March 2016	An update of the CoCG was presented to the Board on 23 June

Please note any items relating to Board business are embargoed and should not be made public until after the meeting

Item Number 6.1

AUDIT67/2016
Audit Committee
1 September 2016

FTF AUDIT AND MANAGEMENT SERVICES INTERNAL AUDIT PROGRESS REPORT

1. PURPOSE OF THE REPORT

The aim of this paper is to brief the Audit Committee on the progress on the 2015/16 and 2016/17 internal audit plans.

2. RECOMMENDATIONS

The Audit Committee is asked to note the progress on the 2015/16 and 2016/17 internal audit plans.

3. EXECUTIVE SUMMARY

Work on the completion of the 2015/16 plan is continuing and progress on the 2016/17 plan is as expected.

3.1 Completed Audit Work

The following audit products, with the audit opinion shown, have been issued since the Audit Committee meeting on 5 May, 2016. A summary of each report is included for information within Appendix 1 'Summary of Report Content'.

		Opinion	Draft Issued	Finalised
2015/16				
T11/16	Best Value	B	24 August, 2016	26 August, 2016
T18C/16	Health & Social Care Integration – Dundee	N/A	27 April, 2016	16 June, 2016
T31/16	Tayside Health Fund	N/A	20 April, 2016	11 May, 2016
T34/16	eHealth Strategy, Planning and Governance	N/A	23 June, 2016	22 August, 2016
T36D/16	Ninewells Ward 11 departmental review	A-	4 July, 2016	22 August, 2016
2016/17				
T06/17	Annual Internal Audit Report	N/A	8 June, 2016	15 June, 2016
T07/17	Governance Statement	N/A	8 June, 2016	15 June, 2016
T15A/17	Angus IJB Annual Report	N/A	16 June 2016	21 June, 2016
T15B/17	Dundee IJB Annual Report	N/A	16 June, 2016	20 June, 2016
T15C/17	Perth & Kinross IJB Annual Report	N/A	16 June, 2016	21 June, 2016
T23/17	Property Transaction Monitoring	N/A	12 August, 2016	24 August, 2016

3.2 Draft Reports Issued

		Draft Issued
2015/16		
T36A/16	CAMHS[1]	4 April, 2016

[1] This review is nearing completion and will be reported with covering paper to the December 2016 Audit Committee.

3.3 WORK IN PROGRESS

The following reflects the work in progress on the 2015/16 and 2016/17 plan, where assignment plans have been approved:-

		Planned Audit Committee date
2015/16		
T12/16	Assurance Framework	Dec 2016
T17/16	Workstream Governance[2]	Sept 2016
T19/16	Clinical Governance – Mortality Reviews[2]	Sept 2016
T20/16	Patient Safety Programme[2]	Sept 2016
T25A/16	Consultants Leave[2]	Sept 2016
T28A/16	Property Management Strategy	Dec 2016
T27A/16	Follow Up of Financial Planning and Financial Management[2]	Sept 2016
2016/17		
T09/17	Audit Follow Up	Dec 2016
T15/17	HSCI	May 2017
T24/17	Financial Process Compliance	Dec 2017
T25/17	SSPS / NDI	May 2017

[2] Fieldwork on these audits is nearing completion and will be reported to the December 2016 Audit Committee. Whilst it was anticipated that these audits would be finalised for this Audit Committee, staff annual leave over the summer period, availability of client staff in the areas under review and complex issues to clear reports have all had an impact on delivery. The Audit Committee lead officer has been appraised on these issues.

The following are projects for which we do not produce a formal report. A year end summary will be reported to the May 2017 Audit Committee.

T02/17	Audit Management & Liaison with Directors
T03/17	Liaison with External Auditors
T04/17	Audit Committee
T05/17	Clearance of Prior Year
T10/17	Code of Corporate Governance (SOs, SFIs and SoD)
T11/17	Board, Operational Committees & Accountable Officer (CIA Advice)
T20/17	Deputy FLO

3.4 Planning Commenced

The following reflects audits where risk analysis is currently being undertaken to allow assignment plans to be agreed with client management:-

T16/17	Adverse Event Management
T18/17	Food, Fluid & Nutritional Standards
T20b/17	Bribery Act
T23b/16	Strategic Planning
T24/16	Staff Governance Committee and Area Partnership Forum[3]
T27/16	EDL[o]
T27B/16	Workforce Strategy, Operational Planning & Information[3]
T26/17	Tayside Health Fund

[o] T27/16 has been discussed with the Director of Finance and will be planned around the implementation of the SSTS module later in the financial year.

[3] At the request of the members of the Chief Executive and Directors group on 21 March, 2016, T24/16 will be carried out later in the year.

5. MEASURES FOR IMPROVEMENT

Each audit report includes an action plan that contains prioritised actions, associated lead officers and timescales. Progress on implementation of agreed actions is monitored through the NHS Tayside Audit Follow System and is reported regularly to the Audit Committee.

6. RESOURCE IMPLICATIONS

Financial
There are no direct financial implications.

Workforce
As of 19 August, 2016, actual input against the 2016/17 NHS Tayside plan stood at 134 days (21%) of the 645 days planned audit input for 2015/16. We can confirm that we will complete audit work sufficient to allow the Chief Internal Auditor to provide his opinion on the adequacy and effectiveness of internal controls at year-end.

7. DELEGATION LEVEL

Progression of the audit plan is undertaken under the supervision of the Chief Internal Auditor. The Tayside Team is operationally managed by the Regional Audit Managers.

8. RISK ASSESSMENT

The work of Internal Audit and the assurances provided by the Chief Internal Auditor in relation to internal control are one of the key assurance sources taken into account when the Chief Executive undertakes her annual review of internal controls, and forms part of the consideration of the Audit Committee and Board prior to finalising the Governance Statement included and published in the Board's Annual Accounts.

Non-completion of Governance Statement critical elements of the planned internal audit work would jeopardise the ability of the Chief Internal Auditor to provide this opinion, and would, therefore, impact on the assurance system available to the Audit Committee, Chief Executive and the Board when considering the internal control framework.

9. IMPLICATIONS FOR HEALTH

There are no direct implications for health improvement.

10. CONSULTATION
INFORMING, INVOLVING & CONSULTING WITH PUBLIC & STAFF

This paper has been prepared by the Regional Audit Managers in consultation with the Chief Internal Auditor and the ,Director of Finance.

11. EQUALITY & DIVERSITY IMPACT ASSESSMENT

Not applicable.

12. TIMETABLE FOR IMPLEMENTATION AND LEAD OFFICER

The Internal Audit year runs from May to April. Since the date of the last meeting, the Internal Audit Team has continued to progress the outstanding reviews from 2015/16 plan and commenced the 2016/17 audit plans under the supervision of the Chief Internal Auditor. Audit work is planned to allow the Chief Internal Auditor to provide the necessary assurances prior to the signing of the accounts.

Barry Hudson BAcc CA
Regional Audit Manager

Lindsay Bedford
Director of Finance

Jocelyn Lyall BAcc CPFA
Acting Regional Audit Manager

September 2016

Tayside NHS Board
Summary of Report Contents

Ref	Audit	Grade	Report Summary
T11/16	Best Value	B	Our testing of Committees' annual reports and the Best Value assurance provided for the Board found examples where the evidence cited did not provide overt assurance that the relevant characteristic had been demonstrated. Our report provides a high level summary of our initial findings for each Committee. We have shared our detailed assessment of each Committee via the Board Secretary and agreed to discuss our findings with relevant staff for each committee through upcoming committee pre-agenda meetings. Overall, we noted an improved level of detail in the information provided under the evidence/outcome assessment. This included good practice where committees and the Board provided additional information where further work is needed or planned on a specific characteristic or where the information provided implied that the assessment was that the characteristic was not yet fully in place. However, the current format of Best Value assurance tables encourages an implicit assumption that any evidence cited means the requirement has been fulfilled. We would recommend that the template be amended to allow conclusions to be shown for the outcome such as 'In place/ Partially in place/ Not demonstrated in year' as well as the evidence and any further work planned for the future to address identified gaps. With the exception of the Audit Committee using a previous Best Value framework, our testing confirmed that all committees and the Board included all their delegated characteristics in their annual reports and Best Value assurance assessment. Our testing showed that not all Committees' workplans reflected all their delegated Best Value requirements. Internal Audit has previously made recommendations in relation to reviews of these committees' workplans and these will be followed up separately. We will also include these points in our detailed discussions through committee pre-agenda meetings as set out above. We have reviewed the Best Value framework in full and discussed in detail our findings in relation to required updates with the Board Secretary and Head of Committee

			Administration. Updates include taking account of developments in NHS Tayside such as the Transformation Programme, addressing duplications in the requirements and updating those characteristics impacted by Health and Social Care Integration. We also reviewed Local Authorities Best Value guidance to identify any gaps. The updated framework will be presented to the Audit Committee under separate cover.
T18C/16	HSCI - Financial Assurance (Dundee)	N/A	One of the most important items of business for a newly established Integration Joint Board (IJB) will be to obtain assurance that its resources are adequate to allow it to carry out its functions and to identify, quantify and assess the risks associated with this. In order to facilitate this, Financial Assurance guidance states that it is recommended that: '*the Audit Committees are provided with a report, produced jointly by the Health Board and Local Authority Chief Internal Auditors (and copied to the shadow IJB), on the assurance work that has been carried out by the Health Board and Local Authority*.' We provided assurance that in our opinion the due diligence processes undertaken on the initial sums for the integrated budget comprehensively covered the requirements of the national financial assurance guidance. The information provided to the Dundee (Shadow) IJB at meetings and development events throughout 2015, concluding in the Final Due Diligence report to the special IJB meeting on 15 March 2016 provided a full and detailed picture of the financial position of the budgets in scope. In addition, the financial assurance / due diligence and summary of risks reports met all the requirements of the Financial Assurance Guidance in relation to risk assessment. We also acknowledge the level of collaborative working that has taken place with a concerted effort to achieve a successful outcome for all parties. Whilst the remit of this audit review was designed to establish whether or not the financial assurance / due diligence process followed was in line with the Financial Assurance Guidance, we would note that whilst we conclude this is the case, the main value of the process that was followed is in the provision of a framework that key stakeholders can utilise to help inform their assessment on the adequacy or otherwise of the delegated resources. The Final Due Diligence paper presented to the March 2016 IJB meeting provided Dundee IJB members with the Chief Finance Officer's assessment in relation to

			transparency, proportionality and adequacy of the resources to be delegated both in relation to Dundee City Council and NHS Tayside. This assessment highlights important outstanding issues as well as the risks relating to these questions including the allocation of the former CHP Management costs, outstanding issues within Mental Health and Learning Disabilities, transfer from the Medicine Directorate and allocations to NHS Tayside from the Scottish Government. In overall terms, the financial assurance / due diligence process followed was considered to be robust and carried out in line with the Financial Assurance Guidance. The level of collaborative working that took place throughout the process, with a common goal of achieving a successful outcome for all parties, is acknowledged. Whilst, with the exception of the IJB having to potentially take a share of some specific Dundee City Council organisational-wide savings targets, risks were clearly identified and reported throughout the financial assurance / due diligence process, the risk management arrangements required to be developed further, including the compilation of a comprehensive risk register.
T31/16	Tayside Health Fund (Endowments)	N/A	The 2015/16 Tayside Health Fund Report was presented to and discussed by the Endowment Advisory Group on 7 June 2016.
T34/16	eHealth Strategy, Planning and Governance	N/A	A number of departmental clinical systems in NHS Tayside have been developed by eHealth in collaboration with clinicians utilising non recurring grant funding with no recurring funding for ongoing support and development costs. At the request of eHealth Management we examined seven departmental clinical systems to determine whether these aligned to the NHS Tayside eHealth 5 year investment plan and whether exit strategies were in place to allow the functionality of the systems to be maintained by moving this to key "building block" systems (eg TrakCare, eMIS web). We also considered whether clinicians would continue to be able to view all the data they require through the locally developed clinical portal following migration of functionality to another system. As the audit was undertaken at the request of management it is not appropriate to provide an audit opinion. Our findings were intended to aid decision making regarding future use of the systems but these decisions rest with NHS Tayside clinical and eHealth

<table>
<tr><td></td><td></td><td></td><td>management.

NHS Tayside is at the planning stage of replacing its Patient Administration System (PAS) with the nationally mandated product (TrakCare). The Head of Service – eHealth advised that learning from this planning will be applied to determine whether the functionality of systems used in NHS Tayside, including those considered in this review, can be provided by TrakCare.

We concluded that there were no exit strategies documented for any of the seven systems evaluated. These systems are stand alone silo based systems which are contrary to the fundamental principles of the National eHealth Strategy and Local NHS Tayside eHealth Delivery Plan and are not supportable by eHealth in the longer term. Management have informed us that a collaborative approach, between eHealth and clinical system leads will be taken to document exit strategies for each system during the introduction of TrakCare. The exit strategies will reflect any changes to practices required to administer patients and record patient information as a result of the system change.</td></tr>
<tr><td>T36D/16</td><td>Ninewells Ward 11 departmental review</td><td>A-</td><td>
<table>
<tr><th>A</th><th>B</th><th>C</th><th>D</th><th>E</th><th>F</th></tr>
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This audit focussed upon the following areas, which were graded individually: Risk Management B+; Organisational Culture A; Infection Control A; Endowment Funds C; Complaints B; Ordering and Receipting of Goods and Services A; Food, Fluid & Nutrition A; Medicines Management A.

Management has agreed actions to address the main recommendations which were as follows:
• Datix should be updated immediately and an outstanding adverse event should be verified as per the Adverse Event Management Policy;
• Management should ensure that all completed endowment donation forms clearly state their purpose;
• Segregation of duties on PECOS should be rolled out to all departments across NHS Tayside with immediate effect.</td></tr>
</table>

			Based on Internal Audit observation and through the use of the '15 Steps Challenge' document, our overall impression was that the ward was a well managed, efficient, and friendly place. There were no issues with cleanliness, which was evident from internal audit observation and as reported in the 29 April 2016 audit by the NHS Tayside Infection Control team. Performance monitoring showed that all three complaints were acknowledged with the SPSO timescale but that only one complaint was responded to within the 20 working day SPSO timescale. There were however mitigating circumstances for the delays with each complaint. It was noted that there was no paper trail held by the department for one complaint. This was broadly in line with NHS Tayside's statistics during 2015/16 whereby 94% of complaints were acknowledged within 3 working days and 46% of complaints were responded to within 20 working days.
T06/17	Annual Internal Audit Report	N/A	Report was presented in full to the June 2016 Audit Committee.
T07/17	Governance Statement	N/A	Report was presented in full to the June 2016 Audit Committee.
T15A,B &C/17	IJB Annual Reports	N/A	The Integrated Resources Advisory Group (IRAG), established by the Scottish Government to develop professional guidance, outlines the responsibility of the IJB to establish adequate and proportionate internal audit arrangements for review of the adequacy of the arrangements for risk management, governance and control of the delegated resources. This guidance also states that the IJB has responsibility for reviewing the effectiveness of the governance arrangements including the system of internal control. Internal Audit is required to provide an annual assurance statement on the overall adequacy and effectiveness of the framework of governance, risk management and control and the annual report to the IJB provides the Chief Internal Auditor's opinion on the IJB's internal control framework for the financial year.

			For the three Tayside IJBs, the Chief Internal Auditor concluded that the IJBs had adequate and effective internal controls in place proportionate to their responsibilities in 2015/16 and he did not advise management of any concerns around consistency of the Governance Statement with information that we were aware of from our work. Our evaluation of the three IJBs' Governance Frameworks showed that the control standards we expected to see at this stage of development of the IJBs were in place. To inform our assessment of the internal control framework, Internal Audit developed a self assessment governance checklist for completion by management. The checklist was based on requirements of the Integration Scheme, guidance issued by the Scottish Government to support HSCI and best practice. Internal Audit validated the assessments reached through discussion with management and examination of the supporting evidence and documentation. Based on our validation work, we provided assurance on the Key Arrangements in place as at year end 2015/16; Developments in 2016/17 - in place or planned by management; and also recommended further issues for consideration by management. The three annual reports have subsequently been presented to each of the IJBs.
T23/17	Post Transaction Monitoring	N/A	See separate agenda item 9

Please note any items relating to Committee business are embargoed and should not be made public until after the meeting

Item Number 7

AUDIT61/2016
Audit Committee
1 September 2016

UPDATES TO THE NHS TAYSIDE CODE OF CORPORATE GOVERNANCE
Section A – Remit of the Universities Strategic Liaison Committee

1. SITUATION AND BACKGROUND

The purpose of the report is to seek the Audit Committee's recommendation for the Board's approval of an update to the Code of Corporate Governance, Section A, COMMITTEES, 8. Purpose and Remits, Universities Strategic Liaison Committee.

There has been ongoing discussion about the crossover between the Universities Strategic Liaison Committee (USLC) and the Academic Health Science Partnership (AHSP) and the possibility of the AHSP taking on the role of the USLC.

This is currently not possible following discussion it has been agreed that the terms of reference of the USLC should be updated and should have more representation from AHSP.

Arrangements are in hand for this to be discussed at the next meeting of the USLC scheduled to be held in November 2016.

2. ASSESSMENT

This update to the Code of Corporate Governance is attached to this report as appendix 1 and has been shared with the Corporate Governance Review Group. This Group has the remit to oversee and co-ordinate the changes resulting to the Code of Corporate Governance.

The Audit Committee's role is to scrutinise the proposed update and to approve recommendation to Tayside NHS Board at their meeting on 27 October 2016. The Board retains the responsibility for approving any updates to the Code of Corporate Governance.

3. RECOMMENDATIONS

The Audit Committee is asked to:

Scrutinise the attached update to the Code of Corporate Governance and recommend its approval by the Board at its meeting on 27 October 2016

4. REPORT SIGN OFF

Margaret Dunning
Board Secretary

Lindsay Bedford
Director of Finance

September 2016

Universities Strategic Liaison Committee

1.1 Purpose

The Committee will advise the Board on strategic matters concerning clinical teaching, research, ACT funding and facility requirements.

The Committee will provide an inclusive forum for strategic dialogue, development and planning between the Universities of Dundee, Abertay and St Andrews and with the NHS in Tayside and Fife.

1.2 Composition

Membership of the Universities Strategic Liaison Committee will be:

A minimum of four Non-Executive Members of Tayside NHS Board including:

- University of Dundee Member
- Employee Director
- Chair, Area Clinical Forum

Membership will also include:

- Chief Executive, NHS Tayside (Lead Officer)
- ~~One Non-Executive Member of NHS Fife~~
- 3 representatives from the University of Dundee covering Medicine, Nursing and Dentistry
- 2 representatives from St Andrews University covering Medicine and Nursing
- 2 representatives from Abertay University covering Medicine and Nursing
- 2 representatives from Fife NHS Board
- 1 representative NHS Education for Scotland
- 4 r~~R~~epresentatives from AHSP ~~– Tayside Research and Development Director~~
- ~~In addition there will be in attendance:~~
- ~~Director of Medical Education, NHS Fife~~

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The Chair will be a Non Executive Member of Tayside NHS Board. The Vice-Chair will be a representative of one of the Universities.

Other Directors will only attend if they are presenting a report to the Committee or the Committee requests their attendance.

1.3 Meetings

Meetings of the Committee shall be quorate when five or more Members are present, at least two of whom will be a Non-Executive Member of the Board.

1.4 Remit

To provide the opportunity for collaborative dialogue in relation to government policies and their impact within the region.

To provide a dialogue around the new 20/20 Workforce Vision.

To provide the opportunity for collaborative development and planning in relation to research and development in Healthcare.

To engage and inform future strategies for community health and social care and research.

Consider teaching and training resources for the next 5 years.

~~To feed outcomes into individual workplans for NHS Tayside and Universities.~~

To provide strategic guidance in developing models of healthcare.

1.5 Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference, and is authorised to seek any information it requires from any employee.

In order to fulfil its remit, the Universities Strategic Liaison Committee may obtain whatever professional advice it requires, and require Directors or other officers to attend meetings.

1.6 Reporting Arrangements

The Universities Strategic Liaison Committee reports to Tayside NHS Board.

Following a meeting of the Universities Strategic Liaison Committee, the minutes of that meeting should be presented at the next Tayside NHS Board meeting.

The Universities Strategic Liaison Committee should annually and within three months of the start of the financial year provide a work plan detailing the work to be taken forward by the Universities Strategic Liaison Committee.

The Universities Strategic Liaison Committee will produce an Annual Report for presentation to the Audit Committee. The Annual Report will describe the outcomes from the Committee during the year and provide an assurance to the Audit Committee that the Committee has met its remit during the year. The Annual Report must be approved by the Universities Strategic Liaison Committee before it is presented to the Audit Committee meeting considering the Annual Accounts.

Item Number 8

Please note any items relating to Board business are embargoed and should not be made public until after the meeting

AUDIT70/2016
Audit Committee
1 September 2016

BEST VALUE FRAMEWORK 2016/17

1. PURPOSE OF THE REPORT

The purpose of the report :

- To present the revised Best Value Framework 2016/17 for scrutiny before approval by the Board

2. RECOMMENDATIONS

The Audit Committee is asked to:

- Scrutinise the Best Value Framework 2016/17 as attached in Appendix 1 before submission to the Board for approval

3. EXECUTIVE SUMMARY

Best Value guidance requires that NHS Tayside is able to demonstrate through its assurance and self-assessment processes how Best Value attributes and practices are embedded within the way it works and how continuous improvement is achieved and monitored.

The Framework is based on the Best Value guidance and also incorporates relevant elements of the Governance Statement guidance, Good Governance Principles for Public Life (Langlands), Public Sector Internal Audit Standards, Governance for Quality, Scottish Public Finance Manual, IJB Governance Checklists and Local Authority Best Value Guidance.

4. REPORT DETAIL

The Best Value Framework is based on the fundamental concept that Best Value is simply a codification of good governance and good management, therefore existing governance processes should be utilised wherever possible. Best Value, by its very nature pervades all aspects of NHS Tayside‘s delivery and governance structures. The framework is only intended to identify the Committee responsible for providing lead governance assurance on the relevant characteristic of Best Value, not all those Committees which engage with that particular characteristic in the course of their work.

The Best Value Framework for 2016/17 is attached as Appendix 1. Measures/expected outcomes have been completed in all areas. Tayside NHS Board’s Standing Committees will now need to discuss and agree the likely evidence applicable to them. This will assist in scheduling the work of the Committees and help to determine whether the organisation is achieving continuous improvement and Best Value.

The Best Value Framework has been updated to take account of the findings of Internal Audit Report T11/16 Best Value. The template Framework document has been updated to now allow conclusions to be shown for the outcome such as “in place”, “partially in place” , or “not demonstrated in year” as well as the evidence and any further work planned for the future to address identified gaps.

Once approved, the Board and Standing Committees will need to ensure that they fulfil their individual responsibilities for Best Value by incorporating the relevant sources of evidence into their work plans for the year and considering their overall conclusion on those Best Value characteristics elements delegated to them within their annual report.

5. CONTRIBUTION TO NHS TAYSIDE’S STRATEGIC AIMS

The functions of Tayside NHS Board include strategic leadership and direction and relate to Best Value Characteristic 1, Vision and Leadership.

6. MEASURES FOR IMPROVEMENT

Best Value Characteristic 5 focuses on performance management and a Best Value organisation is one that embeds a culture and supporting processes which ensures that it has a clear and accurate understanding of how all parts of the organisation are performing and that, based on this knowledge, it takes action that leads to demonstrable continuous improvement on performance and outcomes.

7. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

Equality is integral to all our work as demonstrated by its positioning as a cross- cutting theme in the Best Value Framework for Allocating Best Value Characteristics. Public Bodies have a range of legal duties and responsibilities with regard to equality.

A Best Value organisation will demonstrate that consideration of equality issues is embedded in its vision and strategic direction and throughout all of its work.

8. PATIENT EXPERIENCE

A Best Value organisation will show how it, and its partnerships, are displaying effective collaborative leadership in identifying and adapting their service delivery to the challenges that clients and communities face.

9. RESOURCE IMPLICATIONS

Financial
There are no financial implications.

Workforce
There are no workforce implications.

10. RISK ASSESSMENT

A Best Value organisation will be able to demonstrate structures, policies and leadership behaviours.

The monitoring against the Best Value Framework will provide an assurance that the organisation has robust processes and procedures in place along with a suitable focus on continuous improvement.

11. LEGAL IMPLICATION

There are no legal implications.

12. INFORMATION TECHNOLOGY IMPLICATIONS

There are no IT implications.

13. HEALTH & SAFETY IMPLICATIONS

There are no Health & Safety implications.

14. HEALTHCARE ASSOCIATED INFECTION (HAI)

There are no Healthcare Associated Infection implications.

15. DELEGATION LEVEL

The Board approves the Framework for Allocating the Best Value Characteristics delegates work to achieve this to its Committees.

16. TIMETABLE FOR IMPLEMENTATION

Immediate implementation

17. REPORT SIGN OFF

Margaret Dunning
Board Secretary

Lindsay Bedford
Director of Finance

September 2016

18. SUPPORTING DOCUMENTS

Appendix 1 - Best Value Framework 2016/17

Appendix 1

Tayside NHS Board
Best Value Framework 2016/17

Vision and Leadership
A Best Value organisation will have in place a clear vision and strategic direction for what it will do to contribute to the delivery of improved outcomes for Scotland's people, making Scotland a better place to live and a more prosperous and successful country. The strategy will display a clear sense of purpose and place and be effectively communicated to all staff and stakeholders. The strategy will show a clear direction of travel and will be led by Senior Staff in an open and inclusive leadership approach, underpinned by clear plans and strategies (aligned to resources) which reflect a commitment to continuous improvement.

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned)
Executive and Non-Executive leadership demonstrate a commitment to high standards of probity and integrity including the Nolan principles.	Tayside NHS Board members sign up to the Members Code of Conduct in the NHS Tayside's Code of Corporate Governance.	**BOARD**	Annual		
NHS Tayside acts in accordance with its values, positively promotes and measures a culture of ethical behaviours and encourages staff to report breaches of its values.	Culture Diagnostics Toolkit Whistle blowing Policy	**BOARD** **STAFF GOVERNANCE COMMITTEE**	Annual On review as required		
NHS Tayside can demonstrate that continuous improvement is incorporated into its strategy and plans.	The inclusion of trajectories against the HEAT Targets will demonstrate continuous improvement.	**BOARD**	Annual		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned)
NHS Tayside has defined quality standards for its outcomes.	NHS Tayside's Clinical Governance Measurement & Monitoring Framework	**CLINICAL AND CARE GOVERNANCE COMMITTEE**	Regular reporting		
Non-executive members are discriminating about getting involved in matters of operational detail.	Non–executive members are visible in the organisation dealing with strategic and governance issues.	**CHAIRMAN**	Annual	Annual Appraisal	
Resources required to achieve the strategic plan and operational plans e.g. finance, staff, asset base are identified and additional/changed resource requirements identified.	Strategic Financial Plan, Workforce Plan and PAMS. 5 year Strategic transformational plan	**FINANCE AND RESOURCES / STAFF GOVERNANCE COMMITTEE** **BOARD THROUGH TRANSFORMATION PROGRAMME BOARD**	Annual		
The Board agrees a strategic plan which incorporates the organisations's vision and values and reflects stated priorities.	5 year Strategic transformational plan	**BOARD THROUGH TRANSFORMATION PROGRAMME BOARD**	Every five years		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned)
The strategic plan and operational plans are based on relevant, reliable and sufficient evidence.	Business Unit to feed into development of the 5 year Strategic transformational plan. LDP based on data	**BOARD THROUGH TRANSFORMATION PROGRAMME BOARD** **BOARD**	Every five years Annually		
The strategic plan is translated into annual operational plans with meaningful, achievable actions and outcomes and clear responsibility for action.	Annual operational plan underlying the 5 year strategic transformational plan.	**BOARD THROUGH TRANSFORMATION PROGRAMME BOARD**	Annual		
The Board has identified the risks to the achievement of its strategic and operational plans are identified together with mitigating controls.	Each strategic risk has an Assurance Framework which maps the mitigating actions/risks to help achieve the strategic and operational plans. Assurance Framework contains the overarching strategic risks related to the strategic plan.	**BOARD**	Three times per year		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned)
The Board has clearly recorded delegation to Committees and management.	The Board has established terms of reference for its Committees and has a Scheme of Delegation.	**BOARD**	Every two years	Code of Corporate Governance	
The Board of governance has defined its purpose, role and responsibilities and recorded how these will be fulfilled.	Tayside NHS Board's purpose role and responsibilities are clearly set out in NHS Tayside's Code of Corporate Governance.	**BOARD**	Every two years	Code of Corporate Governance	
The organisation's strategy is communicated effectively to all staff and stakeholders.	A communication and engagement strategy to be developed during 2016/2017.	**BOARD**	Every three years		
There are mechanisms within the organisation to develop and monitor relevant leadership and strategic skills in Board members and senior management.	This is achieved through the development of Personal Development Plans and Annual Appraisals.	**CHAIRMAN/CHIEF EXECUTIVE**	Annual		

EFFECTIVE PARTNERSHIPS

The "Effective Partnerships" theme focuses on how a Best Value organisation engages with partners in order to secure continuous improvement and improved outcomes for communities, not only through its own work but also that of its partners.

OVERVIEW

A Best Value organisation will show how it, and its partnerships, are displaying effective collaborative leadership in identifying and adapting their service delivery to the challenges that clients and communities face. The organisation will have a clear focus on the collaborative gain which can be achieved through collaborative working and community engagement in order to facilitate the achievement of its strategic objectives and outcomes.

REQUIREMENT	**MEASURE/EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year**	**Comment (Future work planned?)**
The Board develop relationships and works in partnership wherever this leads to better service delivery. The organisation seeks to explore and promote opportunities for efficiency savings and service improvements through shared service initiatives with partners	NHS Tayside involvement in IJB Strategic Commissioning plans.	**BOARD**	As required		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
Clear governance arrangements are in place in respect of partnerships and other group-working. Responsibilities and reporting lines in respect of all governance arrangements have been clarified agreed by all parties and reflected in NHS Tayside's Code of Corporate Governance and the structure of assurance	All reports to the Board where appropriate should explicitly detail whether partnership working has been considered. Where partnership arrangements are in place the reports should detail the performance management and governance arrangements. Input into the IJB Strategic Plans and IJB performance arrangements to be agreed with IJBs and the Board.	**BOARD**	As required		
In joint working with any partners the Board works openly to an agreed vision, objectives and performance management and reporting mechanisms	NHS Tayside involvement in IJB Strategic Commissioning plans.				

GOVERNANCE AND ACCOUNTABILITY

The "Governance and Accountability" theme focuses on how a Best Value organisation achieves effective governance arrangements, which help support Executive and Non-Executive leadership decision-making, provide suitable assurances to stakeholders on how all available resources are being used in delivering outcomes and give accessible explanation of the activities of the organisation and the outcomes delivered.

OVERVIEW

A Best Value organisation will be able to demonstrate structures, policies and leadership behaviours which support the application of good standards of governance and accountability in how the organisation is improving efficiency, focusing on priorities and achieving value for money in delivering its outcomes. These good standards will be reflected in clear roles, responsibilities and relationships within the organisation. Good governance arrangements will provide the supporting framework for the overall delivery of Best Value and will ensure openness and transparency. Public reporting should show the impact of the organisations activities, with clear links between the activities and what outcomes are being delivered to customers and stakeholders. Good governance provides an assurance that the organisation has a suitable focus on continuous improvement and quality. Outwith the organisation, good governance will show itself through an organisational commitment to public performance reporting about the quality of activities being delivered and commitments for future delivery.

REQUIREMENT	**MEASURE/EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year**	**Comment (Future work planned?)**
The Board has identified its stakeholders and understands its relationships with them.	Corporate communications and engagement strategy (to be developed).	**BOARD**	By 31 March 2016		
The Board understands citizen, patient, staff partner and stakeholder views, perceptions, and expectations.	Board reports should show evidence of the views of its stakeholders.	**BOARD**	As required		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
These views inform strategic and operational plans, priorities and actions.	Communication & Engagement Strategy for Transformation Programme. The links between the engagement outcomes and the strategy / operational plans should be evident in Impact Assessments and full 'for decision' template Board Reports.	**BOARD THROUGH TRANSFORMATION PROGRAMME BOARD**	As required		
Board and Committee decision-making processes are open and transparent.	Board and Committee meetings are held in open session and minutes are publically available.	**BOARD/ COMMITTEES**	On going		
Board and Committee decision-making processes are based on evidence that can show clear links between activities and outcomes	Reports for decision to be considered by Board and Committees should clearly describe the evidence underpinning the proposed decision.	**BOARD/ COMMITTEES**	As required		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
NHS Tayside has a robust framework of corporate governance to provide assurance to relevant stakeholders that there are effective internal control systems in operation which comply with the SPFM and other relevant guidance.	Explicitly detailed in the Governance Statement.	**AUDIT COMMITTEE**	Annual		
The performance of the Board is self-assessed and appropriate actions identified and implemented as required.	Board diagnostic toolkit and Best Value Framework	**BOARD**	Annual		
The performance of non-executive Directors is regularly evaluated.	Non-executives appraisals	**CHAIRMAN**	Annual		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
NHS Tayside regularly conducts rigorous review and option appraisal processes of all areas of activity, develops and develops and monitors action plans for any required improvements.	Transformation Programme	**BOARD THROUGH TRANSFORMATION PROGRAMME BOARD**	As required		
NHS Tayside has developed and implemented an effective and accessible complaints system in line with Scottish Public Services Ombudsman guidance.	Complaints system in place and regular complaints monitoring.	**CLINICAL AND CARE GOVERNANCE COMMTTEE**	Ongoing		
NHS Tayside can demonstrate that it has clear mechanisms for receiving feedback from service users and responds positively to issues raised.	An annual feedback report is published.	**CLINICAL AND CARE GOVERNANCE COMMITTEE**	Annual		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
NHS Tayside can demonstrate that it has clear mechanisms for receiving feedback from staff and responds positively to issues raised.	To be reported to the Staff Governance Committee as part of the reporting around 'I Matter'. Staff survey results reported to Staff Governance Committee.	**STAFF GOVERNANCE COMMITTEE**	Annual		

USE OF RESOURCES

The "Use of Resources" theme focuses on how a Best Value organisation ensures that it makes effective, risk-aware and evidence-based decisions on the use of all of its resources.

OVERVIEW

A Best Value organisation will show that it is conscious of being publicly funded in everything it does. The organisation will be able to show how its effective management of all resources (including staff, assets, information and communications technology (ICT), procurement and knowledge) is contributing to delivery of specific outcomes.

REQUIREMENT	**MEASURE/EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year**	**Comment (Future work planned?)**
NHS Tayside understands and measures and reports on the relationship between cost, quality and outcomes.	Transformation Programme	**BOARD THROUGH TRANSFORMATION PROGRAMME BOARD**	As required		
The organisation has a comprehensive programme to evaluate and assess opportunities for efficiency savings and service improvements including comparison with similar organisations.	National Benchmarking undertaken through Corporate Finance Network. Local bencmarking with similar sized organisation undertaken where information available. Participation in National Shared Services.	**FINANCE AND RESOURCES COMMITTEE**	As required	e.g theatres benchmarking work and potential roll out	

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
Organisational budgets and other resources are allocated and regularly monitored.	Corporate Finance Reports and Capital reports.	**FINANCE AND RESOURCES COMMITTEE**	Every meeting		
NHS Tayside has a strategy for procurement and the management of contracts (and contractors) which complies with the SPFM and demonstrates appropriate competitive practice.	Procurement updates to Finance and Resources Committee. Delegated authority and waiver of competitive tendering reported to each Finance and Resources Committee.	**FINANCE AND RESOURCES COMMITTEE**	Twice per year and as required		
NHS Tayside maintains an effective system for financial stewardship and reporting in line with the SPFM.	Annual Accounts process.	**AUDIT COMMITTEE**	Annual		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
There is a robust information governance framework in place that ensures proper recording and transparency of all NHS Tayside's activities.	Information Governance Committee Annual Report.	**FINANCE AND RESOURCES COMMITTEE**	Annual		
NHS Tayside understands and exploits the value of the data and information it holds.	Business Unit data informs transformation programme. Performance information reported to Board/Committees is validated.	**BOARD THROUGH TRANSFORMATION PROGRAMME BOARD**	Annual		
NHS Tayside ensures that all employees are managed effectively and efficiently, know what is expected of them, their performance is regularly assessed and they are assisted in improving.	EKSF process and Executive and Senior Manager Performance reporting. Medical performance appraisal.	**STAFF GOVERNANCE COMMITTEE/ REMUNERATION COMMITTEE**	Annual and as required		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
NHS Tayside understands and measures the learning and professional development required to support statutory and professional responsibilities and achieve organisational objectives and quality standards.	Medical revalidation report and monitoring Nursing revalidation.	**STAFF GOVERNANCE COMMITTEE**	As required		
Staff performance management recognises and monitors contribution to ensuring continuous improvement and quality.	Service Improvement and Quality are core dimensions of EKSF process. Executive and Senior Manager Objectives – core collective objectives include performance and leadership.	**STAFF GOVERNANCE COMMITTEE/ REMUNERATION COMMITTEE**			

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
Fixed assets including land, property, ICT, equipment and vehicles are managed efficiently and effectively and are aligned appropriately to organisational strategies.	Property and Asset Management Strategy	**FINANCE AND RESOURCES COMMITTEE**			

PERFORMANCE MANAGEMENT

The “Performance Management” theme focuses on how a Best Value organisation embeds a culture and supporting processes which ensures that it has a clear and accurate understanding of how all parts of the organisation are performing and that, based on this knowledge, it takes action that leads to demonstrable continuous improvement in performance and outcomes.

OVERVIEW

A Best Value organisation will ensure that robust arrangements are in place to monitor the achievement of outcomes (possibly delivered across multiple partnerships) as well as reporting on specific activities and projects. It will use intelligence to make open and transparent decisions within a culture which is action and improvement oriented and manages risk. The organisation will provide a clear line of sight from individual actions through to the National Outcomes and the National Performance Framework. The measures used to manage and report on performance will also enable the organisation to provide assurances on quality and link this to continuous improvement and the delivery of efficient and effective outcomes.

REQUIREMENT	**MEASURE/EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year**	**Comment (Future work planned?)**
Performance is systematically measured across all key areas of activity.	The Board delegates to Committees the performance reporting for key areas of activity. Board receives regular performance reports.	**COMMITTEES/ BOARD**	As required Every meeting		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
The Board and its Committees approve the format and content of the performance reports they receive which should include – Assess its performing against the following criteria: Performance reporting provides an understanding of whether the organisation is on track to achieve its short and long-term strategic, operational and quality objectives	The Board/Committees reviews the performance reporting under its remit and agrees the measures.	**COMMITTEES/ BOARD**			
Performance reporting allows a reasonable and informed judgement on how the organisation is likely to perform in future.	Board performance report shows trends.	**BOARD**	Every meeting		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
Public performance reports show performance against: ◊ objectives, targets and service outcomes; ◊ past performance; ◊ improvement plans; ◊ other relevant bodies.					
Reports are honest and balanced and subject to proportionate and appropriate scrutiny and challenge from the Board and its Committees.	Board Minutes show scrutiny and challenge when performance is poor as well as good.	**BOARD**	Every meeting		
The Board has received assurance on the accuracy of data used for performance monitoring.	Board performance reporting information uses validated data.	**BOARD**	Every meeting		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
NHS Tayside's performance management system is effective in addressing areas of underperformance, identifying the scope for improvement, agreeing remedial action, sharing good practice and monitoring implementation.	Board's regular performance report and regular reporting on Local Delivery Plan.	**BOARD**	Every meeting and quarterly		
NHS Tayside has evidence that it has the necessary capacity and capability to deploy when performance is slow or weak	Where underperformance has been identified, resources are deployed as required.	**BOARD**	As required		
NHS Tayside prioritises performance improvements likely to have the greatest impact	Transformation Programme	**BOARD THROUGH TRANSFORMATION PROGRAMME BOARD**	As required		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
NHS Tayside overtly links Performance Management with Risk Management to support prioritisation and decision-making at Executive level, support continuous improvement and provide assurance on internal control and risk.	Board Assurance Framework	**BOARD**	Quarterly		
Clients, citizens and other stakeholders are involved in developing indicators and targets and monitoring and managing performance so that information provided is relevant to its audience	Participation standards Business cases developed in partnership for new or changed services.	**CLINICAL AND CARE GOVERNANCE COMMITTEE** **BOARD**			

CROSS-CUTTING THEME – SUSTAINABILITY

The "Sustainability" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded a sustainable development focus in its work.

OVERVIEW

The goal of Sustainable Development is to enable all people throughout the world to satisfy their basic needs and enjoy a better quality of life without compromising the quality of life of future generations. Sustainability is integral to an overall Best Value approach and an obligation to act in a way which it considers is most sustainable is one of the three public bodies' duties set out in section 44 of the Climate Change (Scotland) Act 2009. The duty to act sustainably placed upon Public Bodies by the Climate Change Act will require Public Bodies to routinely balance their decisions and consider the wide range of impacts of their actions, beyond reduction of greenhouse gas emissions and over both the short and the long term.

The concept of sustainability is one which is still evolving. However, five broad principles of sustainability have been identified as:

- ◊ promoting good governance;
- ◊ living within environmental limits;
- ◊ achieving a sustainable economy;
- ◊ ensuring a stronger healthier society; and
- ◊ using sound science responsibly.

Individual Public Bodies may wish to consider comparisons within the wider public sector, rather than within their usual public sector "family". This will assist them in getting an accurate gauge of their true scale and level of influence, as well as a more accurate assessment of the potential impact of any decisions they choose to make.

A Best Value organisation will demonstrate an effective use of resources in the short-term and an informed prioritisation of the use of resources in the longer-term in order to bring about sustainable development. Public bodies should also prepare for future changes as a result of emissions that have already taken place. Public Bodies will need to ensure that they are resilient enough to continue to deliver the public services on which we all rely.

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
NHS Tayside can demonstrate that it is making a contribution to sustainable development by actively considering the social, economic and environmental impacts of activities and decisions both in the shorter and longer term.	Sustainability and Environmental report to Finance and Resources Committee during year and progress incorporated in the Annual Accounts process.	**FINANCE AND RESOURCES COMMITTEE**	Annual		
NHS Tayside can demonstrate that it respects the limits of the planets environment, resources and biodiversity in order to improve the environment and ensure that the natural resources needed for life are unimpaired and remain so for future generations.	Sustainability and Environmental report to Finance and Resources Committee during year and progress incorporated in the Annual Accounts process.	**FINANCE AND RESOURCES COMMITTEE**	Annual		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
NHS Tayside contributes to building a strong, stable and sustainable economy which provides prosperity and opportunities for all.	Annual Report of Healthcare Academy and reporting on modern apprenticeships.	**STAFF GOVERNANCE COMMITTEE**			
NHS Tayside promotes personal well-being, social cohesion and inclusion.		**BOARD**			
NHS Tayside has self-assessed and reported against the Public Bodies Climate Change Duties Guidance.	Part of Annual Accounts process.	**AUDIT COMMITTEE**			

CROSS-CUTTING THEME – EQUALITY

This section should be read in conjunction with guidance on the UK Equality Act 2010 which will become available in 2011.

The "Equality" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded an equalities focus which will secure continuous improvement in delivering equality.

OVERVIEW

Equality is integral to all our work as demonstrated by its positioning as a cross-cutting theme. Public Bodies have a range of legal duties and responsibilities with regard to equality. A Best Value organisation will demonstrate that consideration of equality issues is embedded in its vision and strategic direction and throughout all of its work.

The equality impact of policies and practices delivered through partnerships should always be considered. A focus on setting equality outcomes at the individual Public Body level will also encourage equality to be considered at the partnership level.

REQUIREMENT	**MEASURE/EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME/EVIDENCE: Fully in place/ Partially in place/ Not demonstrated in year**	**Comment (Future work planned?)**
NHS Tayside meets the requirements of equality legislation.	Regular reporting against NHS Tayside Mainstreaming Report and Equality Outcomes 2013-2017.	**CLINICAL AND CARE GOVERNANCE/ STAFF GOVERNANCE**	Twice per year		
The Board and senior managers understand the diversity of their customers and stakeholders.	Equality Impact Assessments are reported to the Board and Committees as required and identify the diverse range of stakeholders.	**BOARD/ COMMITTEES**	As required		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE: Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
NHS Tayside openly engages in a fair and inclusive dialogue to ensure information on services and performance is accessible to all.	Accessible Information document to be developed.	**BOARD**	As required		
NHS Tayside's Performance Management system regularly measures and reports its performance in contributing to the achievement of equality outcomes.	Regular reporting against NHS Tayside Mainstreaming Report and Equality Outcomes 2013-2017.	**CLINICAL AND CARE GOVERNANCE/ STAFF GOVERNANCE**	Twice per year		
NHS Tayside ensures that all members of staff are aware of its equality objectives.	Induction Equality and Diversity is core dimension in EKSF Equality and Diversity Learn Pro Module Equality and Diversity Champions.	**STAFF GOVERNANCE**	Annual		

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE: Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
NHS Tayside's policies, functions and service planning overtly consider the different current and future needs and access requirements of groups within the community.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments consider the current and future needs and access requirements of the groups within the community.	**BOARD/ COMMITTEES**	As required		
Wherever relevant, NHS Tayside collects information and data on the impact of policies, services and functions on different equality groups to help inform future decisions.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments will collect this information to inform future decisions.	**BOARD/ COMMITTEES**	As required		

Please note any items relating to Board business are embargoed and should not be made public until after the meeting

Item Number 9

AUDIT66/2016
Audit Committee
1 September 2016

PROPERTY TRANSACTION MONITORING

1. PURPOSE OF THE REPORT

In return for operational independence in respect of property transactions that NHS Boards are allowed, Scottish Government Health and Social Care Directorate (SGHSCD) require the procedures laid out in the Property Transactions Handbook (PTH) to be followed.

The purpose of the report is to advise the Committee of the Internal Audit of the property transactions completed in 2015/16, which provides assurance that the required procedures have been followed.

2. RECOMMENDATIONS

The Committee is requested to note that:-

i. the requirements of the PTH have been complied with;
ii. the internal audit report is attached at Appendix 1, and
iii. arrangements are in place to issue the Board's Annual Property Transactions Return to SGHSCD by the deadline of 30 October, 2016, and that the return be submitted with no significant issues identified.

