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 9 March 2017 at 9.30 within the Board Room, Kings Cross Hospital.** 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 - 17 January 2017	S Hay	Attached - for approval
	4.2	Action Points Update	L Bedford	Attached - to note update
	4.3	Audit Committee Work Plan 2016/17	L Bedford	Attached – to note update
	4.4	Matters Arising	S Hay	
5.	**INTERNAL AUDIT**			
	5.1	Internal Audit T22/17 – Follow Up of Financial Planning and Management	L Bedford/ T Gaskin	AUDIT25/2017 Attached – to note update
	5.2	Internal Audit T12/17 – Assurance Framework	M Dunning	AUDIT19/2017 Attached – to note update
	5.3	Internal Audit Progress Report	B Hudson	AUDIT22/2017 Attached – to note progress
	5.4	Internal Audit T08/17 – Interim Evaluation of Internal Control Framework 2016/17	T Gaskin	AUDIT26/2017 Attached – to note progress
6.	**EXTERNAL AUDIT**			
	6.1	NHS Tayside External Audit Progress Report February 2017	B Crosbie	AUDIT20/2017 Attached – for noting
7.	**RISK MANAGEMENT**			
	7.1	Risk Appetite	M Dunning/ H Walker	AUDIT14/2017 Attached – for approval
8.	**POLICIES**			
	8.1	Skin Health Surveillance Policy	K Wilson/ A Cook	AUDIT15/2017 Attached – for approval
9.	**PAYMENT VERIFICATION: FAMILY HEALTH SERVICE (FHS) CONTRACTORS**		J Haskett	AUDIT16/2017 Attached – to note report
10.	**AUDIT COMMITTEE HANDBOOK**		L Bedford	AUDIT23/2017 Attached – to note report

ITEM NO.		LEAD OFFICER	REPORT NO AND ACTION REQUIRED
11.	**ANNUAL ACCOUNTS PROCESS UPDATE**	F Gibson	AUDIT24/2017 Attached – to note report
12.	**ACCOUNTING POLICIES**	F Gibson	AUDIT21/2017 Attached – for approval
13.	**COMPLIANCE WITH SCOTTISH GOVERNMENT WORKFORCE DIRECTORATE CIRCULARS AND NHS TAYSIDE EMPLOYMENT POLICIES**	C Smith	AUDIT17/2017 Attached – to note report
14.	**PAPERS/MINUTES FOR INFORMATION**		
	14.1 Strategic Risk Management Group Minute - 24 November 2016	M Dunning	Attached – for information
	14.2 Corporate Governance Review Group Action Note – 30 November 2016 (unapproved)	M Dunning	Attached – for information
	14.3 Attendance Record	S Hay	Attached – for information
15.	**DATE OF NEXT MEETING:** **Thursday 11 May 2017 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

16.	**MINUTES OF PREVIOUS MEETINGS**		
	16.1 Minute of the Audit Committee Reserved Business - 17 January 2017	S Hay	Attached – for approval
	16.2 Action Points Update	L Bedford	Attached – to note update
	16.3 Matters Arising	S Hay	

FOISA 33(1)
Commercial Interests and the Economy

17.	**NHS SCOTLAND COUNTER FRAUD SERVICES**		
	17.1 NHS Scotland Counter Fraud Services and National Fraud Initiative Update	R Mackinnon	AUDIT18/2017 Attached – to note report
18.	**PRIVATE DISCUSSION**		

Mr S Hay
Chair
March 2017

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	Dr R Peat
Councillor G Middleton	Mrs F Gibson	Mr H Robertson
	Mr B Hudson	Mrs A Rogers
	Mrs J Lyall	Prof A Russell
	Mr R MacKinnon	Prof M Smith
	Ms F Mitchell-Knight	Mrs S Tunstall-James
	Mrs H Walker	Dr D Walker
	Representative of Area Partnership Forum	

Minute NHS Tayside

TAYSIDE NHS BOARD
AUDIT COMMITTEE - OPEN BUSINESS

Minute of the meeting of Tayside NHS Board Audit Committee held at 9.30 a.m. on **Thursday 17 January 2017** in the Committee Room 1, Level 10, Ninewells Hospital, Dundee

Present:
Mr D Cross, OBE, Non Executive Member, Tayside NHS Board
Ms L Dunion, Non Executive Member, Tayside NHS Board
Mr S Hay, Non Executive member, Tayside NHS Board (Chair)
Councillor G Middleton, Non Executive Member, Tayside NHS Board

Chair, Chief Executives and Senior Officers
Mr L Bedford, Director of Finance, NHS Tayside
Mr R MacKinnon, Associate Director of Finance - Financial Services & Governance/FLO, NHS Tayside

External Auditors
Mr B Crosbie, Senior Audit Manager, Audit Scotland

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
Mr M Anderson, Head of Property, NHS Tayside (for item 6.2)
Mr D Colley, Finance Governance Accountant, NHS Tayside
Ms M Dunning, Board Secretary, 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 (for item 10)
Mrs L Lyall, Capital Finance Manager, NHS Tayside (for item 6.2)
Ms A Machan, Senior Auditor, Audit Scotland
Mr R Marshall, Representative of Area Partnership Forum
Ms G McClure, Quality and Services Manager, Primary Care, NHS Tayside (for item 9)
Mr J Ngoie, Head of Instrumentation and Clinical Engineering, NHS Tayside (for item 5.3)
Mr M Valentine, Property Asset Manager, NHS Tayside (for item 6.2)
Ms L Wiggin, Chief Operating Officer, NHS Tayside (for item 6.3)

Apologies
Prof J Connell, Chair, Tayside NHS Board
Mr G Doherty, Director of Human Resources & Organisational Development, NHS Tayside
Councillor D Doogan, Non Executive Member, Tayside NHS Board
Mrs J Golden, Non Executive Member, Tayside NHS Board
Mr M Hussain, Non Executive Member, Tayside NHS Board
Ms L McLay, Chief Executive, NHS Tayside
Ms F Mitchell-Knight, Assistant Director, Audit Scotland
Mrs H Walker, Risk Manager, NHS Tayside

Mr S Hay in the Chair

1. WELCOME | **ACTION**

Mr Hay welcomed all to the meeting. It was noted this meeting was not being recorded

2. APOLOGIES

The apologies were noted as above.

3. DECLARATION OF INTERESTS

There were no declarations of interests.

4. MINUTE OF PREVIOUS MEETING

4.1 Minute of the Audit Committee Minute – 21 June 2016

The Audit Committee Minute of the meeting held on 21 June 2016 was approved on the motion of Mr Doug Cross and seconded by Cllr Glennis Middleton upon her arrival at 10:40am.

4.2 Minute of the Audit Committee Minute – 1 September 2016

The Audit Committee Minute of the meeting held on 1 September 2016 was approved on the motion of Mrs Linda Dunion and seconded by Mr Doug Cross.

4.3 Action Points Update

Mr Bedford spoke to the Action Points Update.

External Review of all Mental Health Sites – Mr Bedford advised that an update was included as an appendix to the Action Points Update and invited Mr Mark Anderson to speak to this update.

Mr Anderson re-iterated that following receipt of the Health and Safety Executive (HSE) Improvement Notice there was the requirement to produce a time bound action plan to mitigate and control the known ligature points in the ward environment of Murray Royal Hospital (MRH). It was noted following the attendance of two HSE investigators to MRH on 7 January 2017 there was satisfaction that NHS Tayside had complied with the Improvement Notice.

Mr Anderson advised that whilst progress had been made, work continued to progress with weekly meetings and the development of a matrix system. It was noted the HSE had raised their own concerns regarding the existing bedroom windows. Mr Anderson advised a decision was imminent around the best solution in the replacement or modification of bedroom windows, bedroom doors and en-suite doors with a report being submitted to the Finance and Resources Committee in due course. It was noted HSE were well informed around the decision making process.

Mrs Dunion sought clarification regarding the statement, included within the Appendix to the Action Points Update, from the NHS Scotland Principal Architect. Mrs Dunion requested for the purposes of the Minute there was clarity around the last sentence of this statement. Mr Anderson advised that the Principal Architect had confirmed that in relation to the MRH facility, the developer and architect had provided what had been requested by NHS Tayside. Mr Anderson commented that the statement referred to by Mrs Dunion confirmed that the provision of a Mental Health Facility such as MRH required consideration not only to the safe environment but also the therapeutic needs of the patient and all had been delivered in line with guidance that was in place at that time. It was noted there was no off the shelf solution for a service of this nature and that NHS Tayside must anticipate that further risks would emerge over time which must be recognised and addressed accordingly.

9:40am Cllr Glennis Middleton arrived

The Committee discussed the need for assurance that standards would be maintained/transferred across all Mental Health sites, for example, the Carseview site. Mr Anderson advised that whilst lessons had been learned from MRH and experiences must be considered across all sites there was the need to recognise differing clinical needs and therefore clinically led risk assessments must be carried out to ensure the most appropriate measures were put in place at all times.

Ms Wiggin advised the Committee Risk Assessments were vital taking into account the areas and instructions.

Mr Cross queried who the accountable officer now was in place of Dr Karen Ozden. Ms Wiggin advised Rob Packham, Chief Officer was the accountable Officer for the services delegated and hosted through the Perth & Kinross IJB and that she was the accountable officer for Child and Adolescent Mental Health Service (CAMHS) and the regional service provided at MRH. It was

noted Professor Andrew Russell was the risk owner.

Mr Hay queried the expected timeline for reporting, in relation to Finance, to the Finance and Resources Committee. Mr Anderson advised the development of timelines and a project plan where underway and would be submitted to Finance and Resources Committee in the near future.

The Committee requested a further update at its meeting in May 2017. **MA**

Work Plan 2016/17 – It was noted this was an Agenda item at this meeting.

Interim Evaluation of Internal Control Framework 2015/16 Audit No T08/16 – It was noted this was an Agenda item at this meeting.

Recording Equipment – It was noted a draft protocol had been developed and was being discussed in partnership with Staff Side. Legal advice was that there must be approval from all parties prior to the recording of meetings.

Progress on Internal Audit Report T21/14 Medical Instrumentation and Devices – It was noted this was an item on the Agenda and Mr Jean Ngoie, newly appointed to the post of Head of Instrumentation and Clinical Engineering, would provide a verbal update to the Committee.

4.4 Work Plan 2016/17

Mr Bedford advised the Committee the Work Plan 2016/17 had been updated to included items submitted to the Committee at its meeting on 1 September 2016.

It was noted there was an additional Audit Committee meeting scheduled for Tuesday 21 February 2017. This meeting would focus on the Internal Audit Interim Review 2016/17 and Internal Audit reports T12/17 Assurance Framework, T13/17 Strategic Planning and T22/17 Follow Up of Financial Planning and Management.

The Committee

- **Noted the Work Plan 2016/17**

4.5 Matters Arising

There were no matters arising.

The Committee agreed Item 6.2 would be taken next on the Agenda

6.2 Internal Audit T28A/16 – Property Management Report (AUDIT01/2017)

Mr Mark Anderson, Mr Mark Valentine and Mrs Louise Lyall were in attendance for this report.

Mr Anderson advised the Committee that Property Asset Management and the focus on property disposal was critical to NHS Tayside and wished to thank Internal Audit colleagues for their help and support.

Mr Anderson advised he was pleased with the progression of issues raised within the Interim Audit Review 2015/16 and noted work was in progress, lessons had been learned and was confident future audits would reflect this.

Mr Anderson advised an asset team was now in place, and with the addition of a support officer due to be in post early February 2017, an effective resource was now there, to ensure the delivery of outstanding actions and provide more robust assurance moving forward. This was re-iterated by Mr Valentine and Mrs Lyall with the anticipation that relationships within the team and finance colleagues would be strengthened as a result.

Mr Hay sought clarification around the linkages between the Property and Asset Management Strategy (PAMS) and the Clinical Services Strategic Framework and its supporting strategies. Mr Anderson advised it was crucial both these strategies supported the other and the development of site Master plans were essential to inform Scottish Government of the intention for a site, such as Ninewells and the PAMS should capture those strategic intentions clearly to support services and looking to the future development of services and as a result sites.

10:00am Ms Gail McClure arrived

Mr Gaskin advised that the Internal Audit Report having been given a category C grade, recognised work was progressing positively. It was noted many of the issues highlighted with the report were historic and positive progression was evident. A further review would be carried out in the next financial year.

Mr Cross advised that the Finance and Resources Committee had not provided the correct level of scrutiny to Property Management and had therefore updated its work plan to receive regular updates and the invitation to Mr Anderson to present critical risk issues to the Finance and Resources Committee.

Mr Hay noted the progress made was encouraging however, queried the adequacy of resources and the management of data quality issues. Mr Anderson confirmed there were adequate resources and improvements had been made around data quality, in particular, housekeeping issues to ensure greater governance.

Mr Bedford advised the Committee that two new service level risks were to be developed on the organisation's ability to deliver the PAMS and the accuracy of the PAMS. The Capital Finance Manager would be the Risk Owner and the Property and Asset Manager would be the Risk Manager. These service risks would enhance the management of the Reduction in Capital Strategic Risk, and updates on performance would be reported to the Committee.

The Committee

- **Noted the Internal Audit T28A/16 – Property Management Report update**

The Committee agreed Item 5.3 would be taken next on the Agenda

5.3 Medical Equipment and Devices T21/14 – Head of Instrumentation Update

Mr Hay advised the Committee that Mr Jean Ngoie was in attendance to provide a verbal update to this item. Mr Hay requested introductions from around the table be provided for Mr Ngoie.

Mr Ngoie advised he had been appointed as Head of Instrumentation and Clinical Engineering, taking up post in September 2016 and had reviewed the outstanding actions contained within Internal Audit Report T21/14. Mr Ngoie provided an update to the following actions points

Action Point 5b – A report was to be submitted to the Medical Equipment Management Group (MEMG) advising of the current position of all actions points within the action plan of T21/14. It was noted the MEMG was under the leadership of Dr Gavin Main, Consultant Radiologist/Associate Medical Director and a review of the structure of the group would be carried out to ensure compliance with CEL 43.

Action Point 14 – This action noted that Nurses in charge of ward areas were required to carry out checks on equipment under their control as per protocols. Mr Ngoie advised that there had now been a change to this practice in that Medical Physics were now responsible for carrying out these checks. It was noted a SOP had been implemented as of 16 January 2017.

Action Point 17b – This action was in relation to the renewal of contracts. Mr Ngoie advised the Committee that this practice had been enhanced with a further SOP implemented. It was noted that a meeting with stakeholders reviewing performance, satisfaction of users and reduction in contracts was required to take place 4 weeks prior to the renewal date.

Mr Gaskin welcomed the change in practice, of Medical Physics now carrying out checks of equipment in ward areas.

Ms Wiggin advised the Committee the leadership by Mr Ngoie since being appointed to post had been of great benefit to NHS Tayside.

Mr Hay raised a query in relation to procurement and ensuring value for money. Mr Ngoie advised he was working closely with the Procurement Department to ensure all contract terms met with NHS Tayside's, once this was clear reviewing options to ensure value for money was explored.

Mr Cross welcomed the introduction of meetings with stakeholders however, queried if issues arose would the 4 week timescale be sufficient. Mr Ngoie advised that a contract officer was in place reviewing contracts on an ongoing basis, if a problem were to arise or a user noted issues this would be managed immediately.

Mr Hay noted issues around tracking. Mr Ngoie confirmed that whilst new software had been acquired there had been delays regarding the implementation. The scheduled date of implementation was 27 March 2017 and would provide a more robust database. It was noted following a query from Mr Hay regarding the implementation of RFID that work was ongoing with the company 6M to conduct a needs assessment for asset tracking. This would allow for better tracking and management of medical equipment

Mr Hay thanked Mr Ngoie the update provided.

The Committee

- **Noted the verbal update regarding Internal Audit T21/14 – Medical Instrumentation and Devices Report**

10:15am Mr Ngoie left the meeting

The Committee agreed Item 6.3 would be taken next on the Agenda

6.3 Internal Audit T36A/16 – Child and Adolescent Mental Health Service (CAMHS) Report (AUDIT02/2017)

Ms Wiggin was in attendance to present this report.

Ms Wiggin advised the Committee that a significant amount of work had been undertaken at the request of Tayside NHS Board following the audit being carried out. It was noted that although a number of challenges remained around workforce planning the 18 week referral to treatment (RTT) target had been achieved. Ms Wiggin advised work was ongoing to recruit to vacant posts and alternative models of care were actively being reviewed.

The Committee noted specific work had been undertaken to address concerns raised by Tayside NHS Board in relation to demand forecasting. It was noted Tayside NHS Board had requested a review of lessons to be learned, in particular with the calculation of demand trajectory planning. It was noted the original trajectory did not identify “soon” referrals and “Did Not Attend” (DNA). Ms Wiggin advised significant work had been undertaken with additional work ongoing around the Demand, Capacity, Activity and Queue (DCAQ) forecasting system.

The Committee noted that challenges remained and this continued to be a work in progress, however, there was assurance a full improvement plan was in place.

Ms Wiggin noted that the audit report had been beneficial and would welcome a further audit at a later date.

Mr Hay sought clarification regarding the information provided in the table included within para. 29 of the report. There was assurance that better data was available moving forward. It was noted that services provided differed across Health Boards and there was the need to determine how and who NHS Tayside benchmarked with.

Mr Cross queried whether it had been a conscious decision by NHS Tayside not to include those under the age of 18 years not in education. Ms Wiggin advised that NHS Tayside had taken that decision, given capacity that it would not extend its admission criteria at this time. It was noted that the inclusion of those under the age of 18 years, not in education, was now a requirement and NHS Tayside was required to be compliant, however, clarification regarding timelines expectations was required and a report would be submitted to Tayside NHS Board further in the year.

The Committee noted the improvements made and were assured that there were adequate forecasting tools currently in place which would be enhanced following the implementation of TrakCare.

The Committee

- **Noted the content of the report**

The Committee agreed Item 9 would be taken next on the Agenda

9. Payment Verification: Family Health Service (FHS) Contractors (AUDIT05/2017)

Ms Gail McClure was in attendance for this item.

Ms McClure advised the Committee the report had been prepared and submitted following the same format as a continuation of the report to the September 2016 Committee meeting. The purpose of the report was to provide assurance to the Committee that payment verification (PV) was in place.

It was noted that the report contained summaries relating to each of the four areas, General Dental, Ophthalmic, Pharmaceutical and Medical Services with no specific areas to be highlighted. Ms McClure advised current arrangements in place for PV would continue including arrangements for General Medical Services would continue until details of the new contract had been received.

Mr Hay thanked Ms McClure for a model report and advised the Committee was asked to note the report.

10:30am Ms McClure left the meeting and Ms Margaret Dunning and Miss Donna Howey arrived

The Committee

- **Noted the content of the report**

The meeting resumed from Item 5.1 on the Agenda

5.1 Audit Follow Up (AFU) – Mid Cycle Update Report (AUDIT09/2017)

Mr Bedford advised the Committee that the report provided a mid cycle update on Audit Follow Up and reviewed high risk action points and Audits with a D status. It was noted there were a number of audits highlighted within Appendix 1 of the report with relevant commentary.

T21/14 Medical Equipment and Devices – It was noted one key appointment was to the Head of Instrumentation and Clinical Engineering to which Mr Jean Ngoie was now in post and was of significant benefit to NHS Tayside. Mr Ngoie would provide a verbal update to the Committee regarding the Medical Equipment and Devices audit under Item 5.3 of the Agenda.

Mr Bedford advised an update on the Interim Review of Internal Control Framework from last year would be provided under Item 5.2 of the Agenda.

CFE2/16 Endowment Fund from MMG Archbold – It was noted a redirection of resources to allow for further dedicated time for Endowments was being reviewed.

CFE3/17 Annual Report from PwC – It was noted regular discussions with Scottish Government (SG) continued and the Transformation Programme Board (TPB) was also in place. Mr Bedford highlighted that the pace of deriving efficiency remained a challenge and two reports had been submitted to Tayside NHS Board at its meeting in December 2016 around Medicines Management and Nursing Workforce.

CFE4/17 National Fraud Initiative from Audit Scotland – It was noted an update would be provide under Item 14.1 of the Agenda.

The Committee

- **Noted the further progress made during the period from June 2016 to December 2016**

5.2 Interim Evaluation of Internal Control Framework 2015/16 Audit Report No. T08/16 (AUDIT11/2017)

Mr Bedford advised the Committee that this report provided an update in relation to the implementation of the Audit Recommendations as a consequence of Internal Audit Report T08/16 Interim Evaluation of Internal Control Framework. It was noted the report had broad range of assessments which were considered in detail by the Committee and on their recommendation by Tayside NHS Board. The significance of the report and the actions/recommendations arising from it were recognised by Tayside NHS Board and Senior Officers.

It was noted that text highlighted in bold within Appendix 1 of this report reflected revised information from that presented to the Committee at its meeting in September 2016. Mr Bedford advised however, in relation to recommendation 6, a meeting convened by the Chair, had taken place with attendance from each of the three Health and Social Care Partnerships (HSCP) and Tayside NHS Board to consider issues highlighted in relation to governance and shared understanding of the position following the incorporation of the Integrated Joint Boards (IJBs). It was noted that due to being unable to attend, the Chief Internal Auditor had provided a briefing to assist with discussions. Mr Bedford highlighted this was a difficult area and work was ongoing.

Mr Hay advised in relation to a query from Mr Cross that there was not a common view amongst the Chief Officers. Ms Dunning advised that a further meeting with the Chief Internal Auditor would be arranged prior to the next full meeting with Chief Officers.

Mr Bedford advised that both the Staff Governance and Finance and Resources Committee had reviewed their Terms of Reference and Remits which had been agreed at their respective December and November 2016 meetings. It was noted joint reporting work had also been commissioned between the two Committees. This progress would be incorporated into the Interim Evaluation of Internal Control Framework which would be considered at the February 2017 Committee meeting whilst also recognising the significant challenges faced in moving NHS Tayside in the medium term to a financially stable position.

The Committee

- **Noted the current position**

6.1 Internal Audit Progress Report (AUDIT08/2017)

Mrs Lyall advised the Committee the report provided an update around the 2015/16 and 2016/17 internal audit plans.

It was noted work was ongoing on the completion of T19/16 Clinical Governance – Mortality Reviews from the 2015/16 plan and progress was as expected on the 2016/17 plan.

Mrs Lyall advised the Committee that section 3.1 of the report highlighted audit products which had been issued since the Committee meeting in September 2016 with a summary of each audit report included within Appendix 1 of the report. Mrs Lyall highlighted that T17/16 Transformation Programme Board Governance Arrangements was a positive report and advised the Committee that as part of the 2016/17 plan, Internal Audit would review the outputs and monitoring arrangements of specific workstreams.

Mrs Lyall informed the Committee that Internal Audit reports T12/17 Assurance Framework, T13/17 Strategic Planning and T22/17 Follow Up of Financial Planning and Management and T08/17 Interim Review 2016/17 would be submitted to the additional Committee meeting in February 2017.

The Committee noted that the final grade for audit report T28A/16 Property Management was a C grade.

The Committee

- **Noted the progress on the 2015/16 and 2016/17 internal audit plans**

7. EXTERNAL AUDIT

7.1 NHS Tayside Annual Audit Plan 2016/17 (AUDIT03/2017)

Mr Bruce Crosbie was in attendance for this item.

Mr Crosbie wished to thank the Committee for the opportunity to present the Annual Audit Plan (AAP), this the first of the five year appointment and also the Director of Finance and his team for assistance provided in completion of the plan.

It was noted Audit Scotland (AS) operate in accordance with the Code of Audit Practice (CoAP) which was revised from 2016/17 and enhanced wider scope audit and transparency of audit work. The CoAP required a risk based approach to be taken and work had been ongoing since October 2016 in assessing risks to NHS Tayside which impacted on audit work.

Mr Crosbie advised the Committee that Exhibit 1 of the AAP highlighted the risks which had been identified and categorised those into those that impacted on the financial statements and those that addressed the wider dimension audit.

The first three of the risks detailed within Exhibit 1 were financial risks in relation to the risk of fraud. These were standard across audited bodies and not specific to NHS Tayside and in line with Auditing Standards (ISA 240) and the CoAP. The remaining financial risks were in relation to the use of estimation and judgements in preparing the accounts and the potential for management bias, Enhancement During Leave (EDL) and the Consolidation of Integrated Joint Boards (IJBs), which reflected the requirement for timeous submission to NHS Tayside for the preparation of Governance Statements.

The wider dimension risks referred to difficulties faced by Tayside NHS Board regarding financial sustainability, challenges in achieving financial balance, various workforce management arrangements, including the use of supplementary staff and senior management appraisals.

It was noted Audit Scotland intended to undertake ICT overview work in order to gain a greater understanding of eHealth within NHS Tayside.

Mr Crosbie advised reporting arrangements were included within page 8 of the AAP with Exhibit 2 setting out target dates for the delivery of agreed outputs, including Audit Scotland's Annual Report on the Audit. It was noted all Audit Scotland reports were available publicly through the Audit Scotland website.

It was noted that the audit fee for 2016/17 was £201,652, this was a 21.4% reduction of the fee for 2015/16 of £256,667. The scope and timing of work on the financial statements, including AS materiality assessment was detailed within Exhibit 3 of the AAP with the agreed financial statements timetable included at Exhibit 4.

Mr Crosbie informed the Committee that AS placed reliance on Internal Audit (IA) where possible and had conducted an assessment of FTF which concluded FTF generally operated in accordance with Public Sector Internal Audit Standards (PSIAS). It was noted that two areas had been identified, in relation to financial statement work, where reliance on IA reviews was planned with a number of other reports being assessed in respect of wider dimension audit responsibilities.

It was noted that AS audit was based on four audit dimensions the framed the wider scope of public sector audit requirements. This was shown in Exhibit 5 of the AAP.

Mr Hay asked why extra work was required in relation to EDL. Mr Crosbie advised that EDL had been highlighted as a specific risk and work would be undertaken in line with the AAP.

The Committee

- **Noted the Audit Scotland NHS Tayside Annual Audit Plan 2016/17**

7.2 Audit Scotland Statutory Fees 2016/17 (AUDIT07/2017)

Mr Bedford advised the Committee this report was for noting and provided background to Item 7.1 NHS Tayside Annual Audit Plan 2016/17.

The Committee

- **Noted the Audit Scotland Statutory Fee for 2016/17**

8. RISK MANAGEMENT

8.1 Risk Management Mid Year Report (AUDIT04/2017)

Ms Margaret Dunning was in attendance to present the report on behalf of Mrs Hilary Walker, Risk Manager.

Ms Dunning advised the Committee the Risk Management Mid Year Report had been endorsed by the Strategic Risk and Management Group (SRMG) at its meeting in November 2016 and was presented to the Committee for approval.

The purpose of the report was to demonstrate the adequate and effective arrangements in place for risk management and covered the period 1 April to 30 September 2016.

Ms Dunning advised the Committee the Strategic Risk profile was under continual review and the use of horizon scanning was actively encouraged. It was noted the continual review process had resulted in the addition of two new risks and the archiving of one. The total number of Strategic Risks was noted as being 21.

It was noted the approval of incorporating Operational Risks as part of Strategic Risk Reports presented to the relevant Standing Committees had been approved by SRMG in August 2016 following the suggestion by Mr Doug Cross, Chair of Finance and Resources Committee.

The Committee noted a Datix Risk Group with a multidisciplinary membership and inclusive of representation from front line staff had been re-convened. The Minutes of the Group would be reported to through the organisation accordingly.

Ms Dunning highlighted the work undertaken in relation to Adverse Event Management. It was noted improvements had been made to ensure accurate reporting, a review of Local Adverse Event Review (LAER) timescales completed and the development of a process and flowchart for sharing LAER reports. These changes would be incorporated into the revised AEM Policy to be submitted to Directors meeting in February 2017 and the Committee in March 2017.

Mrs Dunion queried whether the one page learning summaries, noted within the report, which had been requested by Health Improvement Scotland (HIS) had been circulated for information to the Clinical and Care Governance Committee and the Integrated Joint Boards (IJBs) in order to share the learning. Ms Dunning advised she was unaware of these being shared however, agreed this would be beneficial. Ms Dunning agreed to raise this with Ms Walker to provide assurance of where these were shared or look to extend the sharing of these. **MD**

Mr Cross noted the work undertaken over the last twelve months and highlighted that receiving assurance was critical. It was noted if risk appetite came through the Standing Committees this would aid in focusing on key issues.

The Committee

- **Reviewed and approved the report attached in Appendix 1**
- **Agreed Ms Dunning would seek assurance around the scope of the sharing of learning**

10. UPDATES TO THE NHS TAYSIDE CODE OF CORPORATE GOVERNANCE (AUDIT13/2017)

Ms Margaret Dunning and Miss Donna Howey were in attendance for this item.

Ms Dunning advised the Committee was asked to scrutinise the amendments and recommend approval of these by Tayside NHS Board at its meeting on 23 February 2017. It was noted there had been a change in the routine reporting of the updates, at the request of Non Executive Members, with tracked changes now being included within Appendix 1 of the report.

Ms Dunning advised of the following additional updates to the Code of Corporate Governance:

- Section A – How the Business is Organised – 33. Records Management - second paragraph, “intranet” to read “Staffnet”
- Section A - How the Business is Organised – Purpose and Remits, i) Staff Governance Committee – Add to in attendance – Associate Director of Human Resources – Resourcing
- Section E – Reservation of Powers and Delegation of Authority – References to the Director of Finance – Financial Services and Governance, Fraud Liaison Officer to be amended to Associate Director of Finance with the exception of a few areas to highlighted in the report to Tayside NHS Board on 23 February 2017
- Section F – Standing Financial Instructions – Section 15 Losses and Special Payments to be updated to include the Chief Operating Officer.

Miss Howey advised the Committee all additional amendments would be included within the report to Tayside NHS Board on 23 February 2017.

Ms Machan queried the removal of the eHealth and Information Governance sections from the Finance and Resources Committee remit. Miss Howey agreed to clarify this with the Director of Finance.

Mr Hay queried whether the Staff Governance Remit, paragraph 4, 1st bullet point be amended to read “well informed and appraised”. Mr Hay agreed he and Ms Dunning would raise this with Mr Munwar Hussain, Chair of the Staff Governance Committee and Mr George Doherty, Director of Human Resources and Organisational Development.

The Committee

- **Scrutinised the amendments and updates, including additional minor amendments, to the Code of Corporate Governance and approved the recommendation of approval of these by Tayside NHS Board at its meeting on 23 February 2017**
- **Noted the update of the actions taken in response to the letter from the Director of Finance, Scottish Government Health and Social Care Directorate in respect of the UK Bribery Act 2010 – Gifts, Gratuities and Hospitality**

11. PAPERS/MINUTES FOR INFORMATION

11.1 Strategic Risk Management Group Minute – 15 August 2016

The Strategic Risk Management Group Minute of 15 August 2016 was presented to the Committee for information.

The Committee

- **Noted the Strategic Risk Management Group Minute – 15 August 2016**

11.2 Corporate Governance Review Group Action Note – 19 August 2016

The Corporate Governance Review Group Action Note of 19 August 2016 was presented to the Committee for information.

The Committee

- **Noted the Corporate Governance Review Group Action Note – 19 August 2016**

11.3 Audit Committee Schedule of Meetings 2017/18

The Committee was asked to note the Audit Committee Schedule of Meetings 2017/18

The Committee

- **Noted the Audit Committee Schedule of Meetings 2017/18**

11.4 Audit Scotland – Reports

The Agenda provided links to the following Audit Scotland Reports:

- Technical Bulletin 2016/3
- Technical Bulletin 2016/4
- The 2015/16 Audit of NHS Tayside: Financial Sustainability – Section 22
- NHS in Scotland 2016
- Social Work in Scotland
- Our Approach to Setting Audit Fees

The Committee

- **Noted the Audit Scotland Reports**

11.5 Attendance Record

The Committee

- **Noted the Attendance Record**

12. DATE OF NEXT MEETING

The next meeting of the Audit Committee will take place on Tuesday 21 February at 9:30am in Committee Room 1, Level 10, Ninewells Hospital Dundee

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 17 January 2017, and approved by the Committee at its meeting held on 9 March 2017.

.....…….. .....

CHAIR **DATE**

NHS Tayside Audit Committee – 9 March 2017 Open Business
Action Points Update

New Actions arising from meeting on 17 January 2017

MEETING	MINUTE REF.	HEADING	ACTION POINT	RESPONSIBILITY	STATUS
17 January 2017	4.3	APU – External Review of all Mental Health Sites	The Committee requested a further update to the May 2017 meeting	Mark Anderson	Update to May 2017 meeting
17 January 2017	8.1	Risk Management Mid Year Report	Ms Dunning agreed to seek assurance around the scope of the sharing of the HIS one page summaries	Hilary Walker	HIS one page summaries are being submitted to the Clinical Quality Forum at its meeting on 13 March 2017

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

Completed Actions

Item Number 4.3

NHS Tayside

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 17 Jan 2017	Meeting 9 Mar 2017	Meeting 11 May 2017	Meeting 22 June 2017
REGULAR REPORTS									
Audit Follow Up									
Full Cycle Reports	D Colley				**Item 5.1**				
Mid Cycle Reports	D Colley		**Item 5.1**			**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 17 Jan 2017	Meeting 9 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 Mid Year Report	H Walker	**6 monthly**				**Item 8.1**			
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**	**-**	**-**	**-**	**-**	**-**		
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 17 Jan 2017	Meeting 9 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**	**Item 7**				
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**		**Item 6.1**		**X**	**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						**X**		
Approval of Internal Audit Strategy and Annual Plan	T Gaskin								
Private Discussions	T Gaskin		**Item 22**	**Item 17**	**Item 17**		**X**	**X**	**X**

AUDIT COMMITTEE WORKPLAN 2016/17

	Responsible Officer	Comment	Meeting 5 May 2016	Meeting 21 Jun 2016	Meeting 1 Sept 2016	Meeting 17 Jan 2017	Meeting 9 Mar 2017	Meeting 11 May 2017	Meeting 22 June 2017
External Audit (PWC/AS)									
Annual Audit Plan **(presented to Committee 4/2/16)**						**Item 7.1**			
External Audit Plan Progress Report			**Item 7.1**				**X**		
External Audit Interim Report									
Audit Scotland Financial Overview Report	G Meldrum								
Audit Scotland Annual Report on NHS Scotland	L Bedford				**Item 11.4**				
Audit Scotland Publications		**As & when available**			**Item 11.4**	**Item 11.4**			
Audit Scotland Technical Bulletins		**quarterly**			**Item 11.4**	**Item 11.4**	**X**		
Financial Statements Checklist	L Bedford						**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**	**Item 17**		**X**	**X**	**X**

AUDIT COMMITTEE WORKPLAN 2016/17

	Responsible Officer	Comment	Meeting 5 May 2016	Meeting 21 Jun 2016	Meeting 1 Sept 2016	Meeting 17 Jan 2017	Meeting 9 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					**Item 15**			
Other reports									
Property Transactions Monitoring	L Lyall		**Item 14**		**Item 9**			**X**	
Litigation Monitoring	R MacKinnon			**Item 16**		**Item 16**			**X**

AUDIT COMMITTEE WORKPLAN 2016/17

	Responsible Officer	Comment	Meeting 5 May 2016	Meeting 21 Jun 2016	Meeting 1 Sept 2016	Meeting 17 Jan 2017	Meeting 9 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**		**Item 15.1**	**Item 14.1**	**X**	**X**	
National Fraud Initiatives (& Bribery Act) Progress Report	R MacKinnon		**Item 20.1**		**Item 15.1**	**Item 14.1**		**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	J Haskett	**Standing item**	**Item 21.1** **Item 21.2** **Item 21.3**		**Item 10 & Item 16.1**	**Item 9**	**X**	**X**	
Revision of Payment Verification Protocols	J Haskett								
Other Reserved									
Banking and Treasury Management Report	R MacKinnon				**Item 15.2**				
Annual Reports									
Audit Committee Annual Report	L Bedford			**Item 7.7**					**X**
Audit Committee Terms of Reference & Workplan	L Bedford		**Item 11**					**X**	
Audit Committee Handbook & Checklist	L Bedford						**X**		

AUDIT COMMITTEE WORKPLAN 2016/17

	Responsible Officer	Comment	Meeting 5 May 2016	Meeting 21 Jun 2016	Meeting 1 Sept 2016	Meeting 17 Jan 2017	Meeting 9 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**			**Item 11.1 15/08/16**	**X 24/11/16**	**X 02/02/17**	
Governance Review Group	M Dunning	**As & when available**	**Item 9.3 04/03/2016**		**Item 11.1 19/5/16**	**Item 11.2 19/08/16**	**X 30/11/16**		
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

AUDIT25/2017
Audit Committee
9 March 2017

FTF AUDIT AND MANAGEMENT SERVICES
INTERNAL AUDIT T22/17 – FOLLOW UP OF FINANCIAL PLANNING AND MANAGEMENT

Lindsay Bedford

Director of Finance

March 2017

FINAL REPORT

NHS TAYSIDE
INTERNAL AUDIT SERVICE

FOLLOW UP OF FINANCIAL PLANNING AND MANAGEMENT

REPORT NO. T22/17

Issued To: L McLay, Chief Executive
L Bedford, Director of Finance
S Lyall, Head of Finance

B Nicoll, Director of Strategic Change

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

NHS Tayside Audit Follow Up
Audit Committee
External Audit

Date: 6 March 2017

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INTRODUCTION & SCOPE

1. In accordance with the revised Internal Audit plan, approved by the Audit Committee in February 2016, the scope of this review is to follow up issues raised in recent finance reports, external reviews of financial governance and other issues arising from the Auditor General for Scotland Section 22 report issued in October 2015, as well as to follow up previous Internal and External Audit financial control and efficiency recommendations.
2. Internal Audit have made a number of recommendations in relation to financial control and efficiency in recent years, and these have been augmented by recommendations from NHS Tayside's External Auditors. In October 2015, the Auditor General for Scotland issued a Section 22 report '*The 2014/15 Audit of NHS Tayside: Financial Management'*. Subsequently, a further s.22 Report has been issued and is currently under review by the Public Audit and Post Legislative Scrutiny Committee.
3. In August 2015, the Chief Executive pro-actively commissioned an independent review of NHS Tayside's financial accounts and position. On 15 December 2015 the Chief Executive updated the Board on the outcomes of the Strategic Financial Review and provided members with a briefing on the draft 5 year Change Programme 2016 – 2021. 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. A NHS Tayside draft financial framework 2016/17 to 2020/21 was presented to the Special Board meeting on 15 December 2015. This framework represents NHS Tayside's approach to rebalancing its financial position. We have been informed that the financial planning approach underlying the production of this document is intended to address the recommendation made by External Audit in their 2014/15 report to review the effectiveness of their annual budgeting process.
4. This audit links to Corporate Risk 36 – Strategic Financial Plan, which has a risk rating of Red (Very high).
5. This report follows up the implementation of a number of Internal Audit recommendations as well as the External Audit recommendations referred to above. Some of these were actioned after the original due date and therefore this audit was deferred in order to allow us to review their implementation and incorporate our assessment into this report.

OBJECTIVES

6. Financial planning is an integral part of the wider Local Delivery Plan (LDP) process and all NHS Scotland Boards are required to submit detailed financial plans as part of their annual LDP submission. Boards are required to complete financial templates setting out planned performance against key financial targets and outlining trajectories for financial performance and efficiency savings. Each NHS Board is expected to meet their statutory financial targets as follows:

   - Revenue Resource Limit – resource funding for net revenue expenditure allocated by the Scottish Government for ongoing operations;
   - Capital Resource Limit - resource funding for net capital expenditure allocated by the Scottish Government for investment in fixed assets;

- Cash Requirement – cash required to fund the net payments for all ongoing operations and capital investment.

RISKS

7. The following risk could prevent the achievement of the above objectives and was identified as within scope for this audit:

   - Agreed, appropriate and effective management action to address identified control weaknesses may not have been taken in response to all finance related audit recommendations and findings.

AUDIT OPINION AND FINDINGS

8. The appointment of a permanent Director of Finance and the introduction of the Transformation Programme Board provided an opportunity to re-assess and re-calibrate Financial Planning in NHS Tayside and to work towards a sustainable financial model which supports clinical priorities. It is accepted that this will require a long-term approach, particularly in relation to the rebasing of budgets which will not be achievable until services have been reconfigured. The repayment of outstanding brokerage to Scottish Government Health & Social Care Directorate (SGHSCD) will remain a significant challenge for the foreseeable future.

9. The Strategic Risk Profile for NHS Tayside considered at the October 2016 Board meeting includes Corporate Risk 36 – Strategic Financial Plan 2016/17 – 2020/21. This risk has been scored as 25 (the highest possible risk score) since February 2016 and the Planned Risk Exposure is also currently set at 25 to reflect the fact that although mitigating actions are in place, the impact of these actions is not deemed significant enough to reduce the risk profile. Overall, we would conclude that the achievement of the unbalanced LDP for 2016/17 is at risk.

10. The report is complex, addressing audit recommendations over a number of years and during the course of this audit we were able to see that whilst not all internal and external audit recommendations around financial planning and financial management were completed on time and some are still outstanding, progress has been made and is continuing.

11. We have been advised that the SGHSCD has not formally signed off the LDP for 2016/17. The 26 May 2016 special meeting of the Board considered in private session a paper which stated that "*An update will be provided to the NHS Tayside Board by the end of June 2016 with appropriate dialogue being maintained with SGHSCD in the intervening period*." However, we could not find any update on the status of the LDP being presented to the June 2016 Board meeting and it is not clear whether the Board has been informed whether the SGHSCD has agreed that the assumptions inherent within the five year Strategic Financial Plan, including those around brokerage. We have been advised that the outcome of the mid-year review discussions with the SGHSCD will be reported to the Board in December 2016 and this update will cover the SGHSCD response to the LDP.

12. Given the above, and in particular the planned risk score of 25, our audit opinion is necessarily **Category D** – There is increased risk that objectives may not be achieved. Whilst considerable work has been undertaken and many improvements made, further improvements are still required and the pace of change will need to accelerate if targets are to be achieved.

13. The planned improvements to the budget setting process, from financial year 2017/18 onwards, will assist in further aligning resources to corporate priorities; will identify and factor in known cost pressures and will allow early discussion and identification of the projects to deliver required efficiency savings. However, the cumulative effect of the recurring efficiency savings required to achieve financial balance in the last four years of the five year Strategic Financial Plan (Revenue) will place significant pressure on the system. This will require much closer alignment between budgetary control, risk management and performance management over the next four years and therefore the pace of change requires to be accelerated to ensure that the changes required to deliver financial sustainability are achieved. Whilst the position around repayment of outstanding brokerage has not been overtly considered by the Board, we have been informed that Scottish Government Finance have been clear, both in discussion and most recently at the Parliamentary Audit and Post-Legislative Scrutiny Committee, that the key priority is returning the Board to financial balance and at that point will they then agree a plan of repayment of the outstanding brokerage.

A description of all audit opinion categories is given in the final section of this report.

14. The following chart shows where the grade lies within the D band:

A	B	C	D	E	F
			X		

15. Internal and External audit reports dating from 2013 onwards were reviewed and any recommendations relating to financial planning or financial management were followed up. National performance reports and Board specific reporting by Audit Scotland were also included. The external audit reports examined were published by PricewaterhouseCoopers (PwC) who were the Board's appointed external auditors during the period under review.

16. Our audit approach has focused on the review of key financial reports and discussions with the Director of Finance and other Finance Managers. In analysing the recommendations from previous reports it became apparent that some are no longer applicable having been overtaken by subsequent events. For example, a number of recommendations relating to Steps to Better Healthcare have been superseded by the workstream activity overseen by the Transformation Programme Board which was subject to a separate internal audit review as part of report T17/16 – Workstream Governance Arrangements.

17. A number of general themes emerged from our review and discussions and therefore both internal and external audit recommendations followed up have been grouped under these thematic headings as follows:

    - Governance
    - Budgeting
    - Efficiencies
    - Benchmarking
    - Financial Planning

18. There remain a number of fundamental uncertainties around the impact of Health and Social Care integration. Amongst these is a clear understanding of the respective responsibilities of the Board and the IJB for the delivery of services within budget and the achievement of planned savings. These issues have been reported within other Internal Audit outputs and are therefore not included within this report, although they could have a significant impact on financial control in the medium term.

Governance

19. Internal Audit report T28/14 – Financial Monitoring recommended that "*in order to provide even more up to date information on the most recent position, consideration could be given to scheduling F&R Committee (F&RC) meetings towards the end of each month to allow the same information as just reported to the government to be incorporated in the papers for the F&RC."* However, F&RC meetings are still held mid-month. Given the current financial position and the frequency and timing of meetings of the F&RC it is imperative that the committee receives information which is as up to date as possible. Meetings are currently scheduled so that 3 are held in the first 9 months with the remaining 3 condensed into the final three months. Whilst this is an overt decision, made for good reasons and we would highlight that the Board and Transformation Programme Board also receive regular reports accompanied by verbal updates throughout the year, the timing of these meetings may need to be reconsidered to reflect the delivery of savings moving from in-year savings skewed to the final quarter, to a longer term programme of savings linked to transformational change.

20. The Audit Scotland report 'NHS in Scotland 2015' contained a comprehensive checklist, which is also designed to help non-executive directors with their role in overseeing the performance of NHS boards. This checklist includes financial performance and also service performance, workforce and future service delivery. The Interim Report 2015/16 update, provided by the Director of Finance to the Audit Committee in September 2016, advised that the checklist had been circulated to all non-executive directors to inform a Board Development Event. An F&RC workshop event was held on 22 September 2016, which discussed the checklist and received a presentation on a revised budget setting process. The approach required to introduce a revised budget setting process, from financial year 2017/18 onwards, was agreed at the workshop. The final revised budget setting process has been considered by the Chief Executive and the Director of Finance and was considered at a Board Development session in November 2016.

21. Internal audit report T08/16 – Interim Review also recommended that "*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...."* The agreed implementation date for this recommendation was 31 March 2016. The Interim Report 2015/16 update, provided to the Audit Committee in September 2016, advised that discussions had taken place between the chairs of both the Audit Committee and the F&RC in relation to the review of the F&RC and that a paper would be prepared for the November 2016 meeting of the F&RC. An updated terms of reference for the F&RC, together with the committee workplan for 2016/17, was considered at the F&RC meeting on 17 November 2016. While this progress is welcomed, the benefits arising from the review were not realised as early as anticipated.

22. Internal audit report T08/16 – Interim Review, issued in January 2016, highlighted the loss of key staff from the finance team and recommended a review of the current capability and configuration of the Finance Department to support the Board in meeting the significant financial challenges which exist. This action was agreed for 31 March 2016. During 2016 the Director of Finance has overseen a review of the finance function and a proposed structure has been discussed with the Chief Executive, Director Team and the Employee Director. Work to fully populate this revised finance structure through an organisational change process is ongoing. Specific work to bring experienced Band 6 and 7 accounting staff into the organisation has been successful. This is a crucial element of the review of the finance function given the specific skills required to provide effective financial support to major transformation projects moving forward.

23. Following requests from members of the F&RC at the April 2015 and September 2015 meetings, it was agreed that enhancements were required to the financial reporting process. The need for a comprehensive review of financial reporting recognised the specific challenges of monitoring financial performance in difficult circumstances. Internal Audit T08/16 recommended that *"finance reports should be fully understood by all Committee members and provide a clear and unequivocal view of the financial position and impending issues and risks".* It is clear that steps have been taken to revise the format of the Corporate Financial Report and a significant amount of detail is provided to show the breakdown of spend across subjective cost headings (such as pay, prescribing etc.). We note and commend the decision taken in August 2015 to submit the Corporate Financial Report to all Board meetings.

24. Although the minutes of the F&RC reflect positive feedback from committee members regarding the revised reporting format of the Corporate Financial Report the use of complex, technical NHS accounting terms was still apparent and we would note that a glossary might be helpful in this regard. In addition, issues were often described in isolation rather than being presented in a way which would allow the reader to readily understand the accumulated financial position of the Board, the steps required to achieve financial targets and the impact that these steps may have on service delivery and performance in both the short and longer term.

25. The need for clear reporting on the actions required to achieve financial balance was initially highlighted in internal audit report T28/14 – Financial Monitoring and a commitment was made at that time to enhance financial reporting accordingly. Significant enhancements have been made to the Corporate Financial Reports to provide detailed breakdown of subjective spend. However, it is not clear from recent Corporate Financial Reports that committee members are always being provided with all of the information they require to accurately gauge performance against key targets such as the 40% target for recurring efficiency savings and the target level of deferred expenditure included in the financial plan. A supplementary report on 'Forecast Outturn and Further Actions' was considered in the private session of the NHS Tayside Board meeting on 27 October 2016, which did provide a breakdown of efficiency savings identified but does not include detail on performance against the 40% recurring savings target. This supplementary report also sets out the financial position against the unbalanced LDP submission to SGHSCD and requests support from Board members for a summary of actions to minimise the shortfall against available resource. However, the report presented to the December Board did provide an overall estimate of performance against the recurrent savings target.

Budgeting

26. PwC's Annual Report on the audit of NHS Tayside for 2014/15 recommended a review of the effectiveness of the Board's annual budgeting process. This message was reinforced in the Audit Scotland s22 report 'The 2014/15 audit of NHS Tayside – Financial Management'. Some progress in addressing perceived deficiencies in the budgeting process was evidenced in the Annual Report on the audit of NHS Tayside for 2015/16, where PwC commented that a *"More realistic budget setting is also evidenced by the projection of a deficit for 2016/17. We recognise that the return to financial sustainability requires the Board's continued commitment and can only be achieved in the medium to long-term."*

27. Until recently, the approach adopted in NHS Tayside largely relied on the interaction between Finance Managers and budget holders. Section 3.1.2 Annex 3 of the NHS Tayside Standing Financial Instructions (SFIs) refers to *"an incremental approach to budget setting where existing budgets are rolled forward year on year..."* This approach has continued to be used in circumstances where operational budgets have overspent for a number of years. A further consequence of rolling forward budgets without a formal methodology for challenging the expenditure base is that this could potentially perpetuate inefficiencies in existing budgets. It is our view that where budget holders are faced with taking responsibility for a budget which has frequently been overspent in previous years then they are less likely to take ownership of this budget figure as a realistic figure for which they can be held accountable. We acknowledge that more recently, the Board's budgets have specifically addressed legacy issues to provide more meaningful and achievable targets.

28. Whilst Annex 3 of the SFIs does give some brief guidance on this topic, there is currently no detailed guidance describing the NHS Tayside approach to the budget process and whilst practice is changing (see below) it has not yet been formally documented and issued to the relevant staff.

29. The 15 December 2015 Board meeting considered the adequacy of cost control and the need for an appropriate budget setting model with changes to the budget setting process." In previous years, the Board did investigate other approaches, including use of the Integrated Resource Framework and steps were taken to recognise "legacy issues" as part of the budget setting process for 2016/17.

30. In order to improve the budget setting process, work is already underway to introduce a revised approach to budget setting from financial year 2017/18 onwards. The final version of this revised approach, updated to reflect the feedback arising from the F&RC workshop event on 22 September 2016, has been has been approved by the Chief Executive and the Directors' Group and incorporated within the 2017/18 Financial Framework. The new budget setting process will require to be embedded into the existing finance arrangements with a clear timetable set for completion of standardised budget documentation. The new process will involve the creation of Budget Review Panel (BRP) meetings which will scrutinise cost pressures and planned efficiency savings to arrive at a resource allocation figure which is sustainable over a five year window and owned by budget holders.

31. A key element of this change in approach will be a move away from the incremental, retrospective financial management (as described in Section 3.1.2 Annex 3 of the SFIs) towards a longer term commitment to the delivery of transformational change and financial sustainability. In order to deliver this new approach a shift in emphasis is required to reflect the changing role of finance staff in monitoring and reporting on financial performance but also supporting the delivery of efficiency savings and providing financial support to major transformational change projects. This will be a difficult balance to achieve and maintain given the financial pressures facing all corporate support functions. In order to be successful this change requires to be reflected in a planned approach to the training and recruitment of Finance staff going forward. We recognise that the changing environment faced by NHS Tayside will be impacting on many Health Boards in NHS Scotland and therefore there may be the opportunity for developing joint training programmes and common solutions.

32. The practice of deferring expenditure relating to SGHSCD allocations has been a recurring feature of the NHS Tayside budget setting process for many years. Essentially this means that the deferred expenditure carried forward from 2015/16 will be paid from 2016/17 SGHSCD allocations. Board Committed Earmarks totalled £25.7m in deferred expenditure carried forward at 31 March 2016.

33. The current format of the Corporate Financial Report includes a specific section on Board Committed Earmarks.

34. The 2015/16 Financial Plan predicted year-end deferred expenditure of £23.5m. However, due to unforeseen circumstances, the actual level of deferred expenditure at March 2016 stood at £25.7m, resulting in a higher level of deferred expenditure carried forward. Had this not occurred, the Board would have been required to contain expenditure by an additional £2.2m or seek additional brokerage.

35. The Financial Plan for 2016/17 provided for £22.5m to meet deferred expenditure carried forward from 2015/16 consistent with the previous Financial Plan but not with the actual level of expenditure carried forward.

36. The Corporate Financial Report to the October 2016 meeting of the Board highlights the fact that £3.2m of savings are required from the £25.7m expenditure brought forward and Board reserves. However, it was not clear how these savings would be delivered and this was explained to the Board. The savings required represent 12% of the expenditure deferred into financial year 2016/17, much larger than the 6% savings target, levied overall as a proportion of Core RRL, as part of the 2016/17 savings plan. Therefore there is a risk that delivery of the £3.2m savings required to bring 2016/17 deferred expenditure in line with the £22.5m included in the financial plan may potentially compromise the delivery of the full range of activity which the initial SGHSCD allocations were intended to fund. The deferred expenditure target for 31 March 2017 has been set at £23.5m but this target figure may again come under pressure during the period between the submission of the 2017/18 LDP and the financial year end depending on the financial position at that point.

37. Although the Board made a commitment to reduce the level of carry forward of deferred expenditure, this has been challenging and recent Corporate Financial Reports have recognised the risk which is posed to this arrangement by the re-routing of central partnership funding through IJBs, which would previously have been hosted by NHS Tayside. There is therefore a risk that the income from SGHSCD allocations previously utilised to fund the deferred expenditure from the previous year will not be accessible in the same way that it has been previously with a corresponding and significant impact on future savings plans. The Financial Framework to be presented to the Board in March 2017 contains detailed proposals for significant reductions in the level of deferred expenditure over the 5 year cycle of Finance has committed to providing regular reports to the Finance and Resource Committee on this issue which will provide the opportunity for challenge and review.

Efficiencies

38. We previously made a number of specific recommendations in relation to savings delivered through the Steps to Better Healthcare (SBH). We did not find evidence that the required improvements to performance or reporting had been achieved whilst SBH was in existence, although the SBH activity and programmes have now been incorporated into the Transformation Board which does have appropriate monitoring and reporting..

39. The reporting of workstream figures for financial year 2015/16 were more transparent as they did reflect actual realised savings, but it is noted that the initial efficiency target of £7.5m (as reported to the F&RC in November 2015) was reduced to £5.5m in subsequent reports without any explanation.

40. Figures for total efficiency savings made by NHS Tayside from 2013/14 to 2015/16 are summarised in Table 2 below:

Table 2 Total NHS Tayside savings 2013-16

Year	***2013/14 £m***	***2014/15 £m***	***2015/16 £m***
Target	21.0	22.0	27.0
Identified	22.1	22.0	23.4
Actual	22.1	22.0	23.4
Variance	1.1	-	(3.6)

41. As part of the Financial Framework 2016/17-2020/21 presented to the Board on 10 March 2016, a target of £58.4m efficiency savings was highlighted. Subsequently at the Board meeting of 31 March 2016, this target was reduced to £33m as a result of applying a Business As Usual (BAU) trajectory cost savings of £13.4m and further corporate finance savings of £12m.

42. From discussions with Finance staff we were informed that BAU savings are based on the continuation of savings and expenditure controls applied in January to March 2016, projected forward for 2016/17. This method of extrapolation was cross-referenced to savings plans and performance from previous years, with figures amended where appropriate, to ensure that projections are realistic and the approach sustainable.

43. It was noted that at the meeting of the Transformation Programme Board on 23 March 2016 the Chief Executive stated that "*There were several ways in which the £13.4m run rate of efficiency saving could be incorporated into the efficiency targets for 2016/17. The decision had been made to incorporate it into the workstream targets*." £12 million of corporate efficiencies were included in the initial Financial Framework presented to the Board. The revised LDP submission shows a slightly increased savings figure of £12.25m of corporate efficiencies. On the basis that an unbalanced LDP position of £11.65m was put forward by NHST this gives a revised savings total of £46.75m for 2016/17.

44. The reporting of efficiency savings was addressed by Internal Audit T30/13 which recommended that *"reporting should be clarified to ensure a distinction between realised savings to date and a best estimate of the full year amount, allow savings to date to be compared against trajectory, clarify the amounts achieved recurrently or non-recurrently and the source of the savings."* Reporting of efficiency savings in the Corporate Financial Report has been enhanced to show savings achieved to date against planned trajectory and to explicitly show the level of unachieved savings to date. However, further work is required to address all of the previous reporting issues identified.

45. The message around classification of reported savings was reinforced in internal audit report T08/16 – Interim Review, which recommended that "*the efficiency savings element of the financial reports should be specifically reviewed; savings should be overtly classified as recurring or non-recurring*". The latest Corporate Financial Report considered by the NHS Tayside Board in October 2016 does not differentiate between recurring and non-recurring efficiency savings, although the narrative does recognise that the Financial Framework sets a target of 40% of efficiency savings on a recurring basis.

46. A supplementary report on 'Forecast Outturn and Further Actions' was considered in the private session of the NHS Tayside Board meeting on 27 October 2016. This report does differentiate between recurring and non-recurring savings and provides a breakdown by workstream/initiative. However, the report does not make it clear whether these are identified savings to date or the projected savings position as at 31 March 2017.

47. Neither the Corporate Financial Report, nor the supplementary paper considered in private session, provide commentary on performance against the 2016/17 recurring savings target of 40%. This important information was not being routinely reported to Non-Executive Board members in writing and they were not being advised on the knock-on impact which any shortfall in recurring savings will have on future financial years until the December Board. As part of the five year Strategic Financial Plan for the period 2016/17 to 2020/21 the target level of recurring savings increases to 50% for financial year 2017/18 and therefore the knock-on implications of any failure to deliver recurring savings will increase correspondingly.

48. The latest efficiency savings figures reported to the Board showed a shortfall in anticipated savings of £1.155m to 30 September 2016. A shortfall of £7.35m was also highlighted for savings schemes which have not yet been identified. In order to address the identified shortfall in the £46.75m savings plan for 2016/17 a short term/accelerated action plan was presented to the NHS Tayside Board for consideration in private session at the October 2016 Board meeting as an appendix to the supplementary paper 'Forecast Outturn and Further Actions'. Going forward it is important that the short term/accelerated actions are included in the calculation of the proportion of recurring/non-recurring savings delivered. By definition a number of these short term/accelerated actions are non-recurring and therefore omission of these savings from the overall calculation would skew the performance against the 40% recurring savings target (increasing to 50% for 2017/18).

49. There are various financial risks recorded on Datix including: EDL; Strategic Financial Plan; reduced capital resources; recurring savings; end of life drugs; failure to achieve cost reductions; savings; and cost pressures etc. Internal audit report T30/13 - Efficiency Savings recommended that "*Consideration should be given to manage the risk that NHS Tayside is not operating as efficiently as possible against its stated strategic aim to make best use of resources*". Work is ongoing to review both corporate and operational financial risks with input from the Risk Management Department.

Benchmarking

50. Internal audit report T30/13 - Efficiency Savings highlighted an exercise on Theatre Utilisation which was undertaken in 2014. This project was presented to the F&RC on 21 January 2015 and advised that the objective of the exercise was to address the high usage of agency staff and to focus upon areas where there was a requirement to create and maintain sufficient staff to meet demands (eventually across the whole system). It was reported that *"as a result of the in-depth analysis the team identified a number of areas for improvement and remodelled and reshaped services."* However, although an action was agreed for implementation by 31 March 2014 we can find no evidence of follow up reporting on the outcomes from this project to the F&RC, although subsequently this work has been subsumed within the Shaping Surgical Services project, a major service change redesign which does have an established Programme Board and reports through the Transformation Board to the NHS Tayside Board.

51. An overview benchmarking presentation was made by the Chief Executive to the NHS Tayside Board on 29 January 2016. This presentation focussed upon comparisons with NHS Grampian and NHS Lothian. The results of the benchmarking exercise highlighted that NHS Tayside receives 7.73% of Scotland's funding on Acute Services yet consumes 9.3% of the spend. There were similar levels of over-consumption on Portering; Hospital Energy; Property Maintenance and Management & Administration. The report was based upon research undertaken by an external management consultant, which highlighted significant spends on administrative staffing, (especially within Clinical Support and Estates) and Nursing. Moving forward it is imperative that the areas of operation where NHS Tayside is not consistent with peer Boards are explored and appropriately challenged as part of the budget setting process, so that the areas which can deliver the biggest benefit can be prioritised first.

52. NHS Tayside has agreed with ISD Scotland to become a test site for the implementation of NSS Discovery, which is an information system that provides approved users with access to a range of comparative information to support performance and quality improvement. Indicators within NSS Discovery can be viewed by NHS Board of treatment or residence. The information within NSS Discovery can help NHS Boards to review performance, benchmark against peers and identify areas where resources can be targeted to address local health and care needs. Initial work with NSS Discovery will focus on a "deep dive" in orthopaedics with a view to a further rollout.

Financial Planning

53. Within the 2016/17 Financial Framework the Director of Finance acknowledged that NHS Tayside has *"an operating service model that is too expensive".* The latest Corporate Financial Report, for the period ending 30 September 2016, was presented to the October meeting of the NHS Tayside Board. This report highlighted an overspend of £7.751m for the first half of the financial year.

54. Seven workstreams have been set up to deliver the planned cost savings of £175m as required by the five year Strategic Financial Plan (Revenue). The process to govern the delivery of the workstream outputs was covered in the separate internal audit output T17/16 – Workstream Governance Arrangements. Further reviews of the project management and individual workstreams/projects will be undertaken in future internal audit plans. The workstreams cover the following areas:

    - Workforce & Care Assurance
    - Better Buying Procurement
    - Realistic Medicine
    - Service Redesign
    - Facilities and Estates
    - Right Patients in Tayside/Repatriation
    - Property & Our Estate

55. The Audit Scotland S.22 report 'The 2014/15 audit of NHS Tayside – Financial Management' recommended the need for the *"Development of a Strategic Clinical Framework to provide a high-level reference for decision making and prioritisation."* The draft Clinical Services Strategy was presented to the Board in June 2015, and highlighted the estimated changes to demography over the next 25 years. Tayside's population is expected to rise by 14.1%, which is higher than the Scottish average. Furthermore the proportion of the population over 65 years of age continues to rise with a projected figure of 49% of the Tayside population by 2037. The Director of Finance has confirmed that he views demographic changes and fluctuations in demand for health services as longer term strategic aims which would be addressed in 2017/18 - year two of the five year financial plan.

56. The Audit Scotland S.22 report 'The 2014/15 audit of NHS Tayside – Financial Management' reported that NHS Tayside received SGHSCD brokerage for three years running amounting to £19.3m. In 2016 SGHSCD agreed to a further £5m brokerage for 2015/16, bringing the total level of brokerage outstanding to £20m.