3. EXECUTIVE SUMMARY

Under the PTH regulations, the Audit Committee is charged with oversight of the monitoring of the process of property transactions. The monitoring process is a cyclical exercise with the Committee receiving details of property transactions by May of the following year. The information considered by the Committee at that stage was copies of each of the monitoring pro-formas for the individual transactions completed in the year.

There were three property transactions during 2015/16 that were previously advised to the Committee at the 5 May, 2016, meeting, and FTF Internal Audit were requested to review this transaction to ensure that the requirements of the PTH were followed.

The audit report (Appendix 1) assessed the three transactions at grade A, i.e. transactions properly completed, and identified one recommendation which management have accepted.

The Post Transaction Certification for the surplus land at the former Royal Dundee Liff Hospital site presented to the Audit Committee on 5 May, 2016, inaccurately detailed the split of sale proceeds between NHS Tayside and the Scottish Executive Environmental and Rural Affairs Department (SEERAD). NHS Tayside is entitled to 52% of the total sale proceeds, whereas the Certification stated that the sale proceeds would be shared on a 50:50 basis. Following internal audit discussion with management and SEERAD, it has been agreed that a revised certificate for the financial split is not required as all parties are aware of the required split for sale proceeds.

A clean property transactions return in respect of 2015/16 can, therefore, be submitted to SGHSCD by the deadline of 30 October, 2016.

4. MEASURES FOR IMPROVEMENT

An improvement to procedures was identified, which is set out in the Audit Report.

5. RESOURCE IMPLICATIONS

The financial implications were reported to Tayside NHS Board.

6. DELEGATION LEVEL

Authorisation of property transactions is reserved for Tayside NHS Board. The Finance and Resources Committee also review and monitor disposals.

7. RISK ASSESSMENT

No risks have been identified for NHS Tayside.

8. IMPLICATIONS FOR HEALTH

No direct health implications identified.

9. TIMETABLE AND LEAD OFFICER

The Lead Officer is the Capital Finance Manager. The property transactions are required to be reported to SGHSCD by 30 October each year in respect of the previous fiscal year.

10. CONSULTATION

Not required.

11. EQUALITY AND DIVERSITY IMPACT

Not applicable.

Louise Lyall
Capital Finance Manager

Lindsay Bedford
Director of Finance

September 2016

FINAL REPORT

NHS TAYSIDE
INTERNAL AUDIT SERVICE

POST TRANSACTION MONITORING

REPORT NO. T23/17

Issued To: L McLay, Chief Executive
L Bedford, Director of Finance
L Lyall, Capital Finance Manager

K Armstrong, Director of Operations
M Anderson, Head of Property
M Valentine, Property Asset Manager
G Nixon, Property and Asset Management Lead
G McIntyre, Property and Asset Manager

M Dunning, Board Secretary
D Colley, Finance Governance Accountant
A Napier, Associate Director of Clinical Governance & Risk Management
L Green, Audit Committee Members' Library Copy

Tayside Audit Follow Up
Audit Committee
External Audit

Date: 24 August 2016

INTRODUCTION

1. NHS Boards have operational independence in relation to property transactions. In return for this independence the Scottish Government Health & Social Care Directorates (SGHSCD) require that Boards follow procedures laid out in the Property Transactions Handbook (the Handbook). The NHS Scotland Property Transactions Handbook provides guidance on the responsibility and procedures to be followed by Holding Bodies, i.e. Tayside NHS Board, to ensure that property is bought, sold and leased at a price, and on other conditions, which are the best obtainable for the public interest at that time.

2. Part A, Sections 6.3 and 6.4 of the Handbook state that '*Post-transaction monitoring must be an integral part of the internal audit programme. The Audit Committees of the Boards of Holding Bodies are responsible for the oversight of the programme. The Internal Auditor reports his/her findings to the Audit Committee. The Audit Committee's oversight of the work of the Internal Auditor includes reporting to the Board. The Board is responsible for submitting monitoring reports (including nil returns) to the SGHSCD no later than* ***30 October annually.*** *Such monitoring reports should be submitted with appropriate supporting information and explanations for all transactions not classed as Category A*'.

3. We reviewed the disposals by sale of NHS Tayside property during the financial year 2015/16 for compliance with the property transaction procedures as set out in the Handbook.

SCOPE

4. We have been advised that there were 3 completed property transactions during 2015/16 falling under the remit of the Handbook and therefore requiring review by Internal Audit:

Sale: Ashludie Hospital & IT Centre Monifieth, Dundee	£5,277,878
Sale: 8 Western Avenue Perth	£275,000
Sale: Surplus land at former Liff Hospital, Dundee (co-owned by NHS Tayside and by the Scottish Executive Environmental and Rural Affairs Department (SEERAD) and NHS Tayside is entitled to 52% of the total sale proceeds)	£3,800,000

OBJECTIVES

5. The principle objective of the review was to establish that mandatory controls outlined in the Handbook have been adhered to. Transaction files were examined to ensure that:

   ◊ Property needs are appropriately identified and suitable action taken;
   ◊ Transactions are properly managed;
   ◊ Certificates are completed as required.

RISKS

6. There is a risk that all property transactions are not completed in accordance with the Handbook.

AUDIT OPINION AND FINDINGS

7. In preparing inspection reports on individual transactions, Internal Auditors and professional advisers are required to use the following categorisation:

   A. Transaction has been properly conducted, or

   B. There are reservations on how the transaction was conducted, or

   C. A serious error of judgement has occurred in the handling of the transaction.

8. The Capital Finance Manager provided details of property transactions to the May 2016 Audit Committee to allow it to confirm the inspection programme with the Internal Auditors.

9. The audit opinion is

   - ✧ Sale of Ashludie Hospital and IT Centre, Monifieth: **Category A**
   - ✧ Sale of 8 Western Avenue, Perth: **Category A**
   - ✧ Surplus land at former Royal Dundee Liff Hospital: **Category A**

10. Review of the completed transactions for 2015/16 confirmed that the transactions were largely concluded in accordance with the Handbook.

We did however note that:

11. The Post Transaction Certification for the surplus land at the former Royal Dundee Liff Hospital site, as presented to the May 2016 Audit Committee, inaccurately detailed the split of sale proceeds between NHS Tayside and SEERAD. Following discussion with management, Scottish Executive Environmental and Rural Affairs Department (SEERAD) and SGHSCD, it has been agreed that a revised certificate for the financial split is not required as all parties involved are aware of the required split for sale proceeds.

12. Section 1.7 of the Handbook states that an Independent Valuer must be appointed in major or potentially difficult disposal cases to provide additional professional advice, and must be independent of the marketing agent appointed to handle the sale. The Independent Valuer can be a District Valuer, or a suitably qualified private sector valuer, otherwise unconnected with the disposal, and should be appointed by competitive tender. The role of the independent valuer is of particular importance where the selling price is likely to be in excess of £5m and where the final price is at a price below the guide price and certification is required, jointly with the marketing agent, that it is the best offer reasonably obtainable.

13. The Independent Valuers appointed for the Ashludie and Liff Hospital transactions did not sign off the Post Transaction Certifications provided to the May 2016 Audit Committee. However we can now confirm that these have now been signed by the required relevant parties. Whilst we were able to evidence the original Ashludie site valuation by Ballantynes Surveyors and Estate Agents, the District Valuer property valuation for the Ashludie site was not available within the files provided to Internal Audit Following discussions with NHS Tayside Property Team, we have now had sight of a letter from the District Valuer, dated 5 October 2015, which confirms the £7.5million headline price, and also provides external 3rd party assurance that the requirements of the NHS Property Transactions Handbook have been met in terms of advertising, setting of closing date and consideration of offers for the Ashludie Hospital and IT Centre site.

14. For 2 of the 3 transactions examined (8 Western Avenue, Perth and Ashludie Hospital and IT Centre, Monifieth) there was a time delay of more than 1 month between the date of settlement and the Property Transaction Certificate being signed by the Chief Executive. This is not fully compliant with the Handbook which states that: '*Final certification must be completed by the Chief Executive of the Holding Body when the* proceeds *are received (i.e. date of settlement of transaction)'* and *'Certification should be signed at the point where an offer for property is to be submitted or accepted'*. This issue was previously reported in Internal Audit T28/16 – PTM and whilst there has been a significant improvement, management should continue to implement the agreed procedure to avoid unnecessary delays.

15. Section 2.28 of the Handbook requires that the organisation monitors the work of the marketing agent to avoid the risk that unnecessary delay occurs or that any important feature is overlooked. Whilst there was no formal evidence of this monitoring process, Management informed Internal Audit that this takes place on an informal basis and any delays in progressing transactions would be addressed as they arise.

Record Keeping

16. T28/16 was issued on 25 August 2015 and recommended that considering the substantial property transactions which were anticipated to be concluded in 2015/16, NHS Tayside should ensure that all Handbook requirements are demonstrated and should ensure that appropriate records are kept as each transaction progresses; for example through the use of the checklists previously provided to the Property Department by Internal Audit. The Property Disposal checklist was partially completed for the Surplus Land at Liff Hospital transaction and not at all for the other 2 transactions reviewed, although we note that the Ashludie and Western Avenue transactions was concluded prior to issue of T28/16. The application of this control was discussed in detail with Management who stated that whilst they were committed to implementing the specifically designed checklist for monitoring purposes, this had not been achieved because of departmental staffing pressures including the retirement of the Property and Asset Management Lead in December 2015 and staff illness.

17. Generally, we found that the property transaction files contained a high level of duplication and it was difficult to locate key documentation. We note that the Property Department structure has now been strengthened through the appointment of a Property Asset Manager and 2 Asset Officers. We recommend that the current systems and processes for all property transactions, and specifically the completeness and quality of record keeping, should be strengthened to ensure that all Handbook requirements can be demonstrated and a clear audit trail is easily available for all property transactions.

ACTION

18. An action plan has been agreed with management to address the identified weaknesses. A follow-up of implementation of the agreed actions will be undertaken in accordance with the audit reporting protocol.

ACKNOWLEDGEMENT

19. We would like to thank all members of staff for the help and co-operation received during the course of the audit.

Jocelyn Lyall BAcc (Hons) CPFA
Acting Regional Audit Manager

Action Plan

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
1.	T28/16 previously recommended that NHS Tayside should ensure that all Handbook requirements are demonstrated and should ensure that appropriate records are kept as each transaction progresses; for example through the use of the checklists previously provided to the Property Department by Internal Audit. The Property Disposal checklist had been partially completed for the Surplus Land at Liff transaction only, although we note that the Ashludie transaction was concluded prior to issue of T28/16. In general, we found that the property transaction files provided contained a high level of duplication and it was difficult to locate key documentation. In particular, the District Valuer property valuation for the Ashludie site was not available within the files provided to Internal Audit.	The current systems and processes for all property transactions, and specifically the completeness and quality of record keeping, should strengthened to ensure that all Handbook requirements can be demonstrated and a clear audit trail is easily available for all property transactions.	**2**	A review of systems and processes will be undertaken for all property transactions that will update activities required to ensure compliance with Property Transaction Hand Book. Resources supporting the work to ensure completeness and quality of record keeping is being actively pursued at the present time and it is anticipated that a Project Support Officer will be in post by end of October 2016.	Property Asset Manager 31 March 2017

DEFINITION OF ASSURANCE CATEGORIES AND RECOMMENDATION PRIORITIES

Categories of Assurance:

A	Good	There is an adequate and effective system of risk management, control and governance to address risks to the achievement of objectives.
B	Broadly Satisfactory	There is an adequate and effective system of risk management, control and governance to address risks to the achievement of objectives, although minor weaknesses are present.
C	Adequate	Business objectives are likely to be achieved. However, improvements are required to enhance the adequacy/ effectiveness of risk management, control and governance.
D	Inadequate	There is increased risk that objectives may not be achieved. Improvements are required to enhance the adequacy and/or effectiveness of risk management, control and governance.
E	Unsatisfactory	There is considerable risk that the system will fail to meet its objectives. Significant improvements are required to improve the adequacy and effectiveness of risk management, control and governance and to place reliance on the system for corporate governance assurance.
F	Unacceptable	The system has failed or there is a real and substantial risk that the system will fail to meet its objectives. Immediate action is required to improve the adequacy and effectiveness of risk management, control and governance.

The priorities relating to Internal Audit recommendations are defined as follows:

Priority 1 recommendations relate to critical issues, which will feature in our evaluation of the Governance Statement. These are significant matters relating to factors critical to the success of the organisation. The weakness may also give rise to material loss or error or seriously impact on the reputation of the organisation and require urgent attention by a Director.

Priority 2 recommendations relate to important issues that require the attention of senior management and may also give rise to material financial loss or error.

Priority 1 and 2 recommendations are highlighted to the Audit Committee and included in the main body of the report within the Audit Opinion and Findings

Priority 3 recommendations are usually matters that can be corrected through line management action or improvements to the efficiency and effectiveness of controls.

Priority 4 recommendations are recommendations that improve the efficiency and effectiveness of controls operated mainly at supervisory level. The weaknesses highlighted do not affect the ability of the controls to meet their objectives in any significant way.

Item Number 10

Please note any items relating to Committee business are embargoed and should not be made public until after the meeting

AUDIT62/2016
Audit Committee
1 September 2016

PAYMENT VERIFICATION: FAMILY HEALTH SERVICE (FHS) CONTRACTORS

Payment Verification Annual Process Update

1. PURPOSE OF THE REPORT

The purpose of the report is to inform the Audit Committee in relation to:

a) Updates to the guidance on payment verification procedures and arrangements for payment verification for 2016/17 for FHS Contractors, i.e. General Dental; Ophthalmic; Pharmaceutical; and Medical Services (DL (2016) 11 Appendix 1); and

b) Assurances in respect of the discharge of financial governance to ensure best practice, fairness, and the proper use of public funds.

2. RECOMMENDATIONS

The Committee is asked to note the content of the report.

3. EXECUTIVE SUMMARY

The Board is required to ensure that the payments made to the FHS contractor groups on their behalf are timely, accurate and valid. Whilst the majority of payment verification is undertaken by Practitioner Services, NHSScotland, in accordance with the Partnership Agreement between Practitioner Services and the Board, accountability for payment verification ultimately rests with the Board and the FHS contractors are required to co-operate in the payment verification process under their respective terms of service.

Payment verification in respect of Dental, Ophthalmic and Pharmaceutical Services takes place at 4 levels, which include; routine automated pre-payment checks; trend analysis and sample testing; extended sample testing; and random assessment of claims which may require inspection of clinical records and/or patient examination.

Due to the different nature of the General Medical Services contract, payment verification uses various techniques such as; validation of data quality; checking of source documentation and activity monitoring; inspection of clinical records; and payment verification practice visits.

Clinical governance assurances are reported to the Clinical and Care Governance Committee.

4. REPORT DETAIL

In addition to payment verification, the regular reporting gives NHS Tayside an insight into the activity of their FHS contractors and can also act as an early warning to where there may be a performance issue.

The main areas investigated are:

4.1 General Dental Services:

- Earnings summary
- Cost per case
- General earnings
- Assistants and Trainee earnings
- Earning and list size
- Full cost per case
- Ortho earnings
- Ortho Assistants & Trainees
- Salaries earnings
- Orthodontic contractors currently subject to higher than normal monitoring
- Dental Allowances report on Allowances received

4.2 General Ophthalmic Services:

- Primary Eye Examination Claims
- Supplementary Eye Examinations
- Domiciliary Visits
- Spectacle Vouchers
- Repair/Replacement Vouchers
- Inspection of Ophthalmic Records and Practice Visits

4.3 Pharmaceutical Services:

- Minor Ailments Service
- Chronic Medication Service
- Influenza Vaccination Programme (Seasonal)
- Public Health Service-Emergency Hormonal Contraception
- Random Sampling
- Regional Office Payment
- Small Pack Endorsing
- Gluten Free Food
- Cross Boundary Flow
- Dispensing Doctors
- Patient Medication Record Review

4.4 General Medical Services:

- Global Sum
- Organisational Core Standard Payment
- Core Standard Payment
- Temporary Patient Adjustment
- Additional Services
- Payments for a Specific Purpose
- Section 17c Contracts
- Seniority
- Enhanced Services
- Quality and Outcomes Framework:
- Clinical Inspection of Medical Records

As reported on 5th May 2016, a new Scottish GMS Contract is being developed with implementation from 2017 which will seek to reflect new models of care being tested. The Quality Outcomes Framework was dismantled with effect from 1 April 2016 and all points were transferred into a standard payment within the Global Sum. With effect from 1 April 2016, the professionalism of GPs and GP practice staff will be relied upon to provide all of the elements of that care that they consider to be clinically appropriate.

As a result of this change, the scope of payment verification for GP Contractors will significantly reduce from 2017/18. We are yet to be advised of any payment verification processes from April 2017 onwards. An update will be come to Committee when arrangements are clearer.

Copies of the notes of the regular review meetings between Practitioner Services, relevant NHS Tayside staff and the representatives of each of the professions are available for inspection on request.

5. CONTRIBUTION TO NHS TAYSIDE'S STRATEGIC AIMS

The payment verification process for FHS contractor groups provides assurances in respect of the discharge of financial governance to ensure best practice, fairness, and the proper use of public funds.

6. MEASURES FOR IMPROVEMENT

The payment verification requirements are produced following consultation with representatives from NHS Health Boards, Practitioner Services, Audit Scotland and FHS Contractor Representative Bodies, e.g. Scottish General Practitioners Committee of the BMA; and are subject to regular review in respect of performance and contractual changes.

The payment verification process and regular scrutiny of all claims across the FHS contractor groups provides a programme discouraging false or erroneous claims.
The process also contributes to providing assurances over the clinical care provided. These assurances are reported to the Clinical and Care Governance Committee.

7. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

In order to give the Board assurance on the level of payment verification checking carried out, Practitioner Services Payment Verification Teams produce quarterly reports and meet at regular intervals with appropriate Health Board personnel and professional advisory representatives of the FHS contractor groups to discuss the level of checking carried out in each contractor stream and to decide upon appropriate action in relation to any specific issues of interest.

8. PATIENT EXPERIENCE

The process also contributes to providing assurances over the clinical care provided. These assurances are reported to the Clinical and Care Governance Committee.

9. RESOURCE IMPLICATIONS

Financial

The payment verification process ensures that appropriate payments are made to FHS contractor groups, through the monitoring of agreed high risk areas.

Workforce

Additional analysis undertaken as necessary by appropriate Health Board personnel and professional advisory representatives of the FHS contractor groups

10. RISK ASSESSMENT

The payment verification requirements are produced following consultation with representatives from NHS Health Boards, Practitioner Services, Audit Scotland and FHS Contractor Representative Bodies, e.g. Scottish General Practitioners Committee of the BMA; and reflect the outcome of a comprehensive risk assessment process. The payment verification process is subject to regular review in respect of performance and contractual changes.

11. LEGAL IMPLICATION

Legal implications may arise from any fraudulent activity identified through the process. NHS Tayside would be guided by Counter Fraud Services and the Central Legal Office.

12. INFORMATION TECHNOLOGY IMPLICATIONS

Not applicable

13. HEALTH & SAFETY IMPLICATIONS

Not applicable

14. HEALTHCARE ASSOCIATED INFECTION (HAI)

Not applicable

15. DELEGATION LEVEL

General Dental Services: Clinical Director, General Dental Services; General Manager Primary Care Services; and Senior Management Accountant.

General Ophthalmic Services: General Manager Primary Care Services; Optometric Adviser; and Senior Management Accountant.

Pharmaceutical Services: Head of Prescribing Support Unit; Locality Pharmacist; and Senior Management Accountant.

General Medical Services: General Manager Primary Care Services; Clinical Lead(s); and Senior Management Accountant.

16. TIMETABLE FOR IMPLEMENTATION

Assurance framework is reviewed and revised annually. The arrangements are set out in circular.

17. REPORT SIGN OFF

Jane Haskett
General Manager, Primary Care Services

Lindsay Bedford
Director of Finance

September 2016

18. SUPPORTING DOCUMENTS

DL (2016) 11 Appendix 1

The Scottish Government
Directorate for Health Finance

Chief Executives and Directors of Finance
NHS Health Boards

The Scottish Government
Riaghaltas na h-Alba

Dear Colleague

REVISED PAYMENT VERIFICATION PROTOCOLS – GENERAL DENTAL SERVICES, PRIMARY MEDICAL SERVICES, GENERAL OPHTHALMIC SERVICES, PHARMACEUTICAL SERVICES

The attached document updates and supersedes the guidance on payment verification procedures contained in DL (2015) 18 and outlines the arrangements for payment verification for 2016-17.

BACKGROUND

This revision includes the following main changes:

Dental

The revision for 2016-17 has resulted in no change to the protocol.

Medical

The changes reflect the continuing development of the GP contract from 2016-17 onwards and in particular the creation of the Core Standard Payment.

Ophthalmic

- The revision for 2016-17 has resulted in only minor changes to the protocol.
- Act in accordance with the Partnership Agreement in tackling NHS fraud.

DL (2016) 11

19 May 2016

Addresses

For action
Chief Executives and Directors of Finance, NHS Boards

Chief Executive, NHS National Services Scotland

For information
Chief Executives and Directors of Finance, Special Health Boards

Auditor General

NHSScotland Counter Fraud Services

Enquiries to:

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Directorate for Health Finance
Basement Rear
St Andrew's House
Regent Road
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Pharmacy

The protocol for 2016-17 has been rewritten to replicate the layout used by Dental, Medical and Ophthalmic. The payment verification arrangements in place for each payment and contractor type are described at levels 1-4, and the outputs required to meet NHS Board quarterly reporting requirements are stated.

ACTION

Chief Executives are asked to:

- note the revised protocol and ensure that relevant staff within their Boards are familiar with this;
- share the protocol with FHS contractors;
- ensure that their Audit Committee have sight of the protocol;
- work with Practitioner Services in ensuring the implementation of the protocol;
- note that contractors must retain evidence to substantiate the validity of payments and, where this cannot be found, any fees paid may be recovered; and
- note that tri-partite discussion should take place between Practitioner Services, NHSScotland Counter Fraud Services and the relevant NHS Board where a concern relating to potential fraud arises in the course of payment verification, and that, where a tri-partite meeting is deemed necessary, this should take place within 2 weeks of the simultaneous notification of the concern to the Board and NHSScotland Counter Fraud Services by Practitioner Services.

Where an FHS practitioner refuses to co-operate in the payment verification process, he or she may be in breach of his/her contract or terms of service. In such cases, NHS Boards are asked to take appropriate action.

FURTHER INFORMATION

Further information is available from Alasdair Pinkerton, Associate Director – Contractor Finance, Practitioner Services, NHS National Services Scotland:

- email: alasdair.pinkerton@nhs.net
- telephone: 0131 275 6682

Yours faithfully,

Christine McLaughlin
Director of Health Finance

Payment Verification Protocols

Payment Verification Programme for 2016-17

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Introduction

1.1 As the accountable bodies for FHS spend, NHS Boards are required to ensure that the payments made to contractors on their behalf are timely, accurate and valid.

1.2 With respect to the validity of the payments, as far as possible claims will be verified by pre-payment checks. The checking process will be enhanced by a programme of post-payment verification, across all contractor groups – Dentists, GPs, Optometrists and Community Pharmacists.

1.3 Accountability for carrying out payment verification ultimately rests with NHS Boards. Whilst the majority of payment verification will be undertaken by Practitioner Services (in accordance with the Partnership Agreement between Practitioner Services and the NHS Boards) there may be instances where it is more appropriate for payment verification to be undertaken by the NHS Board. Consequently, there is an onus on Practitioner Services and NHS Boards to agree the annual payment verification programme.