57. The property strategic plan agreed by the Board in August 2015 set out a three year property rationalisation strategy for the period to March 2018. This plan set out the overall risks relating to the property disposal strategy and the potential impact on the brokerage plan. The revised savings plan incorporated within the latest LDP submission for 2016/17 includes £4.5m in asset disposal proceeds for 2016/17. Given the nature of the workstream projects being overseen by the Transformation Programme Board the structural change required to move towards financial balance may take significantly longer than non-recurring short term cost cutting measures. This will render a one year view of efficiency savings largely redundant. There is therefore a risk that for the foreseeable future the proceeds of any asset disposals will be an integral part of the efficiency savings plan or will be required to offset in-year overspending on operational activity. At the time of our audit we concluded that, against this backdrop it was difficult to envisage how and when the outstanding balance of brokerage funding due to SGHSCD could be reduced in the remaining four years of the five year Strategic Financial Plan (Revenue). However, subsequently, NHS Tayside's share of NRAC funding has increased which does improve the position somewhat, although NHS Tayside is being held at 1% below funding parity.

ACTION

58. 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

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

A Gaskin BSc CA
Chief Internal Auditor

Action Plan

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
1.	Internal Audit T28/14 – Financial Monitoring recommended that '*in order to provide even more up to date information on the most recent position, consideration could be given to scheduling F&RC meetings towards the end of each month to allow the same information as just reported to the government to be incorporated in the papers for the F&R C.'* However, F&RC meetings are still held mid-month. Given the current financial position it is imperative that the F&RC receives information which is as up to date as possible. Meetings are currently scheduled so that 3 are held in the first 9 months with the remaining 3 condensed into the final three months. Whilst this is an overt decision, made for good reasons we would highlight that the Board and Transformation Programme Board also receive regular reports accompanied by verbal updates throughout the year.	As part of the ongoing review of the F&RC operations, consideration should be given to changing the frequency and timing of meetings for financial year 2017/18 to reflect the delivery of savings moving from in-year savings skewed to the final quarter, to a longer term programme of savings linked to transformational change. .	**2**	In conjunction with the Chair of the Finance & Resources Committee the frequency and timing of the meetings will be reviewed.	Director of Finance April 2017

Action Plan

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
2.	From our review of recent Corporate Financial Reports, the use of complex, technical NHS accounting terms was still apparent; issues were often described in isolation rather than being presented in a way which would allow the reader to readily understand: • the accumulated financial position of the Board, • the steps required to achieve financial targets and, • the impact that these steps may have on service delivery and performance in both the short and longer term.	The format of the Corporate Financial Report should be further revisited to ensure that future reports present a clear picture of the accumulated financial position of the Board, the steps required to achieve financial targets and the impact that these steps may have on service delivery and performance in both the short and longer term.	**2**	The Corporate Financial Report will continue to be reviewed to ensure that it provides members with the optimal level of information in order to present a clear picture of the financial position of the Board and the steps required to achieve financial targets.	Director of Finance April 2017
		Consideration should be given to a glossary of financial terms being provided as a standing appendix to all Financial papers to the Board and F&RC.	**3**	A glossary will be developed and will be regularly reviewed for completeness and understanding with members.	Director of Finance April 2017

3.	There is a risk that the income from SGHSCD allocations previously utilised to fund the deferred expenditure from the previous year will not be accessible in the same way that it has been previously.	Whilst the Financial Framework to be presented to the Board in March 2017 contains detailed proposals to reduce the level of deferred expenditure over the 5 year cycle, Board Committed Earmarks should be specifically incorporated into the Finance BAF and specific monitoring arrangements put in place so that the F&R Committee can monitor its status throughout the year and understand its underlying impact on the year-end financial position and on future years.	**1**	The Financial Framework to be presented to the Board in March 2017 contains detailed proposals to reduce the level of deferred expenditure over the 5 year cycle. The appropriate level of reporting will be put in place for the F&RC to monitor its status throughout the year.	Director of Finance April 2017
4.	The Public Services Reform (Scotland) Act 2010 places a duty onto public bodies to provide information on the exercise of functions including: '*As soon as is reasonably practicable after the end of each financial year each listed public body must publish a statement of the steps that it has taken during that financial year […]*	The information on efficiency, effectiveness and economy required under the Public Services Reform (Scotland) Act 2010 should be published on the Board website.	**3**	The required information will be published on the Board website	Director of Finance June 2017

	to improve efficiency, effectiveness and economy in the exercise of its functions.' Information relating to 2012/13 has been published on the NHST website, but no such information has been posted in relation to subsequent years.				
5.	There is currently no detailed guidance describing the budget process and NHS Tayside's approach to this. It is acknowledged that Annex 3 of the Standing Financial Instructions (SFIs) does give some brief guidance on this topic but in our view this does not provide sufficient detail for finance staff or budget holders.	Detailed guidance should be developed on the budget process adopted in NHS Tayside to guide finance staff and budget holders through the budget setting process for financial year 2017/18.	**2**	In line with the revised Business Planning process, the Standing Financial Instructions will be updated. Where appropriate more detailed operational guidance will be developed. This will continuously be reviewed.	Director of Finance September 2017

6.	The new budget setting process for financial year 2017/18 will involve a move away from the incremental, retrospective financial management towards a longer term commitment to the delivery of transformational change and financial sustainability. A shift in emphasis is required to reflect the changing role of finance staff in monitoring and reporting on financial performance but also supporting the delivery of efficiency savings and providing financial support to major transformational change projects. This will be a difficult balance to achieve and maintain given the financial pressures facing all corporate support functions. In order to be successful this change requires to be reflected in a planned approach to the training and recruitment of Finance staff.	A Finance Workforce Plan should be developed to ensure that a planned approach to the training and recruitment of finance staff is in place to ensure that there is sufficient capacity to meet the changing demands which will be placed on Finance staff to support the delivery of transformational change and achieve financial sustainability.	**2**	Recent recruitment approaches and the development of the Finance microsite will continue. Links will be enhanced with the national training resource to support the development of finance staff to create a planned approach to training.	Director of Finance September 2017

7.	The Corporate Financial Report to the October 2016 meeting of the Board highlights the fact that £3.2m of savings are required from deferred expenditure brought forward and board reserves. However, it is not clear how these savings will be delivered and this has not been explained to the Board.	Future reporting to the Board and the Finance and Resources Committee should clearly explain the steps which are being taken to deliver the £3.2m savings required from expenditure brought forward and board reserves and the impact this will have on the delivery of the projects which the SGHSCD allocation was intended to deliver. In addition, the year end reporting should explicitly highlight the deferral of expenditure into the following financial year, the impact this has had on the achievement of financial targets and the knock-on implications which deferred expenditure will have on future levels of savings required.	**2**	An enhanced level of reporting has already been established as part of the Corporate Finance Report. The year-end report will incorporate any impact flowing into the following financial year.	Director of Finance March 2017
8.	The Corporate Financial Report considered by the NHST Board in October 2016 does not differentiate between recurring and non-recurring efficiency savings,	The layout of the Corporate Financial Report should be further revisited to include: • a breakdown of recurring and non-	**2**	Reports to the most recent standing committees have already incorporated this enhanced level of reporting.	Actioned

	although the narrative does recognise that the Financial Framework sets a target of 40% of efficiency savings on a recurring basis. However, the proportion of savings delivered on a recurring basis is not reported and therefore it is not possible to gauge performance against the 40% target or the impact any shortfall in recurring savings will have on future financial years. A supplementary report on 'Forecast Outturn and Further Actions' was considered in the private session of the NHST Board meeting on 27 October 2016 and this report does differentiate between recurring and non-recurring savings and provides a breakdown by workstream/ initiative. However, the report does not make it clear whether these are identified savings to date or the projected savings position as at 31 March 2017.	recurring savings identified. • the quantified impact of any shortfall against the 40% recurring target on future financial years. Any savings relating to short term/ accelerated actions should be reflected in the calculation of the performance against target to ensure accuracy and transparency. • A projected savings position as at 31 March split by recurring and non-recurring. • Performance against the % recurring savings target. • An estimate of the knock-on impact on future financial years of any shortfall in recurring savings.			

9.	Work is ongoing to review both corporate and operational financial risks with input from the Risk Management Department.	It is imperative that the work to refresh and update financial risks is progressed as a matter of urgency and the actions required to effectively manage these risks are reported timeously to the F&RC.	**2**	The review of Corporate and Operational Risks is a feature at each and every Finance & Resources Committee meeting. Updates to the Risk Profile and mitigating actions will continue to be highlighted.	Director of Finance Immediate
10.	NHS Tayside has agreed with ISD Scotland to become a test site for NSS Discovery. Moving forward it is imperative that the areas of operation where NHS Tayside is not consistent with its peer Boards are explored and appropriately challenged as part of the budget setting process.	The budget setting process for 2017/18 should take account of the outputs from benchmarking activity with peer Boards to identify and address significant variances in spend which cannot be justified.	**2**	Local Delivery Plans require the Board to incorporate a quality and cost assessed improvement pan to respond to Productive Opportunities identified from benchmarked performance. This will inform the efficiency programme.	Director of Finance June 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.

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

Item Number 5.2

AUDIT19/2017
Audit Committee
9 March 2017

FTF AUDIT AND MANAGEMENT SERVICES INTERNAL AUDIT T12/16 – ASSURANCE FRAMEWORK

Margaret Dunning
Board Secretary

Lindsay Bedford
Director of Finance

March 2017

FINAL REPORT

NHS TAYSIDE
INTERNAL AUDIT SERVICE

ASSURANCE FRAMEWORK

REPORT NO. T12/16

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

M Dunning, Board Secretary
A Gall, Interim Director of Performance
H Walker, Risk Manager
A Napier, Associate Director of Clinical Governance & Risk Management
D Howey, Head of Committee Administration

D Colley, Finance Governance Accountant
L Green, Audit Committee Members' Library Copy
Tayside Audit Follow-Up

Audit Committee
External Audit

Date: 28 February 2017

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INTRODUCTION & SCOPE

1. The Board Assurance Framework (BAF) Strategic Risk Profile aims to identify the strategic risks that could impact on the delivery of NHS Tayside's objectives. It sets out controls to reduce or mitigate (manage) the risks and the assurances that have been received which show if the controls are having the desired impact. It includes an action plan, which details mitigating actions to be taken, to further reduce the risks and an assessment of current performance is also provided. The Strategic Risk Profile presented to Board on 23 June 2016 comprised 20 strategic risks, 6 of which have a risk rating of 'Very high' and the remainder of which have a risk rating of 'high'.

2. This area was last reviewed in Internal Audit T11a/15 – Board Assurance Framework, which provided each relevant risk owner with suggested enhancements to BAFs. As part of the work taken forward from T13B/14 – Risk Maturity Assessment and T11A/15 – Effectiveness of Committee Structure, it was agreed that a new report format would be introduced for reports to Board or Standing Committee whose primary purpose was assurance, and that the format of the Standing Committee Chairs' reports should also be changed to allow the Board/Committee to understand quickly and easily the nature of the assurance being provided, any key risk, issues or other matters which should be the focus of Board/Committee attention and any items being formally escalated. To improve further how the Board operates and to facilitate the consideration of the main issues facing the Board the format of the Board agenda was also updated.

3. Since the BAF was last reviewed by Internal Audit, Integration Joint Boards (IJBs) were established during 2015/16 and 'went live' on 1 April 2016.

OBJECTIVES

4. Our audit work was designed to evaluate whether appropriate systems were in place and operating effectively to mitigate risks to the achievement of the objectives identified below.
5. The functions of Tayside NHS Board include strategic leadership and direction and ensuring efficient, effective and accountable governance of NHS Tayside. A robust set of risk management arrangements allow these to be achieved.

RISKS

6. The following risks could prevent the achievement of the above objectives and were identified as within scope for this audit:

   6.1. The BAF process may not provide Board members with the required assurances through relevant, reliable and sufficient evidence that controls are in place and functioning as expected;

   6.2. Strategic risks may not be kept up to date and there may not be a clear, robust process for horizon scanning, updating key risks and reporting of these updates;

   6.3. Identification of new risks and potential revisions to existing risks, as identified from previous Internal Audit reports or elsewhere, may not have been appropriately escalated and implemented;

6.4. Assurances may not adequately cover all areas of the organisation's activity and appropriate assurance may not be provided through Board/Standing Committee;

6.5. Assurance needs resulting from the new HSCI environment may not yet be appropriately articulated and necessary assurances may not be adequately reported through governance structures.

AUDIT OPINION AND FINDINGS

7. Whilst some further developments could be made, overall the BAF has moved forward since our last review, particularly with the introduction of the assurance report template and Committee assurance reports. The overall audit opinion for paragraphs 6.1 - 6.4 above is therefore **Category 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.

8. As noted above IJBs were established during 2015/16 and went live on 1 April 2016. However, there is currently no agreed formal setting out of the precise responsibilities of the Health Board, Council and the IJB in relation to operational activities. Therefore, there is still considerable uncertainty around the exact nature of the delegation of functions to the IJBs and the resultant allocation of responsibilities and therefore risk. There is therefore fundamental ambiguity in the risk environment which means that the assurance systems of the Board may not reflect current risks, controls and assurances. Therefore the overall audit opinion for paragraph 6.5 is **Category 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.

9. A description of all audit opinion categories is given in the final section of this report.

10. Our audit opinion reflects our positive view on the processes and structures put in place. However, the environment in which they operate has changed significantly and it is fundamentally unacceptable that at this stage there is no clarity over where responsibility lies and therefore how the assurance systems and reporting lines have to adapt in response.

BAF Process

11. The Board Assurance Framework is a cornerstone of NHS Tayside's governance arrangements. It is intended to provide an easy and clear mechanism for Board members to easily see whether risks are described accurately, controls are in place and assurances over these controls would provide early warnings of increased risk.

12. The BAF report is now presented to the Board four times per annum and individual strategic risks are discussed by the Standing Committee to which they are delegated.

13. We would note the increased number of strategic risks since our last review, which potentially dilutes the ability to focus on each risk and we would make the following observations:

- ◊ Based solely on the information available to a reader of the BAF, it would appear that some strategic risks currently on NHS Tayside's risk profile could be re-categorised as operational risks and attached to the relevant strategic risk. If this is not the case, their description should better describe why they need to be considered in isolation. An example of this would be the 2c/Managed Practices risk which could sit under the Sustainable Primary Care strategic risk.

- ◊ Internal Audit has contributed to ongoing work to develop a risk appetite for NHS Tayside. Once formalised, this may allow well controlled risks to be de-escalated from the strategic risk profile to allow Board members to focus on those risks above the agreed risk appetite.

14. We reviewed individual BAFs as reported to the Board in October 2016 and will be discussing our detailed findings on those individual risks with the Board Secretary and the NHS Tayside Risk Manager, as well as individual risk owners where possible. We would note that since we last undertook this work which was reported under T12a/15 in March 2015, significant improvements are evident in the system.

15. We identified some areas of very good practice and we would suggest that these be shared, together with a reiteration of the template which provides examples of how BAFs should be completed.

16. Whilst we commend the improvements since our last review, we would also note the following general points which should be taken into consideration in the next review of each BAF to further enhance the process:

- ◊ Operational risks linked to each strategic risk are no longer listed on the individual BAFs. However, we are aware of continuous improvement work in the development of the assurance template for reporting strategic risks to the responsible Standing Committee which will include an update on progress in relation to related operational risks
- ◊ Some BAFs were recorded as being recently reviewed but still contained outdated information. We were pleased to note the ongoing work in relation to enhancing guidance to risk owners and managers which is intended to address this issue.
- ◊ Many controls listed on various risks are in fact discrete/one-off actions rather than controls;
- ◊ Mitigating actions should be future planned actions to bring the risk from its current score to the planned score and therefore should when completed become part of an enhanced control environment. However, many actions currently listed have now passed but have not been incorporated into the key controls.
- ◊ Within a Board Assurance Framework, assurances must ultimately be provided to a governance body i.e. a Standing Committee or the Board. Many if not most assurances do not demonstrate the route through which assurances will reach this level.
- ◊ The current performance sections often do not contain any or sufficient data to enable the reader to conclude on whether current performance is consistent with the current risk score. Equally, the narrative which should justify the current and planned scores does not do so;

◊ We identified a number of specific examples where HSCI may impact on risks, controls and assurances.

We have previously listed questions to help Board members' scrutiny of the BAFs We would recommend that when completing BAFs, risk owners or managers also keep in mind whether the information they provide will enable the reader to answer these questions.

◊ Does the risk score 'feel' right

◊ Do the current controls match the stated risk

◊ Will actions bring risk down to the planned level

◊ Does the assurance you receive tell you how controls are performing

◊ Does the BAF make sense in isolation and how does it compare to other BAFs

◊ Are we focusing our limited resources on controlling areas of high risk rather than in investing in areas that are already well-controlled as shown by their current risk score

◊ Is sufficient time taken to scrutinise/challenge BAFs

◊ Is the BAF the response to a new risk or report

◊ Do Board/Committee papers identify risk clearly and link to BAFs

17. The BAF is now presented as a print-out from the DATIX system rather than the original BAF template from the NHS Tayside Risk Management Strategy. The print-out is now much longer and less user friendly than the template and therefore does not facilitate the level of scrutiny and understanding essential to this key document.

18. However, approaches have already been made to the software supplier and due to technical restrictions it is not possible to adjust the detail to be printed. Additionally, a paper based system would create additional resource requirement and lead to a risk of inconsistent or outdated information being reported manually.

19. As noted in paragraph 12 above, Standing Committees as well as the Board discuss their delegated strategic risks in detail at four meetings per annum and as part of the enhanced governance arrangements, assurance reports from the Chairs of Standing Committees are provided to Board and include information on the results of the detailed reviews of strategic risks aligned to each committee.

20. We recommend that as this enhanced risk assurance system beds in, BAF reporting should be reviewed in consultation with Board members. The Board may choose to receive less detail on each risk and may find an enhanced strategic risk profile summary paper, including risk appetite and exception reporting, more beneficial for scrutiny of the overall strategic risk profile. In the interim, Internal Audit will work with the NHS Tayside Risk Manager to identify ways in which the Datix print out report could be shortened by excluding certain sections.

Horizon Scanning

21. At its meeting on 10 March 2016, the Board agreed a new format of assurance reporting which includes both assurance reports from the Chairs of Standing Committees and a third type of report format for reports whose primary purpose is assurance. We have concluded that this represents a substantial improvement in the way that risk information is communicated to the Board and its Standing Committees. The Committee Chairs Assurance Reports referred to above, include a requirement to highlight any new potential risks which the Board should be aware of.

22. Since February 2016, the Strategic Risk Management Group (SRMG) includes a standing agenda item at the end of every meeting for horizon scanning in order to identify any new risks which should be included within the strategic risk profile.

23. At the 23 June 2016 Board meeting the Board Secretary highlighted to the Board that since the Board last considered the BAF and Strategic Risk Profile on 25 February 2016, the SRMG had agreed to the addition of two new strategic risks, Health and Safety and TrakCare. In addition to these new strategic risks, the Board was asked to consider the addition of a further risk to the Strategic Risk Profile around Managed/2c Practices. However, we note from a review of the Datix system that no strategic risk for Health & Safety has as yet been formulated. We would recommend that work is undertaken on this.

24. We have previously identified risks which potentially could have been foreseen and managed through the BAF or risk management systems. Whilst the enhancements referred to above are welcome, we would suggest that if, despite this, any further significant unexpected issues which impact on the Board arise, a brief post-event review is undertaken by the SRMG to understand why the issue had not been identified earlier and learn the lessons for future risk identification.

25. We reviewed a sample of papers to the October 2016 Board meeting. Whilst there is a risk section in the full ‘for decision making’ report format with accompanying clear guidance available, this is often not completed as intended. We note that the minutes of the 10 March 2016 Board meeting state that concern was raised regarding the availability of reports at pre-agenda meetings. Proper consideration of this area and overt linkage to the BAF could short-cut unnecessary discussion and allows the BAF process to be used to its full potential. We note that risk management processes have become more sophisticated since the guidance was written and are aware that work is ongoing to update this.

Assurances - Coverage across the organisation and its activities

The remit of the SRMG states that it is responsible for evaluating the effectiveness and performance of risk management across the organisation. Work is ongoing in relation to the review and development of KPIs for risk management. We would recommend that a KPI is included designed to measure whether risk management covers all areas and activities of the organisation.

HSCI

26. Internal Audit has previously raised the issue of a lack of clarity of the impact of HSCI on the accountability structures in place. Our 2015/16 Annual report, reiterating findings and recommendations from previous reports, recommended that *'There needs to be a clear, consistent and coherent understanding of accountabilities so that all parties can design comprehensive assurance systems which reflect that shared understanding, minimise duplication as far as possible and ensure that there are no omissions. The review should include update of the HSCI corporate risk and alignment, as far as practicable, of the IJB and NHS Tayside risk registers.'* The Chief Internal Auditor further expanded on this control issue in his presentation to the May 2016 Audit Committee on the subject of HSCI governance.

27. This lack of clarity and understanding of accountabilities has not yet been addressed.

28. There are a number of elements of the Integration Schemes and risk management systems in each organisation which do not appear to be consistent.

29. Standing Committee minutes do demonstrate that, for certain risks, there is an awareness that updates to take account of the HSCI environment are required. However, this has not been universal and has not yet translated into meaningful amendments to the risks and, of course, cannot do so until clarification on responsibilities is received.

30. As a result, readers of the BAF are not in a position to understand whether the information reported represents an accurate picture of the risks owned by the Board, the controls operated over those risks and the assurances which can be obtained by the Board.

31. Our positive opinion on the BAF processes and structures in place is therefore compromised by this fundamental lack of clarity, which, unless addressed urgently, will also impact on the ability of the Audit Committee to provide meaningful assurance to the Board and Accountable Officer.

ACTION

32. 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

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

A Gaskin BSc. ACA
Chief Internal Auditor

Action Plan

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
1.	Our interim review will again make recommendations about the fundamental need for clarity on the respective responsibility of the Board and the IJB in relation to the operational management of delegated functions and therefore the allocation of and responsibility for the associated risks.	Once agreed, these responsibilities must be incorporated into the BAF Framework as a matter of urgency. In particular, the content and indeed direction of year-end assurances between the Board Audit Committee and its IJB equivalents should be discussed in sufficient time to allow appropriate, adequate and proportionate year-end assurance arrangements to be put in place and delivered. Great care will need to be taken to choreograph these assurances so that all of the relevant bodies can receive and provide the relevant assurances in accordance with their requirements.	**1**	Agreed. In the first instance, a meeting to be arranged with the NHS Tayside Chairman, Chief Executive Board Secretary, 3 Chief Officers of the HSCPs and Chief Internal Auditor. Thereafter the remainder of this recommendation can be addressed based on the outcome of these discussions.	Board Secretary 31 January 2017

Action Plan

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
2.	We would comment on the increased number of strategic risks since our last review, which potentially dilutes the ability to focus on each risk.	Based solely on the information available to a reader of the BAF, it would appear that some strategic risks currently on NHS Tayside's risk profile could be re-categorised as operational risks and attached to the relevant strategic risk. If this is not the case, their description should better describe why they need to be considered in isolation. Internal Audit has contributed to ongoing work to develop a risk appetite for NHS Tayside. Once formalised, this may allow well controlled risks to be deescalated from the strategic risk profile to allow Board members to focus on those risks above the agreed risk appetite.	**2**	Risk appetite statement has been re-drafted in conjunction with Board Secretary, Head of Committee Administration and Non-Executive Board Member. To be taken to Strategic Risk Management Group for approval and then incorporated into Risk Management Strategy, Guidance Note and Datix system.	Risk Manager 31 March 2017

Action Plan

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
3.	We reviewed individual BAFs as reported to the Board in October 2016 both in detail and to identify general points.	We will be discussing our detailed findings on individual risks with the Board Secretary and the Risk Manager, as well as risk owners where possible. We identified some areas of very good practice and we would suggest that these be shared, together with a reiteration of the template which provides examples of how BAFs should be completed. The general points noted in this report should also be taken into consideration in the next review of each BAF to further enhance the process.	**2**	Meetings will be arranged for Internal Audit to meet with the relevant risk owners along with the Board Secretary and Risk Manager. Thereafter risks to be updated by Risk Owners with advice and support available from Risk Manager.	Internal Audit/ Board Secretary / Risk Manager 31 July 2017
4.	The BAF is now presented as a print-out from the DATIX system rather than the original BAF template from the NHS Tayside Risk Management Strategy. The print-out is now much longer and	We recommend that as this enhanced risk assurance system beds in, BAF reporting should be reviewed in consultation with Board members. The Board may	**2**	Report to be shortened in the short term, with a view to introducing risk appetite to the summary risk profile and exception reporting for those risks exceeding the appetite. In addition work will be conducted in	Board Secretary / Risk Manager 30 April 2017

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
	less user friendly than the template and therefore does not facilitate the level of scrutiny and understanding essential to this key document.	choose to receive less detail on each risk and may find an enhanced strategic risk profile summary paper, including risk appetite and exception reporting, more beneficial for scrutiny of the overall strategic risk profile. In the interim, Internal Audit will work with the Risk Manager to identify ways in which the Datix print out report could be shortened by excluding certain sections.		conjunction with the Head of Committee Administration to incorporate guidance into the Risk and Committee Chairs Assurance Report.	
5.	We note from a review of the Datix system that no strategic risk for Health & Safety has as yet been formulated.	We would recommend that work is undertaken on this.		Chief Operating Officer is the risk owner and this is being monitored by the Strategic Risk Management Group who at their last meeting asked this strategic risk to be placed in Datix as soon as practically possible.	Board Secretary 31 March 2017

Action Plan

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
6.	We have previously identified risks which potentially could have been foreseen and managed through the BAF or risk management systems.	We would suggest that if, despite this, any further significant unexpected issues which impact on the Board arise, a brief post-event review is undertaken by the SRMG to understand why the horizon scanning process had not identified the issue earlier and learn the lessons for future risk identification.	**2**	Awareness will be raised at next SRMG meeting. Thereafter, arrangements will be implemented to ensure that should such a situation arise, a specific agenda item is added to the next meeting of the SRMG.	Board Secretary/ Risk Manager/ Committee Support Officer 30 March 2017
7.	We reviewed a sample of papers to the October 2016 Board meeting. Whilst there is a risk section in the full 'for decision making' report format with accompanying clear guidance available, this is often not completed as intended. We note that the minutes of the 10 March 2016 Board meeting state that concern was raised regarding the availability of reports at pre-agenda meetings. We note that risk management processes have become more sophisticated since	Proper consideration of this area and overt linkage to the BAF could short-cut unnecessary discussion and allows the BAF process to be used to its full potential.	**2**	Guidance for completion of the risk section contained within 'for decision making' has been updated and is available for use Board and Standing Committee Meetings from January 2017 onwards.	Head of Committee Administration/ Committee Chairs/Support Officers 31 March 2017

Action Plan

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
	the guidance was written and are aware that work is ongoing to update this.				
8.	The remit of the SRMG states that it is responsible for evaluating the effectiveness and performance of risk management across the organisation. Work is ongoing on the development of Key Performance Indicators for risk management.	We would recommend that a Key Performance Indicator is included designed to measure whether risk management covers all areas and activities of the organisation.	**3**	Key Performance Indicators have been revisited and are available in draft. To be taken to Strategic Risk Management Group for approval. Thereafter performance against these will be incorporated into Risk Management Mid and Annual Reports which are presented to the SRMG for endorsement before being submitted to the Audit Committee for approval.	Risk Manager 31 March 2017

Action Plan

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
9.	At its meeting on 29 October 2015, Tayside NHS Board approved the recommendation that its strategic risks should be reported to the Board or the relevant Standing Committee on a quarterly basis. Whilst this is being done, this is not reflected in Risk Management Strategy or Risk Management Guidance notes. Neither states how the BAF should be reported.	At the next update of these documents, reporting arrangements should be included.	**4**	At the time of the Board meeting neither of these documents were due for review. However, this is now underway and information will be incorporated.	Risk 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.

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

Item Number 5.3

AUDIT22/2017
AUDIT COMMITTEE
9 March 2017

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 2016/17 internal audit plans.

2. RECOMMENDATIONS

The Audit Committee is asked to:

- Note the progress on the 2016/17 internal audit plan.

3. EXECUTIVE SUMMARY

Progress on the 2016/17 plan is as expected.

4. REPORT DETAIL

4.1 COMPLETED AUDIT WORK

The following audit products, with the audit opinion shown, have been issued since the Audit Committee meeting on 1 September 2016. All reports are separate agenda items.

		Opinion	Draft Issued	Finalised
2016/17				
T08/17	Interim Review 2016/17	N/A	21 Dec 2016	7 March 2017
T12/17	Assurance Framework	B/D	11 Nov 2016	28 February 2017
T22/17	Follow Up of Financial Planning and Management	D	18 Nov 2016	6 March 2017

4.2 WORK IN PROGRESS

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

		Planned Audit Committee date
2016/17		
T15/17	HSCI	Various
T16/17	Adverse Events Management	May 2017
T18/17	Food, Fluid & Nutrition	May 2017
T19/17	Medicines Management – Realistic Medicines Workstream	August 2017
T20/17	Bribery Act	May 2017
T24/17	Financial Process Compliance	May 2017
T25/17	National Payroll System	May 2017
T26/17	Tayside Health Fund	August 2017
T31/17	Workforce & Care Assurance Workstream	August 2017

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

4.3 PLANNING COMMENCED

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

T14/17	Organisational Performance Management
T28/17	Information Security Framework

4.4 CHANGES TO OPERATIONAL AUDIT PLAN 2016/17

Following detailed discussion with the Director of Finance on priorities, risks, resources and planned external audit reviews, the following audits will be incorporated into future audit plans.

T19/16	Clinical Governance – Mortality Reviews
T12/17	Staff and Patient Environment
T13/17	Strategic Planning
T17/17	Infection Control
T21/17	Savings programme
T25/17	NDSI
T27/17	Information Assurance
T29/17	NHS Scotland Waiting Times Methodology
T31/17	Departmental Reviews

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 28 February 2017 actual input against the 2016/17 NHS Tayside plan stood at 332 days (64%) of the 518 days planned audit input for 2016/17 (Overall days reflects section 4.5 above). 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 his 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 2016/17 plan and the one outstanding product from the 2015/16 plan under the supervision of the Chief Internal Auditor. Audit work is planned so as 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

March 2017

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

Item Number 5.4

AUDIT26/2017
Audit Committee
9 March 2017

FTF AUDIT AND MANAGEMENT SERVICES
INTERNAL AUDIT T08/17 – INTERIM EVALUATION OF INTERNAL CONTROL FRAMEWORK 2016/17

Tony Gaskin
Chief Internal Auditor

Lindsay Bedford
Director of Finance

March 2017

FINAL REPORT

NHS TAYSIDE
INTERNAL AUDIT SERVICE

INTERIM EVALUATION OF INTERNAL CONTROL FRAMEWORK 2016/17

REPORT NO. T08/17

Issued To: L McLay, Chief Executive
A Russell, Deputy Chief Executive
L Wiggin, Chief Operating Officer
L Bedford, Director of Finance

IJB Chief Officers

M Dunning, Board Secretary
NHS Tayside Directors

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

Audit Committee
External Audit

Date Issued: 7 March 2017

INTRODUCTION & SCOPE

1. As Accountable Officers, Chief Executives are responsible for maintaining sound systems of internal control. On 18 December 2014 the Scottish Government issued the latest guidance on this area in the Dear Colleague letter 'Governance Statement'. As required by HM Treasury, Chief Executives must prepare a Governance Statement that complies with the guidance provided in the Scottish Public Finance Manual (SPFM) and that is accurate, complete and fairly reports the facts. A fundamental part of the Accountable Officer's responsibility is to manage and control all the available resources used in his or her organisation.

OBJECTIVE

2. This review examined the current framework in place for the preparation of the financial year end 2016/17 Governance Statement to provide assurance to the Chief Executive as Accountable Officer that there is a sound system of internal control that supports the achievement of the Board's objectives. The review considered corporate, clinical, staff, financial and information governance frameworks when evaluating the established systems and processes.

3. The principal objective of this interim review was to confirm that a framework has been established which is designed and operated to provide reasonable assurance, and that there is an effective system of internal control to manage the principal risks identified by the organisation.

4. We would highlight that the Scottish Government has not issued updated national Governance Statement guidance for 2016/17 and it is our understanding that there will be no change in extant guidance, and NHS Boards will continue to operate under the 2015/16 guidance.

RISK

5. The following risk could prevent the achievement of the above objectives and have been identified as within scope for this audit:

   - ✧ Suitable local arrangements may not be in place to meet the requirements of the extant Governance Statement guidance issued by SGHSCD.

AUDIT OPINION AND FINDINGS

6. The audit findings from our overview of the main areas of risk within the current internal control framework indicate that NHS Tayside continues to operate effective governance arrangements, which are subject to continuous review and improvement as part of an ongoing process. This interim review is intended to highlight areas for improvement which will enhance the Board's governance arrangements going forward.

7. Both Treatment Time Guarantee (TTG) performance and brokerage issues resulted in disclosures in the 2015/16 Governance Statement and the Auditor General issued a second Section 22 report in October 2016, setting out the scale of the challenge NHS Tayside faces in meeting its financial targets. As previously reported by the Auditor General in October 2015, NHS Tayside has needed financial assistance from the Scottish Government for four successive years in order to break even. The Auditor General's Section 22 report was considered by

the Public Audit and Post Legislative Scrutiny Committee of the Scottish Parliament on 15 December 2016.

8. The 2015/16 Internal Audit Interim Review identified a number of fundamental issues and contained a series of high priority recommendations. The report was considered in detail by both the Audit Committee in February 2016 and, on their recommendation, by Tayside NHS Board.

9. The 2015/16 Annual Internal Audit Report identified eight further recommendations, the first of which was that the Audit Committee should receive a detailed report setting out the Board's response to the key recommendations from the Interim Review 2015/16. The Director of Finance presented an update on the actions within the interim report to the Audit Committee on 1 September 2016. At this meeting it was noted that close working with Internal Audit would continue and a further update would be provided to the March 2017 Audit Committee meeting.

10. The status of actions from the 2015/16 Interim Review and Annual Report is detailed at Appendix 1 to this report.

11. The risk environment continues to be challenging both nationally and locally. Whilst progress appears to be appropriately focussed, the pace of change has not been sufficient to deliver the required actions within a timescale that can significantly influence outcomes during 2016/17. Based on current progress, the benefits of the improvements recommended during 2015/16 may not be evident until the 2017/18 financial year at the earliest.

12. The 2015/16 Annual Internal Audit Report drew attention to the need for the NHS Tayside Board to assure itself that it has the necessary capacity and capability to deliver transformational change whilst improving performance, in order to ensure significant and early progress. The Chief Executive presented a report to the Board on 27 October 2016 presenting the new senior management structure. Whilst that paper did not provide overt evidence of how the Board can be assured on capacity and capability, we have been informed that the Chief Executive will provide a further paper detailing the final senior management structure to the Remuneration Committee in March 2017 and a more detailed paper to the Board in April 2017 which will provide the necessary assurances. Although the structure presented to the Board in April 2017 will not have been fully implemented in-year, the paper will demonstrate how the Chief Executive has actively ensured that sustainable and safe services have been in place during this transition period and external resources have been provided to the Finance, HR and Transformation teams from across NHSScotland as well as specific support for individual workstreams.

13. The 2015/16 Annual Internal Audit Report also recommended an assessment of the capability of the finance department. Appointments have been made to a number of accountant posts. Appointments to senior posts reporting directly to the Director of Finance are still in progress.

14. Overall, we would conclude that whilst progress has been made in establishing the intended structures, and appointments to key posts are planned to populate these, assurance on the essential question of whether NHS Tayside has the capacity and capability to deliver its operational and strategic objectives will need to be provided to Board through the Chief Executive's paper in April 2017.

15. The 2015/16 Interim and Annual Internal Audit Reports stated that substantial further work needed to be undertaken to reflect the impact of HSCI on governance arrangements and highlighted the need for a clear, consistent and coherent understanding of accountabilities. Although IJBs have been live since 1 April 2016, nationally there is a level of ambiguity with regard to arrangements and locally there is no agreed, formal agreement setting out of the precise responsibilities of the Health Board, Council and the IJBs in relation to operational activities, the exact nature of the delegation of functions to the IJBs and the resultant allocation of responsibilities and risk. However, the Chief Executive has provided assurances that NHS Tayside has continued to operate existing arrangements and the Chief Executive and Executive Officers have worked in tandem with partner organisations.

16. In response to an Internal Audit report on Board Assurance, meetings have taken place to consider these issues but there is still ambiguity in the risk environment, which means that the assurance systems of the Board may not reflect current risks, controls and assurances. Whilst progress is being made, there remains the risk that agreement of key principles may not be achieved by year-end.

17. The lack of national and local clarity over the implications of HSCI on governance arrangements has the capacity to impact on almost every component of our report, particularly the Board Assurance Framework and Risk Management, but also the individual Committees and their assurance systems.

ACTION

18. This report highlights a number of ongoing key activities. We will consider the implementation of these activities as part of our year-end work to inform our Annual Report which in turn informs the Governance Statement in the Board's Annual Accounts.

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

ACKNOWLEDGEMENT

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

A Gaskin BSc. ACA
Chief Internal Auditor

Corporate Governance
On-going key activities:
• In October 2016 the process to complete the national Board diagnostic toolkit commenced with the Organisational Development department conducting interviews with Non Executives. A Development event on the toolkit took place on 12 January 2017 and a masterclass on 'Culture and Collective Leadership' was held on 23 February 2017. • Internal Audit T12/16 – Assurance Framework reflected that the Board Assurance Framework (BAF) is a cornerstone of NHS Tayside's governance arrangements and has moved forward since our last full review, particularly noting the introduction of the new assurance report template and Committee assurance reports presented to the Board. It also recommended improvements to the presentation of the BAF and highlighted the need to amend BAF risks to take account of HSCI (see planned developments section below). • On 5 May 2016 the Audit Committee approved its Terms of Reference, the detailed cyclical work plan and the Internal Audit annual plan. The Director of Finance is now the Lead Officer for the Audit Committee. • Annex F of the Audit Committee Handbook will be discussed at an Audit Committee Development event in early 2017 and the completed document will be presented to the Audit Committee on a two year cycle. The CIPFA tool will continue to be completed annually and will underpin the work on Annex F. • Audit Follow Up (AFU) reports were presented to Audit Committee in May and September 2016. • The annual external audit review of internal audit compliance concluded that the Internal Audit service is generally compliant with the Public Sector Internal Audit Standards (PSIAS). • FTF have been appointed as lead auditors for the three Tayside Health & Social Care Partnerships and their 2015/16 Annual Internal Audit Reports have been presented to the NHS Tayside Audit Committee in accordance with IRAG guidance. • The draft 2016/17 Local Delivery Plan (LDP) was approved by the Board on 26 May 2016, prior to submission to the Scottish Government. The LDP identified a potential year end shortfall of £11.65m. The October 2016 Board was informed that, as a consequence, the LDP had not been formally approved by the SGHSCD. At that time, it was anticipated that there would be a letter from the SGHSCD outlining what would be required for a sign off position, but this has not yet emerged. • The draft Transformation Programme 2016 – 2021 and the supporting Operational Delivery Plan 2016/17 were endorsed at the June 2016 Board meeting. T17A/16 reviewed Transformation Programme Board (TPB) governance and accountability and concluded that the governance arrangements were appropriate. However, given the changes to culture required and ongoing issues around capacity to drive forward the work streams, there are continuing challenges to the timely delivery of outputs. This area is under review in T19/17 – Realistic Medicines Workstream and T31/17 –

Workforce & Care Assurance.

- The NHS Tayside Annual Review took place on 26 October 2016 and Scottish Government feedback stated that Treatment Time Guarantee (TTG) progress has not been in line with trajectory and identified five actions relating to: delivery of key responsibilities for clinical governance, risk management, quality of care and patient safety and HEI actions; HAI arrangements; access targets and standards; sickness absence; in year and recurrent financial balance and local efficiency savings programme.
- On 23 June 2016 the Board considered the paper 'Strategic risk assurance on Waiting Times and Referral To Treatment', which provided a summary of the plans to achieve targets, including investment requirements and performance trajectories for 2016-17 as well as specific areas of risk to achievement of targets. Although the paper highlighted over £4m of interventions, two of the three trajectories identified are still being exceeded. The paper set out a revised assurance framework including monthly meetings with the Scottish Government Access Support Team.
- Performance to end of September 2016 was reported to the Board on 1 December 2016, with TTG, Cancer Waiting Times and three of the seven 18 weeks RTT targets not on track. We have been informed by Management that the Boards ability to secure external support and the set up time for the SLA with Golden Jubilee National Hospital have impacted on performance.
- T36A/16 – Children and Adolescent Mental Health Service (CAMHS) highlighted the sustained improvement in the achievement of CAMHS waiting times targets, despite the workforce issues around senior medical staff.
- 83% of policies were within their review dates as at 3 November 2016, a slight improvement from year-end.
- The 27 October 2016 Board approved an updated Best Value Framework 2016/17, following discussion at the September 2016 Audit Committee meeting, which takes account of the findings of Internal Audit Report T11/16 – Best Value, issued August 2016. The Head of Committee Support and the Principal Auditor have completed a series of meetings with Standing Committee Chairs, Lead Officers and Support Officers to help ensure that Committees fulfil their BV obligations in 2016/17.
- The Endowment Board of Trustees and Endowment Advisory Group have approved Terms of Reference and work plans for 2016/17. T26/17 will review the Endowment systems and processes based on the 5 year risk based audit plan.

Developments in place or planned by management:

- The Corporate Governance & Review Group annual work plan includes the substantial further update of Standing Orders and the Scheme of Reservation & Delegation to reflect both revised management structures and the impact of HSCI.
- The Director of Finance's September 2016 update to Audit Committee provided assurance that NHS Tayside Board and Senior Officers had recognised the significance of the 2015/16 Interim and Annual Internal Audit Reports and the actions/recommendations. Progress against these actions is detailed at Appendix 1 to this report.

- The strategic risk profile was reported to the Board in June and October 2016 and in February 2017, with strategic risks discussed by the Standing Committee to which they are delegated. The Board's approach to defining risk appetite is being progressed, as is a review of risk management KPIs.
- In discussion with management, Internal Audit identified areas where the Board's planning and monitoring arrangements could be clarified and will work with management to ensure that systems are in place to provide appropriate assurance on arrangements to deliver strategic objectives in line with the Scottish Government's 2020 vision.
- Our 2015/16 Annual Internal Audit report recommended that the Board should receive assurances on the arrangements in place to ensure the leadership, capability and capacity required to deliver the Board's objectives. The new senior management structure was presented to the Board on 27 October 2016. The final structure will be presented to the Remuneration Committee in March 2017 and the final management arrangements will be presented to Board in April 2017. We have been informed that the Chief Executive has actively focussed on ensuring that sustainable and safe services have been in place during the transition process and that external resources from across NHSScotland have been provided to the Finance, HR and Transformation teams as well as specific support for individual workstreams.
- T14/17 – Organisational Performance Management will review the process for identification of priorities for improvement and effective remedial action.
- The Board agreed that a paper on Single Outcome Agreements and Community Planning Partnerships should be brought to the Board. Although Community Planning was the subject of a September 2016 Board Development event and the Executive team has recently considered a report on Community planning and Joint Working, formal output has been delayed by the need to take account of recently published guidance on Community Planning, Part 2 of the Community Empowerment Act (2015), which has significant impact on the roles and responsibilities of the Board.
- The need for a clear, consistent and coherent understanding of precise responsibilities and accountabilities of the Health Board, Council and the IJBs in relation to operational activities and in the context of HSCI was reported in the 2015/16 Interim and Annual Internal Audit Reports and reinforced in the Chief Internal Auditor's HSCI presentation to the May 2016 Audit Committee and elsewhere. Nationally there remains a level of ambiguity with regard to arrangements for integration. Although formal transfer of functions to the IJBs took place on 1 April 2016, there is still no agreed, formal setting out of the precise responsibilities of the Health Board, Council and the IJB in relation to operational activities and uncertainty around the exact nature of the delegation of functions to the IJBs and the resultant allocation of responsibilities and therefore risk. As a consequence, year-end assurance processes have not yet been finalised. There has been recognition that this matter requires immediate resolution and meetings to resolve these issues are ongoing.

Recommended further issues for consideration by year-end:

- NHS Tayside's governance arrangements are operating within a local and national environment of increasing pressures and risks, meaning that management controls which may hitherto have been appropriate, may not now be sufficient to mitigate them effectively.

- Whilst accepting that the Board has a number of urgent issues to address, high priority internal audit recommendations from interim and annual reviews are inextricably linked to assurance over the Board's key objectives and we would normally expect them to be implemented in line with the dates agreed with Internal Audit and reported to the Audit Committee. Internal Audit will work with the Accountable Officer to ensure that any significant delays are identified and resolved.
- The October 2016 Board was informed that the unbalanced LDP had not been formally approved by the SGHSCD. The Board has not received an LDP progress report during 2016/17.

Clinical Governance
On-going key activities:
• In February 2016 the Clinical & Care Governance Committee (CCGC) authorised the review of the Clinical Governance Strategy, including the development of the framework for IJB performance and clinical governance for Health and Social Care. • The Clinical Governance Strategy is supported by a framework of performance reviews. • A Public Health Performance Management Framework is now in place, reporting through the Clinical Quality Forum (CQF) and CCGC. • The membership and remit of the CQF has been updated and has an increased focus on learning and sharing of good practice, as well as further emphasis on the review of strategic clinical risks to provide assurance to the CCGC. • The CCGC reviews all strategic clinical risks delegated to it at each meeting, with the exception of the most recent Mental Health risk report. Risks are also reviewed in detail by the CQF. The format of risk reporting has been enhanced by a move to summary assurance reports and Datix print outs. • T20/16 – Patient Safety Programme concluded that there are appropriate arrangements to ensure that risks and controls in relation to patient safety are appropriately identified, mitigated, monitored and controlled. • The Adverse Event Management (AEM) Policy is in line with latest Healthcare Improvement Scotland (HIS) guidance and adverse events are reported to the CCGC and CQF. The policy is currently under review. • Local and national reports are a CCGC standing agenda item and the CQF considers external visits and external clinical scrutiny reports at every meeting.
Developments in place or planned by management:
• A lack of capacity and administration to support performance review meetings has been highlighted to the CQF. Two risks have been recorded on Datix in relation to this. • Duty of Candour has been discussed at each CCGC meeting to date and will be incorporated into the AEM Policy when national guidance is available. This area is under review in T16/17. • NHS Tayside has complied with the Health and Safety Executive (HSE) Improvement Notice following the deaths by suicide of two patients in Moredun Ward, Murray Royal Hospital. An action plan is in place and assurances have been provided to the CCGC that the risks associated with the improvement notice are being actively mitigated and managed. However, the Procurator Fiscal has notified the Central Legal Office of a likely prosecution against the organisation. Reports to the CGCC indicated that not all ligature points in Tayside had been removed timeously. • An external professional/clinical review of these events and of internal governance arrangements has been commissioned but delayed by the inability of the original appointee to complete the review.

Recommended further issues for consideration by year-end:

- The agreed review and update of the Clinical Governance Strategy should be included in the workplan of the CCGC/CQF. The update should clarify clinical governance arrangements for integrated services, including the method and level of reporting by the IJBs and for recently established regional services. These arrangements should be reflected in the CCGC's terms of reference and workplan.
- Consideration should be given to reviewing the scheduling of meetings to allow CQF minutes and assurance reports to be reported more timeously to the CCGC.
- No Mental Health performance review meetings have taken place since April 2016. Management should ensure there is sufficient capacity and administration to support performance review meetings across all departments and particularly for Mental Health.
- There is a risk that any defence against the likely prosecution in relation to the deaths in Moredun Ward could be compromised by an ongoing failure to clarify governance and assurance arrangements and to maintain appropriate review processes in the interim, most particularly through the performance reviews which are intended to be a mainstay of clinical governance arrangements.
- Arrangements set out in 'Getting it Right for Everyone', have not yet been fully implemented in that the R1 Group has not met and therefore has not provided assurance to the Board and IJBs as originally envisaged.

Staff Governance
On-going key activities:
• The implementation of previous audit recommendations on the Staff Governance Committee (SGC) remit and workplan have been considered and whilst the draft Terms of Reference presented to the December Committee were broadly similar to the previous versions based on the Staff Governance Standard, there is evidence that workforce reports are being adapted to meet these recommendations. • The SGC is responsible for 3 corporate risks - Medical Workforce, Workforce Optimisation and Nursing & Midwifery Workforce. These risks were appropriately considered by the SGC and the draft 2016/17 LDP highlights the risk of being unable to recruit to key positions, specifically nurses. • The Staff Governance Standard was a Standing Agenda item at each of the SGC meetings in the year so far and three of the five strands of the Standard have been considered. This means that the SGC will have to cover the remaining two strands at their March 2017 meeting. • The 2015-17 Staff Governance Monitoring Framework action plan has been agreed and progress reported. The December 2016 update confirmed progress against all actions as green and included the NHS Tayside response to the Scottish Government's Head of Staff Governance. • The 'People Matter Strategic Framework 2016 – 2021' supports the Board's delivery of the 2020 'Workforce Vision - 'Everyone Matters'. It was adopted by the SGC on 21 June 2016 and noted by the Board on 25 August 2016. • The June SGC endorsed the Corporate Workforce Plan 2016 and Workforce Projections were endorsed by the SGC on behalf of the Board. Workforce Projection figures for job families other than Medical & Dental, Nursing & Midwifery and Other Therapeutic services in 2015/16 were flat-lined in order to align the Corporate Workforce Plan with the Financial Plans for NHS Tayside. • Workforce information for Quarter 1 and Quarter 2 was reported to the September and December SGCs. • An updated Whistleblowing Policy was endorsed by the SGC on 21 June 2016 and the December 2016 SGC considered the 6 month report (1 April – 30 September 2016) from the non-executive Whistleblowing Champion. • Recommendations from T23A/16 formed part of the Remuneration Committee Self-Assessment 2015/16, approved by the Committee on 21 June 2016. • At the October 2016 Board meeting, members were informed that the new performance evaluation scheme for Executives and Senior Managers is now in place and will provide a more structured approach that allows continuous development of senior staff. • Sickness absence for the second quarter of 2016/17 was 4.64% against the standard of 4% (0.5% tolerance). This represents a slight annual decrease of 0.06% on the similar period for 2015/16.

Developments in place or planned by management:

- The SGC is currently considering how best to demonstrate oversight and ownership of key workforce issues. We would support the use of a dashboard approach to provide ongoing assurance in this area. Our annual report will revisit this area to assess progress.
- Workforce reports will be adapted to demonstrate how they support the achievement of the Board's operational and strategic objectives. Going forward, papers such as the Promoting Attendance at Work and Recruitment Activity SBAR cover papers will provide an overt link to the organisation's financial position and the achievement of organisational objectives.
- In order to track progress against the 'People Matter Strategic Framework 2016 – 2021', each item will now have an action plan in addition to using outcomes from iMatter. The SGC has agreed the establishment of the 'People Committee' which will work alongside the Area Partnership Forum (APF) to consider wider strategic issues and provide updates on progress with actions to the SGC.
- 'Developing Our Culture' presented to the 21 June 2016 SGC contained proposals to refresh and develop NHS Tayside's culture, as a key enabler to its Transformation Programme and to address issues identified from the NHS Scotland Staff Survey and iMatter. This work is being progressed by the Discovery Sub-Group and a verbal report was provided to the January 2017 APF meeting.
- Local Workforce Plans are still to be developed in partnership and in conjunction with the transformational change decisions.
- Following a joint meeting of SGC and F&RC Chairs and Leads, it was agreed that a high level report on workforce implications will be produced alongside, and informed by, the Board's draft Financial Plan in final quarter 2016/17, to ensure that an informed position on workforce resourcing can be understood by the Board and Committees in agreeing the Financial Plan. This will, in turn, inform ongoing detailed local service workforce plans. The recently issued national Health and Social Care delivery plan states that CEL 32(20011) will be superseded in 2017 and that National H&SC workforce plans will be published in 2017/18.
- A review of Health & Safety is underway and the Health and Safety 2016 Annual Report will be presented to the March 2017 SGC. After a prolonged hiatus, a dedicated operational committee with Health & Safety responsibility has been established which reports to the Strategic Risk Management Group, and will provide an annual assurance report to the SGC.
- Draft Director Objectives 2016/17 were presented to the Remuneration Committee meeting on 27 September 2016 and following detailed consideration and comment by the Committee, were resubmitted to the expected standards in December 2016.
- The revised senior leadership structure was presented and approved by the Remuneration Committee on 12 April 2016 subject to several caveats. A progress update was provided to the 21 June 2016 meeting and on 27 October 2016 the Board endorsed the approach taken to revise the structure. It was agreed that the completed structure in totality would come back to the Board in April 2017.

- The June 2016 Remuneration Committee noted the importance of the Committee's consideration of Executive and Senior Manager Performance Assessment Outcomes and of due diligence in the performance management processes. The Remuneration Committee noted that sampling by Non Executive Members would be undertaken as the new arrangements bedded in.
- As at end November 2016, 42% of staff on Agenda for Change had a PDR in place and 39% had a PDP in place compared to the agreed target of 80%.
- In November 2016, an Associate Medical Director for Professional Governance was appointed. The organisation has recognised that revalidation for doctors has highlighted the importance of having the postholder to be the appraisal lead for secondary care and with overall responsibility for the development of a structured approach to supporting all aspects of revalidation.
- 26% (2015 – 27%) of secondary care doctors' appraisals and 33% of GP appraisal for the period to end October 2016 have been completed. An update on the Scheme for Medical Appraisal and Revalidation was presented to the 13 December 2016 SGC.

Recommended further issues for consideration by year-end:

- The SGC meets four times per annum and there will only be one further meeting in 2016/17 following agreement of the SGC Terms of Reference and workplan in December 2016. Our review of the 2016/17 SGC minutes highlighted that items have been frequently deferred to the next meeting and this may impact on the Committee's ability to complete their 2016/17 work plan. We will reconsider this area at year-end.

Financial Governance
On-going key activities:
• The Strategic Risk Profile for NHS Tayside considered by the October 2016 Board meeting included Corporate Risk 36 – Strategic Financial Plan 2015/16 – 2019/12. This risk score and planned exposure are both scored 25 (the highest possible risk score) because mitigating actions in place are not considered sufficient to reduce the risk profile below that level. Progress has been made in addressing issues raised in previous internal and external audit reports around financial planning and financial management, but not all actions have been implemented and overall the achievement of the unbalanced LDP for 2016/17 is at risk. • The Finance & Resources Committee (F&RC) considered the Financial Framework 2016/17 to 2020/21 on 10 March 2016 and Tayside NHS Board approved the plan on the same date. On 26 May 2016 the Board was presented with the financial planning templates to support the LDP. The LDP included a planned deficit of £11.65m and at that time required total savings of £175m over a 5 year period. • The Auditor General Report on the 2015/16 Audit of NHS Tayside was presented to Tayside NHS Board on 27 October 2016. NHS Tayside informed the December 2016 meeting of the Public Audit and Post-legislative Scrutiny Committee that the savings programme will now include repayment of all outstanding brokerage, with the consequence that the 5 year savings requirement has increased to £214m. • T32/17 – Bribery Act, will assist NHS Tayside in ensuring compliance with the requirements of the 15 June 2016 Scottish Government Director for Health Finance correspondence with regard to the UK Bribery Act 2010 – Gifts Gratuities and Hospitality. • Following the Board's decision in December 2015 to make retrospective interim EDL payments, the August Board was informed that incorrect payments had been made. The Board agreed to apply the NHS Tayside Overpayment of Salaries and Wages Policy and the Chief Executive gave a reassurance that this risk was being mitigated. An update was presented to the February 2017 F&RC.
Developments in place or planned by management:
• The latest financial report shows that whilst the current overspend is below trajectory, the level of planned savings was below forecast and an accelerated programme of (non-recurrent) efficiency measures is in place to step up the pace of savings delivery and mitigate the impact of emerging cost pressures. The Board has not yet received formal written assurance on whether the SGHSCD will provide the brokerage required to achieve break-even, although we have been informed that discussions with Scottish Government have always recognised this exposure level. • Following discussion at Audit Committee, the Audit Scotland Self Assessment Checklist was provided to all Board members to inform a F&RC workshop event on 22 September 2016. At this workshop the implementation of a revised budget setting process from financial year 2017/18 onwards was agreed. A Board Development Event on Financial Planning and Budgeting was held on 24

November 2016 and included 'Making and Taking Decisive Action'.

- Non Executive responses to the Audit Scotland Self Assessment checklist questions were presented on a Red, Amber, Green (RAG) basis with three of the 41 questions classed as Red as follows: achievement of revenue and capital limits; appropriate balance between recurring and non recurring savings to ensure future savings targets are met; awareness of ongoing developments with the Scottish Government proposed 10-15 year plan and the implications for the Board and affect on current plans and initiatives.
- Internal Audit report T28a/16 was reported to the January 2017 Audit Committee and noted a number of areas for improvement in relation to the Governance of the Property Asset Management Strategy and its accuracy, as well as the documentation relating to property disposals.
- The Chair of the Transformation Board's assurance report highlighted to the October 2016 Tayside NHS Board that there was a concern regarding the delay in selling marketed properties and that these may not be completed by the financial year end and this would have a knock on effect to the projected financial position.

Recommended further issues for consideration by year-end:

- T22/17 is reported to the March 2017 Audit Committee as a separate agenda item and highlights a number of areas for improvement, as well as noting that many previous Internal and External Audit recommendations had not been implemented in full. It also provides an assessment of current financial performance. Management has agreed an action plan to address the recommendations within the report.

Information Governance
On-going key activities:
• DL (2015) 17 – Information Governance and Security Improvement Measures 2015-17 was issued in June 2015 and in July 2015 the NHSScotland Information Security Policy Framework was issued. T28/17 – Information Security Framework will review this area in detail. • Progress on implementation of the DL is monitored by the Information Governance Committee (IGC) which considered an updated version of the IG and Security Improvement / Information Security Policy Maturity Assessment at their July 2016 meeting. The maturity assessment was presented to the Information Governance Committee in October 2016. The most up to date version of the maturity assessment was presented to the F&RC on 17 November 2016 and identifies key areas of work in the IG and Security Improvement Plan 2015 - 2017. • The revised IG Policy, including the appointment of the SIRO, was approved by the IGC in February 2016. • The IG midyear report was approved by the IGC on 26 October 2016 prior to presentation to the 17 November 2016 F&RC. • The IG strategic risk is monitored by the IGC, F&RC and the Board. As reported to the 17 November 2016 F&RC, the current risk score of 'high' reflects ongoing work to comply with DL (2015)17. • As recommended in the 2015/16 Internal Audit Annual Report, a standalone Information Security Policy was published in July 2016, following approval by the IGC. The policy has been publicised to staff and is appropriately aligned to the NHSScotland Information Security Framework. Security Incident reporting is an IGC Standing Agenda item. • The F&RC noted the eHealth Delivery Plan 2015-2020, and its financial implications, at its February 2016 meeting. • The remit of the Area Business Information Management and Technology (IM&T) Group includes responsibility to 'assist the F&RC and Executive Team in conducting a regular review of the effectiveness of the business aspect of the eHealth Delivery Strategy covering the funding, procurement, development and implementation of information technology systems in accordance with national and local eHealth strategies.' The Area Business IM&T Group considered the Delivery Plan status update at their 10 August 2016 meeting and the eHealth Delivery Plan was included in the F&RC workplan presented to the February 2017 meeting. • A HSCI progress update was presented to the Area Business IM&T Group in August 2016 and a further paper was prepared for the cancelled November 2016 meeting. The updates focussed on the Tayside Health and Social Care IT Approach and Telehealth/Telecare Programme from the eHealth Delivery Plan. • T34/16 – eHealth Strategy, Planning and Governance was issued on 22 August 2016 and concluded that no exit strategies were documented for the seven systems evaluated, and that these systems were stand alone silo based systems. This report was considered at the August 2016 Area Business IM&T Group.

Developments in place or planned by management:

- Management have informed us that an IG/Security update was not provided to the October 2016 IGC because a gap analysis to identify NHS Tayside's position in relation to the requirements of the Information Security Performance Framework was underway. A working group has been established involving IG, eHealth and HR to take the forward an Action Plan arising from the gap analysis.
- Section 5 of the Information Security Framework Policy states that the Board will identify key assets and their owners and document these in a high-level Information Asset Register. An Information Asset Register in the form of an access database has been produced but has not been populated. Management have informed us that a report on this requirement was scheduled for presentation to the Directors Meeting and Senior Management Team in December 2016.
- Historically, SGHSCD eHealth representatives met with NHS Tayside every six months to discuss progress on delivering its eHealth Delivery Plan. The Scottish Government Head of eHealth contacted Boards in September 2016 to propose trialling a system in 2016/17 of holding formal meetings for the end-year reviews only and using the mid-year progress update provided by Boards to update the LDP analysis for presentation to the eHealth Leads at the group's November meeting.
- As reported in the IG Mid Year report 2016/17, the draft Data Quality Strategy was reported to the September 2015 meeting of the IG Committee where it was agreed that to fully develop the draft Data Quality Strategy, it would need to be presented to and discussed with key individual and relevant groups and progress with development of this Strategy would be reported to the IGC for monitoring and input. Once complete and agreed by the IGC the Strategy will be widely circulated for consultation and the proposed final version will be presented to the F&RC for final approval.
- As reported in the IG Mid Year report, the FairWarning process remains dependent on manual extraction of system data and manual incorporation of personnel data from different sources. Therefore, there is currently no pro-active way of identifying incidents (inappropriate access/breach of confidentiality) within NHS Tayside. Investigations on the practicality of FairWarning working with Trakcare are ongoing. T27/17 – Information Assurance will review this area in detail.

Recommended further issues for consideration by year-end:

- We noted slippage in the IG and Security Improvement Plan 2015 – 2017 presented to the IGC on 27 July 2016. In particular, a formal report on information security training should have been provided to the IGC by end of July 2016.
- The IG Policy states the IGC should prepare a work plan but there is no evidence that such a work plan has been approved and is monitored by the IGC.
- The Area Business IM&T Group met on 21 April 2016 but the 9 November 2016 meeting was cancelled due to the number of apologies. The group will need to put appropriate arrangements in place to ensure it meets its remit during 2016/17.