1.4 It is vital that a consistent approach is taken to PV across the contractor streams and this paper outlines the ways in which this matter will be taken forward across the various payment streams.

1.5 These requirements have been produced following consultation with representatives from NHS Health Boards, Practitioner Services and Audit Scotland and reflect the outcome of a comprehensive risk assessment process. The payment verification processes will be subject to regular review in respect of performance and contractual changes.

1.6 Payment verification of the exemption/remission status of patients (Patient Checking) is dealt with within a Partnership Agreement between Counter Fraud Services and the NHS Boards.

Contractor Checking

Ophthalmic, Pharmaceutical and Dental Payments

2.1 It is intended that payment verification checks will take place on 4 levels:

2.2 **Level 1:** Routine pre-payment checking procedures carried out by PSD staff, including automated pre-payment checking by Optix/MIDAS/DCVP, with reference to the Community Health Index (CHI) where appropriate.

2.3 **Level 2:** PV Teams will undertake a trend analysis and monthly/quarterly sample testing, where:

- the results of level 1 checks indicate that this would be beneficial;
- the results of statistical trend analysis indicate a need for further investigation; and
- the formal assessment of the level of risk associated with a particular payment category indicates a need for more detailed testing.

2.4 **Level 3:** PV Teams will, as appropriate, undertake extended sample testing, send out patient letters, or conduct targeted inspection of clinical records in order to pursue the outcome of any claims identified at Levels 1 and/or 2 as requiring further investigation.

2.5 **Level 4:** PV Teams will undertake a random assessment of claims, which may require an inspection of clinical records and/or patient examination.

GMS Payments

2.6 Due to the different nature of the GMS contract, payment verification will use various techniques such as:

- validation of data quality;
- checking of source documentation and activity monitoring. The purpose of this is to reduce the requirement to access patient medical records during practice visits; and
- payment verification practice visits.

Inspection of Clinical Records

2.7 Inspection of clinical records may or may not necessitate a practice visit, depending on the contractor type and also on the implementation of PV protocols at a local NHS Board level. The methodology of actual practice visits is detailed further in Appendix A of the Medical and Ophthalmic Annexes.

Risk Assessment

3.1 In order to ensure that maximum use is made of the finite resources available for payment verification, it is imperative that PV work is targeted at the areas of highest risk. Risk matrices have been developed and applied to facilitate the appropriate risk assessment of the payment areas and targeted use of payment verification resources.

3.2 In order to ensure that these risk matrices continue to reflect both the materiality of, and the risks relating to, all contractor payment types, it is intended that the application of the risk assessment methodology will be subject to annual review. This review will be undertake by the appropriate PV Contractor Group, and shall be subject to approval by the PV Governance Group.

Reporting to NHS Boards

4.1 NHS Boards also require assurance on the level of payment verification checking carried out in their respective areas, in relation to the guidance set out in this document.

4.2 In order to support this, the Practitioner Services PV teams will produce quarterly reports for each of the contractor streams, providing information on the level of checking carried out in each NHS Board area and highlighting any specific issues of interest.

4.3 In addition, for all categories of payments, it is important that any matters of concern arising from the payment verification work undertaken are acted upon quickly and appropriately. In such circumstances the procedure noted at Section 6 below will be followed.

Countering Fraud

5.1 NHS Scotland Counter Fraud Services has the responsibility of working with others to prevent, detect and investigate fraud against any part of the NHS in Scotland. Under the Scottish Government's Strategy to Combat NHS Fraud in Scotland, everyone within NHS Scotland has a part to play in reducing losses to fraud and, to increase deterrence, effective sanctions will be applied to all fraudsters. Professional bodies representing all FHS Practitioners have signed a counter fraud charter with CFS, committing their members to assist in reducing fraud against NHS Scotland.

5.2 Where Practitioner Services or an NHS Board, through the application of their internal control systems, pre or post-payment, identify irregularities which could potentially be fraud, they shall make their concerns known to CFS. Where necessary, tri-partite discussion will be held to determine the best way forward in accordance with the Counter Fraud Strategy, and the NHS Board/CFS Partnership Agreement.

Adjustment to Payments

6.1 All proposals to make additional payments or to seek recoveries of overpayments from contractors as a result of PV investigations will be the subject of discussion and agreement between Practitioner Services and the relevant NHS Board. Although any recovery is officially in the name of the NHS Board and any formal action to recovery will have to be taken in their name, it is important that recoveries are affected by Practitioner Services through the Practitioner Services payment processes. This will ensure that all such adjustments are recorded in the payment systems and that any consequential adjustments for other payments (such as pension deductions) take account of the adjustment.

Annex I – Dental Payments

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Introduction

The following sections detail the payment verification requirements for General Dental Services (GDS).

It should be noted that Practitioner Services (Dental) operates under the aegis of the Scottish Dental Practice Board (SDPB) whose powers are set out in statutory legislation. The role of Practitioner Services Dental, as agents of the Scottish Dental Practice Board, is to attest that care and treatment proposed or provided under GDS is appropriate having undertaken a risk versus benefit analysis. Where appropriate, the outputs from this clinical governance process will inform the verification of payments.

Practitioner Services (Dental) operates a computerised payments system (MIDAS) as well as an optical character recognition system (iDent), both of which undertake extensive pre-payment validation on dental payment claims. Electronic Data Interchange (EDI) is accepted by MIDAS and the checks noted below apply equally to scanned paper claim input and data fed through EDI.

Retention of Evidence

Practices are required to retain evidence to substantiate the validity of payments. The requirement for this evidence will be in accordance with the NHS (GDS)(Scotland) Regulations 2010, the Statement of Dental Remuneration (SDR) and the Scottish Dental Practice Board Regulations 1997, para 10(2). The Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 also provides a schedule listing the retention period for financial records in NHS Scotland. This specifies six years plus the current year as minimum retention period for most financial records. For the avoidance of doubt this would relate to any information used to support NHS payments to dental practitioners.

Where evidence to substantiate the validity of payments cannot be found, any fees paid will be recovered.

Capitation & Continuing Care

Capitation and continuing care payments are based on the numbers and ages of the patients registered with the dentist. These details are gathered when dental claim forms are submitted and payment will continue unless the patient registers with another dentist, dies, embarks (has left the United Kingdom) or is de-registered by the dentist.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- claim forms by MIDAS/iDENT – to ensure all mandatory information is present
- patient existence/status by matching to CHI
- validation against the SDR
- duplication on MIDAS

Level 2 will comprise trend analysis of claims, including, but not limited to:

- number of registrations by contractor
- registrations by contractor that are unmatched to CHI
- registrations by contractor with no IOS claims

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- Patient letters
- Sampling of patient records and associated documentation
- Liaison with private capitation scheme providers to establish registration status

Level 4 will comprise of a percentage of unmatched registrations (where an IOS Claim has been made) being included in the random examinations of patients by the Scottish Dental Reference Service (SDRS) as per Appendix A.

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries

Items of Service

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- claim forms by MIDAS/iDENT – to ensure all mandatory information is present
- patient existence/status by matching to CHI
- validation against the SDR and any provisos or time limits that apply, including tooth specific validation where appropriate for specific items of service.
- duplication on MIDAS
- the patient's date of birth for age exemption
- checking the total value of the claim and applying prior approval as appropriate

Prior Approval - claims with values in excess of the prior approval limit require to be submitted for checking before treatment is carried out. These are assessed for both clinical and financial appropriateness.

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- individual and combinations of item of service claims
- items claimed where the patient does not pay the statutory charge
- level of earnings
- cost per case and throughput

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- Patient letters
- Sampling of patient records and associated documentation
- Applying the "special prior approval" process or the "prior approval by targeting" regulation
- Referral of patients to the SDRS to confirm that treatment proposed or claimed was in accordance with the SDR in compliance with the NHS (GDS)(Scotland) Regulations 2010
- Further investigation as a result of adverse outcome of SDRS examination.

Level 4 will involve the SDRS examining a sample of patients, chosen at random, from every NHS dentist to confirm that treatment claimed was in accordance with the Statement of Dental Remuneration in compliance with the NHS (GDS) (Scotland) Regulations 2010.

Any practitioner who receives an unsatisfactory report from the SDRS in relation to the validity or standard of treatment provided to the patient is automatically referred to the NHS Board for consideration.

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Details of information used to verify service provision
- Any necessary recommendations, actions and recoveries
- SDRS reports

Allowances

Allowances are based on existing data held within MIDAS (e.g. General Dental Practice Allowance and Commitment Payment) or they are the subject of separate claims submitted by the dentist or practice.

Level 1 will comprise 100% checking of:

- mandatory information and supporting documentation is present
- validation against the SDR and any provisos or time limits that apply
- duplication on MIDAS

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries

Appendix A – Examination of Patients – Scottish Dental Reference Service (SDRS)

1 Background

1.1 One of the methods of verifying payments made under General Dental Services (GDS) arrangements is to examine patients. This service is carried out by a Dental Reference Officer (DRO) employed by the SDRS. The DRO inspects patients' mouths before extensive work is carried out, or after they have received treatment.

1.2 All patients receiving treatment under GDS sign to say that they agree to be examined by a dental reference officer if necessary

2 Selection of Patients

2.2 Every year a number of patients from every NHS dentist are invited to attend the SDRS. Patients may also be invited to attend where the application of risk assessment or trend analysis in relation to claims received from practitioners suggests that this would be appropriate.

2.3 Practitioners are advised about appointment timings for their patients and are permitted to attend the examination.

3 SDRS Reports

3.1 Once a practitioners patients have been examined, a report is produced which details DRO's opinion of the clinical care and treatment/clinical treatment proposals, and any concerns relating to possible clerical errors, mis-claims or regulatory concerns.

3.2 Clerical errors, mis-claims or regulatory concerns are classified in a SDRS report as follows:

Administrative (i) m: possible mis-claim e.g. claiming the wrong code

Administrative (i) c: possible clerical error e.g. mixing an upper and lower or left and right on the charting of a restoration

Administrative (i) r: possible regulatory error e.g. claiming an amalgam on the occlusal surface of a premolar when a composite was provided

Administrative P: possible violation or avoidance of Prior Approval Regulations/requirements

3.3 The code assigned to the examination by the DRO will determine the course of action to be taken. This may include no further action, further patient examinations, discussion with or referral to the NHS Board, or in some cases a tri-partite meeting between Practitioner Services, the NHS Boards and Counter Fraud Services.

Annex II – Medical Payments

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Introduction

The following sections detail the payment verification requirements for Primary Medical Services for the 2016/17 financial year.

It should be noted that, as part of the GMS Contract Agreement for 2016/17, the Quality and Outcomes Framework (QOF) will be dismantled and Transitional Quality Arrangements (TQA) will be implemented in 2016/17. However, the 2015/16 QOF achievement will be subject to payment verification in 2016/17. This remains in accordance with previous PV arrangements.

The verification arrangements outlined will require local negotiation between NHS Boards and Practitioner Services on implementation. This should ensure that a consistent approach is taken to payment verification irrespective of who performs it.

Each of the three Practitioner Services Regional Offices supports a dedicated Medical PV team to undertake the required payment verification work. These teams work in close co-operation with their respective NHS Boards and colleagues in the other Medical departments to ensure co-ordination in payment verification and related activities.

Retention of Evidence

Practices are required to retain evidence to substantiate the validity of payments relating to the GMS Contract. The requirement for this evidence will be in line with that detailed in the Contract, in the Statement of Financial Entitlements or in locally negotiated contract documentation. It is particularly important to retain evidence that is generated by the running of a computer generated search, as this provides the most reliable means of supplying data, that fully reconciles with the claim submitted should practices be required to do so. Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 provides a schedule listing the retention period for financial records in NHS Scotland. This specifies six years plus the current year as minimum retention period for most financial records. For the avoidance of doubt this would relate to any information used to support a payment to the GP Practice.

Where evidence to substantiate the validity of payments cannot be found, any fees paid will be recovered.

Data Protection

PCA (M)(2005) 10, Confidentiality & Disclosure of Information Code of Practice, illustrates the circumstances under which disclosure of patient identifiable data may be made in relation to checking entitlement to payments and management of health services. The guidance contained in this document is consistent with this code of practice.

The practice visit protocol, contained as Appendix A in this document, pays particular attention to minimising the use of identifiable personal data in the payment verification process. The use of clinical input is recommended to streamline the process, provide professional consistency, and limit the amount of investigation necessary in validating service provision.

Premises and IT Costs

Expenditure on premises and IT will be met through each Board's internal payment systems and as such will be subject to probity checks through the Board's normal control processes. There is therefore no payment verification required. Where Practitioner Services are required to make payments on behalf of NHS Boards these will be checked for correct authorisation.

Payment Verification for Global Sum

METHOD

The Global Sum is the payment to GP Contractors for delivering essential and additional services. Arrangements for the Payment Verification of the Global Sum include the Core Standard Payment (which will include the transfer of QOF funding in 2016-17) as outlined in the Statement of Financial Entitlements.

A GP Practice's global sum allocation, excluding Core Standard Payments, is dependent on their share of the Scottish workload, based on a number of weighting factors (reference Annexe B, Scottish Allocation Formula, GMS Statement of Financial Entitlements).

The accuracy of the Global Sum is dependent upon the data held on the Community Health Index (CHI).

The verification of the data held on the CHI is achieved in a number of ways. Although the intent of these control and verification processes is primarily focussed on the accuracy of patient data for health administration purposes, assurance can be taken from the existence and application of many of these controls for payment verification purposes.

The following controls and processes are used to verify GP Practice Population List Size and weighting factors:

System/Process Generated Controls

- All new patient registrations transferred electronically via PARTNERS to the Community Health Index (CHI) are subject to an auto-matching process against existing CHI records. If a patient cannot be auto-matched further information is requested from the GP Practice so that positive patient identification can be ensured.
- All patient addresses transferred by PARTNERS to CHI are subject to an auto-post coding process to ensure validity of address within the Health Board Area.
- All deceased patients are automatically deducted from the GP Practice on CHI using an interface file from NHS Central Register (information being derived from General Register of Scotland). Patients registering elsewhere in the UK are deducted from the GP Practice on CHI following matching by NHS Central Register.
- Patients are automatically deducted from GP Practice on registration with another GP Practice in Scotland.
- All patients confirmed as no longer residing at an address are removed on CHI and automatically deducted from GP Practice lists via PARTNERS.
- Quarterly archiving of GP Practice systems and generation of PARTNERS reports ensures that all patient transactions (acceptances and deductions) have been completed by the GP Practice.
- All patients whose address is an exact match with a Care Home address will automatically have a Care Home indicator inserted on CHI.

- Where new patient registrations are not transferred by PARTNERS manual scrutiny of registration forms is undertaken.
- Registration Teams check unmatched patients (without CHI number) to NHS Central Register database to ensure positive patient identification.

Random Checking

- Validation on patient data for a minimum of 10% of GP Practices annually via Patient Information Comparison Test (PICT) to ensure that patient data on CHI and on GP systems match. The following fields can be validated:
  1. Date of Birth and Sex differences
  2. Name differences
  3. Unmatched patients
  4. Patients on CHI but not on practice system
  5. Patients who have left the practice
  6. GP Reference differences
  7. Address differences
  8. Possible duplicates
  9. Missing CHI Postcodes
  10. Mileage differences

Targeted Checking

- Manual scrutiny of registration forms where there is concern regarding the quality of registration data submitted via PARTNERS.

- Data Quality work which contributes to the removal of patients from CHI:
  1. UK and Scottish Duplicate Patient matching exercises to ensure that patients are only registered with one GP Practice.
  2. Bi-annual short term residency checks on patients such as, Students, c/o Addresses, Holiday Parks, or Immigrant status.
  3. Annual checks on patients aged over 100.
  4. Quarterly checks on Care Home Residents.
  5. All mail to patients (medical card or enquiry circular) that is returned in post is followed up with the GP Practice and where appropriate patients are removed from CHI and from the GP Practice list.

- Validation on patient data via PiCT for capitation dispute, data quality concerns or system migration (fields as above).

Payment Verification Practice Visit

- Where patient registration data is submitted via PARTNERS the Payment Verification visiting team will check a sample of recent patient registrations to ensure that General Practice Registration Form (GPR) has been completed and retained by the practice electronically as verification that a contract between the GP Practice and the patient exists.

Trend Analysis

- Monitoring of levels of the following using the Quarterly Summary Totals report by Health Board Area:
  1. Capitation Totals by age/sex bands
  2. Patients in Care Homes registered with the practice in the last 12 months
  3. Patients in Care Homes registered with the practice more than 12 months ago
  4. All other patients registered with the practice in the last 12 months
  5. All other patients registered with the practice more than 12 months ago
  6. Number of Dispensing Patients
  7. Number of Mileage patients

- Monitoring of levels of the following through Key Performance Indicators using the Quarterly Summary Run:
  1. Number of new registrations in CHI in quarter
  2. Number of patients removed from CHI as deceased

- Number of patients removed from CHI as moved out of Health Board Area.
- Pre-Payment checking of quarterly payments being authorised by GP Practice on the value of the Global Sum Payment to ensure that variances no more than +/- 5% of the value of the previous quarter.

OUTPUTS:

- A Global Sum Verification Report will be generated on a quarterly basis.

  The report will detail the results of the checking and any actions taken as a result of the checks and provide recommendations to the Health Board.

Payment Verification of Organisational Core Standard Payment - 2015-16

METHOD
To verify practice compliance with these standards the following technique will be used:

- Discussion and verification of GP Practice policies and procedures either during a practice visit or as part of office based verification work.

OUTPUTS:

- Results and status of checking process.
- Details of information used to verify compliance with the Organisational Core Standard Payment.
- Any necessary recommendations, actions and recoveries.

Payment Verification of Core Standard Payment

As part of the 2014-2015 GMS Contract Agreement, 264 QOF points were transferred to Global Sum. In 2016-17 the remaining 659 QOF points were transferred to the Global Sum and merged with the clinical and organisational core standard payments to create a single Core Standard Payment.

The decision on whether or not it is appropriate to provide a particular service to a patient in these areas is taken by the GP, usually in conjunction with the patient, and is based on clinical judgement rather than simply whether the action was previously required to achieve a QOF indicator.

The expectation is that for the clinical areas transferred via the Clinical Core Standard Payment in 2014-2015 and the Core Standard Payment in 2016-17, these services will continue to be provided and suitably recorded in the patient's clinical record, where it is considered clinically appropriate by the practice.

There will be no specific payment verification arrangements aligned to the Core Standard Payment, other than those applicable to the Global Sum

If it appears that there is a systematic failure to provide any of the transferred services, this may require recourse to a formal review of the clinical decision making recorded within the patient file. This process is not part of payment verification.

Payment Verification for Temporary Patient Adjustment (TPA)

METHOD
To verify that the payment of the TPA is appropriate the following checks will be undertaken:

- Random sampling of GP Practice records for evidence of service provision at practice visit.
- Complaint logs will be reviewed annually to identify complaints, or a pattern of complaints, that could indicate a lack of service provision. If an absence of service is found, this should be subject to further investigation, and if necessary further action taken.
- Where concerns exist over an absence of provision of service, a practice may be asked to demonstrate their process of recording instances where treatment of a temporary patient(s) has been refused.

The incorrect registration of temporary patients as permanent patients will be checked as part of the payment verification for Global Sum.

OUTPUTS:

- Number of records checked at practice visit and results.
- Record of check made to complaint logs.
- Any necessary recommendations, actions and recoveries.

Payment Verification for Additional Services

METHOD
To verify that these services are being provided one or more of the following verification techniques will be undertaken as applicable:

- Practice Visit – the purpose of which is to examine a percentage of patient records. Records to be reviewed will be selected at random. See Appendix A.
- Analysis of anonymised practice prescribing information.
- Review of practice activity information including national call/recall systems.

OUTPUTS:

- Number of records checked at practice visit and results.
- Details of information used to verify service provision.
- Any necessary recommendations, actions and recoveries.

Payment Verification for Payments for a Specific Purpose

METHOD
To verify that these payments are valid, one or more of the following verification techniques will be undertaken as applicable:

- Confirmation of adherence to entitlement criteria as per the relevant section of the Statement of Financial Entitlements (SFE) are met
- Confirmation that all relevant conditions of payment as per the relevant section of the SFE are met
- Analysis of outlier detail

Immunisations

METHOD
To verify that these services are being provided, one or more of the following verification techniques will be undertaken as applicable:

- Practice Visit – the purpose of which is to examine a percentage of patient records. Records to be reviewed will be selected at random. See Appendix A.
- Analysis of anonymised practice prescribing information.
- Review of practice activity information including national call/recall systems.

OUTPUTS:

- Numbers and values of payments made by practice type and practice.
- Any specific matters arising in the processing of payments.
- Number of records checked at practice visits and results.
- Details of information used to verify service provision.
- Any necessary recommendations, actions and recoveries.

Payment Verification for Section 17c Contract

METHOD
Payments to practices holding section 17c contracts are split into two streams:

- Payments that map to those received by section 17j practices.
- Payments that are specific to their section 17c contract.

Payments that map to those received by section 17j practices are subject to the payment verification processes outlined elsewhere in this document.

To verify that payments specific to a section 17c contract are appropriate, these practices will be subject to NHS Boards' contract monitoring processes which may involve:

- NHS Board quarterly review.
- Analysis of practice produced statistics which demonstrate contract compliance.
- Reviewing as appropriate section 17c contracts against other/new funding streams to identify and adjust any duplication of payment.
- Practice Visit – the purpose of which is to examine a percentage of patient records. Records to be reviewed will be selected at random. See Appendix A.

OUTPUTS:

- Number of records checked at practice visit and results.
- Details of information used to verify service provision.
- Any necessary recommendations, actions and recoveries.
- As per agreed local monitoring process.

Payment Verification for Seniority

METHOD
To verify that new claims for Seniority payments are valid, checks will be undertaken, prior to payment, as follows:

- Reasonableness of claim – to check appropriateness of dates against information on form seems appropriate - General Medical Council (GMC) registration date, NHS service start date.
- check for length of service.
- check eligibility of breaks in service.
- where applicable check with Scottish Government (SG) for eligibility of non-NHS Service.

OUTPUTS:

- details of new claimants received in quarter and level of seniority.
- results and status of checking process.

Payment Verification for Enhanced Services

INTRODUCTION

The method and output sections below provide generic guidance for the payment verification of all Enhanced Services.

METHOD

To verify that these services are being provided the relevant specification for the service must be obtained. The practice's compliance against this specification will be verified by one or more of the following techniques:

- Practice Visit – the purpose of which is to examine a percentage of patient records. Records to be reviewed will be selected at random. (See Appendix A). Verification may also include the inspection of written evidence retained outwith the patient record and a review of the underlying systems and processes that a practice has in place.
- Analysis of anonymised practice prescribing information.
- Analysis of GP Practice activity information.
- Discussion of GP Practice policies and procedures.
- Confirmation letters/surveys to patients.
- Review of Complaints log.
- Discussion of how Extended Hours service was planned and organised. Checks to provide evidence that the service is being provided, (e.g. check that the correct additional consultation time is being provided via the appointment system, notification of service availability to patients - practice leaflet, posters, etc.)

OUTPUTS:

- Results and status of checking process.
- Details of information used to verify service provision.
- Any necessary recommendations, actions and recoveries.