Action Plan

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
1.	The Chief Executive presented a report to the Board on 27 October 2016 setting out the new senior management structure and whilst that paper did not provide overt evidence of how the Board can be assured on capacity and capability, we have been informed that the Chief Executive will provide a further paper detailing the final senior management structure to the Remuneration Committee in March 2017 and a more detailed paper to the Board in April 2017, which will provide the necessary assurances.	The Chief Executive's Board paper detailing the final senior management structure should clearly set out the reporting lines and responsibilities of the senior management team in order to provide robust assurance that NHS Tayside has the capacity and capability to deliver its operational and strategic objectives.	**2**	The Chief Executive will update the Remuneration Committee in March 2017 on the emerging direct reports sub structure and provide the appropriate assurances to the April 2017 Board meeting.	Chief Executive April 2017

Action Plan

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
2.	The unbalanced 2016/17 LDP was not formally approved by the SGHSCD and the Board has not received an LDP progress report during 2016/17.	Tayside NHS Board should be provided with an LDP progress report.	**2**	Financial aspects are reported to the Finance & Resources Committee and the Tayside NHS Board at each meeting. Performance reporting is provided at each meeting of the Tayside NHS Board. A formal LDP mid year report on progress within the six strategic priority areas will be incorporated into the Tayside NHS Board workplan.	Chief Executive October 2017
3.	Whilst progress is being made in agreeing formally set out precise responsibilities of the Health Board, Council and the IJB in relation to operational activities, there is no guarantee that key principles will be agreed before year-end and there is an urgent need to agree year-end assurance arrangements between the Board and the IJBs.	As a priority, key principles for HSCI and year-end assurance arrangements between the Board and the IJBs should be formally agreed and documented.	**1**	Work is ongoing involving the Chief Internal Auditor. An overview document detailing the governance processes will be produced for agreement by the year end.	Board Secretary May 2017

Action Plan

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
4.	In February 2016 the CCGC authorised the review of the Clinical Governance Strategy, including development of the framework for IJB performance and clinical governance for Health and Social Care. No further update has been received and it is not clear when an updated Strategy is to come forward for approval. This update is not referenced in the Committee's remit or workplan for 2016/17, or that of the CQF.	The review and update of the Clinical Governance Strategy should be progressed and included in workplans for the committees and groups involved.	**2**	An update to the Clinical Governance Strategy is being progressed and will be brought to Committee on completion. The workplan will also be updated.	Medical Director/Nurse Director September 2017
5.	Clarification in respect of the clinical governance and reporting arrangements for integrated services remains a work in progress. Arrangements set out in 'Getting it Right for Everyone', have not yet been fully implemented in that the R1 Group has not met and therefore has not provided assurance to the Board and IJBs as originally envisaged.	The updated Clinical Governance Strategy should clarify clinical governance arrangements for integrated services, including the method and level of reporting by the IJBs and for recently established regional services. These arrangements should be included in the CCGC's terms of reference and workplan.	**2**	An update to the Clinical Governance Strategy is being progressed and will be brought to Committee on completion. The CCGC's terms of reference and workplan will also be updated	Medical Director/Nurse Director

Action Plan

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
6.	The reporting line from the CQF to the CCGC provides valuable upward assurance to the committee. However, currently the CQF meetings frequently fall just after a CCGC meeting date, meaning that they may be a time delay on reporting.	Management should consider reviewing the scheduling of meetings to allow CQF minutes and assurance reports to be reported more timeously to the CCGC.	**3**	Actioned	Medical Director/Nurse Director Immediate

Action Plan

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
7.	A lack of capacity and administration to support performance review meetings has been highlighted to the CQF. Two risks have been recorded on Datix in relation to this. No Mental Health performance review meetings have taken place since April 2016. There is a risk that any defence against the likely prosecution in relation to the deaths by suicide of two patients in Moredun Ward, Murray Royal Hospital could be compromised by an ongoing failure to clarify governance and assurance arrangements and to maintain appropriate review processes in the interim, most particularly through the performance reviews which are intended to be a mainstay of clinical governance arrangements.	Management should ensure there is sufficient capacity and administration to support performance review meetings across all departments and particularly for Mental Health.	**2**	A Mental Health Performance Review will take place in March 2017 with the timetabling of future meetings reflective of the normal cycle of Performance Review meetings for operational areas.	Medical Director March 2017

Action Plan

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
8.	The SGC meets four times per annum and there will only be one further meeting in 2016/17 following agreement of the SGC Terms of Reference and workplan in December 2016. During 2016/17 SGC items have been frequently deferred to the next meeting and this may impact on the Committee's ability to complete their 2016/17 work plan.	Agenda setting for the last SGC of 2016/17 needs to ensure that the committee can demonstrate completion of its workplan.	**2**	Noted	Director of HR & OD March 2017
	The Staff Governance Standard was a Standing Agenda item at each of the SGC meetings in the year so far and three of the five strands of the Standard have been considered. This means that the SGC will have to cover the remaining two strands at their March 2017 meeting.			Noted	Director of HR & OD March 2017

Action Plan

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
9.	We noted slippage in the IG and Security Improvement Plan 2015 – 2017 presented to the IGC on 27 July 2016, in particular that a formal report on information security training should have been provided to the IGC by end July 2016.	The IGC and its lead officers should ensure that the requirements of the IG and Security Improvement Plan 2015 – 2017 are adhered to around the timing of required reports.	**2**	An information security improvement and action plan has been developed which was presented to the IGC in January 2017. Regular training reports, as well as updates for DL17, will be provided to the IGC and F&R in 2017/18.	Board Secretary Actioned
10.	There is no evidence that the IGC has prepared a work plan which has been approved and is monitored by the IGC.	As stated within the IG Policy the IGC should prepare and approve a work plan annually at the start of the financial year and monitor compliance throughout the year.	**2**	It is accepted that no IGC work plan was prepared for 2016/17. The IGC will prepare a workplan for 2017/18, which will be agreed at the next IGC meeting in May 2017.	Board Secretary May 2017
11.	The Area Business IM&T Group met on 21 April 2016 but the 9 November 2016 meeting was cancelled due to the number of apologies.	The Area business IM&T Group will need to put appropriate arrangements in place to ensure it meets its remit during 2016/17.	**2**	Extraordinary meeting held in March 2017 to ensure workplan met.	Director of HR & OD March 2017

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.

Appendix 1 - Internal Audit Interim and Annual Reports 2015/16 - Outstanding and In Progress actions at 1 March 2017

2015/16 Annual Report Action Ref:	Control Issue	Audit Recommendation	Priority	Management Response/Action	Action By/Date	DoF Update
3	**HSCI – this recommendation incorporates 2015/16 Interim Review recommendation 6.**					
	Tayside NHS Board has not overtly considered the impact of HSCI on the accountability structures currently in place, and those required for the future. Following our Interim Review, the HSCI BAF was updated in March 2016 but does not include all of the complex governance and accountability issues referred to above.	In 2016/17 Tayside NHS Board will need to undertake substantial further work to reflect the impact of HSCI on its governance arrangements, including update of the Standing Orders and Scheme of Reservation & Delegation to take account of both revised management structures and HSCI. There needs to be a clear, consistent and coherent understanding of accountabilities so that all parties can design comprehensive assurance systems which reflect that shared understanding, minimise duplication as far as possible and ensure that there are no omissions. The review should include update of the HSCI corporate risk and alignment, as	2	The impact of HSCI on the Board's governance arrangements will be reviewed, recognising the complex governance and accountability issues.	Chief Executive/ HSCI Chief Officers 31 Oct 2016	**In progress**. CIA met with Board Secretary and Interim Director of Performance on 11 November 2016 and it was agreed that a meeting involving the NHS Tayside Chief Executive and the 3 Cos, Chairs of the IJBs and the NHST Chair would be arranged to agree arrangements. The Board Secretary subsequently arranged a meeting on 12 January 2017. A further meeting was held on 8 February 2017 with the CIA, the Board Secretary and the 3 COs. Further work is ongoing with the CIA and the Board Secretary. Once all parties can agree of a coherent and comprehensive assurance

Appendix 1 - Internal Audit Interim and Annual Reports 2015/16 - Outstanding and In Progress actions at 1 March 2017

2015/16 Annual Report Action Ref:	Control Issue	Audit Recommendation	Priority	Management Response/Action	Action By/Date	DoF Update
		far as practicable, of the IJB and NHS Tayside risk registers.				system the Board's governance process can be updated accordingly.
	2015/16 Interim Review:					
	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	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 & Community Care Chief Officers 29 Feb 2016 and ongoing	Once agreement is reached on the Assurance system this can be applied to the clinical governance processes and they can be updated accordingly.

Appendix 1 - Internal Audit Interim and Annual Reports 2015/16 - Outstanding and In Progress actions at 1 March 2017

2015/16 Annual Report Action Ref:	Control Issue	Audit Recommendation	Priority	Management Response/Action	Action By/Date	DoF Update
	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 & Community Care Board Secretary Chief Officers 29 Feb 2016 and ongoing	Once agreement is reached on the Assurance system the Board's Assurance Framework can be reassessed to take account of risks that may no longer be required to be within the Board's Assurance Framework or which risks may now be a shared risk within the Board Assurance Framework.

Appendix 1 - Internal Audit Interim and Annual Reports 2015/16 - Outstanding and In Progress actions at 1 March 2017

2015/16 Annual Report Action Ref:	Control Issue	Audit Recommendation	Priority	Management Response/Action	Action By/Date	DoF Update
		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.	**2**	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 Officers	It has been agreed that scenario planning would be put on hold at present.
5	The Corporate Financial report for the year ended 31 March 2016 shows a 31% increase in agency and bank costs. Although the December 2015 SGC meeting, questioned whether there should be a separate report in relation to spend on Agency staffing, this did not result in an action point or additional reporting.	This issue should be added to the SGC workplan.	**3**	Agreed. Changes to the Staff Governance Committee Terms of Reference will be discussed at its meeting in June 2016, with a view to amendment supporting closer alignment with assurance on key business performance. Final amendments will be adopted at the following meeting of the Committee in September 2016.	Director of HR & OD 30 Sep 2016	SGC and F&R joint reporting work commissioned and scheduled to be considered in full at the SGC at its meeting in March 2017.

Appendix 1 - Internal Audit Interim and Annual Reports 2015/16 - Outstanding and In Progress actions at 1 March 2017

2015/16 Annual Report Action Ref:	Control Issue	Audit Recommendation	Priority	Management Response/Action	Action By/Date	DoF Update
6	The Integration Schemes state that '*The Parties will deliver, within 3 months of the establishment of the IJB, a Workforce and Organisational Development Strategy for integrated functions. The Strategy will set out how support and development will be provided for and to the workforce. Reviews of the Strategy will be undertaken in conjunction with the IJB'.*	The requirement to develop a Workforce and Organisational Development Strategy for integrated functions needs to be included in SGC remit and appropriate processes established to develop the Strategy.	**3**	Agreed. Changes to the Staff Governance Committee Terms of Reference will be discussed at its meeting in June 2016, with a view to amendment supporting closer alignment with assurance on key business performance. Final amendments will be adopted at the following meeting of the Committee in September 2016.	Director of HR & OD 30 Sep 2016	**Action superseded.** Local Partnership model agreed for IJBs which ensures local consideration of Staff Governance elements, including development of Workforce plans, in partnership, with assurance reporting to SGC via APF. Business performance measures and delivery by IJBs included in proposed corporate dashboard, to be considered at March 2017 of the SGC.

Appendix 1 - Internal Audit Interim and Annual Reports 2015/16 - Outstanding and In Progress actions at 1 March 2017

2015/16 Annual Report Action Ref:	Control Issue	Audit Recommendation	Priority	Management Response/Action	Action By/Date	DoF Update
8	The draft Data Quality Strategy was presented to the September 2015 IG Committee meeting and no further updates have been provided since. The draft policy has not yet been formally approved.	NHS Tayside should formally approve the draft Data Quality Strategy at the earliest opportunity.	**3**	The September 2015 IG Committee agreed that to fully develop the draft Data Quality Strategy it would need to be presented to and be discussed with key individuals and relevant groups to progress this to a complete Strategy. Therefore, the progress with the development of this Strategy will be reported to the IG Committee for monitoring and input. Once completed and agreed by the IG Committee the Strategy will be widely circulated for consultation and the proposed final version will be formally approved by the F&R Committee.	Board Secretary & IG Manager 31 Mar 2018	**In progress.** Draft Data Quality Strategy was reported to the September 2015 meeting of the IG Committee where it was agreed that to fully develop the draft Data Quality Strategy, it would need to be presented to and discussed with key individuals and relevant groups and progress with development of this Strategy would be reported to the IGC for monitoring and input. Once complete and agreed by the IGC the Strategy will be widely circulated for consultation and the proposed final version will be presented to the F&R Committee for final approval.

Appendix 1 - Internal Audit Interim and Annual Reports 2015/16 - Outstanding and In Progress actions at 1 March 2017

2015/16 Interim Review Action Ref:	Control Issue	Audit Recommendation	Priority	Management Response/Action	Action By/Date	DoF 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 Apr 2016	The Chief Executive will update the Remuneration Committee in March 2017 on the emerging direct reports sub structure and provide the appropriate assurances to the April 2017 Board meeting.

Appendix 1 - Internal Audit Interim and Annual Reports 2015/16 - Outstanding and In Progress actions at 1 March 2017

2015/16 Interim Review Action Ref:	Control Issue	Audit Recommendation	Priority	Management Response/Action	Action By/Date	DoF Update
	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 Jun 2016	The Performance Reports to Board continue to be enhanced to provide a comprehensive understanding of the effectiveness of actions taken.

Appendix 1 - Internal Audit Interim and Annual Reports 2015/16 - Outstanding and In Progress actions at 1 March 2017

2015/16 Interim Review Action Ref:	Control Issue	Audit Recommendation	Priority	Management Response/Action	Action By/Date	DoF Update
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. Workforce plan.	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.	**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.	Revised Committee Terms of Reference agreed at the December 2016 meeting. SGC and F&R joint reporting work commissioned and scheduled to be considered in full at the SGC at its meeting in March 2017.

Appendix 1 - Internal Audit Interim and Annual Reports 2015/16 - Outstanding and In Progress actions at 1 March 2017

2015/16 Interim Review Action Ref:	Control Issue	Audit Recommendation	Priority	Management Response/Action	Action By/Date	DoF Update
	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 of the workforce plan.	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.				

Appendix 1 - Internal Audit Interim and Annual Reports 2015/16 - Outstanding and In Progress actions at 1 March 2017

2015/16 Interim Review Action Ref:	Control Issue	Audit Recommendation	Priority	Management Response/Action	Action By/Date	DoF 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 Jun 2016	SAAT responses prepared in partnership, agreed via APF, presented to Staff Governance Committee and submitted as agreed to Scottish Government. National review of SAAT reporting underway; future format to be confirmed. Scottish Government has confirmed it will not undertake a traditional annual Staff Governance Monitoring/SAAT exercise for 2016/17.

Appendix 1 - Internal Audit Interim and Annual Reports 2015/16 - Outstanding and In Progress actions at 1 March 2017

2015/16 Interim Review Action Ref:	Control Issue	Audit Recommendation	Priority	Management Response/Action	Action By/Date	DoF Update
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 Mar 2016	Recruitment to a number of management accounting posts has been successful with the direct reporting sub structure to be reported as part of the Chief Executive's paper to the Remuneration Committee on March 2017.

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

Item Number 6.1

AUDIT20/2017
Audit Committee
9 March 2017

NHS TAYSIDE EXTERNAL AUDIT PROGRESS REPORT FEBRUARY 2017

Mr Bruce Crosbie
Senior Audit Manager

Lindsay Bedford
Director of Finance

March 2017

NHS Tayside

External audit progress report February 2017

AUDIT SCOTLAND

Prepared for NHS Tayside
February 2017

Who we are

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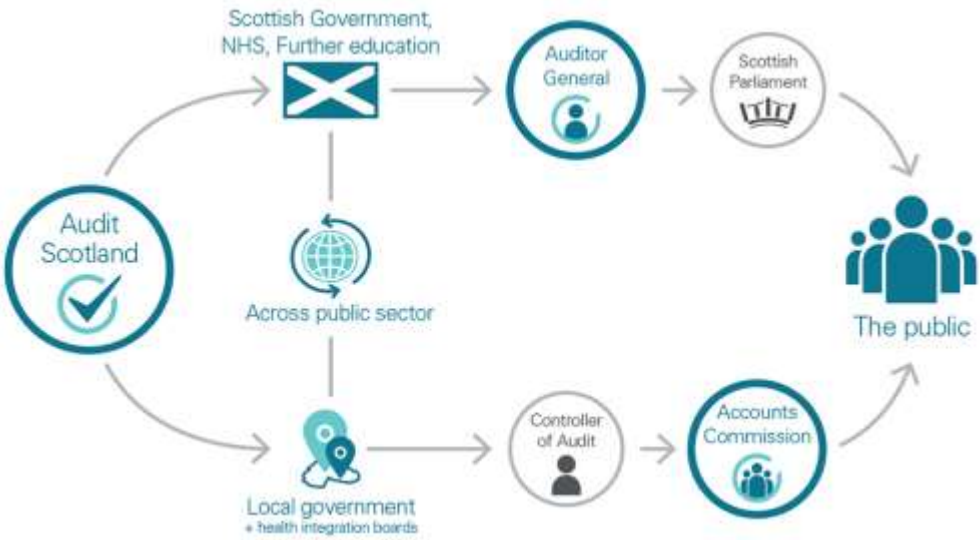
- Audit Scotland is governed by a board, consisting of the Auditor General, the chair of the Accounts Commission, a non-executive board chair, and two non-executive members appointed by the Scottish Commission for Public Audit, a commission of the Scottish Parliament.



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Our vision is to be a world-class audit organisation that improves the use of public money.

Through our work for the Auditor General and the Accounts Commission, we provide independent assurance to the people of Scotland that public money is spent properly and provides value. We aim to achieve this by:

- carrying out relevant and timely audits of the way the public sector manages and spends money

- reporting our findings and conclusions in public

- identifying risks, making clear and relevant recommendations.

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Interim audit progress

Introduction

1. This progress report contains a summary of the financial statements and wider dimension work we have undertaken to date as part of our 2016/17 audit at NHS Tayside.

Financial statements

2. We have made good progress with our review of governance and internal controls. The internal controls work informs our overall testing strategy for the 2016/17 audit and has focused on the board's key financial systems to enable us to gain assurances over risks of material misstatement in the annual accounts. Where possible we will place reliance on the work of internal audit to avoid duplication of effort.

3. We are progressing early substantive testing in some of the key transaction streams, such as accounts payable, accounts receivable and capital. We will continue with this work where appropriate over the coming months in advance of the receipt of the draft accounts on 8 May 2017.

4. We plan to report the results of the interim work in our 2016/17 interim report which we plan to present to management in March 2017 and to the Audit Committee in May 2017.

5. We will be contacting management soon to arrange a suitable time to commence our audit work on 'Enhancements During Leave'. We will report our findings from this work to the Audit Committee in June 2017 in our annual audit report.

Wider dimension

6. In September 2010 the Auditor General published a report on the role of boards. The report highlighted a number of key messages on:

- how they are accountable to the Scottish Government and the Scottish Parliament
- board members' skills and expertise
- how boards operate.

7. All public sector auditors have been requested to provide information to support follow up performance audit work on the role of boards, including governance, decision-making and scrutiny arrangements and Board members and staff training and development. We are progressing local work in this area.

8. In our 2016/17 Annual Audit Plan we noted that, as this is our first year in a 5 year audit appointment cycle we will undertake an Information and Communications Technology overview to inform our understanding of the eHealth and information governance environment within NHS Tayside. We are currently progressing this ICT overview work.

9. We will report our findings from our wider dimension work to the Audit Committee in June 2017 in our annual audit report.

National fraud initiative (NFI)

10. During 2016/17 we will be monitoring NHS Tayside's participation and progress with the current NFI exercise. NHS Tayside submitted the relevant data in October 2016 and matches for investigation were made available in January 2017. We will undertake our assessment of NHS Tayside's NFI arrangements over the coming months and provide an update in our annual audit report.

Performance audit

11. Audit Scotland's Performance Audit and Best Value Group undertake a programme of national studies on behalf of the Auditor General and the Accounts Commission. Performance audits are conducted and reported to inform and assist all public sector bodies in their own individual improvement agendas. Audit Scotland expects public bodies to review these reports and determine what actions may be appropriate at a local level, including the discussion of reports at the appropriate governance committee.

12. Recent reports which will be of interest to NHS Tayside are: NHS in Scotland 2016, published in October 2016 and Scotland's NHS workforce, published in February 2017.

13. Future work which will be of interest to NHS Tayside is: children's mental health; digital in health; NHS workforce; and health and social care integration: Part 2.

14. All our outputs and any matters of public interest will be published on our website: www.audit-scotland.gov.uk.

NHS Tayside

External audit progress report February 2017

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Item Number 7.1

AUDIT14/2017
Audit Committee
9 March 2017

RISK APPETITE

1. PURPOSE OF THE REPORT

To present to the Audit Committee a proposed risk appetite statement for NHS Tayside for the period 1 April 2017-31 March 2018.

2. RECOMMENDATIONS

The Committee is asked to:

- Approve the Risk Appetite Statement for NHS Tayside
- Recommend any further action it considers necessary

3. EXECUTIVE SUMMARY

The Good Governance Institute (GGI) led a workshop on risk appetite for Executive Directors in October 2013. Subsequently on 10 February 2014 the SRMG approved the NHS Tayside risk appetite statement followed by Tayside NHS Board on 27 February 2014.

Internal Audit Report T13b/14 – Risk Maturity which was published on 29 May 2014 recommended that Board members should consider how to articulate risk appetite. Subsequently Internal Audit Report T13B/16 – Follow Up of T13B/14 – Risk Maturity was published on 12 November 2015. While this report concluded that a substantial amount of work had been undertaken since the issue of the original risk maturity report, it suggested further articulation of risk appetite in numerical terms as the next step to progress the organisation's level of risk maturity.

Following liaison with other NHS Boards, a shortlife working group, consisting of Board Secretary, Risk Manager, Head of Committee Administration along with Internal Audit and Doug Cross, Non Executive Member, input into the development of the revised draft risk appetite statement for NHS Tayside which is attached at Appendix A.

4. REPORT DETAIL

Please refer to risk appetite statement contained in Appendix 1.

5. CONTRIBUTION TO NHS TAYSIDE'S STRATEGIC AIMS

The functions of Tayside NHS Board include strategic leadership and direction and to ensure efficient, effective and accountable governance of NHS Tayside a robust set of risk management arrangements allow these to be achieved.

6. MEASURES FOR IMPROVEMENT

Within NHS Tayside a series of Measures for Improvement/Key Performance Indicators have been developed and agreed for Risk Management as identified within the Risk Management Strategy.

Additionally, Performance Reviews contain a series of Measures for Improvement for all Directorates. These are also included in the Clinical Governance & Risk Management Reports for each Directorate/HSCP.

7. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

All risks influenced by any equity and diversity issue will have an impact assessment undertaken.

Consultation and involvement was undertaken with the Board Secretary to produce this paper.

8. PATIENT EXPERIENCE

Clinical Governance and Risk Management systems and processes are embedded across NHS Tayside. This ultimately contributes to the patient experience by reviewing adverse events, implementing improvements and minimising risk exposures across all services. There is also a drive to ensure that patients and/or their families are advised when an adverse events occurs during their care and are kept updated on any actions taken to improve the service and reduce the likelihood of the adverse event recurring.

9. RESOURCE IMPLICATIONS

Financial and Workforce
The system arrangements for Clinical Governance and Risk Management are contained within current resource.

10. RISK ASSESSMENT

This paper links directly with the Clinical Governance Strategic Risk which encompasses Risk Management systems and process and is recorded within the DATIX system graded as High/Amber (4x4).

11. LEGAL IMPLICATION

The Chief Executive, as Accountable Officer, has responsibility for maintaining a sound system of Internal Control and reviewing the effectiveness of the system within their organisation culminating in the preparation of the Governance Statement.

In NHS Tayside the Audit Committee has delegated responsibility for evaluating the organisation's risk management arrangements, systems and processes.

As part of the governance reporting arrangements for risk management it has been agreed that the Audit Committee receives and reviews the:

- Annual Workplan in respect of Risk Management
- Annual Committee Report from Strategic Risk Management Group
- Mid and Year End Reports on effectiveness, adequacy and robustness of risk management

12. INFORMATION TECHNOLOGY IMPLICATIONS

There are no IT implications associated with this paper.

13. HEALTH & SAFETY IMPLICATIONS

There are no Health and Safety Implications associated with this paper.

14. HEALTHCARE ASSOCIATED INFECTION (HAI)

There are no HAI issues associated with this paper.

15. DELEGATION LEVEL

Ms Lesley McLay is Chief Executive and Accountable Officer.

Ms Margaret Dunning, Board Secretary, is the Executive Lead for Strategic Risk Management Systems.

Mrs Hilary Walker, Risk Manager, is responsible for the implementation of risk management plans and follow up process.

16. TIMETABLE FOR IMPLEMENTATION

The Lead Officer for Strategic Risk is the Board Secretary with support from Mrs Hilary Walker, Risk Manager.

Following approval by the Audit Committee, the risk appetite statement will be incorporated into the Risk Management Strategy and thereafter will be subject to an annual review.

Hilary Walker
Risk Manager

Lindsay Bedford
Director of Finance

Margaret Dunning
Board Secretary

March 2017

Appendix A

Risk Appetite

NHS Tayside recognises that its reputation depends upon its relationship with patients, relatives and carers and as such is willing to consider all options and select the one most likely to result in successful, positive outcomes for patients.

Risk appetite is 'the amount of risk that an organisation is prepared to accept, tolerate or be exposed to at any point in time.' (HMT Orange Book, 2005)

It is about taking well thought-through risks where the long-term rewards are expected to be greater than any short term losses and it will be necessary to be involved in activities that expose the organisation to a measure of risk.

It is important that NHS Tayside determine risk appetite as it avoids stifling innovation or service improvement. It can also speed up decision making and improve organisational outcomes.

Risk are expressed as a measure of likelihood x consequence (Table 1: Risk Assessment Matrix) and are scored as inherent (without any controls) and current (showing the effect of existing controls in place). The current risk score is then compared to the expressed appetite for risk (Table 2: Risk Appetite Matrix)

Where the current risk score exceeds the expressed appetite for risk, mitigating actions, which will bring the risk down from its current level, should be developed and the risk scored for planned level (anticipated risk grading after all mitigating actions have been implemented). These are the actions which will bring the risk down from its current to planned level and to within an acceptable appetite. Increased monitoring of the risk should also be introduced as per the Risk Review Matrix (Table 3).

Where risks have been controlled such that the current score is the same as or lower than the appetite, the risk is deemed to be controlled and no further control measures are necessary (but may still be introduced).

The Board discharges its corporate responsibility for the governance of risk management through the Audit Committee which biannually reviews the effectiveness of risk management through presentation of a Mid Year and Annual Report.

At each meeting of the Strategic Risk Management Group (SRMG), members review the nature and extent of the significant risks they have agreed they are willing to take to achieve the organisations strategic objectives and through provision of horizon scanning explore any additions to the portfolio.

Each strategic risk is aligned to a Standing Committee of the Board or reserved for consideration by Tayside NHS Board itself with progress reports are provided four times per year via the Assurance Template.

On an annual basis, the SRMG will review and set the risk appetite statement taking into account what worked well, what failed and what needs to be done differently, prior to submission to the Audit Committee in favour of recommendation to Tayside NHS Board for approval.

Table 1: Risk Assessment Matrix

			CONSEQUENCE				
			1	**2**	**3**	**4**	**5**
			Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
LIKELIHOOD	**5**	**Almost Certain**	5 Medium	10 High	15 High	20 Very High	25 Very High
	4	**Likely**	4 Medium	8 Medium	12 High	16 High	20 Very High
	3	**Possible**	3 Low	6 Medium	9 Medium	12 High	15 High
	2	**Unlikely**	2 Low	4 Medium	6 Medium	8 Medium	10 High
	1	**Rare**	1 Low	2 Low	3 Low	4 Medium	5 Medium

Table 2: Risk Appetite Matrix

Current Risk Exposure Rating	**Score**	**Risk Appetite Response/Description**
Very High	20-25	Exceeds risk appetite, therefore requires immediate measures to be put in place to reduce risk exposure, with increased monitoring as per Table 3. Eager to be innovative and choose options offering potentially higher rewards despite greater inherent risk
High	10-19	Requires measures to be put in place to reduce exposure also with regular monitoring Willing to consider all options and choose the one that is most likely to result in success, while also providing an acceptable level of reward
Medium	4-9	Acceptable level of risk exposure subject to regular active monitoring Preference for safe delivery options that have a low degree of inherent risks and may only have limited potential for reward
Low	1-3	Acceptable level of risk subject to passive monitoring at local management level Preference for ultra safe business delivery options/avoidance of risk and uncertainty is a key organisational objective

Table 3: Risk Review Matrix

	Datix	Directorates/ Departments	Performance Review	SRMG	Standing Committee	Tayside NHS Board
Risks Exceeding Appetite			**<u>Service Level Risks</u>**: To considered in full and at each meeting until appetite falls within acceptable boundary		**<u>Operational Risks:</u>** To be considered in full and at each meeting of relevant standing committee until appetite falls back within acceptable boundaries	**<u>Strategic Risks</u>**: To be considered in full and at each meeting until appetite falls back within acceptable boundary
Strategic Risks	All risks should be reviewed within a 12 month period			Quarterly through exception updates by Risk Owner	Quarterly using Assurance Template	Twice per year as part of Summary Risk Profile. Risks reserved for Board review - Quarterly using Assurance Template
Operational Risks				By Exception		
Service Level Risks		Bi-monthly as a minimum	Each directorate as per performance review schedule/cycle	By Exception		

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Item Number 8.1

AUDIT15/2017
Audit Committee
9 March 2017

SKIN HEALTH SURVEILLANCE POLICY

1. PURPOSE OF THE REPORT

To seek Audit Committee approval of the new Skin Health Surveillance Policy in relation to NHS Tayside's statutory requirements to comply with Health and Safety law.

2. RECOMMENDATIONS

The Audit Committee is asked to review and adopt the Skin Health Surveillance Policy.

3. EXECUTIVE SUMMARY

The Health and Safety Executive (HSE) visited NHS Tayside on 1 and 2 March 2016 and identified that there were contraventions of health and safety law in relation to the management of skin health. HSE served NHS Tayside with a Notice of Contravention with specific requirements and actions to be addressed.

In addressing the notice of contravention NHS Tayside undertook a full review of the control measures, reporting of the skin health surveillance programme and the performance of the occupational health provider to develop a Skin Health Improvement Plan (SHIP).

A Skin Health Improvement Group was established and identified that although there was skin health guidance and supporting processes in place, there was an essential requirement for a Skin Health Surveillance Policy which would set out clear roles and responsibilities for the management and monitoring of skin health which applies to all staff.

A policy development group was therefore established, consultation and engagement undertaken approval through groups and committees in line with the development of a Health and Safety Policy. Feedback from the consultation and engagement has been incorporated into the policy appended.

4. REPORT DETAIL

Work-related skin problems are common, and occur in most workplaces, but within the NHS, there can be an increased risk due to the frequency of hand cleansing and/or contact with other substances that may cause irritation. If staff are exposed to skin damaging substances the NHS has a legal duty to conduct regular skin checks called 'Skin Health Surveillance'.

Legislation, and specifically the Control of Substances Hazardous to Health Regulations (COSHH), requires employers to adequately control exposure to materials in the workplace that cause ill health, and this includes those materials that may enter the body through the skin or induce allergic responses. Where exposure cannot be eliminated, there is a legislative requirement to establish and manage a skin health management and surveillance programme for staff.

The vast majority of skin problems in healthcare are cases of irritant dermatitis which may occur over short periods, and are susceptible to minor changes in hand washing or emollient use. It is known that skin problems that can be picked up early and are managed, resolve quicker and avoid becoming chronic. Local skin health inspections carried out as part of the skin health surveillance programme by a trained "Responsible Person" (RP) can support in early detection of skin health issues and onward referral to Occupational Health.

Under the auspices of the Skin health Improvement Group a short life Policy Development Group was established with the remit of developing a Skin Health policy for adoption by the end of March 2017. The policy has also been developed to incorporate the requirements from the HSE Notice of Contravention including:

- Education for managers about referral pathways in relation to statutory health surveillance or a defined workplace risk, with highlighting of any further investigation which may be necessary; defining feedback expectations on fitness to work, giving example questions to ask with feedback timescales.
- Ensure that employees including the relevant purchasing staff are familiar with the relevant hazards, risks, processes and control options that should be available within Tayside Health Board.
- Ensure that the occupational health provision includes staffing levels and defined competencies; knowledge, skills, qualifications, experience and training for the tasks performed and that there is a system to monitor compliance.
- Ensure that employees at all levels are familiar with the appropriate policies and procedures when undertaking statutory health surveillance. Training records should demonstrate that employees have been trained and understand the risks and legal requirements which should be embedded in our protocols.
- Ensure that our managers understand the interaction that should take place between occupational health professionals, health and safety, pharmacy, purchasing and infection control when managing an employee's health including any accountability for service quality and delivery.
- Clearly identify those individuals who should commence Statutory Health Surveillance on employment.

The policy applies to all staff including medical and dental staff. There is a key responsibility for managers who must ensure that they conduct a suitable and sufficient risk assessment to determine which staff are risk stratified as requiring to be included in the skin health surveillance programme. Where an individual thinks that they should/should not actually be included in skin surveillance following the risk assessment, they should have the opportunity to discuss this with their manager in case it is indeed appropriate and reasonable that they do/do not fit the criteria. If someone is taken off/ joins the surveillance programme then the reasons why should be documented.

The policy builds on existing skin health guidance and applies to all staff. It incorporates a robust risk stratification process to identify staff who should be included within the skin health surveillance programme.

5. CONTRIBUTION TO NHS TAYSIDE'S STRATEGIC AIMS

NHS Tayside, as an employer is responsible for ensuring governance systems are in place with clear lines of accountability and clearly defined roles and responsibilities to support the effective management of skin health in order to meet legal requirement under Health and Safety law.

6. HEALTH EQUITY

This policy ensures an equitable approach for all staff in the management of their skin.

7. MEASURES FOR IMPROVEMENT

- compliance for staff risk stratified to be included in the skin health surveillance programme. This will be monitored through the critical systems checklist and through a database for medical staff including junior medical staff and reported through Directorate Performance Reviews and the Health and Safety Management Group.
- Occupational Health (OH) key performance indicators have been agreed to monitor the service level provided by OH for the management of skin health

8. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

The equality impact assessment is integral to the policy.

Informing, consultation and engagement has been through the following groups in addition to circulation through Senior Management Team for onward distribution:

- Hospital Consultants Sub Committee
- Clinical Leads Group
- Joint Negotiating Committee
- Operational Unit Partnership Forum
- Area Partnership Forum
- Workforce and Governance Committee
- Skin Health Improvement Group
- Directors Group

9. PATIENT EXPERIENCE

Robust management of staff skin health ultimately contributes to the patient experience by minimising any associated risk exposure.

10. RESOURCE IMPLICATIONS

Financial

There are no identified financial implications in the policy implementation.

Workforce

No workforce issues are identified.

11. RISK ASSESSMENT

Risk Description

Mitigating actions in relation to the management of Skin have been taken forward through the Skin Health Improvement Group.

12. LEGAL IMPLICATION

NHS tayside has a legal duty to safeguard the health, welfare and safety of employees in line with the Health and Safety at Work Act 1974 and this is further clarified in the Management of Health and Safety at Work Regulations 1999 (as amended).

13. INFORMATION TECHNOLOGY IMPLICATIONS

There are no identified IT implications.

14. HEALTH & SAFETY IMPLICATIONS

There are no associated health and safety implications.

15. HEALTHCARE ASSOCIATED INFECTION (HAI)

There are no associated HAI implications.

16. DELEGATION LEVEL

The Chief Executive Officer is the Accountable Officer.

17. TIMETABLE FOR IMPLEMENTATION

The Policy will be implemented immediately on adoption by the Audit Committee following formal communication through the Corporate Distribution.

18. REPORT SIGN OFF

Lorna Wiggin
Chief Operating Officer

Lindsay Bedford
Director of Finance

Alan Cook
Medical Director, Operational Unit

March 2017

19. SUPPORTING DOCUMENTS

Skin Health Surveillance Policy

DRAFT

Remove draft once the policy is adopted by the Standing Committee

HEALTH AND SAFETY

Health and Safety
Skin Health Surveillance Policy

DRAFT

Policy Manager	Policy Group
Alan Cook / Kerry Wilson	Skin Health Improvement Group

Policy Established	Policy Review Period	Last Updated
March 2017	**March 2018**	16 January 2017

This policy does apply to Medical/Dental Staff

UNCONTROLLED WHEN PRINTED

Version Control

Version Number	Purpose / Change	Author	Date
1.0	Issued	Skin Health Policy Development Group	16/01/2017

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EXECUTIVE SUMMARY

Health and Safety (H&S) Legislation, and specifically the Control of Substances Hazardous to Health Regulations (COSHH), requires employers to adequately control exposure to materials in the workplace that cause ill health, and this includes those materials that may enter the body through the skin or induce allergic responses.

Where exposure cannot be eliminated, there is a legislative requirement to establish and manage a skin health management and surveillance programme for staff.

Line Managers, including Clinical Leads, are therefore legally obliged to:

- risk assess, on an annual basis, those under their line management as to whether or not they require to be included in a skin health surveillance programme
- ensure that those that require skin surveillance are adequately screened on at least an annual basis, or more frequently as might be required
- make employees aware of their legal responsibility to comply with skin surveillance requests
- hold adequate local employee records detailing health surveillance undertaken and make that available for inspection e.g. to the Health and Safety Executive (HSE)
- ensure that all cases that meet Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) requirements are reported to the HSE (whilst Occupational Health (OH) will aim to do this on a manager's behalf, it remains a management responsibility to check this has happened)

In addition Line Managers and Clinical Leads must:

- ensure adequate access to trained Responsible Persons (RP's) who can undertake initial, or first line skin surveillance
- allow local RPs time to discharge their skin surveillance responsibilities during the working day
- ensure all those risk assessed to be included attend a skin health awareness presentation
- support colleagues locally who have been identified as having skin ill health concerns
- ensure timely appointments are made with Occupational Health if required
- provide necessary data for internal reporting on compliance with skin health surveillance programme

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1. PURPOSE AND SCOPE

1.1 Purpose and Scope

Work related skin problems are common in the health and social care sector as staff have to wash their hands frequently and their skin can regularly be exposed to chemicals or other materials used in the manufacture of personal protective equipment (PPE) such as gloves.

NHS Tayside as an employer must, under their duty of care, comply with the legal requirements of the Health & Safety at Work etc Act 1974 and the Management of Health and Safety at Work Regulations 1999 (as amended) for the health, safety and welfare of all employees.

NHS Tayside recognises and accepts that it has a legal requirement for managing skin health and will establish a balance of proactive and reactive skin health management processes to identify those staff at risk and to support all staff in preventing the development of skin ill health.

This policy covers all staff, clinical and non-clinical. Specific elements of the policy will also apply to students, contractors and casual employees (e.g. bank staff).

1.2 Definitions of Key Terms

Term	Definition
COSHH	Control of Substances Hazardous to Health
IgE	Immunoglobulin E (**IgE**) are antibodies produced by the immune system. If you have an allergy, your immune system overreacts to an allergen by producing antibodies called Immunoglobulin E (**IgE**). These antibodies travel to cells that release chemicals, causing an allergic reaction
Skin Integrity	**Skin integrity** means that the **skin** is healthy, undamaged and able to perform its basic functions. A **skin integrity** issue might mean that the **skin** is damaged, vulnerable to injury or unable to heal quickly
Skin Sensitiser	A substance that can induce dermatitis through an allergic reaction

1.3 Statement of Policy

NHS Tayside assigns the highest importance to the health, safety and welfare of its staff and in particular recognises the significance and implications of skin ill health.

This policy specifically addresses the fulfilment of the above Health and Safety legislation. The policy will also ensure that NHS Tayside has a comprehensive system of employee skin health surveillance designed to safeguard employees against occupational dermatitis and robust processes in place to take early effective action where this is identified and to monitor existing control measures.

This policy ensures that NHS Tayside provides clarity to all staff in the management of skin health. The policy sets out the roles and responsibilities of all staff who must explicitly follow the policy, skin health guidance and standard operating procedures. Staff must fully participate in the skin health surveillance programme if risk stratified by the organisation as requiring to do so.

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1.4 Legislative background

Employers have a legal duty to safeguard the health, welfare and safety of employees (Health & Safety at Work etc Act 1974) and this is further clarified in the Management of Health & Safety at Work Regulations 1999 (as amended), which requires employers to undertake a suitable assessment of risk in the workplace and introduce health surveillance where appropriate.

The Control of Substances Hazardous to Health Regulations (COSHH 2002, as amended), provides further detail as to when health surveillance is required.

Having recognised that NHS Tayside cannot eliminate all known risks to staff skin health, it is essential that measures are implemented to detect any health problem that might arise through working practices in order to mitigate risk.

Effective skin health surveillance will detect early signs of disease so that preventative action can be taken to safeguard the health of an employee. Skin health surveillance will also review existing risk assessments and control measures and provide assurance that workplace controls are adequate. As skin health surveillance is a statutory requirement employees must attend assessments as requested by their employer. Failure of an employee to attend assessments or participate in the skin health surveillance programme will be an Employee Conduct issue.

1.5 Background Information

Staff at risk of occupational dermatitis includes clinical staff and other staff groups, for example, Domestic Services, Estates and Catering.

Some of the key skin irritants include Latex, Wet-work and Chemicals.

Symptoms can prevent employees from working due to pain and loss of function and once the protective layer of skin is breached or damaged due to dermatitis, it can act as portal of entry for infections and thus have implications for patient safety.

Latex has previously been one of the most important skin sensitisers (a substance that can induce dermatitis through an allergic reaction) that employees may encounter at work, other substances, including chemicals involved in rubber manufacture (‘accelerators’) can also give rise to either an allergic or irritant dermatitis.

‘Wet-work’ is also likely to give rise to a risk of irritant dermatitis. The Health and Safety Executive [HSE] suggest that 20-40 hand washes/contacts and or prolonged contact of more than two hours per day can give rise to this.

Once an employee is sensitised to latex, or another potential allergen, even minor exposure can lead to a marked flare-up of symptoms, which may also include breathing difficulties and rarely anaphylaxis.

Latex glove usage has decreased over the years, but latex forms part of other medical equipment e.g. catheters, bandages and wound drains. Therefore it can still be encountered in some areas.

Latex free gloves may contain potential allergens such as ‘accelerators’ and allergies to these are rising.

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Therefore whilst identification of new or existing employees with a known or suspected latex allergy remains important, consideration of the potential for allergy/irritancy to other workplace substances must be considered. This will ensure that appropriate action can be taken to protect employees' health e.g. by modification of their work activities.

Serious allergic reactions to latex are termed Type 1 (immediate hypersensitivity) reactions and symptoms usually manifest within five to 30 minutes. Typical symptoms include urticaria ('hives'), but anaphylaxis (circulatory collapse/breathing difficulties) can arise.

Reactions confined to the skin, which take longer to manifest are due to a delayed hypersensitivity reaction (Type 4) e.g. carbamix (an 'accelerator' used in non-latex glove manufacture).

The following groups may be at an increased risk of **latex** sensitivity:

- those whose occupation involves frequent rubber glove use e.g. health care workers and domestic cleaning staff.
- those who have spina-bifida or congenital genito-urinary abnormalities.
- those who have undergone multiple procedures, for instance surgery or pelvic examinations.
- those who have experienced significant mucosal or serosal contact with latex gloves
- those who might have inhaled powder when powdered latex gloves had been used in the past.
- those with eczema, asthma or hayfever.
- those who have worked in the rubber and food-handling industries.
- those with certain food / plant allergies -see table below.

High risk	Medium risk	
Banana Avocado Chestnut	Apple Carrot Celery Papaya	Kiwi Potato Tomato Melon

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2. RESPONSIBILITIES

2.1 Tayside NHS Board & Integration Joint Boards

NHS Tayside Board is responsible for complying Health and Safety legislation and ensuring that a robust governance and assurance framework is in place for Health and Safety including the management of skin health. The Integration Joint Boards are also responsible for ensuring a similar framework is in place for the management of skin health. The above Boards are also responsible for providing a safe place of work so far as is reasonably practicable, and for the provision of safe and suitable equipment.

NHS Tayside Board is responsible for ensuring governance systems are in place with clear lines of accountability and clearly defined roles and responsibilities to support the effective management of skin health.

2.2 The Standing Committees of the Board

Standing Committees of the Board, in accordance with NHS Tayside Code of Corporate Governance, will address each area of risk as appropriate. The Skin Health Policy is a Health and Safety Policy which is governed by the Audit Committee which has a duty to:

- review the organisations risk management arrangements, systems and processes
- review biannual reports from CoResponsible Personorate Risk Owners with risks aligned to this
- review and approve the risk management workplan
- approve the Committee Annual Report of the Strategic Risk Management Group
- receive the minutes from the Strategic Risk Management Group
- approve the bi-monthly clinical governance and risk management reports on effectiveness, adequacy and robustness of the systems.

2.3 Chief Executive (CE)

The Chief Executive:

- is the accountable officer for all Health and Safety within NHS Tayside.
- is accountable for ensuring there is an appropriately designed and practicable system of employee skin health management and surveillance in place in accordance with legal and occupational health (OH) requirements.
- will delegate responsibilities for the day to day management of skin health to appropriate officers in NHS Tayside and the Integration Joint Boards.

2.4 Directors, Chief Operating Officer, Chief Officers, General Managers, Heads of Service or Equivalent

Directors, Chief Officers**,** General Managers, Heads of Service or equivalent are accountable to the Chief Executive for staff activities and areas under their control. They are required to provide a safe place of work, so far as is reasonably practicable.

They:

- are responsible for ensuring that adequate skin health management and surveillance is in place for all employees.
- must ensure critical systems checklists and staff records are maintained.
- must ensure that their line management teams understand their roles and responsibilities for skin health management and surveillance within their areas and that appropriate reporting is in place.
- must ensure that there is appropriate education, awareness and training for employees including students.
- must review and act upon any skin health surveillance compliance reports produced by the Occupational Health Service Management Group and to review local data including DATIX reports, health and safety reports, Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) requirements and to ensure that the skin health surveillance programme is adhered to, taking corrective action where it is not.
- must ensure that there are sufficient trained skin health Responsible Persons to undertake skin health surveillance.

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2.5 Clinical Service Managers/Service Leads or equivalent

Responsible for implementation of the local skin health management and surveillance programme within their area(s) of responsibility and are accountable to Directors, Chief Operating Officer, Chief Officers, General Managers, Heads of Service or Equivalent.

Clinical Service Managers/Service Leads or equivalent must**:**

- ensure that their line managers understand their roles and responsibilities for skin health surveillance within their areas.
- ensure that line managers, or other suitable trained assessors have undertaken COSHH risk assessments and that where appropriate these have been acted upon e.g. ensuring inclusion of employee groups within the skin surveillance program.
- provide confirmation to their line manager that the management of skin health and skin education is in place.
- ensure that recommendations from anonymised grouped reports from OH (e.g. an upward trend in workplace related skin disease) is investigated and appropriate actions taken to ensure that control measures are adequate to safeguard the health of employees and where they are not, to take action to remedy them.
- escalate any concerns about skin health surveillance that cannot be resolved, to their relevant line manager;
- ensure that the use of non-powdered, latex gloves is subject to a written risk assessment (COSHH) i.e. to only use latex gloves in circumstances where an alternative (non-latex) glove type would not suffice.
- ensure that employees identified as having a latex allergy are placed in a non-latex, or latex safe environment and other staff are aware of the need to maintain this.
- ensure that employees with other potential, occupational allergies have appropriate modifications or restrictions in place to prevent further exposure, as advised by OH.

2.6 Line Managers, Supervisors and Clinical Leads

The above group will be referred to as Managers throughout this document

Managers are responsible for day to day implementation and oversight of skin surveillance management and surveillance within their area. Supportive guidance is provided within Appendix 4.7

Managers must**:**

a) risk assess all staff within their area of responsibility and ensure that the Critical Systems Checklist is updated. The risk assessment should be undertaken annually as a minimum or in the event of any change to working practices or products/chemicals used. (see appendix 4.2)

b) undertake COSHH assessments of latex and any other substance in use e.g. hand wash/skin cleansers etc, or any other products that employees might be exposed to at work that could cause skin sensitisation/irritation i.e. any substance labelled either as:

    - R38 ‘Irritating to skin’
    - R43 ‘May cause skin sensitisation by contact’
    - R66 ‘Repeated exposure may cause skin dryness or cracking’

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Or with new changes to labelling and packaging legislation:

- H315 ‘Causes skin irritation’
- H317 ‘May cause an allergic skin reaction’
- EU HO66 ‘Repeated exposure may cause skin dryness or cracking’

In addition managers should recognise that “wet-work” (frequent hand-washing > 20 times/day and/or prolonged exposure to water for around 2 hours or more) can result in an irritant dermatitis and must:

1) where possible, ensure that latex containing gloves/equipment are removed, or replaced with suitable, non-latex substitutes unless clinical necessity (see 4 below) indicates otherwise.

2) ensure that non-latex substances with the hazard phrases mentioned (see (a) above) are, where practicable, removed, or replaced with a suitable, non-irritant/non-sensitising substitute.

3) where it is not possible to remove, or substitute latex containing items or other potential allergens e.g. gloves, because of clinical necessity, the risk assessment must include the reasons why removal/substitution is not possible. The manager must keep this record available for inspection by representatives of the Health and Safety Committee (or equivalent), or by external agencies such as the Health and Safety Executive.

4) ensure that employee exposure time to latex (and other glove types) is kept to a minimum e.g. employees must not wear gloves if there is no necessity to do so and certainly not beyond manufacturers’ published ‘breakthrough’ times.

5) ensure that the potential level of exposure determines the frequency at which health surveillance e.g. periodic skin checks as necessary, but initially these may need to be performed fairly frequently e.g. monthly, quarterly etc to establish a ‘baseline’.

6) ensure that all employees have a current skin health check performed within the first four weeks of employment. Where employees transfer from another area within NHS Tayside, the manager must ensure they receive all skin health employee records to ensure skin health surveillance is up to date and managed. Thereafter, application of skin health matrix and skin health checks must be performed **no less** than annually with robust staff records management in line with the legal requirements for skin health records to be kept for 40 years (either in hard-copy, or electronic format). Please note that this should be for current and previous employees.

7) ensure that the records include employee questionnaire; results of skin check and any advice from OH (see Appendix 4.4, 4.5)

8) nominate at least one Responsible Person (see appendix 4.1) from their area who will undertake first line skin checks for employees risk assessed to be included in the skin health surveillance programme.

9) ensure that Responsible Person(s) have attended appropriate initial training (usually organised by OH) and at a minimum of three yearly intervals thereafter.

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10) ensure that the Responsible Person maintains and securely stores any records that enable them to facilitate their inspection programme e.g. when an employee is due their next assessment.

11) ensure that the Responsible Person(s) nominated to undertake these periodic first line skin checks has attended appropriate training, and that skin checks are performed and documented at a frequency as outlined in the COSHH assessments (see 6 above).

12) allow the Responsible Person time to perform their function and check that this is sufficient.

13) ensure that the register of trained Responsible Person's is updated with any changes as they occur

14) ensure new employees who are allergic to latex (or other substances) are aware of the potential risks (if any) in the workplace, and what steps are in place to prevent, or control that risk.

15) review employee work practices and tasks where first line skin health checks identity a problem and make adjustments where possible to manage employee skin health risks. Unless an urgent referral to OH is indicated from the first line check, it would be reasonable to assess the impact of the adjustments for a 6 week period. If the issues are not resolved then a prompt referral must be made to OH for further advice must be made.

16) where possible should make appropriate adjustments to the workplace/work practices, to accommodate an employee who has developed a latex allergy or some other work related dermatitis to ensure the risk to their health is minimised.

17) where an employee with a latex allergy or other work related dermatitis cannot be accommodated in their current workplace e.g. no adjustments are possible to prevent the risk of future exposure the employee will be supported and suitable alternative posts will be explored in accordance with the Skills Register: Redeployment Protocol.

18) managers must refer employees to OH in line with (Appendix 4.4a-b)

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2.7 Responsible Person Responsibilities

The role requirements and training for the Responsible Person are set out below.

The Responsible Person must:

- undertake the required training prior to conducting skin health checks, and to know when it is appropriate to refer to OH.
- recognise when they need to seek guidance and support
- undertake regular first-line skin health checks of skin integrity for employees in their area or other areas as required.
- undertake skin health checks for individuals annually as a minimum or more frequently depending on circumstances/advice from OH. This should follow the process outlined in Appendix 4.4a-b. Employees must be asked to complete a Skin Questionnaire and have a visual skin check performed as well.

- identify any employees where there is concern that skin integrity/dermatitis or respiratory problems might be work related and inform the appropriate line manager.
- ensure that they access Responsible Person training, at least every three years.

Further supportive information is available on the Skin Health website

2.8 Employee Responsibilities (All staff to whom this policy applies)

All Staff have responsibilities for their own Health & Safety. All Staff must inform their manager if they believe any task may be unsafe, or if there is any reason why they may not be able to carry out the task safely. Staff must follow appropriate systems of work and make full and proper use of equipment provided for their safety. Staff must co-operate with and adhere to the requirements of this policy.

All staff who have been risk assessed by their manager as requiring skin health surveillance must*:*

- comply with the skin health surveillance programme, associated health and safety legislation and local policies.
- co-operate with managers / Responsible Person's and OH in order to achieve compliance with this policy and ensure that they have a minimum of an annual skin health check in line with the risk matrix.
- take responsibility for their own health at work i.e. should concerns arise about skin integrity e.g. dermatitis, they must, in the first instance, seek advice either from the Responsible Person, or manager in their area, or if this is problematic self-refer to OH without delay.
- inform OH if they know they have, or suspect they are at risk of a latex allergy, or believe that they may have developed dermatitis in response to another substance used in the workplace.
- attend any OH or Dermatology appointments notified to them in line with skin health requirements
- follow advice from OH or Dermatology about skin care or other 'control measures'.
- use latex gloves only when there is an over-riding clinical necessity to do so i.e. no other glove type would be suitable for a particular procedure/scenario.
- wear any glove type for the shortest duration possible i.e. to remove gloves if there is no longer a risk of infection/contamination.
- attend a minimum of one Skin Health Awareness Session within three months after commencing post and other related educational events on skin care, as directed by their line manager.

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2.9 Procurement Responsibilities

Head of Procurement must ensure the timely provision of appropriate supplies generically and for specific products as advised by OH.

- non-latex gloves must be supplied as standard, unless a request for latex gloves is confirmed as a medical necessity i.e. alternative glove types are not suitable for clinical (and not personal preference) reasons. The purchasing department will ensure that only gloves from the approved list are supplied via the supplies department.

- supplies of gloves for clinical use should comply with the Department of Health quality assurance standards as laid down by the Medical Devices Agency (MDA).

- ensure that requests by a manager who has received OH advice re: alternative glove types / different skin care products for an employee, are acted upon promptly.

- work collaboratively with OH / Infection Control / Pharmacy / Senior managers etc **before** any new skin care / glove products are introduced across NHS Tayside.

Head of Pharmacy must ensure the timely provision of appropriate supplies generically and for specific products as advised by OH.

- pharmacy will provide the methodology for areas which do not normally place product requests to be supplied with a Pharmacy destination code thus enabling ordering for staff skin health purposes. See Appendix 4.8 for guidance

- soap or moisturising alternative products will be provided for staff following request from OH or Dermatology which will be from the Infection Control approved list.

- products will be perfume free as per national contract requirements.

- ensure that requests by a manager who has received OH advice re: alternative skin care products for an employee, are acted upon promptly.

- work collaboratively with OH / Infection Control / Dermatology / Senior managers etc **before** any new skin care products are introduced across NHS Tayside.

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2.10 Occupational Health Responsibilities

The Director of Human Resources and Organisational Development is responsible for the provision of OH services and the governance and assurance framework for the OH service in line with NHS Tayside requirements.

Specific responsibilities of the OH service are detailed below.

2.10.1 Pre-placement

OH must:

- review all successful candidates pre-placement health questionnaire (if they have not already contacted OH) to ascertain if they have, or suspect they have, a latex allergy; current or past skin problems; are known to be allergic to certain fruits etc; or have a history of atopy (tendency to develop contact irritant hand dermatitis).
- advise any successful candidate who has, or is at an increased risk of dermatological problems **and** is entering a role designated as requiring skin health surveillance, (see Appendix 4.4a-b. OH should share information that is necessary (excluding confidential medical information unless consent given) to the new employee's manager to enable that manager to take such steps as might be necessary to help reduce, or control the risk to the new employee e.g. avoidance of non-accelerator free gloves.
- see all successful candidates, who are subsequently confirmed in post and who have, or are likely to have a latex or other relevant allergy (and meet the criteria in 2 above) initially for regular skin/respiratory health surveillance by OH. They should be provided with written information about the necessity for such surveillance and the frequency it is likely to be performed.

- ask employees who change jobs within NHS Tayside e.g. a promotion, to complete a pre-placement questionnaire which will include questions about potential latex allergy and other skin complaints, in order to detect those who might be at future risk.

2.10.2 Existing Employees

OH must:

- assess all existing employees who are referred, or who self-refer about any skin complaint in order to establish the likelihood of a latex allergic response, or some other form of occupational dermatitis.
- advise employees that at the start of any consultation that 'control measures' in order to safeguard their skin health, as identified by OH, must be disclosed to their line manager. If an employee does not wish to proceed on that basis, the line manager will be informed that OH cannot comment on an employee's fitness for work
- advise affected employees about the management of latex allergy or other suspected occupational dermatitis and to provide written guidance as necessary
- advise managers / Human Resources about the management of an employee with a suspected/known latex allergy, or another occupational dermatitis e.g. irritant dermatitis from repeated hand washing, and give advice on workplace adjustments, or where that is not feasible, advice on relocation to an alternative work environment.

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- either telephone, or e-mail the manager with such advice, pending an assessment of the employee where a referral is received and the information contained suggests that some immediate action might need to be taken – this should be undertaken by an OH Clinician.
- refer all employees with a suspected latex allergy or another occupational allergic dermatitis, or severe irritant dermatitis, to a dermatologist (where possible, testing IgE to latex whilst an appointment is awaited) for further investigation in order to confirm the diagnosis.
- document all potential/known latex allergy cases or other occupational dermatoses in a confidential OH database/spreadsheet for ease of monitoring/reporting
- ensure that following receipt of a report from Dermatology any reported occupational dermatoses are acted upon within two working days, to update/modify advice already given to an employee and/or their manager.
- in the event that a report is received and the original requester is unavailable ensure the report is brought to the attention of another OH clinician by administrative staff.
- where an employee is identified as having a latex allergy etc, or is deemed to be in a 'high-risk' group, to undertake their future skin surveillance within OH. In case of doubt an OH Physician should be consulted.
- provide the Health & Safety Committee or other appropriate body anonymised data about latex allergy/occupational dermatoses on at least an annual basis, or at more frequent intervals e.g. quarterly as required by NHS Tayside.
- provide local managers with regular feedback e.g. quarterly, about their clinical area's compliance with health surveillance and to help managers identify areas of concern, so that risk assessments can be updated.
- complete a Reporting of Injuries and Dangerous Occurrences Regulations (RIDDOR) notification to the HSE where an occupational dermatitis e.g. allergy to accelerators has been identified and to inform the relevant line manger that notification has taken place
- provide and document training to Responsible Persons in each area of the hospital (clinical and non-clinical) in order that they undertake a minimum of annual first line

skin checks. This must be undertaken for of all employees who are risk assessed against the skin health matrix (see Appendix 4.2).

- provide *ad hoc* advice to managers and employees about the avoidance/management of latex allergy and other potential occupational dermatoses

2.10.3 Monitoring Compliance

All referrals submitted to OH will be collated so that overall numbers and areas where initial and routine skin checks of employees have been performed can be monitored via OH database system.

In conjunction with the above, the Critical Systems Checklist (a Health & Safety database) will also highlight areas of concern e.g. areas with no returns.

To produce, as a minimum, annual reports of numbers of employees that have had skin surveillance and the number where latex or other workplace related allergy related or irritant dermatitis has been proven, or suspected.

To audit referral and action times from receipt of a referral to advice from OH back to an employee and their manager.

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2.11 Dermatology Service

All referrals sent to the Dermatology service by OH will be screened by a Consultant Dermatologist and the employee will be appointed to the appropriate clinic e.g. Patch testing service or General Dermatology clinic

If latex allergy is suspected then an IgE RAST to latex will ideally be performed by OH prior to referral.

Once all investigations are complete a report including all results and recommendations for prevention/ treatment of skin problems will be issued by the Dermatology Consultant and sent to OH

2.12 Training and Education

2.12.1 Training – Responsible Persons

A Responsible Person must access training once every three years.

OH is responsible for ensuring appropriate training materials and training plans are in place.

Training will be provided by an OH Nurse Advisor or an appropriately trained competent person and will cover the following:

- COSHH requirements and frequency of skin checks
- the differences between irritants and sensitisers and examples of each
- signs / symptoms of allergic and irritant dermatitis
- frequency and documentation of skin checks
- referral process to OH
- practical exercise and use of documentation

The Senior OH Advisor will ensure that a record is kept of all those that have attended training

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2.12.2 Education – Employees

All staff in NHS Tayside risk assessed to be included within the Skin Health Surveillance Programme (SHSP) will be provided with the appropriate level of information, instruction and training on skin health management.

All employees should have access to the following:

- attend a skin health awareness session within the first three months of taking up post
- correct use of skin cleansing and care products from information, literature and seminars provided by manufacturers and Infection Control.
- a list of substances/products known to contain latex used within their department via COSHH assessment and advice from procurement
- access to other COSHH assessments relevant to their working area.
- supporting information on Skin Health Staffnet page including Presentation, Self assessment questionnaire and Safety Brief

- attend a minimum of one Skin Health Awareness Session within three months after commencing post and other related educational events on skin care, as directed by their line manager.

A supplementary protocol is incorporated within this policy to provide an explanation as to education requirements. It will also be available on the Skin Health website. (See Appendix 4.7)

2.13 Reporting Arrangements

KPI's have been agreed between NHST and OHSAS and will be reported through the NHST performance review process and addressed by accountable Directors

Escalation by the OH Performance Group around issues of variation, non compliance, or other relevant matters arising will flow through the Director of HR & OD, for OH matters, and / or the Chief Operating Officer, as senior service line manager.

3. KEY CONTACTS

The Policy Development Group consisted of representative from across NHS Tayside and the Integration Joint Boards

Alyson Bryden	Consultant Dermatologist
Anne Couser	Head of Nursing
Justine Craig	Head of Midwifery
Mark Dickson	Clinical Governance & Risk Coordinator
Iain Dorricott	HSE Support Officer
Valerie Fyall	Health & Safety Advisor
Cathy Green	Consultant Dermatologist, Joint Negotiating Committee Representative
Margaret Kennedy	Health & Safety Lead Infection Control
Shona Leonard	Locality Site Support Services Manager
Paul Lewthwaite	Consultant NHS Tayside Occupational Health Service
Raymond Marshall	Staff Side Representative (UNISON)
Peter Oswald	Specialty Manager Psychiatry of Old Age
Patricia Tyrie	Administrative Services Manager
Mandy Warden	Clinical Team Manager Psychiatry of Old Age
Judith Willis	Deputy Head of Procurement
Kerry Wilson	General Manager Perth Royal Infirmary

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4. APPENDICES

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Appendix 4.1

GUIDANCE for MANAGERS

Referral to and advice from Occupational Health and Record Keeping

Skin health surveillance is a statutory responsibility and must be undertaken if a COSHH assessment indicates employees are working with, or could be exposed to substances that are known, or suspected skin sensitisers, or where exposure to other substances could give risk to skin irritation e.g. frequent hand-washing.

The Responsible Person(s) that you nominated for your area, should perform basic, first line skin checks and review an employee's completed screening questionnaire.

These checks are required to be performed, at least, annually, but where an employee is experiencing skin problems they may need to be undertaken more frequently and you **must** allow your Responsible Person adequate time to complete those assessments during their working day.