Payment Verification for the Quality and Outcomes Framework – 2015/16

INTRODUCTION

The Quality & Outcomes Framework (QOF), as specified in the Statement of Financial Entitlements (SFE), rewards practices on the basis of the quality of care delivered to patients. Participation in the QOF is on a voluntary basis.

The framework contains four domains, one clinical and three non-clinical domains. Each domain contains a range of areas described by key indicators and each indicator describes different aspects of performance that a practice is required to undertake.

The four domains are:

- Clinical – comprising 17 areas
- Public Health – comprising 5 areas
- Quality & Safety – comprising 5 areas
- Medicines Management

QOF Points Value

The overall number of points that a GP Practice can achieve (in 2015-2016) is as follows:

Domain	Points
Clinical	515
Public Health	20
Quality & Safety	111
Medicines Management	13
TOTAL	**659**

QOF Data Gathering & Reporting

A single national system (QOF Calculator) collects national achievement data, computes national disease prevalence rates and applies computations to calculate points and payments.

Data held within practice clinical systems forms the basis for a practice's achievement declaration in respect of each indicator within the clinical domain and a number of the indicators within the non-clinical domains. Clinical data recording is based on Read codes and only data that is useful and relevant to patient care should be collected i.e. it is not collected purely for audit purposes.

In relation to a number of other indicators within the non-clinical domains, practices declare their achievement via a "Yes/No" answer process and are required to retain written evidence as proof that they have met the requirements of the indicator.

The data for one indicator comes from a source other than the practice:

- Payment for the CS001(S) indicator is actioned by Practitioner Services via the manual input of achievement data from the screening systems utilised by NHS Boards.

QOF Review

The review of a practice's achievement under the QOF involves four distinct processes:

- **Pre-Payment Checking**

1. The monitoring of practices on an ongoing basis to ascertain how their reported disease register sizes within QOF Calculator change and how they compare to the size of the disease register at the end of the preceding financial year.
2. Following the submission of a practice's QOF achievement declaration, NHS Boards and practices have a set period during which pre-payment verification must be carried out. It is only when this process is complete to the satisfaction of the NHS Board that the achievement declaration of each practice can be approved and payment made in respect of QOF. Practices and NHS Boards will sign off their achievement in accordance with a national timetable. Guidance to NHS Boards about how pre-payment verification may be undertaken as part of their annual assurance processes is provided in Appendix B.

- **Post Payment Checking**

3. Where an NHS Board has a practice review programme incorporating an element of QOF review, then any significant issues arising from this process should be made available to be considered as part of payment verification.
4. A payment verification visit to provide assurance in respect of the validity of a practice's QOF achievements, and hence payment, for the preceding financial year. These visits will be on a random sample basis (5% of practices/minimum of 1 practice, per year, per NHS Board). In addition, at the request of the NHS Board, visits may be carried out where, for example, the application of risk assessment or trend analysis suggests that this may be appropriate.

QOF Payment Verification Methodology

Verification of QOF indicators will be undertaken broadly in line with the Scottish Quality & Outcomes Framework – Guidance for NHS Boards and GP Practices.

While the QOF contains four domains, for payment verification purposes it is more practical to group the indicators within these domains under the following three headings according to the type of evidence that a practice holds and where it is recorded.

A - Data Held Within a Patient Record

Each indicator within the clinical domain requires the recording of key data within a patient record, and in addition there are a number of indicators in the non-clinical domains that also require this type of recording. Given the large numbers of indicators of this nature, five groupings have been developed to take cognisance of the effect the indicator has on payment, the indicator type, and the method of verification to be used.

1. **Trend Analysis of Blood Pressure Readings**

   A sample of patients who have met these indicators should be identified and analysis of the historical blood pressure readings contained within their record should take place. This analysis should look at the trends within a patient's blood pressure readings over time, and increases/decreases in prescribing of anti-hypertensive therapy. Assurance should also be gained, where appropriate, by cross matching blood pressure readings to other evidence of face-to-face contact with the patient e.g. entries within the appointment book, records of house calls and information collected by other members of the Community Health Team.

2. **Lab Test Results**

   If lab test results are automatically downloaded into the practice's system, then further verification is not required in respect of these indicators. If lab test results are not automatically downloaded, then a sample of patients who have met these indicators should be identified and the system recorded value cross-referenced to lab test results.

3. **Clinical Review and Clinical Intervention**

   Verification of these indicators is achieved via reference to the records of a sample of patients who have met the indicator in question. In addition, for indicators that involve a face-to-face contact, cross-matching to entries in the appointment book should take place. For indicators that relate to the carrying out of annual reviews, the record should be examined to ensure that all required aspects of the review are documented.

4. **Repeat Prescribing**

   A sample of patients who have met these indicators should be identified and a check made to their medical record that they were prescribed the drug in question during the contract year for which the payment was made. Consideration should be given to cross-referencing prescribing entries with data contained within the appointment book or hospital correspondence.

Within each of these four groupings, the principle of "cross verification" has been utilised where possible.

Exception Coding

In addition to the recording of key data for each indicator, practices may also record "Exception Codes" within a patient record. These codes exclude patients from the performance target for each indicator in order that practices are not penalised financially for patient characteristics which were beyond their reasonable control. In practical terms, this means that an accepted Read Code has been entered into the patient's record to reflect a valid reason for exclusion.

A practice's use of exception coding will be assessed against 'New Guidance on Exception Reporting – October 2006' PCA (M) (2006) 15, CEL 14 (2012) 'Supplementary Guidance on Exception Reporting – April 2012' and Quality & Outcomes Framework (QOF)

Guidance for NHS Boards and GP Practices 2015/16. This will include the review of supporting clinical evidence held within the patient record.

During the verification of the Trend Analysis, Lab Test Results, Clinical Intervention, Clinical Review and Repeat Prescribing indicators, consideration will be given to instances where Exception Coding has assisted the practice in meeting the payment threshold.

Disease Prevalence

The integrity of disease registers is fundamental to the accuracy of a number of QOF indicator payments. It is therefore vital that practices maintain accurate and up to date disease registers.

- A patient's inclusion within a register will be verified via the review of other supporting clinical evidence held within the patient record.
- Registers will be reviewed to ensure that newly diagnosed patients have been added.
- Practices are required to demonstrate how they have maintained accurate and up to date disease registers.

B – Data Held Outwith a Patient Record

Within the non-clinical domains there are a number of indicators which require practices to retain written evidence outwith the patient record as proof that they have met the requirements of the indicator.

Wherever possible, in order to minimise the volume of verification work undertaken, cognisance will be taken of the assurance gained from any review of evidence carried out by the NHS Board in relation to QOF pre-payment verification work.

C - Indicators Where External Verification is relied Upon

There is 1 indicator where external verification is relied upon:

- Additional Services – (CS1).

The achievement data held on screening systems is the subject of routine review by NHS Boards, with further independent verification being provided via the laboratory assessment of samples. No further specific verification is therefore required in respect of this indicator.

OUTPUTS:

- Pre-payment Checking.

  An analysis of how reported disease register sizes within QOF Calculator change, and how this compares to the size of a disease register at the end of the preceding financial year.
- Post Payment Checking.

  Further to the completion of a practice visit, a report will be produced which details the following:

  - information used to verify service provision;

- number of records checked and results;
- any necessary recommendations, actions and recoveries; and
- level of assurance gained.

GP Practice System Security

Payment verification practice visits comprehensively utilise data held within GP clinical systems, and it is therefore necessary to seek assurance that there are no issues regarding the reliability or the integrity of the systems that hold this data.

NHS Boards are responsible for the purchase, maintenance, upgrade and running costs of integrated IM&T systems for GP Practices, as well as for telecommunications links within the NHS. Within each NHS Board area, assurances will be obtained that appropriate measures are in place to ensure the integrity of the data held within each GP Practice's clinical system.

In obtaining this level of assurance, consideration will be given to the following areas:

- an established policy on System Security should exist that all practices have access to and have agreed to abide by;
- administrator access to the system should only be used when performing relevant duties;
- a comprehensive backup routine should exist, backup logs should be examined on a regular basis with issues being resolved where appropriate, and appropriate storage of backup media should occur; and
- Up to date anti-virus software should be installed, and be working satisfactorily.

In addition, confirmation will be sought during a practice visit that users have a unique login to the GP clinical system, that they keep their password confidential, and that they will log off when they are no longer using the system.

OUTPUTS:

- Any necessary recommendations and actions.

Appendix A – Clinical Inspection of Medical Records/Practice Visits

1 Background

1.1 As detailed in the circular, one of the methods of verifying payments under the GMS contract is to carry out a practice visit. During such a visit, certain payments made to the practice will be verified to source details i.e. patient's clinical records. These clinical records may be paper based or electronically held.

1.2 At present, the verification process will require manual access to named patient data. However, it is hoped in future that electronic methods of interrogation, which may allow the anonymity of patients to be preserved, will be developed.

1.3 Particular attention has been paid to minimising the use of identifiable personal data in the payment verification process.

Practices should try to ensure that all patients receive fair processing information notices briefly explaining about these visits – this can be done when the patient registers or visits the surgery.

2 Selection of Practices

2.1 Practitioner Services and NHS Boards will jointly agree the selection of practices.

2.2 Visits may be carried out as a result of random selection (5% of practices/minimum of 1 practice per year, per NHS Board), or where, for example, the application of risk assessment or trend analysis suggests that this may be appropriate

2.3 The contractor will be given at least four weeks' notice of the intention to carry out a visit and the reason for it.

3. Selection of Records

3.1 In advance of the inspection of patients' clinical records, a sample will be identified for examination.

3.2 For payments where data is held centrally, this will be possible via access to the Community Health Index, or on the various screening systems used throughout the country.

3.3 For payments where information is not held centrally, the practice will be asked to identify patients to whom they have provided the services selected for payment verification.

3.4 Where appropriate, this information should be submitted to Practitioner Services via secure e-mail or paper format through the normal delivery service used for medical records.

3.5 The information will cover a minimum time period, to give a reasonable reflection of activity, but also to minimise the number of patients involved. This information should be specific to the service concerned, and where possible should only detail the CHI number and date of service.

3.6 The areas selected for review will be determined by the risk assessment methodology. The numbers selected for review in each area will be determined by the statistical sampling methodology, thus ensuring that a minimum number of

records are accessed for the purposes of verification. The visiting team will ascertain the identity of only the patients selected for audit during the visit.

3.7 Once the practice visit is completed, the outcome agreed and no further audit is required, the entire list from which the sample was taken will be destroyed.

4 Visiting Team

4.1 The team visiting the practice may comprise representatives from Practitioner Services the NHS Board, and a GP who is independent to the practice, who may be from another NHS Board area,

4.2 As all members of the visiting team are NHS staff/contractors, they are contractually obliged to respect patient confidentiality and are bound by the NHS Code of Practice.

4.3 Only the GP team member will be required to access the clinical records. They may also be required to provide guidance in discussions with the practice.

4.4 The team members conducting the visit will be appropriately familiar with the GMS contract.

5. Examining the Clinical Records

5.1 The visiting team should be afforded sufficient space and time to examine the clinical records to ascertain whether evidence exists to verify that the payment made to the practice was appropriate. Only the parts of the record relevant to the verification process will be inspected.

5.2 The audit should be carried out in a private, non-public area of the practice where patient confidentiality can be observed, and clinical details can be discussed where necessary out-with the earshot of patients.

5.3 A member of the practice staff should be available to assist with the location of evidence, if required.

5.4 The visiting team should provide the GP Practice with an annotated list of all the records examined during the visit, signed by the visiting GP. The practice will be advised to securely retain this list for a period of not less than seven years, in order to maintain an audit trail of patient records accessed by medical practitioners from outwith the practice.

5.5 It is recommended good practice that where electronic records are being accessed by the GP from the visiting team, the GP Practice grants access to the computer system via a ‘read only’ account.

6. Concluding the Visit

6.1 Where the visit has identified issues, these will be discussed with the practice with a view to resolving them.

6.2 In instances where resolution of these issues is achieved, the visit may then be concluded, and the practice advised of the following:

- which payments were verified, and which payments were not;
- whether an extended sample of clinical records require to be examined/further investigation carried out;
- what actions the practice is required to take as a result of the visit; and

- whether recoveries require to be made as a result of the visit, and the terms according to which they will be made.

6.3 These discussions, and the agreements reached, will form the basis of the draft practice visit report.

6.4 Where the discussions with the practice do not resolve the visiting team's concerns, no further dialogue will take place and the matter will be reported to the NHS Board and (if appropriate) to CFS simultaneously.

6.5 Practitioner Services do not have any responsibility regarding Clinical Governance within the GP Practice. However, if the visiting team become aware of any significant clinical issues during the visit, these will be referred on to the relevant NHS Board at the earliest opportunity, for them to take forward through the appropriate channels.

7. Practice Visit Report

7.1 The report should be drafted as soon as possible following the visit and every attempt should be made to minimise the use of patient identifiable data contained within it. If significant Clinical Governance issues were identified at the visit, the NHS Board would be notified immediately. It should be noted that Practice Visit reports may be made available under Freedom of Information requests, subject to individual request consideration and report content.

7.2 In instances where the visit has highlighted no areas of significant concern a draft report will be sent to the practice for confirmation of factual accuracy.

7.3 Once the comments have been acknowledged by the practice, a copy of the final report will be sent to the practice and the NHS Board, with a copy being retained by Practitioner Services. In order to comply with the principles of Data Protection and patient confidentiality, patients should not be identifiable in the report sent to the NHS Board.

7.4 In order to facilitate the equitable assessment of contractors, the conclusions resulting from a visit, and any further action required, will be clearly and consistently shown in all final reports. In order to facilitate this, the report will contain one of the following four summary conclusions:

1. High level of assurance gained – no recommendations/actions necessary.
2. Adequate level of assurance gained- no significant recommendations/actions necessary.
3. Limited level of assurance gained – key recommendations/actions made – re testing required following implementation of recommendations.
4. Inadequate level of assurance gained – issues escalated to appropriate authority for consideration of further action.

7.5 In instances where the visit has highlighted significant areas for concern, a report will not be sent to the practice until the tri-partite discussion between Practitioner Services, the NHS Board and Counter fraud services has taken place, and their agreement reached as to the appropriate course of action. This discussion will normally take place within two weeks of the notification of concern.

Appendix B - QOF Year End Pre-Payment Verification

Introduction

Following the submission of a practice's QOF achievement declaration, NHS Boards and practices have a set period during which pre-payment verification must be carried out. It is only when this process is complete to the satisfaction of the NHS Board that the achievement declaration of each practice can be approved and payment made in respect of QOF. Practices and NHS Boards are required to sign off their achievement in accordance with the timetable set out in the SFE.

This appendix provides guidance to NHS Boards about how pre-payment verification may be undertaken as part of NHS Boards' annual assurance processes. While it is for NHS Boards to determine the extent to which the guidance in this appendix is applied, any significant variances from the guidance should be reported to the relevant governance committee within the NHS Board.

QOF Achievement Review

In order to facilitate the pre-payment verification process, NHS Boards will establish a group to review QOF achievement within the Board area. Whilst most of this work will be undertaken during the pre-payment verification period, there is also a requirement for a degree of pre-payment verification throughout the year. NHS Boards should develop and agree a timetable to facilitate this process.

The membership of this group must comprise appropriately experienced NHS Board staff who will report their conclusions via the relevant governance committee within the NHS Board. The conclusions of the review group should be documented and retained in accordance with the requirements of Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1. Auditors may also want to use the outputs from this process to obtain assurance on the QOF payments included within the annual accounts.

This group will consider the outputs of several processes as part of pre-payment verification. Good practice suggests consideration of the following areas:

1. Practice Review Programme

All NHS Boards will have a practice review programme in place. Where this incorporates an element of QOF review then any significant issues arising from this process should be made available to be considered as part of pre-payment verification. If this is not possible due to timing issues, any issues should be considered as part of post payment verification.

2. PV Visit Programme

In accordance with the current payment verification arrangements, 5% of practices (minimum 1) will be randomly selected and visited to have their achievement in respect of QOF for the previous financial year verified. During these visits, an agreed minimum percentage of the achieved points will be verified via direct access to patient and practice records.

The outcomes of the PV visit programme should be fed back into the group reviewing QOF achievement.

3. In-Year Monitoring of Disease Registers

The integrity of disease registers is fundamental to the validity of all payments for the clinical indicators in QOF. It is therefore vital that practices are monitored on an ongoing basis to ascertain how their reported disease register sizes change.

As part of this process it is recommended that NHS Boards:

- Determine locally appropriate variance levels for each disease register size (e.g. +/- 10%) and identify any GP Practices that fall outwith this. Towards the end of the financial year this should be monitored against the previous year end figure on a monthly basis.
- Request practices to run regular (at least annually) clinical searches to determine that all relevant patients are included in the appropriate disease register (e.g. the prescribing of disease specific drugs to a patient not included on the relevant disease register).

It is recommended that practices print out/store their disease registers when the year end submission is made for their current achievement. This will provide more accurate, accessible information should a review or PV visit be required.

4. Year End Data Analysis

Building on the outputs from the practice review programme and the in-year monitoring of disease registers, NHS Boards must carry out specific analysis of points achievement and prevalence data submitted at year end.

As part of this process it is recommended that NHS Boards consider:

Points Achievement

- Identifying a locally appropriate percentage of achievement to ensure outlier practices can be followed up, to the satisfaction of the Board, prior to final sign off.
- Investigating significant variances in achievement for the current year, as compared to previous years.
- Satisfying themselves as to the validity of achievement for those indicators not attained in previous years. To assist this process, reference may be made to any organisational evidence that a Board has opted to request prior to payment.
- Identifying practices within the NHS Board area that have a similar demographic profile, but report a significant difference in achievement.

Prevalence

- Identifying a locally appropriate level of prevalence to ensure outlier practices can be followed up, to the satisfaction of the Board, prior to final sign off.
- Investigating significant variances in prevalence for the current year, as compared to previous years.
- Identifying practices within the NHS Board area that have a similar demographic profile, but report a significant difference in prevalence.

Exception Coding

- Identifying instances where practice (as opposed to system) generated exception coding has resulted in achievement of a payment threshold. In so doing it may also be useful, where possible, to consider this in the context of the number of practices that achieved the payment threshold without the use of exception coding.

Specific Indicator Analysis

- Defining a rationale to select a number of indicators to review in detail. This may focus on new or changed indicators and those with a high number of points. Consideration should also be given to the linkages or relationships between indicators.

Review of "Non-Clinical" Evidence

- Defining a rationale to select a number of "non-clinical" indicators for which evidence will be requested and reviewed.

Assurance from Existing NHS Board Processes

Evidence obtained from existing NHS Board processes may provide assurance in relation to achievement of specific indicators. Details of the assurance obtained from existing Board processes should form part of the report to the governance committee.

Remedial Action

Should the group reviewing QOF achievement discover any issues of concern during the pre-payment verification process, they must consider what remedial action is required.

A common course of action would be to enter into dialogue with the practice in an attempt to clarify any issues of concern. In the case of more serious issues, consideration should be given to the making of an interim payment, with any balance due being paid to the practice once a more in-depth investigation has been carried out.

NHS Boards may also wish to consider the referral of issues of concern to PSD in order that a Payment Verification visit is carried out. Where issues are of a serious nature NHS Boards should consider invoking a tri-partite discussion with PSD and CFS.

Where adjustments to practice achievement are made, by either NHS Boards or practices, appropriate supporting documentation should be retained and reported to the relevant governance committee. This evidence may also inform the annual PV visit programme.

Conclusion

While this appendix aims to provide pre-payment verification guidance, it is for individual NHS Boards to satisfy themselves that an appropriate level of assurance exists about the reasonableness of each individual practice's QOF claims. This guidance provides a framework around which NHS Boards can plan and undertake QOF pre-payment verification. Boards may wish to discuss these arrangements with their auditors, especially where they diverge from this guidance.

Annex III – Ophthalmic Payments

TABLE OF CONTENTS

Introduction

The following sections detail the payment verification requirements for General Ophthalmic Services (GOS).

Practitioner Services (Ophthalmic) operate a scanning and optical character recognition system (iDENT) and a computerised payment system (OPTIX) both of which undertake extensive pre-payment validation on ophthalmic payment claims.

Retention of Evidence

Practices are required to retain evidence to substantiate the validity of payments. The requirement for this evidence will be in accordance with the NHS (GOS)(Scotland) Regulations 2010. The Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 also provides a schedule listing the retention period for financial records in NHS Scotland. This specifies six years plus the current year as minimum retention period for most financial records. For the avoidance of doubt this would relate to any information used to support NHS payments to ophthalmic practitioners.

Where evidence to substantiate the validity of payments cannot be found, any fees paid will be recovered.

GOS 1 Primary Eye Examination Claim

Primary Eye Examination payments are based on claims made by contractors for undertaking examinations to test sight and identify signs of eye disease. Claims are submitted on the GOS 1 form or submitted electronically.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- claim forms by OPTIX/iDENT – to ensure all mandatory information is present validation against the GOS regulations and any provisos or time limits that apply
- duplication on OPTIX
- the patient's date of birth for age exemption
- checking the total value of the claim

Level 2 will comprise random sampling of claims including, but not limited to:

- examination of record cards and associated documentation to establish that they comply with the minimum data set as laid down in " The Statement"
- Check on number of primary examinations conducted in a day

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- patient letters
- further sampling of record cards and associated documentation
- the carrying out of practice visits as per Appendix A

Level 4 checking will be undertaken as follows:

- the carrying out of practice visits as per Appendix A

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Details of information used to verify service provision
- Any necessary recommendations, actions and recoveries

Further to the completion of a practice visit, a report will be produced which details the following:

- Information used to verify service provision
- Number of records checked and results
- Any necessary recommendations, actions and recoveries
- Level of assurance gained

GOS 1 Supplementary Eye Examinations

Supplementary Eye Examination (SEE) payments are based on claims made by contractors where the patient presents and requires an examination prior to the minimum Primary Eye Examination frequency. Claims are submitted on the GOS 1 form or submitted electronically.

Level 1 will comprise 100% checking of:

- claim forms by OPTIX/iDENT – to ensure all mandatory information is present validation against the GOS regulations and any provisos or time limits that apply
- duplication on OPTIX
- checking the total value of the claim

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- Individual and combinations of different SEE code types
- number of SEE

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- patient letters
- sampling of patient records and associated documentation
- the carrying out of practice visits as per Appendix A

Level 4 checking will be undertaken as follows:

- the carrying out of practice visits as per Appendix A

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Details of information used to verify service provision
- Any necessary recommendations, actions and recoveries

Further to the completion of a practice visit, a report will be produced which details the following:

- Information used to verify service provision
- Number of records checked and results
- Any necessary recommendations, actions and recoveries
- Level of assurance gained

GOS 1 Domiciliary Visits

Domiciliary visits are claimed in respect of a patient who is eligible for a GOS eye examination and who is unable to leave the place where they normally reside unaccompanied (for reasons of physical or mental ill health or disability) to attend a practice. Claims are made as an accompaniment to a GOS 1 PEE or SEE claim.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- claim forms by OPTIX/iDENT – to ensure all mandatory information is present

Level 2 will comprise random sampling of claims including, but not limited to:

- examination of record cards and associated documentation

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- patient letters
- sampling of patient records and associated documentation
- the carrying out of practice visits as per Appendix A

Level 4 checking will be undertaken as follows:

- the carrying out of practice visits as per Appendix A

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Details of information used to verify service provision
- Any necessary recommendations, actions and recoveries

Further to the completion of a practice visit, a report will be produced which details the following:

- Information used to verify service provision
- Number of records checked and results
- Any necessary recommendations, actions and recoveries
- Level of assurance gained

GOS 3 Spectacle Vouchers

Spectacle Vouchers are issued by contractors to patients who are eligible for help with costs towards glasses or contact lenses. Claims are submitted on the GOS 3 form or submitted electronically. The GOS 3 voucher may contain a number of payment elements including the voucher value (based on the prescription) and supplementary items such as Prisms, Tints, Small Glasses and Complex Lenses.