If an employee's skin check is unsatisfactory i.e. there is redness/skin cracking etc the Responsible Person **must** discuss that employee with you.

You should review the employee's skin care regime e.g. adequate drying of hands after washing / use of alcohol gel rather than hand-washing where hands are physically clean etc. Therefore mild skin dryness etc does not need an immediate escalation to Occupational Health, but you must monitor and review the situation and where you are satisfied that skin care advice has been adhered to e.g. over a six week period, but skin problems persist then a referral to Occupational Health is merited.

Where an employee reports rapid onset, itchiness or skin lesions e.g. after glove use; repeated skin irritation following the use of skin related products at work, or skin problems re-emerge after a period of leave, you must provide basic skin care advice and refer them to Occupational Health for urgent advice. In the meantime prevent your employee from having contact with any suspected material/substance that may have given rise to their symptoms.

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If referring an employee to Occupational Health please use the Employee Skin Surveillance form for that purpose, but where urgent advice is required please phone the department on ext. 30202 or (01382) 346030.

If you have additional questions ensure that these accompany your referral e.g.

- Is this an irritant or allergic dermatitis?
- What substance(s) is thought likely to have given rise to their symptoms?
- Should my employee refrain from work whilst further assessment/investigation is underway?
- Is there any evidence of a skin infection that may have patient safety implications?

If an employee skin check is satisfactory, but they are known to be allergic to latex (or other workplace substances etc) then this must still be brought to your attention.

Where a skin problem is a simple graze/cut etc e.g. arising from gardening etc then this should be managed locally and does not need to be referred to Occupational Health.

Once the employee has been assessed by Occupational Health you will be given advice, which you are strongly advised to follow e.g. the employee must avoid certain glove types etc.

If the advice is difficult to implement please contact Occupational Health and/or Health and Safety teams to discuss further. In the meantime you must take whatever steps you can to ensure that your employee's health is not further compromised e.g. temporary alteration of duties.

Occasionally you might be advised to report an employee's skin condition under Reporting of Injuries, Disease and Dangerous Occurrences Regulations (RIDDOR). This is formal notification of the condition to the HSE and advice/support to do this can be obtained from Occupational Health.

Once advice is received please ensure you keep this securely along with an employee's questionnaire etc for **40 years** from the date of last entry so that it can be made accessible to the HSE and/or Health and Safety team/Senior line management.

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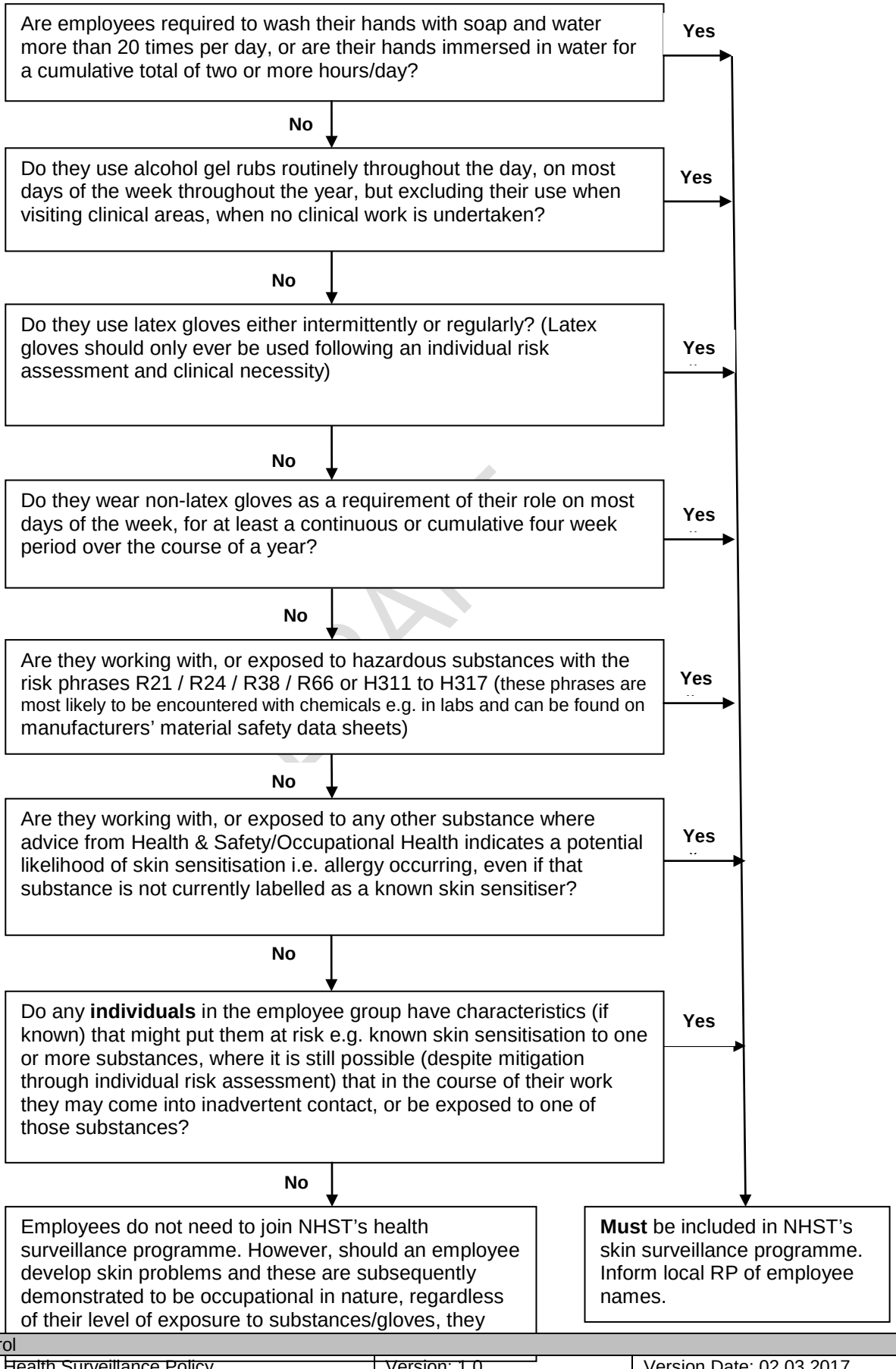
Appendix 4.2

Health Surveillance requirement – decision aid algorithm



Please see Line Manager Sign off over the page

As Line Manager I have risk assessed my staff against the decision aid algorithm.
Total staff in Department/Team:..... Total risk assessed as included in SHSP:.....
Signature:.....
Print Name:.....
Title:..... Date:.....

List of staff names to be included in Skin Health Surveillance and recorded in Critical Systems Checklist (as a number) for..... (insert fiscal year date)

NAME	NAME	NAME

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Appendix 4.3

Occupational Health Action Card

Referral from Responsible Person, or employee self-referral, or employee 'high-risk' for latex allergy.

Establish nature of employee's problem to include a check of how long an employee has worked with, or is exposed to potential skin sensitisers/irritants.

Is the employee known to be allergic to any substance, or certain fruits such as bananas, avocados? Do they have asthma, and has that changed, or have they developed recent symptoms suggestive of asthma?

Have they had dermatitis in the past, and what was thought to be responsible?

↓

Assess skin of hands/forearm, or other affected, exposed area to look for evidence of dermatitis.

↓

Is the history and/or signs in keeping with urticaria? If urticaria likely, or suspected this could represent a type 1 allergic reaction to latex.

Or

Is the history and/or signs in keeping with a type 4 delayed hypersensitivity reaction, or alternatively an irritant dermatitis?

Yes ↓

If urticaria/dermatitis related to an occupational allergy suspected, but not confirmed, instruct employee to avoid contact with suspected items e.g. latex gloves and advise their manager accordingly. Perform latex IgE test and/or give skin care advice to avoid suspected allergen linked with a type IV reaction, or any other substance thought to be acting as an irritant.

↓

Discuss case with Occupational Health physician, or refer direct to a Consultant Dermatologist for further testing e.g. patch

↓

Has a diagnosis of latex or other allergic occupational dermatitis been confirmed?

No → No further action unless remains at 'high risk' of latex allergy, or concern re: irritant dermatitis

Yes ↓

Advise manager (with employee consent*) of diagnosis, and to discuss further management of case and record results of assessment if employee requires ongoing Occupational Health skin health surveillance.

No ↓

Are there any signs, or symptoms of respiratory sensitisation/irritation?

No → No further action unless remains at 'high risk' of latex allergy, or concern re: irritant dermatitis

Yes ↓

Perform respiratory health surveillance.

↓

If abnormal and/or history suggestive of an occupational cause refer to Occupational Health.

*If consent is withheld you **must** still inform the relevant manager of **control** measures e.g. avoidance of certain substances etc. if the HCW is under skin health surveillance. Further medical information must not be shared i.e. actual diagnosis

Appendix 4.4a

Employee (Statutory) Skin Surveillance Declaration

Dear Colleague,

Your post has been identified as one that requires participation in statutory skin health surveillance e.g. there might be a requirement for frequent hand washing and/or potential exposure to hazardous chemicals. Surveillance will be organised by Occupational Health for and on behalf of NHS Tayside.

This is a legal requirement under the Management of Health and Safety at Work Regulations 1999 and the Control of Substances Hazardous to Heath Regulations 2002 as amended.

The purpose of skin health surveillance is to safeguard your health and where necessary to provide you and your manager with advice to achieve this. Therefore you will be required to attend one or more of the following assessments during work time:

- Completion of a skin health questionnaire on at least an annual basis, coupled with a visual skin check e.g. hands/face or other exposed areas, overseen by a Responsible Person (this is likely to be a colleague who has taken on this role after appropriate training and they will be identified to you by your manager and/or at induction if you have just joined the organisation). You may request access to an alternate Responsible Person than the nominated Responsible Person at any time.
- Information about you recorded for the purposes of the skin health surveillance programme will be stored securely at all times
- A more in-depth skin health assessment by your manager following an initial discussion with a Responsible Person.
- An assessment with an Occupational Health Clinician following a referral from a Responsible Person or your manager. They will provide you and your manager with appropriate advice, or control measures.
- You may self-refer to Occupational Health if you have significant concerns about your skin health and it is not feasible to discuss this with your manager e.g. they are on holiday. In that case please do not delay in contacting Occupational Health on ext. 30202 or (01382) 346030. Occupational Health will still be obliged to contact your manager with control measures (if they are deemed necessary).

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You will be required to follow advice/control measures e.g. avoidance of certain glove types etc. and you may be asked to attend for further review by Occupational Health.

If you fail to attend an Occupational Health appointment (your manager will be expected to release you from work for this), one further appointment will be offered, but if you do not attend again, your manager will be informed. If you do not wish to participate in this surveillance you will need to discuss the implications of this with your manager, as it may mean that you cannot be employed by NHS Tayside. Workplace restrictions will be necessary as NHS Tayside still have to fulfil legal obligations to safeguard your health at work.

I **acknowledge that I will** participate in a statutory skin health surveillance programme and have read and understood my obligations as outlined above.

Name (block capitals):
Signature: **Date:**

Appendix 4.4b

Employee (Statutory) Skin Surveillance Health Record Form (Page 1)

Name of employee	DOB
Department/site	Job title
Contact details e.g. phone number:	
Date commenced current role:	

Please read: To safeguard your health and safety at work NHS Tayside is required to undertake regular checks of your skin. Please read and sign the declaration on page 1 before completing the rest of this form.

Employee to complete (please circle)

1. Is this your first skin surveillance since starting this post?	Yes / No
2. Was your last skin health training update over two years ago?	Yes / No
3. Are you or do you think you might be allergic to latex?	Yes / No
4. Are you allergic to any non-latex gloves e.g. nitrile?	Yes / No
5. Do you have any other known fruit allergies e.g. bananas, avocado, kiwis, chestnuts etc?	Yes / No
6. Did you have history of eczema and/or asthma prior to starting this post?	Yes / No
7. Since your last skin assessment (or if this is your first) have you experienced any skin symptoms affecting your hands / fore-arms, or other exposed area e.g. legs, neck, lips etc such as dry skin, redness, rash, itchiness, broken skin etc?	Yes / No
8. Since your last assessment (or if this is your first) have you ever experienced any chest symptoms e.g. recurrent wheeze or cough, since starting work?	Yes / No
9. Since your last assessment (or if this is your first) have you had any ongoing or recurrent eye irritation?	Yes / No
10. Do you suspect any substance/material at work may have contributed to any symptoms that you may have experienced? **Please list them here**:	Yes / No

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Gloves/substances that you use, or might be exposed to in the workplace (tick all that apply)

Latex gloves or other latex products ☐

Non-latex gloves (please state type) ☐

Skin washes (please state type) ☐

Alcohol gel ☐

Other substances e.g. detergents/disinfectants, machine oils etc ☐

Frequency of hand washing during a typical shift e.g. 10x, 20x, 30x. 40x **(please circle)**

Name (block capitals):

Signature: **Date:**

Appendix 4.4b

Employee (Statutory) Skin Surveillance Health Record Form (Page 2)

RESPONSIBLE PERSON to COMPLETE
I confirm that I have given the employee a skin care leaflet: ***YES*** *or* ***NO*** (please circle) Name of employee (capitals): Name of Responsible Person (capitals): Signature of Responsible Person: Date:
Visual skin check result (please circle): **Satisfactory** **Unsatisfactory** (repeat skin check at least annually or more often if recently had skin problems, or on advice from OCCUPATIONAL HEALTH)
Consult with manager if visual skin check is Unsatisfactory **OR** if employee has given a **Yes** answer to any of questions **2 to 10.**

(Please ensure that Page 1 (employee questionnaire) accompanies this form)

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LINE MANAGER to COMPLETE	
Name (of manager) in capitals: Signature: Date: Email Address:	
I wish to refer this employee to OCCUPATIONAL HEALTH because: (Please put a cross in appropriate box)	
Skin check is unsatisfactory and has not responded to local, skin care advice over the last six weeks.	
Skin check is unsatisfactory and the employee has indicated known allergies, or is worried that a workplace substance has caused problems. (**Please enclose a copy of your COSHH assessment for that substance).**	
Skin check is satisfactory, but employee has a known or, suspected occupational allergy or remains concerned that they have problems with a workplace substance/material (**if you have already received advice about this from Occupational Health, you do not need to re-refer unless concerns remain**).	
Date this form sent to Occupational Health if different from above:	

If you have any other information, or have additional questions please ensure that they accompany this form.

Please post completed forms to Occupational Health, Wedderburn House, 1 Edward Street, Dundee, or

Appendix 4.5a

Occupational Health (Statutory) Skin Surveillance – Second Line Outcome / Recommendations

Forename:	Surname:	
Date of Birth:	Job Title:	Email of Employee:
Responsible Person:	Email of Responsible Person:	
Manager:	Email of Manager:	
Date of this 2nd line Assessment:		
Directorate / CHP ; Area/ Department / Ward:		

The result of this skin assessment indicates:

	Satisfactory: skin care advice and information sheet(s) has been given. Please ensure that employee remains in the skin health surveillance programme, with at least an annual review by the Responsible Person.
	Minor skin problem e.g. dryness of skin. If skin care advice is adhered to (please see overleaf) then problem should resolve. Please recheck their skin in 6-8 weeks time. If problems still persist re-refer to Occupational Health, otherwise ensure that they remain in the skin health surveillance programme with a review by your Responsible Person in weeks/months time.
	Moderate skin problem e.g. possible dermatitis. This requires further intervention and investigation. Further information will be provided once the assessment has been completed. In the interim please follow recommendations outlined overleaf.
	Allergic dermatitis etc diagnosed. Ensure that recommendations/restrictions outlined overleaf are followed. The manager **must** urgently review the COSHH risk assessment of the substance involved. The Health and Safety team can assist with this. Please contact the Health and Safety team via safety.tayside@nhs.net
Declined to be checked:	**Did not Attend:**
	RIDDOR reportable. Occupational Health have reported this to the HSE as the dermatitis is more likely than not, due to occupational exposure to one or more workplace substances.

Name (Block Capitals):

Designation of Occupational Health Practitioner:

Signature: **Date:**

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Appendix 4.5a

Occupational Health (Statutory) Skin Surveillance – Second Line Outcome / Recommendations

Employee name:	**Date of Birth:**	**Date of Assessment:**

This employee MUST avoid contact / exposure to the following (Occupational Health will include any additional information, if necessary, on a separate sheet):

	Latex
	Thiuram (an accelerant found in some glove types)
	Carbamix (an accelerant found in some glove types)
	Other (please state):

The following products are recommended:

Social Hand Hygiene

	Liquid soap non perfumed, non coloured as per national contract
	Alcohol based hand rub (ABHR) as per national contract
	Moisturiser Non perfumed, non coloured as per national contract
	Dermol 500 lotion as a hand wash
	Diprobase Cream as a moisturiser

Aseptic Hand Hygiene

	Chlorhexidine 4%, aqueous solution as per national contract
	Alcohol based hand rub as per national contract (if hands physically clean and no infective material exposure)

Surgical Scrub

	Chlorhexidine 4%, aqueous solution for surgical scrub as per national contract
	Povidone Iodine 7.5% surgical scrub
	Hibisol liquid
	Bode Sterillium
	Dermol 500 followed by ABHR following Theatre Scrub policy. (Dermol 500 not licensed for surgical scrub)

Gloves

	Accelerator Free Gloves - supplies offer a range of accelerator free gloves, a suitable risk assessment should be undertaken to ensure their suitability for the task(s) intended. **Please see accompanying text for more information**.

The above products and their use are on the Approved Hand Hygiene Products list which is available on the intranet. Hand Hygiene Advice Information which has been discussed with the employee at the time of consultation. The products are available through NHS Tayside Supplies unless otherwise stated and generic risk assessments can be found on the intranet.

Additional information

	This employee has a significant skin condition and/or requires use of products out with the approved hand hygiene cascade, therefore a case conference is recommended, and this should include Health & Safety, Occupational Health clinician, Line Manager, Infection Control and the employee. Occupational Health administrators will co-ordinate the meeting.

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Appendix 4.5a

Occupational Health Review

	Occupational Health review will be arranged in ……weeks/months (delete as appropriate)
	Occupational Health review not required at this stage, but must remain in skin surveillance programme i.e. at least annual checks.

OCCUPATIONAL HEALTH clinician signature:	**Print:**	**Date:**

Cc Line Manager, Responsible Person, Employee

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Appendix 4.6

Statutory Skin Health Surveillance Record ('Health Record')

Name of Employee (Block Capitals):	National Insurance number (or DOB if unknown)
Department / Site:	Job title
Date commenced employment in current role:	

Date – update if exposure changes	Latex gloves	Other latex containing equipment	Non-latex gloves (state type)	Other substances/material with risk phrases R38, R43, R66 or H315,H317, EH H066	Hand-washing >20X /day

Health Record

	Surveillance type (tick appropriate box)		**Outcome** (tick appropriate box)		**Response from Occupational Health** (if referred)	**Assessor/manager**	
Date	First line questionnaire plus skin check	Occupational Health skin surveillance assessment	Satisfactory	Unsatisfactory Must be referred to Occupational Health (if has not already been seen and being reviewed by OCCUPATIONAL HEALTH)	State outcome once response from Occupational Health obtained **R** = restrictions/adjustments **NR** = No restrictions / adjustments required	Designation	Signature

This health record **MUST** be stored for **40** years from date of last entry. It should be made available for inspection by the HSE etc.

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Appendix 4.6

Statutory Skin Health Surveillance Record ('Health Record')

Employee exposure – tick all that apply

Date – update if exposure changes	Latex gloves	Other latex containing equipment	Non-latex gloves (state type)	Other substances/material with risk phrases R38, R43, R66 or H315,H317, EH H066	Hand-washing >20X /day

Health Record

Must be at least annual check	Surveillance type (tick appropriate box)		Outcome (tick appropriate box)		Advice from Occupational Health	Assessor/manager	
Date	First line questionnaire plus skin check	Occupational Health 2nd line skin surveillance assessment	Satisfactory	Unsatisfactory Consider referral to Occupational Health (if has not already been seen and being reviewed by OCCUPATIONAL HEALTH)	If referred to Occupational Health state outcome once response from Occupational Health obtained R= restrictions/adjustments NR= No restrictions / adjustments required	Designation	Signature

This health record **MUST** be stored for **40** years from date of last entry. It should be made available for inspection by the HSE etc.

If possible, please print on double-sided paper for ease of use/storage.

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Appendix 4.7

Staff Knowledge and Understanding of Skin Health (Supplementary Protocol)

Statement
NHST Staff Skin Health will be managed in accordance with the requirements set out under Health & Safety Legislation and specifically that under Control of Substances Hazardous to Health (COSHH) Regulations

Aim
All staff in NHST who have been risk assessed to be included within the Skin Health Surveillance Programme (SHSP) will be provided with the appropriate level of information, instruction and training on Skin Health Management.

Communication
This protocol will be incorporated, as Appendix 4.7, within the Skin Health Policy. It will also be uploaded to the Skin Health Web Page on Staffnet.

Actions - Line Managers and Supervisors

Having risk assessed the team/staff and identified those staff required to be included in the SHSP the Line Managers and Supervisors must:

- Ensure the training requirements for skin health are assessed annually as part of the staff member's Personal Development Plan
- Ensure that those staff, who must attend a face to face presentation are supported to do so within 3 months of being assessed to be included
- Provide the opportunity for staff to make use of the skin health resources where required utilising the most appropriate method
- Ensure that those staff members with skin health concerns, raised as part of the skin health surveillance checks are supported with the time to review their knowledge and understanding

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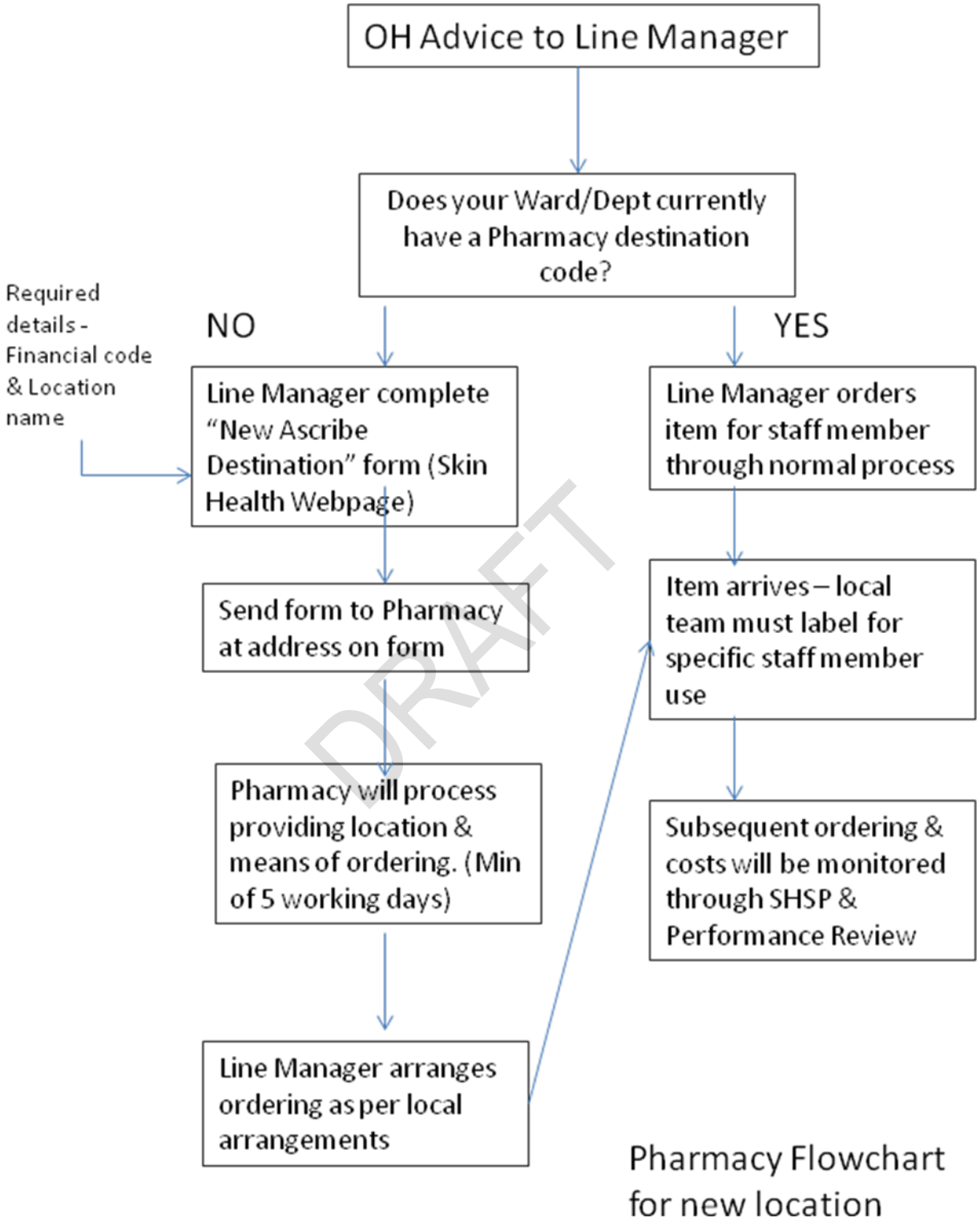
Individual Staff Members

If the individual has been risk assessed to be included within the SHSP they should ensure that they attend an initial Skin Health Awareness presentation within 3 months of their start date in NHST. For future years there is no mandatory requirement to view the presentation/attend a face to face presentation annually however staff should ensure that their knowledge and understanding is at all times up to date and relevant.

Staff members will be responsible for ensuring that their Personal Development Plan is updated in accordance with any Skin Health Awareness updates they undertake/attend.

Appendix 4.8

Pharmacy Flowchart for New location



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Appendix 4.9

NHS TAYSIDE – POLICY APPROVAL CHECKLIST

This form must be completed by the Policy Manager and this checklist must be completed and forwarded with the policy to the Executive Team, Clinical Quality Forum or Area Partnership Forum for approval and to the appropriate Committee for adoption.

POLICY AREA: NHS Tayside
POLICY TITLE: Skin Health Surveillance Policy
POLICY MANAGER: Kerry Wilson, General Manager

Why has this policy been developed?		To ensure that NHS Tayside and the IJB's meet the legislative Health and Safety requirement to for staff and patients. Also to ensure that staff are aware and comply their roles and responsibilities in relation to Skin Health Management.	
Has the policy been developed in accordance with or related to legislation? – Please give details of applicable legislation.		Yes Health & Safety at Work etc Act 1974 and the Management of Health & Safety at Work Regulations 1999 (as amended), which requires employers to undertake a suitable assessment of risk in the workplace and introduce health surveillance where appropriate. The Control of Substances Hazardous to Health Regulations (COSHH 2002, as amended), provides further detail as to when health surveillance is required.	
Has a risk control plan been developed and who is the owner of the risk? If not, why not?			
Who has been involved/consulted in the development of the policy?		See section 4 for those involved in the policy development. Consultation has been through a series of committees.	
Has the policy been Equality Impact Assessed in relation to:-		Yes	
Age Disability Gender Reassignment Pregnancy/Maternity Race/Ethnicity Religion/Belief Sex (men and women) Sexual Orientation	Please indicate Yes/No for the following:	People with Mental Health Problems Homeless People People involved in the Criminal Justice System Staff Socio Economic Deprivation Groups Carers Literacy Rural Language/Social Origins	Please indicate Yes/No for the following:
Does the policy contain evidence of the Equality Impact Assessment Process?		Yes	
Is there an implementation plan?		The implementation will be finalised following the consultation process. Policy awareness sessions will be held during February and March 2017	
Which officers are responsible for implementation?		See section	
When will the policy take effect?		End March 2017	

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Who must comply with the policy/strategy?	All staff including medical and dental staff.
How will they be informed of their responsibilities?	Policy will be issued through line managers
Is any training required?	Skin Health education and training will support the policy implementation
If yes, attach a template	
Are there any cost implications?	No specific cost implication identified
If yes, please detail costs and note source of funding	N/A
Who is responsible for auditing the implementation of the policy?	The Audit Committee Skin Health Improvement Group
What is the audit interval?	Tbc
Who will receive the audit reports?	Tbc
When will the policy be reviewed and provide details of policy review period (up to 5 years)	Annually with the standard operating procedures and guidance updated dynamically in line with the Skin Health Improvement Plan.

POLICY MANAGER: Kerry Wilson DATE: 9 January 2017

APPROVAL COMMITTEE TO CONFIRM: Executive and Directors Group

ADOPTION COMMITTEE TO CONFIRM: Audit Committee

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Appendix 4.10

NHS Tayside

EQUALITY IMPACT ASSESSMENT

Name of Policy, Service Improvement, Redesign or Strategy:

Health and Safety Skin Health Surveillance Policy

Lead Director or Manager:

Alan Cook and Kerry Wilson

What are the main aims of the Policy, Service Improvement, Redesign or Strategy?

To ensure that NHS Tayside has a comprehensive system of employee skin health surveillance designed to safeguard employees against Occupational Dermatitis and to take, early effective action where this is identified and to monitor existing control measures.

This is to ensure that the organisation fulfils its legal obligations under the Health & Safety at Work etc Act 1974 and the Management of Health and Safety at Work Regulations 1999

Description of the Policy, Service Improvement, Redesign or Strategy – What is it? What does it do? Who does it? And who is it for?

This policy ensures that NHS Tayside provides clarity to all staff in the management of skin health. Staff are expected to explicitly follow the skin health guidance and standard operating procedures and to fully participate in the skin health surveillance programme if risk stratified by the organisation as requiring to do so based on their role.

What are the intended outcomes from the proposed Policy, Service Improvement, Redesign or strategy? – What will happen as a result of it? - Who benefits from it and how?

To safeguard employees against Occupational Dermatitis and to take, early effective action where this is identified and to monitor existing control measures.

Name of the group responsible for assessing or considering the equality impact assessment? This should be the Policy Working Group or the Project team for Service Improvement, Redesign or Strategy.

Skin Health Policy Development Group / Skin Health Improvement Group

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SECTION 1 Part B – Equality and Diversity Impacts
Which equality group or Protected Characteristics do you think will be affected?