Level 1 will comprise 100% checking of:

- claim forms by OPTIX/iDENT – to ensure all mandatory information is present
- validation against the NHS (Optical Charges & Payments) (Scotland) Regulations 1998 and any provisos or time limits that apply
- duplication on OPTIX
- the patient's date of birth for age exemption
- checking the total value of the claim

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- ratio of GOS3 claims to total eye examination claims

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- patient letters
- sampling of patient records and associated documentation
- the carrying out of practice visits as per Appendix A
- for glasses that have not yet been collected, verification that the prescription corresponds to that which is being claimed for

Level 4 checking will be undertaken as follows:

- the carrying out of practice visits as per Appendix A
- for glasses that have not yet been collected, verification that the prescription corresponds to that which is being claimed for

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Details of information used to verify service provision
- Any necessary recommendations, actions and recoveries

Further to the completion of a practice visit, a report will be produced which details the following:

- Information used to verify service provision
- Number of records checked and results
- Any necessary recommendations, actions and recoveries
- Level of assurance gained

GOS 4 Repair/Replacement Voucher

Repair and replacement vouchers are issued by contractors, primarily in respect of patients under 16 year of age, whose spectacles have suffered damage or been lost and require either to be repaired or replaced. Claims are submitted on the GOS 4 form.

Level 1 will comprise 100% checking of:

- claim forms by OPTIX/iDENT – to ensure all mandatory information is present
- validation against the NHS (Optical Charges & Payments) (Scotland) Regulations 1998 and any provisos or time limits that apply
- duplication on OPTIX
- the patient's date of birth for age exemption
- checking the total value of the claim

Level 2 will comprise random sampling of claims including, but not limited to:

- examination of record cards and associated documentation

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- patient letters
- sampling of patient records and associated documentation
- the carrying out of practice visits as per Appendix A

Level 4 checking will be undertaken as follows:

- the carrying out of practice visits as per Appendix A

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Details of information used to verify service provision
- Any necessary recommendations, actions and recoveries

Further to the completion of a practice visit, a report will be produced which details the following:

- Information used to verify service provision
- Number of records checked and results
- Any necessary recommendations, actions and recoveries
- Level of assurance gained

Appendix A – Inspection of Ophthalmic Records and Practice Visits

1. Background

1.1 One of the methods of verifying payments made under General Ophthalmic Services (GOS) arrangements is to examine patient records. It has been agreed that these checks may be carried out during practice visits. During these visits a selection of records will be examined looking at a range of items of service.

1.2 These records will usually be paper based though cross-checking may be required with any relevant electronically held information, as well as with order books and appointment diaries.

2. Selection of Practices

2.1 Practitioner Services staff will conduct these visits on either a random basis with regard to the risk matrix and the quota of record card checks to be carried out for that particular NHS Board, or where the application of risk assessment or trend analysis suggests that this would be appropriate.

2.2 Practitioner Services and NHS Boards will jointly agree the selection of practices. In the case of those visits carried out as part of random sampling, consideration will be given to avoiding the selection of any practices that have recently been in receipt of a Practice Inspection or routine record card check

2.3 Contractors will be advised of when the visit will take place and the reason therefor.

2.4 The contractor will be given at least four weeks' notice of the intention to carry out a visit. Every effort will be made to carry out the visit at a mutually convenient time, including giving consideration to visits 'out of hours' where that is feasible.

2.5 In the event that a contractor fails to give access to patient records then the NHS Board will be alerted so that the contractor may be warned that he or she may be subject to a referral for NHS disciplinary procedures.

3. Selection of Records

3.1 In advance of the visit, a number of claims will be identified for examination. Practitioner Services will extract this information from the OPTIX system and cross reference this to the Community Health Index (CHI).

3.2 Practitioner Services will examine record cards from recent visits by patients, though this will be dependent on the 'items of service' being checked and the throughput of the practice.

3.3 The total number of patient records identified for examination would not normally exceed that which it is practical to review in a two to three hour session. This timeframe may however vary, particularly where records are held centrally.

3.4 The numbers of records selected for each 'item of service' as part of the random practice visit will be determined by a risk methodology, thus ensuring that a minimum threshold is achieved for the number of records that are accessed for the purposes of verification. For visits concentrating on specific areas, the volume of checks will be determined by the specific circumstances and in consultation with the relevant NHS Board.

3.5 During the visit, Practitioner Services staff may take copies of a sample of the patient records they have checked, either by photocopying, photographing or by electronic scanning. This will support instances where there is a need for clarification on any matter that cannot be resolved during the practice visit.

3.6 Once the practice visit is completed, the outcome agreed and no further audit is required, the copies of the patient records will be destroyed.

4. Visiting Team

4.1 The team visiting the practice may comprise representatives from both Practitioner Services and the NHS Board. An Optometrist, who is independent to the practice, should also attend.

4.2 As all members of the visiting team are NHS staff/contractors, they are contractually obliged to respect patient and business confidentiality and are bound by the NHS code of practice.

4.3 Should they so desire, the relevant NHS Board may undertake a visit at the same time as the visiting team. This may be of particular assistance if locally run schemes are to be verified by the NHS Board during the visit. In these cases, all of the purposes of the visit will be made clear to the contractor before the visit is made.

5. Examining the Patient Record Cards

5.1 The visiting team should be afforded sufficient space and time to examine the patient record cards to ascertain whether evidence exists to verify that payments made to the contractor were appropriate.

5.2 The audit should be carried out in a private, non-public area of the practice where patient confidentiality can be observed, and issues can be discussed where necessary out-with the earshot of patients.

5.3 A member of the practice staff should be available to assist with the location of evidence, if required.

5.4 It is recommended good practice that, where the visiting team is accessing electronic records, the contractor grants access to the computer system via a 'read only' account.

6. Concluding the Visit

6.1 Where the visit has identified issues, these will be discussed with the practice with a view to resolving them. The independent optometrist may assist these discussions by providing advice and guidance in relation to clinical matters.

6.2 In instances where resolution of these issues is achieved, the visit may then be concluded, and the practice advised of the following:

- Which payments were verified, and which payments were not;
- Whether an extended sample of clinical records require to be examined/further investigation carried out;
- What actions the practice is required to take as a result of the visit;
- Whether recoveries require to be made as a result of the visit, and the terms according to which they will be made.

6.3 These discussions, and the agreements reached will form the basis of the draft practice visit report.

6.4 Where the discussions with the practice do not resolve the visiting team's concerns, no further dialogue will take place and the matter will be reported to the NHS Board and (if appropriate) to Counter Fraud Services simultaneously.

6.5 Practitioner Services do not have any remit regarding Clinical Governance. If, however, they become aware of any significant clinical issues during the course of the visit, these will be referred on to the relevant NHS Board at the earliest opportunity, for them to take forward through the appropriate channels.

7. Practice Visit Report

7.1 The report should be drafted as soon as possible following the visit. It should be noted that practice visit reports may be made available under Freedom of Information requests, subject to individual request consideration and report content.

7.2 In instances where the visit highlighted no areas of significant concern, a draft report will be sent to the contractor for confirmation of factual accuracy.

7.3 Once the contents have been agreed by the contractor, a copy of the final report will be sent to the contractor and the NHS Board, with a copy being retained by Practitioner Services.

7.4 In order to facilitate the equitable assessment of contractors, the conclusions resulting from a visit, and any further action required, will

be clearly and consistently shown in all final reports. In order to facilitate this, the report will contain one of the following four summary conclusions:

1. High level of assurance gained – no recommendations/actions necessary

2. Adequate level of assurance gained – no significant recommendations/actions necessary

3. Limited level of assurance gained – key recommendations/actions made – re testing required following implementation of recommendations

4. Inadequate level of assurance gained - issues escalated to appropriate authority for consideration of further action

7.5 In instances where the visit has highlighted significant areas of concern, a report will not be sent to the contractor until the tri-partite meeting between Practitioner Services, the NHS Boards and Counter Fraud Services has taken place, and their agreement reached as to the appropriate course of action.

Annex IV – Pharmaceutical Payments

TABLE OF CONTENTS

Introduction

The following sections detail the payment verification requirements for General Pharmaceutical Services (GPS).

Practitioner Services (Pharmacy) operates a scanning and optical character recognition system and a computerised payment system (DCVP) both of which undertake extensive pre-payment validation on pharmaceutical payment claims from pharmacies, dispensing doctors, stoma suppliers and appliance suppliers.

Retention of Evidence

Practices are required to retain evidence to substantiate the validity of payments. The requirement for this evidence will be in accordance with the General Pharmaceutical regulations. The Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 also provides a schedule listing the retention period for financial records in NHS Scotland. This specifies six years plus the current year as minimum retention period for most financial records. For the avoidance of doubt this would relate to any information used to support NHS payments to pharmacies, dispensing doctors, stoma suppliers and appliance suppliers.

Where evidence to substantiate the validity of payments cannot be found, any monies paid will be recovered.

Minor Ailments Service

Minor Ailments Service Payments are based on a GP referral and on the provision of consultation, prescribing (within a permitted range) and dispensing services to eligible patients. Patients must be registered with a Scottish GP Practice and pharmacy to receive the service. The pharmacy receives payment for capitation and reimbursement for any drugs dispensed. Registrations and claims are made on form CP2.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- Patients against CHI for existence and eligibility.
- Other checks as detailed in Appendix A.

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- Registration activity.
- Claim activity.
- Random letters to patients to confirm provision of service.

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- Targeted letters to patients to confirm provision of service.
- Sampling of patient medication records and associated documentation.

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries

Chronic Medication Service

Chronic Medication Service payments relate to the provision of services to patients with ongoing long term medical conditions. This includes the assessment and planning of the patient's pharmaceutical care needs and the establishment of a shared care element, which allows the GP to produce a serial prescription to be dispensed at appropriate intervals. Patients must be registered with a Scottish GP Practice and pharmacy to receive the service. The pharmacy receives payment for capitation and reimbursement for any drugs dispensed. Registrations and claims are made on form CP3.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- Patients against CHI for existence and eligibility.
- Claims forms by the Patient Registration System – to ensure all mandatory information is present.
- Other checks as detailed in Appendix A.

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- Registration activity.
- Claim activity.
- Random letters to patients to confirm provision of service.

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- Targeted letters to patients to confirm provision of service.
- Sampling of patient medication records and associated documentation.

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries

Gluten Free Food Service (GFF)

Gluten Free Food Service payments are based on claims submitted for services to patients with a diagnosis of coeliac disease or dermatitis herpetiformis. The service allows patients to order and receive gluten free food from their pharmacy without the need to go through their GP. Claims are made via submission of a CPUS form.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- Patients against CHI for existence and eligibility.
- Other checks as detailed in Appendix A.

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- Claim activity.
- Random letters to patients to confirm provision of service.

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- Targeted letters to patients to confirm provision of service.
- Sampling of patient medication records and associated documentation.
- Review of the GP letter of authority.

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries

Acute Medication Service

The Acute Medication Service (AMS) allows the Electronic Transfer of Prescriptions (ETP) and supports the provision of pharmaceutical care services for acute episodes of care and any associated counselling and advice.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking as detailed in Appendix A.

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- Claim activity.
- Random letters to patients to confirm provision of service.

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- Targeted letters to patients to confirm provision of service.
- Sampling of patient medication records and associated documentation.

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries

Public Health Service - Emergency Hormonal Contraception

This service provides, where clinically indicated, a free supply of emergency hormonal contraception (EHC). The service is available to any female client aged 13 years or over.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking as detailed in Appendix A.

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- Claim activity.

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- Sampling of patient medication records and associated documentation.

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries

Public Health Service – Nicotine Replacement

This service supports the provision of extended access through the NHS, including the provision of advice and smoking cessation products, in order to help smokers successfully stop smoking as part of the Public Health Service (PHS) element of the community pharmacy contract.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- Patients against CHI for existence and eligibility.
- Claim forms by the Patient Registration System – to identify concurrency.
- Other checks as detailed in Appendix A.

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- Claim activity.

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- Targeted letters to patients to confirm provision of service.
- Sampling of patient medication records and associated documentation.

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries

Locally Negotiated Payments

Locally Negotiated Payments will be covered by the NHS Boards' internal and external audit processes and the NSS service audit process.

Out of Pocket Expenses

Community Pharmacies can claim reasonable Reimbursements for Out of Pocket Expenses for certain items, excluding any items in parts 2 – 7 and 9 of the Scottish Drug Tariff.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- System validation against set claim criteria.
- Other checks as detailed in Appendix A.

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- Claim activity.

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- Targeted letters to contractors to request supporting documentation.

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries

Stock Orders

Stock Order Forms (GP10A) should only be used for treatments that are required for immediate use by patients following an un-planned intervention in the GP practice.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- System validation against set claim criteria.
- Other checks as detailed in Appendix A.

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- Claim activity.

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- Targeted letters to GP practices to confirm receipt of items.

Level 4 checking will be undertaken as follows:

- Random letters to GP practices to confirm receipt of items.

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries

Other Contractor Types - Dispensing Doctors

Dispensing GP practices exist in those areas of Scotland where the population density is considered too low to support a pharmacy.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking as detailed in Appendix A.

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- Claim activity.
- Random letters to patients to confirm provision of service.

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- Targeted letters to patients to confirm provision of service.

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries

Other Contractor Types - Appliance/Stoma Suppliers

Appliance/Stoma Suppliers are reimbursed for the provision of specialist products to Scottish patients.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking as detailed in Appendix A.

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- Claim activity.
- Random letters to patients to confirm provision of service.

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- Targeted letters to patients to confirm provision of service.

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries

Appendix A – Level 1 Checks

P&CFS will automatically carry out 100% level 1 checking on the following:

a) All Foreign Forms & Items.
b) All Urgent Fees.
c) All High Value Items above a fixed amount.
d) All Low Value Items, below £0.02
e) All Dummy Items with Over-ride prices.
f) All Out of Pocket claims.
g) All Rejected Items.
h) All Pay & Report Items.
i) Any Unusual Fees above a fixed amount.
j) Any items set for Ambiguity Check.
k) Any Invalid CHI No.
l) All Instalments claimed above a fixed amount.
m) All invalid formulary items, against form type, prescriber type and dispenser type.
n) Any Quantity Limit Exceeded - limits set at item level on EVADIS.
o) Random Check of manually processed items.

The checks will be applied to the various service areas as follows:

- Minor Ailments Service. – b, c, d ,e, g, h, i, j, k, l, m, n, o
- Chronic Medication Service. - b, c, d, e, g, h, j, k, l, m ,n, o
- Gluten Free Food Service (GFF) - a, b, c, d, e, g, h, j, k, l, m, n, o
- Acute Medication Service. - a, b, c, d, e, g, h, i, j, k, l, m, n, o
- Public Health Service – Emergency Hormonal Contraception. - b, c, d, e, g, h, i, j, k, l, m, n, o
- Public Health Service – Nicotine Replacement - b, c, d, e, g, h, i, j, k, l, m, n, o
- Out of Pocket Expenses. – f
- Stock Orders. - c, d, e, g, h, j, m, n, o
- Dispensing Doctors - b, c, d, e, g, h, j, l, m, n, o
- Appliance/Stoma Suppliers - a, b, c, d, e, g, h, i, j, k, l, m, n, o

Appendix B – Random Sampling

1. Background

1.1 One of the methods of verifying payments made under General Pharmaceutical Services (GPS) arrangements is to examine patient records as part of random sampling. During random sampling a selection of records will be examined looking at a range of claim/payment types.

2. Selection of Pharmacies

2.1 Practitioner Services will select the pharmacies to be included as part of the random sample. Pharmacies which have been selected within the previous five years random sampling will be excluded.

2.2 The level of this check will result in a minimum of 1% of all pharmacies across Scotland having records inspected annually and will involve the confirmation of a sample of claims across selected payment categories.

3. Selection of Records

3.1 The size of the sample undertaken will be based on statistical strata using the number of claims submitted by the pharmacy.

4. Examination of Patient Medication Records

4.1 The claims/payments included within the sample will be checked against the details contained within the respective patient medication records from the pharmacy.

Action Note NHS Tayside

CORPORATE GOVERNANCE REVIEW MEETING

Action note from above meeting held at 10:30am on Thursday 19 May 2016 in Committee Room 1, Level 10, Ninewells Hospital

Present
Mr Derek Colley, Financial Governance Accountant
Miss Donna Howey, Head of Committee Administration
Ms Margaret Dunning, Board Secretary
Mrs Lisa Green, Committee Support Officer
Mrs Alison Hodge, Committee Support Officer
Mrs Nicki Owen, Committee Support Officer

Apologies
Ms Jackie Bayne, HR Manager
Mrs Judith Golden, Employee Director
Mr Barry Hudson, Regional Audit Manager
Mrs Jocelyn Lyall, Principal Auditor
Mrs Hilary Walker, Risk Manager, NHS Tayside
Ms Alison Wood, Head of Corporate Services and Business Support, Perth

In Attendance
Mrs Judith Triebs, Principal Auditor

Ms M Dunning in the Chair

ACTION

1. Apologies and Welcome

The apologies were as noted above and all were welcomed to the meeting. Margaret paid a particular welcome to the new members of the Governance Review Group, Lisa Green, Alison Hodge and Nicki Owen.

It was agreed that Jakki Roger who provided support to the Area Clinical Forum and the professional advisory committees, would also be invited to become a member of the Governance Review Group. **Donna Howey**

It was noted that in addition to the Committee Support Officers, a representative from the health and social care partnerships was required and Alison Wood, Head of Corporate Services and Business Support, Perth had agreed to join the Governance Review Group.

2. Action Note of Last Meeting

Action Note – 4 March 2016

The Action Note of the meeting held on 4 March 2016 was approved. It was noted that this action note had gone forward as unapproved to the meeting of the Audit Committee on 5 May 2016.

3. Action Points Update

Governance Reporting of Health and Safety

In addition to the update provided by Hilary Walker, it was noted that a meeting had been arranged to be held on 18 May 2016 with George Doherty, Lorna Wiggin, Hilary Walker, Margaret Dunning and Ken Armstrong to discuss the governance reporting of health and safety.

This meeting had been cancelled and would need to be rearranged.

The Governance Review Group noted the action points update

4. Any Other Matters Arising

There were no other matters arising.

5. Health and Social Care Integration

The presentation given by Tony Gaskin, Chief Internal Auditor to the Audit Committee on 5 May 2016 had been circulated to the Governance Review Group for information. It was noted that it had also been circulated to the Directors.

There was discussion in respect of the responsibility for the mental health service in Tayside and the upcoming consideration of the future model of mental health services for general adult psychiatry. The question of who would have the final decision on this , either the host IJB (Perth and Kinross) or Tayside NHS Board, had been raised with the Scottish Government Health and Social Care Directorate.

The engagement and consultation on the future model of mental health services was continuing and would be reported to both the IJBs and Tayside NHS Board, with a further period of three months consultation.

The previous experience with the regional Rohallion mental health facility was discussed. It was noted that each of the relevant NHS Boards had to sign off on this facility.

It was noted that there was no requirement at the present time to make any major changes to the Code of Corporate Governance. These would need to be done following confirmation of the lines of accountability etc. Staff employed by NHS Tayside were still subject to the NHS Tayside Code of Corporate Governance.

There was discussion about the authorised signatories list. It was noted that NHS Tayside staff spending NHS Tayside monies were covered by NHS Tayside's governance regulations.

In respect of pooled budgets, Judith Triebs advised that no changes were anticipated during 2016/17. Going forward it was expected that these budgets would be merged.

There was discussion about the clinical governance reporting arrangements. It was noted that a Clinical and Care Governance Framework was in place, and assurances would be provided from the IJBs to Tayside NHS Board.

It was noted that the health and social care integration strategic risk was to be presented to the Board on 23 June 2016. It was acknowledged that this risk would now need to be updated post integration.

The Governance Review Group noted the discussion on health and social care integration

6. Code of Corporate Governance Updates

The draft Code updates paper to be submitted to the Audit Committee on 21 June 2016 and the Board on 23 June 2016 was discussed.

It was agreed that this paper could be submitted to the Audit Committee on 21 June 2016.

There was discussion in respect of the new senior leadership team restructuring. It was noted that updates to the Code would be required once the new structure had been confirmed.

It was noted that Section E, 3.3 Signing of Documents, Research Sponsorship was not aligned correctly and this would be changed as part of these Code updates.

The Governance Review Group agreed that these Code updates could be submitted to the Audit Committee on 21 June 2016

7. Section E Reservation of Powers and Delegation of Authority

There was discussion about the potential for further updates to Section E of the Code, Reservation of Powers and Delegation of Authority. It was agreed that the required changes would not be made until the respective governance responsibilities of the IJBs and the Board were fully understood. What was "operational governance" in relations to the IJBs needed to be worked out and then NHS Tayside would be able to update their standing orders accordingly.

The Governance Review Group agreed that the changes to Section E, Reservation of Powers and Delegation of Authority would be held over until the respective governance responsibilities of the IJBs and the Board were fully understood

8. Draft Governance Review Group Annual Report 2015/16

The Draft Governance Review Group Annual Report 2015/16 was discussed and approved.

The Governance Review Group approved the Draft Governance Review Group Annual Report 2015/16

9. Workplan

The Workplan was noted and would be reviewed at the next meeting.

The Governance Review Group noted the Workplan

10. Any Other Competent Business

Transformation Programme Board

In response to a query raised by Adrian Caddick, Principal Auditor, it was confirmed that the Transformation Programme Board operated in the same way as a Standing Committee, but, it was not required to be included in the NHS Tayside Code of Corporate Governance, as it was a short life Programme Board. It was noted that it was also not held in the public domain.

11. Date of next meeting

The date of the next meeting was 19 August 2016 at 10:30am in Committee Room 1, Level 10, Ninewells

Record of Attendance

NHS Tayside

Audit Committee Record of Attendance 1 April 2016 – 31 March 2017

Name	Designation	Organisation	Meeting Date	Meeting Date	Meeting Date	Meeting Date	Meeting Date
			5 May 2016	21 Jun 2016	1 Sept 2016	15 Dec 2016	16 Mar 2017
Members							
Mrs P Campbell	Non Executive Member (resigned 2 June 2016)	NHS Tayside	Present	-	-	-	-
Mr D Cross OBE	Non Executive Member	NHS Tayside	Present	Present			
Cllr D Doogan	Non Executive Member (Vice Chair)	NHS Tayside	Apologies	Apologies			
Mrs L Dunion	Non Executive Member	NHS Tayside	Present	Apologies			
Mrs J Golden	Non Executive Member & Employee Director	NHS Tayside	Apologies	Present			
Mr S Hay	Non Executive Member (Chair)	NHS Tayside	Present	Present			
Mr M Hussain	Non Executive Member	NHS Tayside	Present	Present			
Cllr Middleton	Non Executive Member	NHS Tayside	Apologies	Present			
In Attendance							
Mr L Bedford	Director of Finance	NHS Tayside	Present	Present			
Ms G Collin	Senior Manager	PricewaterhouseCoopers	Present	Present			
Ms M Dunning	Board Secretary	NHS Tayside	Present	Present			
Mr T Gaskin	Chief Internal Auditor	FTF Audit & Management Services	Present	Present			
Mr K Wilson	Partner	PricewaterhouseCoopers	-	Present			
Regular Attendees							
Mr D Colley	Financial Governance Accountant	NHS Tayside	Present	-			
Mr G Doherty	Director of Human Resources	NHS Tayside	Present	Present			
Mrs F Gibson	Head of Financial Servicew	NHS Tayside	Present	Present			
Mr B Hudson	Regional Audit Manager	FTF Audit & Management Services	-	-			

Mrs J Lyall	Principal Auditor	FTF Audit & Management Services	Present	Present			
Mr R MacKinnon	Associate Director of Finance, Financial Svs & Governance/FLO	NHS Tayside	Present	Present			
Mr D Mills	Representative Area Clinical Forum	NHS Tayside	Apologies	Present			
Mrs H Walker	Safety, Governance & Risk Co-Ordinator	NHS Tayside	Present	Apologies			
For Information							
Prof J Connell FMedSci FRSE	Chair, Tayside NHS Board	NHS Tayside	Present	Present			
Mrs G Costello	Nurse Director	NHS Tayside	-	-			
Mrs L Green	Committee Support Officer	NHS Tayside	Present	Present			
Miss D Howey	Head of Committee Administration	NHS Tayside	Present	Present			
Ms L McLay	Chief Executive	NHS Tayside	Apologies	Present			
Mr H Robertson	Non Executive Member	NHS Tayside	-	-			
Mrs A Rogers	Non Executive Member	NHS Tayside	-	-			
Mr A Russell	Medical Director	NHS Tayside	-	-			
Prof M Smith	Non Executive Member	NHS Tayside	-	-			
Mrs S Tunstall-James	Non Executive Member	NHS Tayside	-	-			
Dr D Walker	Director of Public Health	NHS Tayside	-	-			

Minute NHS Tayside

TAYSIDE NHS BOARD
AUDIT COMMITTEE - OPEN BUSINESS

Minute of the meeting of Tayside NHS Board Audit Committee held at 9.45 a.m. on **Tuesday 21 June 2016** in the Board Room, Conference Suite, King's Cross, Dundee

Present:
Mr D Cross, OBE, Non Executive Member, Tayside NHS Board
Mrs J Golden, Non Executive Member, Tayside NHS Board
Mr S Hay, Non Executive member, Tayside NHS Board (Chair)
Mr M Hussain, Non Executive Member, Tayside NHS Board
Councillor G Middleton, Non Executive Member, Tayside NHS Board

Chair, Chief Executives and Senior Officers
Mr L Bedford, Interim Director of Finance, NHS Tayside
Prof J Connell, Chair, Tayside NHS Board
Mr G Doherty, Director of Human Resources, NHS Tayside
Mr R MacKinnon, Associate Director of Finance - Financial Services & Governance/FLO, NHS Tayside
Ms L McLay, Chief Executive, NHS Tayside

External Auditors
Ms G Collin, Senior Manager, PricewaterhouseCoopers
Mr K Wilson, Senior Manager, PricewaterhouseCoopers

Internal Audit – FTF Audit and Management Services
Mr T Gaskin, Chief Internal Auditor, FTF Audit and Management Services
Mrs J Lyall, Acting Regional Audit Manager, FTF Audit and Management Services

Other Attendees
Miss W Aitchison, Endowment Accountant, NHS Tayside
Mr P Crichton, External Auditor, MMG Archbold (Item 5)
Ms M Dunning, Board Secretary, NHS Tayside
Mr G Finnie, Financial Accountant, NHS Tayside
Miss J Flood, Financial Accountant, NHS Tayside
Mrs F Gibson, Head of Financial Services, NHS Tayside
Mrs L Green, Committee Support Officer, NHS Tayside
Miss D Howey, Head of Committee Administration, NHS Tayside
Mr D Mills, Representative Area Clinical Forum, NHS Tayside
Mr D Taylor, External Auditor, Henderson Loggie (Item 6)

Apologies
Councillor D Doogan, Non Executive Member, Tayside NHS Board
Ms L Dunion, Non Executive Member, Tayside NHS Board
Mrs H Walker, Risk Manager, NHS Tayside

Mr S Hay in the Chair

1. WELCOME **ACTION**

The Committee moved into open business.

2. APOLOGIES

The apologies were noted as above.

3. DECLARATION OF INTERESTS

Mr Hay wished to note his thanks to Mrs Penny Campbell for her valuable and helpful contributions to the Committee prior to her resignation.

4. MINUTE OF PREVIOUS MEETING

4.1 Minute of the Audit Committee Minute – 5 May 2016

The Audit Committee Minute of the meeting held on 5 May 2016 was approved on the motion of Mr D Cross and seconded by Mr M Hussain.

4.2 Action Points Update

Mr MacKinnon spoke to the Action Points Update.

Recording Equipment – It was noted this matter was progressing and discussions with staff side colleagues were ongoing.

External Review of all Mental Health Sites – It was noted a report would be submitted to a future Committee meeting following review by the Principal Architect.

Work Plan Progress Report – It was noted this was an Agenda item.

Workshop for Non Executive Members – It was noted the facilitation of a short workshop for Non Executive Members to address issues regarding access to NHS Mail, Staffnet and Network Devices from various devices had been scheduled for 22 September 2016 and further details would be circulated in due course.

Progress on Internal Audit Report T21/14 Medical Instrumentation and Devices – It was noted that the Head of Instrumentation post had been filled and an update would be given to the Committee at its meeting on 1 September 2016.

Risk Manager attendance at Strategic Risk Management (SRMG) meetings – It was noted Mr Hay would consult with the Chief Executive regarding Risk Managers attendance at SRMG following this Committee meeting.

HSCI Governance Presentation – It was noted the HSCI Governance presentation would be given to Tayside NHS Board at its December 2016 meeting.

NHS Scotland Overview Report and Checklist – It was noted a Board Development Session had been arranged for 22 September 2016.

Adverse Events Management Policy – It was noted this would be an Agenda item at the 1 September 2016 meeting.

The Committee noted all completed actions.

4.3 Work Plan Update

Mr MacKinnon advised the Committee that the Work Plan had been updated to include the Annual Accounts cycle to June 2017

The Committee

- **Noted the updated to the Work Plan**

4.4 Matters Arising

There were no matters arising.

ENDOWMENT FUNDS

5. Draft Annual Accounts 2015/16 Tayside NHS Board Endowment Funds (AUDIT50/2016)

The Committee welcomed Mr Crichton, External Auditor for MMG Archbold, who was in attendance for this item.

Mr MacKinnon advised the Committee that the report highlighted the responsibilities of the Audit Committee in terms of the Endowment Fund. It was noted that Mr MacKinnon had reviewed the draft accounts and met with the external auditors following completion of the audit.

Mr Crichton advised the Committee this was the first annual accounts carried out under the Financial Reporting Standard (FRS) 102 and the transition in reporting had gone well providing a clean findings report with no areas for concern and any immaterial errors being reported for information only.

Mr Crichton highlighted the minor errors contained within the report as follows:

- the omission of legacies which had been received post year end. This was due to the timing of the receipt of income
- the omission of a number of accruals from the financial statements. This was due to the timing of the cut off in the current year. It was noted the level had been significantly reduced following the introduction of the PECOS system
- the number of old funds remaining unspent. There was an intention to move funds under £2,000 and those dormant for at least 3 years to unrestricted funds, however, this was in the early stages with no application as yet having been made to The Office of the Scottish Charity Register (OSCR)

It was noted there was a reliance on the work of FTF Internal Audit and there were no concerns over controls.

Mr MacKinnon confirmed a report would be submitted to the Board of Trustees, following the summer recess, taking forward proposals in relation to the unspent and dormant funds.

The Committee

- **Considered the draft annual accounts and recommended that the Board of Trustees should adopt the accounts for the year ended 31 March 2016, and that Professor Connell, in his capacity as Chair of the Board of Trustees, and Ms McLay, in her capacity as Trustee, should sign on behalf of the Board of Trustees:**
  - **The report of the Trustees (page 10)**
  - **The statement of Trustee' Responsibilities for the preparation of the Financial Statements (page 11), and**
  - **The Balance Sheet (page 15)**
- **Considered the Audit Findings Report to the Audit Committee from MMG Archbold**
- **Considered the Letter of Representation to MMG Archbold and recommended that it be signed by Professor Connell, in his capacity as Chair of the Board of Trustees, and Ms McLay, in her capacity as Trustee, on behalf of the Board of Trustees.**
- **Considered the Letter of Confirmation to MMG Archbold and recommended that it be signed by Professor Connell, in his capacity as Chair of the Board of Trustees on behalf of the Board of Trustees**

PATIENTS' FUNDS

6. Patients' Funds – External Audit Report (AUDITR49/2016)

The Committee welcomed Mr Taylor, External Auditor for Henderson Loggie, who was in attendance for this item.

Mr MacKinnon advised that the draft Abstract of Receipts and Payments in respect of Patients' Private Funds was presented for consideration by the Committee prior to submission to Tayside NHS Board.

Mr Taylor advised the Committee that this was the first full year audit following the introduction of the new procedures in June 2014.

Mr Taylor informed the Committee that a small number of errors or system weaknesses were found during the review, however, internal controls in most cases were found to be adequate during audit testing. It was noted that in 2014/15 there were 12 minor action points reducing to 6 minor action points in 2015/16 all categorised as priority C, low risk.

The Committee

- **Reviewed the draft Abstract and Receipts and Payments**
- **Noted the draft audit certificate from Henderson Loggie**
- **Considered the Audit Findings Report from Henderson Loggie**

- **Approved the Recommendation that Tayside NHS Board formally adopts the Abstract of Receipts and Payments in respect of Patients' Private Funds for the year ended 31 March 2016, and authorises the Director of Finance and the Chief Executive to sign the Abstract on behalf of Tayside NHS Board along with the draft letter of representation**

7. EXCHEQUER FUNDS

Mr Hay advised the Committee that Items 7.1 to 7.7 concerned the assurances required for the Audit Committee to approve and recommend the draft report Tayside NHS Board – Assurance by Audit Committee which would be considered under Item 7.8

7.1 Review of System of Internal Control (AUDIT47/2016)

Mr Bedford advised that this report was a scene setter in providing the Committee with the framework for the Committee's review of the system of internal control covered in Item's 7.1 – 7.8 on the Agenda and included the draft Governance Statement (GS) at Appendix 1 of the report.

Mr Bedford highlighted some minor errors contained within this version of the GS as follows:

- Page 1 - minor typo in Tayside Health Board heading
- Page 5 - additional sentence within 3rd paragraph
- Page 9 - Enhancement During Leave – Last sentence to read "An electronic solution will be rolled out across....."

It was noted that these amendments had been reflected within the version of the GS included within Item 7.5 Review of System of Internal Control Lead Officer's Statement to Chief Internal Auditor. It was noted the GS included input from, a range of colleagues and both internal and external audit.

Mr Cross noted that the GS had strengthened from previous years, however, queried what procedures were in place for the Audit Committee to monitor the controls mid-point and highlighted the need for forward planning. It was noted that an Interim Review was submitted to the Committee at its meeting in February 2016. Mr Gaskin advised that Internal Audit would be presenting an Interim Review to the Committee in December 2016 which would be available before February 2017. It was noted Mr Bedford would update the Committee of any issues.

The Committee was asked to review the System of Internal Control and to consider the various terms of its assurance report to Tayside NHS Board. This was to be done by considering each of the reports under Item 7 followed by the conclusion included within Item 7.7 and the Assurance Report at Item 7.8.

The Committee

- **Agreed to review the System of Internal Control and to consider and approve the terms of its assurance report to Tayside NHS Board**

7.2 Annual Reports and Assurances by Committees including Best Value Assurances (AUDIT52/2016)

Mr MacKinnon advised the Committee that all Standing Committees of Tayside NHS Board, with the exception of the Audit Committee, the Board of Trustees and the Governance Review Group had approved their Annual Reports prior to 30 May 2016.

It was noted that Appendix 1 of the report included the overall conclusions from each of these Annual Reports and the Best Value Framework Assurance 2015/16 was included as Appendix 2 of the report. The Best Value Framework Assurance 2015/16 was approved by the Committee at its meeting on 5 May 2016 subject to the inclusion of the Integrated Joint Boards (IJBs) in 2016/17.

Mr MacKinnon advised the Committee that the main function of the Audit Committee was to provide assurance to Tayside NHS Board that an appropriate system of internal control was in place. It was noted Mr Bedford had described work taken place under Item 7.1 of the Agenda.

It was noted that the Audit Committee Annual Report 2015/16 was to be considered separately under Item 7.7 on the Agenda.

Mr Gaskin highlighted that the Clinical and Care Governance Committee conclusion on page 2 of the report did not give assurance on accuracy and effectiveness due to the word "tested" being include within the paragraph *"As a result of the work undertaken during the year I can confirm that measures aligned to the Committee's Terms of Reference tested the effectiveness of clinical governance throughout NHS Tayside services during the year".* Mr Gaskin advised that work carried out by Internal Audit highlighted no concerns and this should be reflected in the conclusion.

The Committee

- **Considered the overall conclusion included within each Standing Committee's Annual Report, Board of Trustees and that of the Governance Review Group and the assurances given therein, in reaching a conclusion on the adequacy and effectiveness of Internal Control in the context of its review of the system of internal control**
- **Noted the Best Value Framework Assurance 2015/16 was approved by the Audit Committee at its meeting on 5 May 2016 subject to the inclusion of the IJBs in 2016/17**

7.3 SHARED SERVICES AUDIT REPORTS (AUDIT53/2016)

7.3a Practitioner & Counter Fraud Services – Service Audit Report

Mr MacKinnon advised the Committee the NHS National Services Scotland (NSS) Service Audit of the Practitioner & Counter Fraud Service had been undertaken in accordance with International Standard on Assurance Engagements 3402 (ISAE 3402), "Assurance Reports on Controls at a Service Organisation", issued by the International Auditing and Assurance Standards Board.

It was noted the Service Audit reflected a satisfactory and sound position with fourteen minor control weaknesses identified, a reduction from the sixteen identified the previous year.

The Committee

- **Noted the audit report from the independent Service Auditors**
- **Noted the Introduction by (NSS) Director of Finance and Management Assertion**
- **Noted the management response to the issues arising set out within the action plan**

7.3b National IT Services Contract – Service Audit Report

Mr MacKinnon advised the Committee the NHS National Services Scotland (NSS) Service Audit of the National IT Services Contract had been undertaken in accordance with ISAE 3402, "Assurance Reports on Controls at a Service Organisation", issued by the International Auditing and Assurance Standards Board.

It was noted the Service Audit reflected a satisfactory position with eight minor control weaknesses identified. The Service Audit confirmed all minor actions from 2014/15 had been resolved.

The Committee

- **Noted the executive summary of the report of the Service Auditors**
- **Noted the audit report from the independent Service Auditors**
- **Noted the management responses to the issues arising**

7.3c National Single Instance Financial Services Ledger – Service Audit Report

Mr MacKinnon advised the Committee the NHS National Services Scotland (NSS) Service Audit of the National Single Instance Financial Ledger Services (NSI) had been undertaken in accordance with ISAE 3402, "Assurance Reports on Controls at a Service Organisation", issued by the International Auditing and Assurance Standards Board. It was noted the report was reviewed and approved by the host Board, NHS Ayrshire and Arran, at its Audit Committee meeting on 13 April 2016.

It was noted the Service Audit reflected a satisfactory position with only minor control weaknesses identified and management responses had been reflected within the report.

The Committee

- **Noted the cover letter from the Director of Finance, NHS Ayrshire and Arran**
- **Noted the Service Audit from the NSI independent Service Auditors, PwC**

7.4 FTF Annual Internal Audit Report 2015/16 (BOARD54/2016)

Mr Gaskin advised the Committee that the report provided an audit opinion based on work undertaken throughout the year and built on audit evidence obtained over a five year audit cycle by Internal Audit and noted that many areas had been covered within the Interim Review.

Mr Gaskin highlighted the amount of added value work which had been undertaken, as part of the annual plan and at the request of management. It was noted this work would be included within the Mid Year Review to be presented to the Committee and Tayside NHS Board in February 2017.

Mr Gaskin advised the Committee that Budgetary Control was graded as D, as was reported in the Interim Review. He stated that this was not necessarily due to a failing of systems, however, there was the need to identify measures for improvement to mitigate increased financial risks. Mr Gaskin noted the impact of the introduction of the Transformation Programme Board and the revised Financial Plan following the Interim Review.

Mr Gaskin acknowledged that achievement of the financial plan in the coming year would be challenging although NHS Tayside was travelling in the right direction.

Mr Gaskin thanked Mrs Jocelyn Lyall and Mr Barry Hudson for work carried out in what had been a challenging year.

Mr Hussain raised concerns regarding the C grade applied to Information Security and queried whether an improvement plan was in place. Mr Hussain also sought assurance regarding the drop in the level of grade A's given from 19 in 2014/15 to 7 in 2015/16.

Mr Gaskin advised that guidance DL 2015/17 had been received highlighting a number of recommendations regarding Information Security with a target date of July 2017. It was noted that these recommendations would be addressed with the support of Ms Margaret Dunning. Ms Dunning advised that the Information Security strategic risk had previously been reported to the Finance and Resources Committee. It was noted that following the retiral of the Information Governance Manager and the cancellation of the December Information Governance Committee meeting work had run off course. Ms Dunning advised that the post of Information Governance Manager had recently been filled and an improvement plan was in place to monitor and address the recommendations set out in DL 2015/17 and was confident there would be an improvement to this grade.

Mr Hay thanked Mr Gaskin and his team for the report and work carried out over the course of the year. The Committee was asked to consider and note the report as part of the portfolio of evidence in support of its evaluation of the internal control environment and the GS, and to take into account the Chief Internal Auditor's conclusion included on page 1 of the report that subject to matters highlighted in the report:

- Tayside NHS Board had adequate and effective internal controls in place
- The 2015/16 Internal Audit Plan had been delivered in line with Public Sector Internal Audit Standards

In addition, take into account that FTF Internal Audit had not advised management of any concerns around the following:

- Consistency of the GS with information that we were aware of from Internal Audit work
- The processes adopted in reviewing the adequacy and effectiveness of the system on internal control and how these were reflected
- The format and content of the GS in relation to the relevant guidance
- The disclosure of all relevant issues. Tayside NHS Board had disclosures in the Treatment Time Guarantee, Enhancements During Leave and Finance

There was agreement from the Committee.

The Committee

- **Noted the FTF Internal Audit Report 2015/16**
- **Considered the report as part of the portfolio of evidence provided in support of its evaluation of the internal control environment and the Governance Statement**
- **Took into account the Chief Internal Auditor's conclusion included in page 1 of the report**
- **Took into account that FTF Internal Audit had not advised management of any concerns around the 4 areas noted on page 1 of the report**

7.5 Review of System of Internal Control – Lead Officers Statement to Chief Internal Auditor (AUDIT55/2016)

Mr MacKinnon advised the purpose of the report was to advise the Committee of the content of the letter, included within the report, from the Lead Officer to the Chief Internal Officer. Mr MacKinnon advised the Committee the letter from the Lead Officer provided a progress update around internal control during 2015/16, to allow the Chief Internal Auditor to satisfactorily conclude on Internal Audit's work in this area for NHS Tayside in the financial year 2015/16.

It was noted the following appendices were included within the report:

- Appendix 1 – Extract from Public Finance and Accountability (Scotland) Act 2000 – Responsibilities for Accountable Officer
- Appendix 2 – Draft Governance Statement
- Appendix 3 – Responses received from Executive Directors providing further reassurance on Internal Control

The Committee

- **Noted the contents of the letter which was consistent with the Governance Statement guidance, and in particular the assurances contained within the report including those pertaining to the discharge of the responsibilities of the Chief Executive as the Accountable Officer which significantly contributed to the Audit Committee's overall assessment of the system of internal control within NHS Tayside**

7.6 Annual Report – Patient Exemption Checking (PECS) (AUDIT51/2016)

Mr MacKinnon advised the Committee the report detailed the work of the Counter Fraud Services (CFS) during 2015/16 in checking the propriety of exemptions claimed by patients for charges for ophthalmic and dental work. It was noted the report also identified the amounts recovered and those which had been written off.

The Committee was asked to note the 2015/16 Annual Reporting Package from CFS, level of recoveries made by both NHS Tayside and NHS Scotland during 2015/16 and the level of write offs across the Contractor Groups, which were recorded in the losses form (SFR 18) in the 2015/16 Annual Accounts.

It was noted that CFS had recovered on behalf of NHS Tayside £16,602 for 2015/16 (£2014/15 - £16,614). This represented 5.6% (2014/15 – 5.9%) of the Scotland total. The value of write offs had decreased from £12,798 last year to £12,169 this year, which represented 6.3% (2014/15 – 5.2%) of Scotland total.

The Committee

- **Noted the 2015/16 Annual Reporting Package from Counter Fraud Services**
- **Noted the level of recoveries made by NHS Tayside and NHS Scotland during 2015/16**
- **Noted the reported level of write offs across the Contractor Groups**

7.7 Annual Report of NHS Tayside Audit Committee 2015/16 (AUDIT56/2016)

Mr MacKinnon presented the Audit Committee Annual Report 2015/16 to the Committee for consideration and approval prior to its submission to Tayside NHS Board at its meeting on 23 June 2016.

It was noted the Annual Report was in the normal reporting format and described the purpose and composition of the Committee. The Annual Report detailed the membership, frequency of meetings, schedule of business considered and outcomes.

The Committee

- **Approved the Audit Committee Annual Report 2015/16 for submission to Tayside NHS Board**

7.8 Report to Tayside NHS Board – Assurance to the Committee (AUDIT57/2016)

Mr Hay referred to the review of the System of Internal Control included under Items 7.1 – 7.7 of the Agenda and asked the Committee to consider and approve the terms of its assurance report under Item 7.8 of the Agenda. In order to do this, Mr Hay asked the Committee to consider in turn each of the strands of assurance as follows, and Item 3, Declaration of Interests, during the year at other Audit Committee meetings.

1. The introductory paper for the review of the Systems of Internal Control, and Governance Statement (considered under agenda Item 7.1)
2. The Annual reports and assurances for 2015/16, previously submitted by the Standing and other Committees and summarised for the Audit Committee together with Best Value Assurances (considered under agenda Item 7.2)
3. The assurances provided by Scott-Moncrieff as Service Auditor to NHS National Services Scotland on the payment process operated by the Practitioners Services Division,(considered under agenda Item 7.3a)
4. The assurances provided by Scott-Moncrieff as Service Auditor to NHS National Services Scotland on the services provided by the Atos Origin Alliance,(considered under agenda Item 7.3b)
5. The assurances provided by PricewaterhouseCoopers as Service Auditor to Ayrshire & Arran Health Board on the National Single Instance (NSI) Financial Ledger Services,(considered under agenda Item 7.3c)
6. Internal Audit, plans and reports considered by the Audit Committee during the year and the Annual Report (considered under Item 7.4)
7. The Audit Committee's Lead Officer's Statement to the Chief Internal Auditor regarding assurances on internal control and the Governance statement,(considered under agenda Item 7.5)
8. The Annual Report of Patient Exemption Checking, provided by Counter Fraud Service (considered under Agenda Item 7.6)
9. The Audit Committee's 2015/16 Annual Report (approved by the Committee under agenda Item 7.7)

The Committee

- **Considered all evidence and was satisfied assurance could be given to Tayside NHS Board with regard to the systems of internal control operating within NHS Tayside**
- **Approved the Draft Terms of its Assurance Report to Tayside NHS Board and agreed the draft Governance Statement would be signed by the Chief Executive as part of the Accountability Report in the Annual Report and Accounts**

8. Annual Accounts for the Year to 31 March 2016 (BOARD58/2016)

Mr Hay advised that Mr Lindsay Bedford, Interim Director of Finance would present the Annual Accounts for the year ended 31 March 2016 and reminded the Committee that Members were asked not to share the contents of the Annual Report and Accounts with Non Board Members at this stage as it was not permitted to make them publicly available until the audited financial statements were laid before Parliament later in 2016.

Mr Bedford introduced the report by advising the Committee of the following minor updates to the Annual Report and Accounts for the year ended 31 March 2016:

- Page 11 – Tayside NHS Board and Committees – updated to include the text "required by the Scottish Health Plan"
- Page 13 – paragraph added to incorporate Primary Care Practitioners Discipline Committee
- Page 35 – Sickness Absence – updated to reflect NHS Tayside absence rate for 2015/16 as being 5.04% not 5.03%
- Page 41 – Balance Sheets as at 31 March 2016 – Sentence updated to state financial statements were included on pages 39 to 97 not 38 to 96

Mr Bedford advised the Committee that Tayside NHS Board was required under the National Health Service (Scotland) Act 1978 to prepare Annual Accounts and that the Accounts for 2015/16 had been prepared in accordance with the Government Financial Reporting Manual (FReM) issued by HM Treasury which follows International Financial Reporting Standards (IFRS) as adopted by the European Union. The Accounts for 2015/16 include the consolidated accounts of Tayside NHS Board Endowment Funds. The Committee's role was to consider the Accounts and associated documents and to recommend adoption of the Accounts by Tayside NHS Board.

Mr Bedford provided an overview and highlighted key issues within the draft accounts.

The format of the Accounts was specified in the Financial Reporting Manual (FReM) which incorporates the Scottish Government's guidance on the accounting policies to be followed in the preparation of the accounts and the additional financial returns.

The Draft Annual Accounts were now presented to the Committee for consideration. The Accounts had been subjected to external audit by PricewaterhouseCoopers. The Endowment accounts had been audited by MMG Archbold and PriceWaterhouseCoopers (PwC) and had taken their assurances from this work.

Boards were now required to prepare an annual report comprising a Performance Report, Accountability Report (which includes the Governance Statement) and the financial statements. This replaced the previous requirement to provide Directors and Strategic Reports. In May 2016 Audit Scotland published a good practice note "Improving the quality of NHS Accounts. The overarching objective of the publication was to help all Boards improve the disclosures included in the Governance Statements to meet the requirements of the Scottish Public Finance Manual. The publication had been reviewed as part of the preparation of the GS included in the Accountability Report.

As part of external audits work, PwC had completed the good practice checklist within the document.

The Draft Annual Accounts pack contained the Performance Report, Accountability Report incorporating the Corporate Governance Report, Directors Report, Governance Statement and Remuneration Report, the Annual Accounts Certificates, Primary Statements, Notes to the Accounts and the Accounts Direction.

A briefing meeting on the Draft Annual Accounts was held on 16 June 2016 with seven Non Executive Directors attending.

The Draft Independent Auditor's Report (pages 37 & 38) indicated that the auditor would express an unqualified opinion on the Accounts in that the Financial Statements:

- give a true and fair view as at 31 March 2016;
- had been properly prepared in accordance with IFRS;
- and had been prepared in accordance with NHS Scotland Act 1978 and ministerial direction

On Regularity, the draft Independent Auditors' Report also indicated that the auditor would express an unqualified opinion that, in all material respects, the expenditure and income shown in the financial statements were incurred or applied in accordance with any applicable enactments and guidance issued by the Scottish Ministers.

The draft Independent Auditors Report on other prescribed matters stated that in their opinion:

- The part of the Remuneration Report has been audited in accordance with the NHS Scotland Act 1978 and ministerial direction
- Information in the Performance Report and Accountability Report was consistent with the financial statements

On matters with which the External Auditors were required to report by exception, there is nothing to report.

The Accounts included a Governance Statement (pages 16 to 25) with three disclosures:

- **Waiting Times (TTG) -** The disclosure highlighted the 3,522 patients that exceeded the 12 week Treatment Time Guarantee in 2015/16.

- **Enhancements During Leave (EDL)** - The disclosure highlighted the work that progressed during 2015/16 that indicated the full liability in respect of EDL for the period to 2014/15 as £8.6m in comparison with the initial assessment of £4.4m. The disclosure recognised the additional accrual brought into the accounts for 2015/16 together with the mitigation of the risk going forward through the planned implementation of an electronic solution.

- **Finance** - The disclosure highlighted the financial challenges faced by Tayside NHS Board in the last 4 years and the current unbalanced LDP submission submitted by Tayside NHS Board for 2016/17. It recognised that Tayside NHS Board required further financial brokerage of £5m in 2015/16, giving a total opening balance for 2016/17 of £20m. The disclosure also confirmed the successful, conclusion of both the disposal of the former Ashludie Hospital site, for which Tayside NHS Board required further brokerage in 2014/15 and also Liff Fields. It referenced also the work being taken forward through the Transformation Programme which in conjunction with the National Initiatives are key elements of returning NHS Tayside to a sustainable financially balanced position.

The three issues had been discussed at Tayside NHS Board, Audit and Finance and Resources Committee's during 2015/16.

Also included was a statement of the Chief Executive's responsibilities as Accountable Officer (page 15) and Health Board Members' responsibilities in respect of the Accounts (page 16). In addition the Chief Executive was expected to sign off the Accountability Report (page 36). This was in line with Corporate Governance in the NHS and gives more detailed assurance on the internal systems designed to ensure good financial control within the organisation.

In order for Tayside NHS Board to approve these statements and adopt the Accounts, the Committee was required to submit an Annual Assurance Statement to Tayside NHS Board.

A full set of Draft Accounts was circulated to all Board members.

RESULTS FOR THE YEAR

The Performance Report and the Accountability Report in the Accounts (pages 2 to 25) set out *inter alia* the Principal Activities and Review of the Year, including a summary of the main aspects which impact on the financial position for the year.

A particular highlight was the improved position around Payment Policy on page 14 where average credit in 2015/16 was 10 days a further improvement on 2014/15 and c84% of all invoices paid within the 10 day target.

Tayside NHS Board was set and monitored against three Financial Targets namely the Revenue Resource Limit (RRL), Capital Resource Limit (CRL) and Cash requirement. In 2015/16 all Financial Targets had been met:

- Core RRL - c£764.2m against which there was an underspend of £0.145m;
- Non-Core RRL- c£44.9m – breakeven;
- Core Capital Resource Limit - £11.09m - breakeven
- Cash Requirement - £843.3m - breakeven

The NHS Scotland Efficient Government 3.0% efficiency savings target for NHS Tayside was £20.05m for 2015/16. Efficient Government savings achieved for 2015/16 amounted to £23.4m of which only 35% was delivered on recurring basis.

During 2015/16 Tayside NHS Board committed around £6.8m of the total Capital Resource of £11.1 million to Backlog and Statutory Compliance and Medical Equipment.

The review summarised performance against the key HEAT targets (pages 7 to 8). The position was reported on a regular basis to Members as part of Tayside NHS Board meetings.

The Remuneration and Staff Report section (pages 26-36) drew out the key required elements to be reported on including Executive and Other Senior Employees of Tayside NHS Board as well as the Non Executive Directors. The report contained the requirement around quantification of Pension Benefits. The earnings relationship between the highest earning Director and the median employee was broadly consistent at 6.30 (page 33), with only a small increase on 2014/15. The gender analysis across the NHS Tayside workforce is highlighted on page 35. Referenced earlier in the report is the position on Sickness Absence. Sickness absence increased from 4.83% to 5.04% which continues to sit below the NHS Scotland average but above the 4% target.

The Statement of Comprehensive Net Expenditure, Summary of Resource Outturn in the Accounts and Balance Sheet (pages 39 to 43) provided a summary of key results for the year. The main features were as follows, with the relevant Note to the Accounts indicated.

Staff Costs - Note 2(a) – Page 59
Staff Costs in 2015/16 accounted for £514.7m of the Operating Costs which represented an increase of c3.9% over 2014/15. Consistently staffing accounts for c60% of the Total Operating Costs. Our staff remained critical to our success in improving health and delivering effective healthcare. Effective staff governance and management were critically important to Tayside NHS Board. The increase in cost is due to 1% pay award (all staff), Incremental Movement (AfC), increased agency spend and an increase in number of staff.

Staff Costs Note 2(b) Higher Paid Employees - Page 60
Nursing, AHP, other Scientists, Clinical Psychology and Pharmacy staff were included in the Clinicians section which was a change introduced in 2010/11. The numbers of clinicians remained static at 853.

Hospital and Community Health - Note 4 – Page 61
Gross expenditure at £784.5m an increase of c£22.1m (2.9%) on 2014/15. Local health services accounted for c93% of this spend, other Scottish Board areas c2.0% and Resource Transfer a further c3%. The increase in Private Sector spend at £1.2m (0.15%) was consistent with 2014/15 and recognised both complex care and spend incurred in the independent sector in delivering TTG.

Family Health Services - Note 5 – Page 62
Gross expenditure on Primary Medical, Pharmaceutical, General Dental, and General Ophthalmic Services had increased by c£6m with the bulk of the increase on Pharmaceutical Service c4.6%.

Administration Costs - Note 6 – Page 62
Decrease in costs identified for 2015/16.

Other Non-Clinical Services - Note 7 – Page 62
The definition of this area of expenditure included significant spend on Clinical Compensation Payments, Health Promotion, and Public Health and Endowment Expenditure.

The increase was identified within CNORIS and reflected settlements and provisions made during the year.

Provisions – Note 17 – Page 78
Due to the sensitivity around Clinical/Non-Clinical compensation cases Mr MacKinnon updated the Committee under “reserved business” on the movements within provisions.

Whilst delivering a minor surplus for the year ended 2015/16 Tayside NHS Board recognised the non recurring sources of income that had enabled this position to be derived. Tayside NHS Board commences 2016/17 with £20m outstanding financial brokerage, a culmination of both the current year and previous year brokerage arrangements with the principles governing the profile of brokerage repayments to be set out in the first half of 2016/17. The increasing challenge to maintain quality services and deliver financial sustainability whilst meeting greater demand and expectations, remained a key focus. Tayside NHS Board had, however, set in place a programme that had strong foundations that would seek to build financial resilience and ensure the organisation was fit for the future.

COMMUNICATION OF AUDIT MATTERS

A report on the audit of the 2015/16 Financial Statements from the external auditor was included with the Accounts pack. This report provided an overall review of the audit, highlighted key accounts and audit issues, and incorporated the draft Independent Auditors' Report.

The draft report had been incorporated into the draft Annual Accounts submitted to this meeting and into those going to Tayside NHS Board for adoption at its meeting on 23 June 2016.

Draft Letter of Representation

The Chair and Chief Executive, on behalf of Tayside NHS Board, were required to submit to the auditor a Letter of Representation in connection with the audit.

The draft was attached, and if approved by the Committee would be recommended to Tayside NHS Board at its meeting.

Draft Annual Assurance Statement

The Annual Assurance Statement was the medium through which, after due consideration, the Chair of the Audit Committee would recommend that Tayside NHS Board should adopt the Annual Accounts. A draft Statement was attached.

RECOMMENDATION

The Audit Committee was asked to review

- The draft Performance Report;
- The draft Accountability Report incorporating;
  - The draft Directors report
  - The draft Statement of the Chief Executive's responsibilities as the Accountable Officer of Tayside Health Board;
  - The draft Statement of Tayside Health Board Members' responsibilities in respect of the Accounts;
  - Governance Statement;
  - Remuneration and Staff Report
- The draft Operating Cost Statement;
- The draft Statement of Recognised Gains and Losses;
- The draft Balance Sheet;
- The draft Cash Flow statement;
- The draft Notes to the Accounts;
- The Accounts Direction;
- The draft Letter of Representation

Mr Bedford paid significant thanks to all staff involved in the Annual Accounts process particularly within the Management Accounting and Financial Services functions. Mr Bedford noted in particular the contribution of Mrs Frances Gibson in drawing the Annual Accounts to its present position.

Mr Hay thanked Mr Bedford for the report and advised the Committee that the recommendations would be carried over and revisited at Item 10 following the presentation of Item 9 by the external auditors, PricewaterhouseCoopers.

9. PricewaterhouseCoopers – Annual Report on the 2015/16 Audit to the Board and the Auditor General for Scotland (AUDIT59/2016)

Mr Hay welcomed Mr Kenneth Wilson and Ms Gillian Collin to present the report.

Mr Wilson advised the Committee that the external audit was conducted in accordance with Auditing Standards (International Standards on Auditing (ISAs') (UK and Ireland) and the Code of Audit Practice ('the Code'). The Code explains how external auditors should carry out their functions under the Public Finance and Accountability (Scotland) Act 2000. The audit of financial statements is covered by engagement and ethical standards issued by the UK Auditing Practices Board (APB), so the Code focuses more on the wider functions of public sector auditors. The audit was conducted in accordance with the relevant requirements of the Code.

Mr Wilson advised the Committee that it was the responsibility of Tayside NHS Board and the Chief Executive, as Accountable Officer, to prepare the financial statements in accordance with the National Health Service (Scotland) Act 1978 and directions made there under. It was noted that it was the responsibility of PricewaterhouseCoopers (PwC) in accordance with the Code of Audit Practice to provide Tayside NHS Board with an audit report on the financial statements and the part of the Remuneration and Staff Report to be audited and give an opinion in whether they gave a true and fair view of the financial position of Tayside NHS Board and its expenditure and income for the year, whether they had been prepared properly in accordance with relevant legislation, applicable accounting standards and other reporting requirements, whether the information which comprised the annual report included with the financial statements was consistent with the financial statements and whether expenditure and receipts had been incurred and applied in accordance with guidance from Scottish Ministers.

It was noted that Tayside NHS Board had achieved savings of £23.4m for 2015/16, 3.5 % short of the savings target of £27m. Tayside NHS Board delivered an overall surplus of £0.145m in 2015/16 against its Revenue Resource Limit (RRL) which was achieved by £5m brokerage received from the Scottish Government Health and Social Care Directorate (SGHSCD) in March 2016. Due to a change in funding for the injury benefits provision from core funding to non-core funding. This released £5.6m of core funding which supported the achievement of the overall surplus. It was noted that none of the £15m brokerage received in previous years, which had been scheduled for repayment during 2015/16, had been repaid.

The Committee was advised that the NHS Tayside Local Delivery Plan 2016/17 submitted to SGHSCD in May 2016 had identified a potential deficit of £11.65m for 2016/17. The efficiency target was set at £58.4m of which £5.966m remained unidentified. Mr Wilson advised that although NHS Tayside was facing significant challenges, work was being undertaken through the Transformation Programme Board and a range of National Initiatives to achieve the delivery of these savings. It was noted that should the level of savings required not be achieved there was a significant risk that a larger deficit may occur.

Mr Wilson advised the Committee that NHS Tayside's accounts for 2015/16 had been prepared on a going concern basis, wherein Tayside NHS Board expects to continue operations for the foreseeable future. It was noted that Auditing Standards requires auditors to take into consideration whether preparing accounts on a going concern basis was appropriate.

Mr Wilson informed the Committee that there was a general assumption within the Public Sector that the Scottish Government (SG) would continue to support NHS Boards, however, it was noted that SG had made no formal indication it would provide additional funding, through either increased funding allocation or the provision of additional brokerage to NHS Tayside.

The Committee noted action 1 of the report. "*The Board should consider the implications of not setting a balanced budget for 2016/17 and the ramifications for the Health Board and future service provision if a balanced budget cannot be achieved. The Board should also seek formal clarification from the Scottish Government of the implications of the Board being unable to manage the current gap in the budget resulting in a deficit at year end".*

The Committee noted the Auditor General for Scotland had issued a Section 22 report to the Scottish Parliament's Public Audit Committee to highlight the financial challenges faced by NHS Tayside in relation to the 2014/15 Annual Report and Accounts. It was noted that further brokerage was required in 2015/16, with no brokerage previously received being repaid during 2015/16 and an updated Section 22 report to the Public Audit Committee was anticipated.

Mr Wilson thanked Mr Bedford and Mrs Gibson for their assistance and co-operation during the audit.

Ms Collin spoke to Section 2 of the report, Significant audit and accounting matters. It was noted there had been a further review of the audit plan, following submission of the plan to the Committee in February 2016, which identified an additional area of elevated risk as being valuation of land and buildings. It was considered due to its significance and significant judgement in its valuation to merit being an elevated risk as opposed to a normal risk. This was explained further in the summary of PwC responses to matters identified within the audit plan along with other noted matters arising.

Ms Collin addressed the issue of Enhancements During Leave (EDL) noting that management had identified in 2014/15 that requirements of NHS Circular PCS (AfC) 2008/12, Changes to the way staff are paid during annual leave, had not been fully complied with and were to be remedied. In March 2015 management had recognised an EDL expense of £4.35m, however, following further work undertaken, management identified further payments to be made to staff were required. During 2015/16 management identified a further EDL exposure of £5.006m to bring the total EDL expense to £9.356m, of which £0.8m related to the financial year 2015/16.

It was noted that payments of £5.480m had been paid during 2014/15 and 2015/16, therefore an accrual of £3.516m was required for payments not yet made. Ms Collin advised that although the total expense of £5.006m, which was included within the 2015/16 financial statements, was below the assigned level of performance materiality this was assessed as being a significant risk due to the financial challenges faced by NHS Tayside. The audit procedures evaluated the total EDL expense of £9.356m which had been recognised within the 2014/15 and 2015/16 financial statements. The Committee noted the summary of procedures performed and audit findings of work carried out in relation to EDL detailed within table 1 of the report.

The Committee noted action 2 of the report. *"In financial year 2016/17 management should perform detailed calculations at an individual employee level for EDL arrears arising in 2015/16 and 2016/17. Management should prioritise testing and implementation of the enhanced SSTS functionality across all wards".*

Mr Wilson acknowledged the hard work of management getting systems in place and the historical elements such as record keeping causing difficulties, however, was confident moving forward annual leave would be monitored correctly with the use of SSTS. It was noted NHS Tayside had conducted a more comprehensive review than carried out by other Health Boards.

Ms Collin highlighted table 2 of the report the summary of asset disposals during 2015/16, table 3 which detailed the 24 assets currently classified as assets held for sale noting the table on page 16 of the report showing the key for IFRS 5 classification criteria.

The Committee noted action 3 of the report. *"Whilst there is no significant impact on the financial outturn of the Board, management should regularly undertake a review of the assets held for sale listing in order to ascertain that all conditions of IFRS 5 are met and the assets disclosed as held for sale are appropriate.*

Property receipts do form part of the future income of the Board and therefore it is important that the anticipated value and timing of the sales are closely monitored to ensure they remain realistic".

Ms Collin advised the Committee that there are been 37 cases identified where reversal of unutilised provision had been credited to general ledger accounts disclosed as core, rather than Annual Managed Expenditure (AME) funded. This had no impact on the net operating costs disclosed within the Statement of Comprehensive Net Expenditure (SOCNE), however, the Summary Of core revenue Resource Outturn (SORO) total core expenditure was understated by £0.252m and total non-core expenditure was overstated by £0.252. Tayside NHS Board had corrected this in the final accounts.

The Committee noted action 4 of the report. *"The Board should review its CNORIS accounting practices to ensure that reversal of unutilised provisions is recognised against annually managed expenditure".*

Ms Collin confirmed that based on normal audit procedures, PwC do not disagree with the disclosures contained within the Governance Statement.

Ms Collin referred to Section 3 of the report which detailed financial performance including, brokerage, financial challenges and efficiency savings.

Ms Collin advised of one minor control weakness identified during the audit. It was noted that testing of the payroll systems identified a number of instances where the person authorising the joiner/leaver form was not included in the list of authorised signatories. Following further investigations it was confirmed that in the concerned instances the form had been signed off by someone of suitable seniority but the authorised signatory list had not been updated. It was recommended that authorised signatory lists should be regularly reviewed and updated.

Ms Collin made reference to risk management and performance management contained within Section 4 of the report and advised that the action plan and completed actions were included within appendices 1 and 2 of the report.

Mr Hay thanked Mr Wilson and Ms Collin for a comprehensive report.

The Committee

- **Noted the PricewaterhouseCoopers – Annual Report on the 2015/16 Audit to the Board and the Auditor General for Scotland**

10. Recommendation to the Board of Annual Accounts

Mr Hay advised the Committee that having reviewed the system of internal control, the Annual Report and Accounts and considered the view of the external auditor, the Committee was asked for approval of the recommendations detailed within Item 8, Annual Accounts for the year ended 31 March 2016.

The Committee

- **Approved the recommendation to Tayside NHS Board that the summary of Losses and Special Payments contained in SFR 18.0 and separately included under agenda Item 16 be approved.**
- **Approved the recommendation to Tayside NHS Board, the adoption of the annual accounts.**
- **Approved the recommendation to Tayside NHS Board that authority be granted to sign the documentation specified within Table 1 of the cover report at Item 8, as follows:**
  a. **Performance report (page 9) – Chief Executive**
  b. **Accountability Report (including the Governance Statement) (page 36) – Chief Executive**
  c. **Balance Sheet (page 41) – Chief Executive and Interim Director of Finance**
  d. **Letter of representation to External Auditors – Board Chair and Chief Executive**

11. Notification from Sponsored Body Audit Committees (AUDIT48/2016)

Mr MacKinnon advised the purpose of the report was to inform the Committee of the content of letter received from Scottish Government Health and Social Care Directorate (SGHSCD), attached as Appendix 1 of the report, which intimated the requirement to notify the Health and Wellbeing Audit and Risk Committee of any significant issues of frauds which arose during 2015/16 that were to be considered to be of wider interest.

The Committee was asked to approve the draft response to SGHSCD.

The Committee

- **Approved the terms of the draft response included in Appendix 2 of the report and authorised this to be signed by the Chair of the Audit Committee**

12. Updates to the NHS Tayside Code of Corporate Governance (AUDIT46/2016)

Ms Dunning advised the Committee the purpose of the report was to seek approval of the amendments to the Code of Corporate Governance.

Ms Dunning advised that the amendments and updates were detailed in Appendix 1 of the report. It was noted many of the amendments were minor housekeeping issues along with amendments required as a result of an Internal Audit report.

The Committee

- **Scrutinised the amendments and updates, detailed in Appendix 1, to the Code of Corporate Governance and recommended Tayside NHS Board's approval of these at its meeting on 23 June 2016.**

13. ATTENDANCE RECORD

The Committee

- **Noted the Attendance Record**

14. DATE OF NEXT MEETING

The next meeting of the Audit Committee will take place on Thursday 1 September 2016 at 9:30am in the Board Room, Conference Suite, Kings Cross.

Subject to any amendments recorded in the Minute of the subsequent meeting of the Committee, the foregoing Minute is a correct record of the business proceedings of the meeting of Tayside NHS Board Audit Committee held on 21 June 2016, and approved by the Committee at its meeting held on 1 September 2016.

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CHAIR **DATE**