Item	Considerations of impact	Explain the answer and if applicable detail the impact	Document any Evidence, Research, Data to support the consideration of impact	Further actions required
1.1	Will it impact on the whole population? Yes or No. If yes will it have a differential impact on any of the groups identified in 1.2. If no go to 1.2 to identify which groups	No, only staff within NHS Tayside	N/A	None
1.2	Which of the protected characteristic(s) or groups will be affected? • Minority ethnic population (including refugees, asylum seekers & gypsies/travellers) • Women and men • People in religious/faith groups • Disabled people • Older people, children and young people • Lesbian, gay, bisexual and transgender people • People with mental health problems • Homeless people • People involved in criminal justice system • Staff • Socio- economically deprived groups	• Staff	Policy and impact considered by Skin Health Improvement Group	None

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Item	Considerations of impact	Explain the answer and if applicable detail the impact	Document any Evidence, Research, Data to support the consideration of impact	Further actions required
1.3	Will the development of the policy, strategy or service improvement/redesign lead to • Discrimination • Unequal opportunities • Poor relations between equality groups and other groups • Other	No	Policy and impact considered by Skin Health Improvement Group	None

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SECTION 2 – Human Rights and Health Impact.
Which Human Rights could be affected in relation to article 2, 3, 5, 6, 9 and 11. (ECHR: European Convention on Human Rights)

Item	Considerations of impact	Explain the answer and if applicable detail the impact	Document any Evidence, Research, Data to support the consideration of impact	Further actions required
2.1	**On Life (Article 2, ECHR)** • Basic necessities such as adequate nutrition, and safe drinking water • Suicide • Risk to life of / from others • Duties to protect life from risks by self / others • End of life questions	No impact	N/A	None
2.2	**On Freedom from ill-treatment (Article 3, ECHR)** • Fear, humiliation • Intense physical or mental suffering or anguish • Prevention of ill-treatment, • Investigation of reasonably substantiated allegations of serious ill-treatment • Dignified living conditions	No impact	N/A	None

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Item	Considerations of impact	Explain the answer and if applicable detail the impact	Document any Evidence, Research, Data to support the consideration of impact	Further actions required
2.3	**On Liberty (Article 5, ECHR)** • Detention under mental health law • Review of continued justification of detention • Informing reasons for detention	No impact	N/A	None
2.4	**On a Fair Hearing (Article 6, ECHR)** • Staff disciplinary proceedings • Malpractice • Right to be heard • Procedural fairness • Effective participation in proceedings that determine rights such as employment, damages/compensation	No impact	N/A	None
2.5	**On Private& family life** (Article 6, ECHR) • Private and Family life • Physical and moral integrity (e.g. freedom from non-consensual treatment, harassment or abuse • Personal data, privacy and confidentiality • Sexual identity • Autonomy and self-determination • Relations with family, community • Participation in decisions that affect rights • Legal capacity in decision making supported participation and decision making, accessible information and communication to support decision making • Clean and healthy environment	No impact	N/A	None

DRAFT

Item	Considerations of impact	Explain the answer and if applicable detail the impact	Document any Evidence, Research, Data to support the consideration of impact	Further actions required
2.6	**On Freedom of thought, conscience and religion (Article 9, ECHR)** • To express opinions and receive and impart information and ideas without interference	No impact	N/A	None
2.7	**On Freedom of assembly and association (Article 11, ECHR)** • Choosing whether to belong to a trade union	No impact	N/A	None
2.8	**On Marriage and founding a family** • Capacity • Age	No impact	N/A	None
2.9	**Protocol 1 (Article 1, 2, 3 ECHR)** • Peaceful enjoyment of possessions	No impact	N/A	None

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SECTION 3 – Health Inequalities Impact
Which health and lifestyle changes will be affected?

Item	Considerations of impact	Explain the answer and if applicable detail the impact	Document any Evidence, Research, Data to support the consideration of impact	Further actions required
3.1	What impact will the function, policy/strategy or service change have on lifestyles? For example will the changes affect: • Diet & nutrition • Exercise & physical activity • Substance use: tobacco, alcohol or drugs • Risk taking behaviours • Education & learning or skills • Other	No impact	N/A	None
3.2.	Does your function, policy or service change consider the impact on the communities? Things that might be affected include: • Social status • Employment (paid/unpaid) • Social/family support • Stress • Income	No impact	N/A	None

DRAFT

Item	Considerations of impact	Explain the answer and if applicable detail the impact	Document any Evidence/Research/Data to support the consideration of impact	Further actions required
3.3	Will the function, policy or service change have an impact on the physical environment? For example will there be impacts on: • Living conditions • Working conditions • Pollution or climate change • Accidental injuries/public safety • Transmission of infectious diseases • Other	The policy promotes a healthy working environment, and ensures staff have support in relation to skin health, if they require it.	Policy and impact considered by Skin Health Improvement Group	None
3.4	Will the function, policy or service change affect access to and experience of services? For example • Healthcare • Social services • Education • Transport • Housing	No	N/A	None

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Item	Considerations of impact	Explain the answer and if applicable detail the impact	Document any Evidence/Research/Data to support the consideration of impact	Further actions required
3.5	In relation to the protected characteristics and groups identified: • What are the potential impacts on health? • Will the function, policy or service change impact on access to health care? If yes - in what way? • Will the function or policy or service change impact on the experience of health care? If yes – in what way?	Staff members are the only group affected. Positive impact on health Yes, it should result in an improvement. No	Policy and impact considered by Skin Health Improvement Group	None

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SECTION 4 – Financial Decisions Impact
How will it affect the financial decision or proposal?

Item	Considerations of impact	Explain the answer and if applicable detail the impact	Document any Evidence/Research/Data to support the consideration of impact	Further actions required
4.1	• Is the purpose of the financial decision for service improvement/redesign clearly set out • Has the impact of your financial proposals on equality groups been thoroughly considered before any decisions are arrived at	No financial implications identified.	N/A	None
4.2	• Is there sufficient information to show that "due regard" has been paid to the equality duties in the financial decision making • Have you identified methods for mitigating or avoiding any adverse impacts on equality groups • Have those likely to be affected by the financial proposal been consulted and involved	No financial implications identified.	N/A	None

DRAFT

Item	Considerations of impact	Explain the answer and if applicable detail the impact	Document any Evidence/Research/Data to support the consideration of impact	Further actions required
5.	Involvement, Consultation and Engagement (IEC) 1) What existing IEC data do we have? • Existing IEC sources • Original IEC • Key learning 2) What further IEC, if any, do you need to undertake?	Policy Health Improvement Group has been involved and consulted throughout the development of the policy. The Group has a wide range of stakeholders from multiple services, localities, and professional groups. Policy to be discussed at Joint Negotiating Committee and with Staff Side representatives.	Policy and impact considered by Skin Health Improvement Group	Policy to be discussed at Joint Negotiating Committee and with Staff Side representatives.

DRAFT

Item	Considerations of impact	Explain the answer and if applicable detail the impact	Document any Evidence/Research/Data to support the consideration of impact	Further actions required
6.	Have any potential negative impacts been identified? • If so, what action has been proposed to counteract the negative impacts? (if yes state how) For example: • Is there any unlawful discrimination? • Could any community get an adverse outcome? • Could any group be excluded from the benefits of the function/policy? (consider groups outlined in 1.2) • Does it reinforce negative stereotypes? (For example, are any of the groups identified in 1.2 being disadvantaged due to perception rather than factual information?)	No	N/A	None

DRAFT

Item	Considerations of impact	Explain the answer and if applicable detail the impact	Document any Evidence/Research/Data to support the consideration of impact	Further actions required
7.	Data & Research • Is there need to gather further evidence/data? • Are there any apparent gaps in knowledge/skills?	No	N/A	None
8.	Monitoring of outcomes • How will the outcomes be monitored? • Who will monitor? • What criteria will you use to measure progress towards the outcomes?	Critical system checklists	N/A	None
9..	Recommendations State the conclusion of the Impact Assessment	Only impact will be with regard to staff, and this should be of a positive nature	N/A	None
10.	Completed function/policy • Who will sign this off? • When?	TBC		
11.	Publication	Staffnet and Vital Signs		

DRAFT

Conclusion Sheet for Equality Impact Assessment	
Positive Impacts (Note the groups affected) Staff Members	Negative Impacts (Note the groups affected)
What if any additional information and evidence is required	
From the outcome of the Equality Impact Assessment what are your recommendations? (refer to questions 5 - 10) Approval of the policy	

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Additional Sheet – Implementation Plan

Communications Plan

The communications and implementation plans include:

Inbox articles, general communication and vital signs to be scheduled in the weeks following approval of the Skin Health Policy to include

- Article on Skin Health Policy – requirement to read within Policy Tracker
- Role of Responsible Person
- Responsible Person Training
- Skin Health Awareness
- How to refer to Occupational Health
- Skin Health website
- Training and Education
- Roles and Responsibilities for all Employees

Supported by:

- Drop in sessions in venues across Tayside prior to 31 March following approval of Skin Health Policy
- Refresh of Skin Health Website
- Other support identified from the consultation process.

DRAFT

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

Item Number 9

AUDIT16/2017
Audit Committee
9 March 2017

PAYMENT VERIFICATION: FAMILY HEALTH SERVICE (FHS) CONTRACTORS

1. PURPOSE OF THE REPORT

The purpose of this report is to give assurances to the Audit Committee in respect of the discharge of financial governance in accordance with the national payment verification procedures and arrangement for payment verification for FHS Contractors, i.e. General Dental: Ophthalmic; Pharmaceutical; and Medical Services (DL(2016)11 (copy available on request).

2. RECOMMENDATIONS

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

3. EXECUTIVE SUMMARY

Payment verification in respect of Dental, Ophthalmic and Pharmaceutical Services takes place at four 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.

The level of payment verification activity has progressed as expected and in line with plans agreed with Practitioner Services colleagues.

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

4. REPORT DETAIL

4.1 General Dental Services

<u>Quarter 2 (July 2016 – Sept 2016)</u>

Post Treatment Referral Analysis

Referral for appointments	138
Reports received	0
Failed appointments	0
Referrals cancelled	2
Outcomes awaited	136

Of the 138 referrals 30 % were non random (PV level 3 & 4).

The report breakdown is as follows:

Post Treatment Reports

	No of Dentists	No. of Patients
Code 1	33	43
Code 2	5	5
Code 3	0	0
Code 4	0	0

Pre Treatment Reports

	No. of Dentist	No of Patients
Code A	2	2
Code B	5	5
Code C	3	3
Code D	0	0

Explanation of Dental Reference Officers Codes

Clinical Codes

Code 1 or Code A
Defines that in the opinion of the Dental Reference Officer the treatment provided/ the treatment proposals are satisfactory.
Code 2
Defines that the Dental Reference Officer confirms that the treatment carried out was satisfactory at completion and something minor is a miss at the time of examination (i.e. a restoration has been lost) OR the dental officer believes the treatment was satisfactory at completion but requires further information to be sure (i.e. the practitioner has not submitted a final root treatment radiograph to confirm that the canal has been satisfactorily obdurated).
Code B
Defines that the Dental Reference Officer believes the treatment proposals are broadly satisfactory but is asking the practitioner to consider minor changes to the treatment proposals or a minor addendum.
Code 3 or Code C
Defines that the Dental Reference Officer has concerns related to the clinical care provided or proposed and is requesting that Practitioner Services carry out further investigations related to the findings.
Code 4 or Code D
Defines that the Dental Reference Officer has concerns related to the clinical care provided or proposed that are of such concern that the matter should be discussed with/ referred to the Health Board.
Code R
The Dental Reference Officer recommends the practitioner obtains a consultant's report.

Report on Investigation and Outliers – Update on Actions – Progress

No of active outliers	23
No of active investigations	4

New cases under investigation	7
Closed cases	1

Monies recovered to date	£3,000.00

4.2 General Ophthalmic Services

Quarter 2 (Jul 2016 to Sept 2016)

i) Level 1: No action required.

ii) Level 2: Random Sampling - Work has commenced on sampling repair/ replacement claims. Outcomes will be reported to future meetings.

iii) Level 2: Outlier data - It was agreed to carry out level three investigations for ten outliers.

iv) Level 3: The data in respect of ongoing level 3 investigations was reviewed. 26 cases were detailed. Three cases have been closed, a recovery mandate has been sent in two cases, records reminders have been sent in four cases and record requests have been sent in nine cases. NHS Tayside will be provided with a further update at the next Payment Verification meeting in March 2017.

v) Level 4: Visits to four practices to randomly inspect clinical records had been finalised for October and November 2016.

4.3 Pharmaceutical Services:

Quarter 1 (April – June 2016)

Payment Verification (PV) Pharmacy and NHS Tayside met on 10th January 2017 at Kings Cross Hospital.

i) Level 1: Checks have been carried out on a range of items including: invalid CHI numbers, high value gross ingredient cost, urgent forms, unusual fees, maximum number of instalments exceeded and no further action was required.

ii) Level 2: PV has developed new Level 2 Reports using the Data Analytics software Tableau. This quarter is the first issue of these new reports and Payment Verification demonstrated the functionality to NHS Tayside which enables level 2 data to be more interactive and visually informative. PV will support NHS Tayside using this new approach by interrogating the system and making suggestions of areas for investigation to NHS Tayside.

Minor Ailments Service: PV highlighted that Boots pharmacies had the highest percentages of Dummy CHIs and PV will approach Boots nationally about this issue.

iii) Level 3: Chronic Medication Service: PV still has an outstanding action to speak to Community Pharmacy Scotland to ask them to remind contractors not to batch register patients for CMS.

iv) Level 4: NHS Tayside requested that PV issue a further 100 Chronic Medication Service patient letter questionnaire sample as has been requested in previous years.

4.4 General Medical Services

Following the retraction of the Quality Outcome Framework (QOF), and as previously reported, details of the new contract and information in respect of future payment verification processes are still awaited. In the interim payment verification visits continue to be made. The detail of the visits for Quarter 3 is provided below.

Quarter 3 (Oct 2016 to Dec 2016)

Five payment verification visits took place in quarter 3. Three were random, two were non random.

A high level of assurance was obtained for three practices.

One practice was deemed to be of an adequate standard although a recovery of £40 has been made in respect of inappropriate exception coding.

A limited level of assurance was obtained for one practice in relation to the Near Patient Testing Enhanced Service. A review of the enhanced service found a number of issues. Consequently, a further visit has been arranged to review an extended sample of claims to determine an accurate level of recovery. In the interim, a recovery of £135 has been made in respect of inappropriate exception coding.

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. MEASUREMENT 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.

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 advisor 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

Not applicable

9. RESOURCE IMPLICATIONS

Financial

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

Workforce

Additional analysis is 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 Representatives, 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 IMPLICATIONS

Legal implications may arise from any fraudulent activity identified through the process. NHS Tayside could 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 INFECTIONS

Not applicable

15. DELEGATION LEVEL

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

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 Supporting 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

The assurance framework is reviewed and revised annually. Payment verification activity is undertaken throughout the year with assurance reports being provided to each Audit Committee.

17. REPORT SIGN OFF

Jane Haskett
General Manager,
Primary Care Services

Lindsay Bedford
Director of Finance

March 2017

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

Item Number 10

AUDIT23/2017
Audit Committee
9 March 2017

AUDIT COMMITTEE HANDBOOK

1. PURPOSE OF THE REPORT

The purpose of this report is to demonstrate the efficient and effective operation of the Committee and compliance with the Audit Committee Handbook and other relevant guidance.

2. RECOMMENDATIONS

The Committee is asked to note the content of the report and confirm that the completed checklist demonstrates adherence to good practice.

3. EXECUTIVE SUMMARY

The Audit Committee should follow good practice principles relating to the role, membership and work of audit committees. Guidance is set out in the Scottish Government Audit Committee Handbook (Appendix 1). The Handbook states that an effective audit committee is key to a strong corporate governance culture and that practices that are based on robust principles are a fundamental part of the responsibilities of an audit committee.

In order to demonstrate the Audit Committee is fulfilling its role, the Handbook's self assessment checklist is completed each year and is discussed with the Chair of the Audit Committee prior to presentation to the Members. The completed checklist is attached at Appendix 2.

Overall the evidence and the report provide assurance to members that the Committee is fulfilling its role and remit for 2016/17.

4. CONTRIBUTION TO NHS TAYSIDE'S STRATEGIC AIMS

The operation of an effective Audit Committee is a fundamental element of sound corporate governance arrangements that support compliance with NHS Tayside's policies and promotes achievement of the NHS Tayside's aims and objectives.

5. HEALTH EQUITY

No direct implications for health equity
.

6. MEASURES FOR IMPROVEMENT

Compliance with the Audit Committee Handbook is the principal measure of improvement.

7. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

The checklist and paper have been discussed with the Chair of the Audit Committee. No Equality Impact Assessment is required.

8. PATIENT EXPERIENCE

Contributes to the delivery of care and services across a range of environments in NHS Tayside.

9. RESOURCE IMPLICATIONS

Financial
No direct financial implications.

Workforce
No direct workforce implications.

10. RISK ASSESSMENT

The risk for NHS Tayside is failure of corporate governance as a result of poor practice by the Audit Committee. The annual demonstration of compliance with the Handbook checklist minimises this risk.

11. LEGAL IMPLICATION

There are no legal implications.

12. INFORMATION TECHNOLOGY IMPLICATIONS

There are no information technology implications.

13. HEALTH & SAFETY IMPLICATIONS

There are no health and safety implications.

14. HEALTHCARE ASSOCIATED INFECTION (HAI)

There are no HAI implications.

15. DELEGATION LEVEL

Not applicable.

16. TIMETABLE FOR IMPLEMENTATION

The Lead Officer is the Director of Finance. The review is performed annually.

Frances Gibson
Head of Financial Services

Lindsay Bedford
Director of Finance

March 2017

The Scottish Government

AUDIT COMMITTEE HANDBOOK

AUDIT COMMITTEE HANDBOOK

The Scottish Government, Edinburgh July 2008

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FOREWORD

Corporate governance is the way in which organisations are directed and controlled. It defines the distribution of rights and responsibilities among the different stakeholders and participants in the organisation, determines the rules and procedures for making decisions on corporate affairs including the process through which the organisation's objectives are set, and provides the means of attaining those objectives and monitoring performance.

Good practice in relation to corporate governance requires that the Board and/or Accountable Officer of a government organisation should ensure that effective arrangements are in place to provide assurance on risk management, governance and internal control. In this respect, the Board and/or Accountable Officer should be independently advised by an audit committee.

This *Handbook** sets out the fundamental principles, with explanatory good practice notes, relating to the role, membership and work of audit committees in those individual accounting entities to which the *Scottish Public Finance Manual* is directly applicable, including the core Scottish Government, Scottish Government Executive Agencies, non-ministerial Executive Agencies and bodies sponsored by the Scottish Government.

The purpose of the audit committee is not materially affected by the Board or governance structure which it supports, but the size of organisation and specific governance arrangements may well impact on the way in which the audit committee functions.

Effective audit committees are key to a strong corporate governance culture and practices that are based on robust principles are a fundamental part of an audit committee's responsibilities. However, a degree of flexibility will be needed in applying the guidance in this *Handbook* to individual organisations.

Securing good governance is essential to the Government in Scotland and we commend this *Handbook* to you.

Sir John Elvidge
Permanent Secretary for the
Scottish Government

Alyson Stafford
Director of Finance for the
Scottish Government

* The *Scottish Government Audit Committee Handbook* draws on, and is consistent with, generally accepted principles concerning corporate governance and the role of audit committees. Relevant source publications include:

HM Treasury's Audit Committee Handbook (March 2007)
HM Treasury's Corporate Governance Code for Central Government Departments (July 2005)
Financial Reporting Council's Combined Code on Corporate Governance (June 2006)
Scottish Public Finance Manual
On Board: A Guide for Board Members of Public Bodies in Scotland (February 2003)

1. GOOD PRACTICE PRINCIPLES FOR AUDIT COMMITTEES

PRINCIPLE 1: THE ROLE OF THE AUDIT COMMITTEE

The Audit Committee should support the Board and Accountable Officer by reviewing the comprehensiveness of assurances in meeting the assurance needs of the Board and Accountable Officer, and reviewing the reliability and integrity of these assurances.

PRINCIPLE 2: MEMBERSHIP, INDEPENDENCE, OBJECTIVITY AND UNDERSTANDING

The Audit Committee should be independent and objective; in addition each member should have a good understanding of the objectives and priorities of the organisation and of their role as an audit committee member.

PRINCIPLE 3: SKILLS

The Audit Committee should own corporately an appropriate skills mix to allow it to carry out its overall function.

PRINCIPLE 4: SCOPE OF WORK

The scope of the Audit Committee's work should be defined in its Terms of Reference, and encompass all the assurance needs of the Board and Accountable Officer. Within this, the Audit Committee should have particular engagement with the work of Internal Audit, the work of the External Auditor, and Financial Reporting issues.

PRINCIPLE 5: COMMUNICATION

The Audit Committee should ensure it has effective communication with the Board and Accountable Officer, the Head of Internal Audit, the External Auditor, and other stakeholders. In addition, the role of the Chair and provision of appropriate secretariat support are important elements in achieving Audit Committee effectiveness. Good practice guidance on these roles is provided, respectively, in **Annex A** and **Annex B**.

2. THE ROLE OF THE AUDIT COMMITTEE

SUPPORTING THE BOARD AND ACCOUNTABLE OFFICER

2.1 The Audit Committee should support the Board and Accountable Officer by reviewing the comprehensiveness of assurances in meeting the assurance needs of the Board and Accountable Officer and reviewing the reliability and integrity of these assurances. Boards and Accountable Officers have many issues competing for their attention. One of the challenges they face is knowing whether they are giving their attention to the right issues. Assurance is key to addressing this – it can be defined as "an evaluated opinion, based on evidence gained from review, on the organisation's governance, risk management and internal control framework".

2.2 Assurance therefore draws attention to the aspects of risk management, governance and internal control that are functioning effectively and, just as importantly, the aspects which need to be given attention to improve them. Assurance helps the Board and Accountable Officer to judge whether or not their agenda is focussing on the issues that are most significant in relation to achieving the organisation's objectives and whether best use is being made of resources. The Audit Committee can help the Board and Accountable Officer to formulate their assurance need, and then advise on how well assurance received actually meets the assurance need.

2.3 Formulation of the assurance need is key to determining the resource that needs to be dedicated to delivery of assurance in the organisation. Key elements of the assurance need include:

- the extent to which the Board and/or Accountable Officer wants to put in place periodic management assurance (e.g. stewardship reports to support year-end accountability and reporting);
- the extent to which the Board and/or Accountable Officer wants to put in place ongoing management assurance (e.g. inspection or compliance teams which provide ongoing review of specific and defined areas of control); and
- the level of confidence required in assurances, including the extent to which the range of assurance providers can be relied on by Internal Audit in delivering its overall opinion on risk, control and governance in accordance with the Government Internal Audit Standards.

2.4 The provision of assurances to the Board and Accountable Officer should be reviewed by the Audit Committee. The Audit Committee is more than a processing centre for the range of assurances available in the organisation; rather the Audit Committee should constructively challenge:

- assurance providers as to whether the scope of their activity meets the assurance need of the Board and Accountable Officer; and
- the actual assurances to test that they are founded on sufficient reliable evidence and that the conclusions are reasonable in the context of the evidence.

This adds to the value and usefulness of assurances by enhancing confidence in their reliability. The Audit Committee should also be proactive in commissioning assurance work from appropriate sources if it identifies any significant risk, governance and control issues which are not being subjected to sufficient review, and in seeking assurance that weaknesses identified by reviews that have been conducted are actually remedied.

2.5 The exact role of the Audit Committee will depend on the particular circumstances of the organisation. Examples of issues affecting the role of the Audit Committee include the strategic risk management arrangements that the Board and/or Accountable Officer have established, whether or not there is a separate Risk Committee, and the whistle-blowing arrangements which have been put in place as part of the anti-fraud and corruption arrangements. An Audit Committee should not have any executive responsibilities or be charged with making or endorsing any decisions, although it may draw attention to strengths and weaknesses in control and make suggestions for how weaknesses might be dealt with. The overarching purpose of the Audit Committee is to advise the Board and/or Accountable Officer; it is then the Board and/or Accountable Officer that makes the relevant decisions.

2.6 To fulfil its role, an Audit Committee should meet at least four times per year. Additional meetings should be convened as deemed necessary. A model 'core programme' of work for an Audit Committee meeting four times a year is provided at **Annex E**. Key lines of enquiry for an Audit Committee are set out at **Annex F**.

TERMS OF REFERENCE

2.7 The Audit Committee should be given formal Terms of Reference by the Board. These should be reviewed regularly and in turn should require the Audit Committee regularly to review its own effectiveness. Model Terms of Reference for an Audit Committee are suggested at **Annex D**. A suggested self-appraisal checklist is provided at **Annex H**.

2.8 The Audit Committee should have appropriate authority to require any member of the organisation either to:

- attend an Audit Committee meeting; or
- provide written report(s) to the Audit Committee for the purpose of providing information to assist the Audit Committee in fulfilling its role of advising the Board and Accountable Officer.

2.9 The Audit Committee will require access to funding to cover the costs incurred in fulfilling its role. The funding should be sufficient to:

- adequately meet the remuneration and working expenses of its members;
- adequately meet the relevant training needs of its members; and
- provide specialist (external) advice or opinions when required.

3. MEMBERSHIP, INDEPENDENCE, OBJECTIVITY AND UNDERSTANDING

INDEPENDENCE

3.1 An effective Audit Committee must have members who are both independent and objective. It is good practice for audit committee members to be independent non-executive directors. To help build a Board capable of providing sufficient qualified members, it is worth remembering that willingness to serve on the Audit Committee could be considered as a factor in making non-executive Board appointments.

3.2 When there are insufficient non-executive directors to form the Audit Committee, independent external members will need to be appointed. These members are appointed to the Audit Committee but not to the Board. They will often be chosen because of particular skills or experience that they hold which will be beneficial to the Audit Committee. They may be remunerated at an appropriate rate for the time and effort they are expected to contribute. As Audit Committee membership will be the only contact they have with the organisation, such members will have to make particular efforts to obtain and maintain appropriate understanding of the organisation, which is vital if they are to make a meaningful contribution to the Audit Committee's considerations. In this respect, appropriate induction training is critical, as is an ongoing programme of activity to ensure the member maintains sufficient appropriate contact with the organisation.

RELATIONSHIP WITH THE EXECUTIVE OF THE ORGANISATION

3.3 Executive members of the organisation, including Accountable Officers, should not be appointed to the Audit Committee. The role of the Executive is to attend, to provide information, and to participate in discussions, either for the whole duration of a meeting or for particular agenda items.

3.4 The Accountable Officer (normally the chief executive or equivalent) and the Finance Director should routinely attend the Audit Committee. It is also normal for the Head of Internal Audit and a representative of the External Auditor to attend. However, the Terms of Reference should also provide for the Audit Committee to sit privately without any non-members present for all or part of a meeting if they so decide.

OTHER PARTICIPANTS

3.5 It is also common for representatives of sponsoring or sponsored bodies to attend Audit Committee meetings (for example, a member of the core Scottish Government may attend the Audit Committee of one of its Executive Agencies). However, such representatives should not be appointed as members of the Audit Committee.

CONFLICTS OF INTEREST

3.6 Normally the process for recording declarations of conflicts of interests in the Audit Committee should mirror the processes used at Board level. Each member of the Committee should take personal responsibility to declare pro-actively any potential conflict of interest arising out of business on the Committee's agenda or from changes in the member's personal circumstances. The Chair of the Committee should then determine an appropriate course of action with the member. For example, the member might simply be asked to leave while a particular item of business is taken; or in more extreme cases the member could be asked to leave the Committee. If it is the Chair who has a conflict of interest, the Board (or Accountable Officer) should ask another member of the Committee to lead in determining the appropriate course of action. A key factor in determining the course of action will be the likely duration of the conflict of interest: a conflict likely to endure for a long time is more likely to suggest that the member should leave.

TERMS OF APPOINTMENT

3.7 All members of Audit Committees should have a clear understanding of:

- what is expected of them in their role, including time commitments;
- how their individual performance will be appraised, including a clear understanding of what would be regarded as unsatisfactory performance and the criteria which would indicate that the termination of Audit Committee membership should be considered; and
- the duration of their appointment and how often it may be renewed.

3.8 The terms of appointment of an Audit Committee member should be clearly set out at the time of appointment. A model letter of appointment is set out at **Annex C**. The letter should also specify what other activities the individual may or may not undertake in relation to the organisation. The impact on independence of further remuneration from other activities should be given careful consideration. More detailed guidance on the making of appointments can be found in the Public Bodies section of the Scottish Government website. Independent external members (and co-opted members) are not subject to the full public appointments process but will be required to comply with the relevant human resources policies and practices of the body concerned.

4. SKILLS

RANGE OF SKILLS

4.1 The Audit Committee is charged with ensuring that the Board and Accountable Officer of the organisation gain the assurance they need on risk management, governance and internal control. So, it needs a range of skills and experience relevant to various aspects of risk, governance and control. A competency framework for an audit committee is at **Annex G**.

4.2 Because of the importance of financial management and financial reporting to every organisation, at least one member of the Committee should have recent and relevant financial experience. This experience should be sufficient to allow them to engage competently with financial management and reporting in the organisation, and associated assurances.

4.3 The Audit Committee should identify, and agree with the Board and Accountable Officer, the other skills required for Committee effectiveness. These identified skills should inform the choice of members of the Committee. The required skills set should be periodically reviewed.

ADDITIONAL SKILLS

4.4 The Audit Committee should be empowered to either:

- co-opt members for a period of time (not exceeding a year, and with the approval of the Board and/or Accountable Officer) to provide specialist skills, knowledge and experience which the Committee needs at a particular time; (Co-opted members may be remunerated at an appropriate rate for the time and effort they are expected to contribute); or
- procure specialist advice at the expense of the organisation on an ad-hoc basis to support them in relation to particular pieces of Committee business. Budgets for such procurement should be approved by the Board and/or Accountable Officer.

TRAINING AND DEVELOPMENT

4.5 All Audit Committee members, whatever their status or background, will have training and development needs. Those who have recently joined the Audit Committee will need induction training, either to help them understand their role; or if they have audit committee experience elsewhere, to help them understand the organisation. In particular, those joining a public sector Audit Committee for the first time will need training to help them understand public sector standards, especially those relating to governance and accountability.

5. SCOPE OF WORK

OVERALL ASSURANCE

5.1 In most organisations there are a number of sources of assurance, both internal and external, sometimes primarily intended for the benefit of the organisation and sometimes primarily intended for the benefit of another stakeholder. The assurance needs of the Board and Accountable Officer are largely met by evaluating the various sources of assurance (or gaps in sources of assurance), testing and determining their reliability, and then forming an overall view on the state of risk management, governance and internal control (which is especially important in supporting the Statement on Internal Control).

5.2 Overall assurance of this kind is unlikely to be capable of expression in a single phrase, sentence or indicator because it is highly unlikely that all risk will be equally managed. Rather, the overall view may draw attention to areas where:

- risk is being appropriately managed (no action needed);
- risk is inadequately controlled (action needed to improve control);
- risk is over controlled (resource being wasted which could be diverted to other use); and
- there is lack of evidence to support a conclusion – and if this concerns areas material to the operations of the organisation more audit and/or assurance work will need to be done.

INTERNAL AND EXTERNAL AUDIT

5.3 In any government related organisation there will be two significant sources of assurance that the Audit Committee can be certain will be present: Internal Audit and External Audit. The work of Internal Audit is carried out primarily for the benefit of the Board and Accountable Officer of the organisation. Although the work of External Audit is normally primarily conducted for the benefit of the Scottish Parliament, it is still of significant benefit to the organisation as well.

5.4 The work of Internal Audit is likely to be the single most significant resource used by the Audit Committee in discharging its responsibilities. This is because the Head of Internal Audit, in accordance with the Government Internal Audit Standards, has a responsibility to offer an annual opinion on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (see Government Internal Audit Standards, Standard 9, Reporting). There is consequently a major synergy between the purpose of the Head of Internal Audit and the role of the Audit Committee.

5.5 The role of the Audit Committee in relation to Internal Audit should include advising the Board and Accountable Officer on:

- the Audit Strategy and periodic Audit Plans, forming a view on how well they support the Head of Internal Audit's responsibility to provide an annual opinion on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes;
- the results of Internal Audit work, and management response to issues raised by that work;
- the resourcing of Internal Audit; and
- the Terms of Reference (or equivalent) for Internal Audit.

5.6 Whilst the work of the External Auditor is not primarily conducted for the benefit of the organisation or its Audit Committee, the Audit Committee should nevertheless engage with the activity of the external auditor. As well as considering the results of external audit work, they should enquire about and consider the external auditor's planned approach and the way in which the external auditor is co-operating with Internal Audit to maximise overall audit efficiency, capture opportunities to derive a greater level of assurance and minimise unnecessary duplication of work.

FINANCIAL REPORTING

5.7 The Audit Committee will not itself be able to review the accounts in detail in order to advise the Accountable Officer whether they are true and fair. In reaching a view on the accounts, the Audit Committee should consider:

- key accounting policies and disclosures;
- assurances about the financial systems which provide the figures for the accounts;
- the quality of the control arrangements over the preparation of the accounts by the Finance Director;
- key judgements made in preparing the accounts; and
- any disputes arising between those responsible for preparing the accounts and the auditors.

6. COMMUNICATION

CO-ORDINATION BETWEEN THE COMMITTEE AND THE BOARD

6.1 The work of the Audit Committee needs to be communicated appropriately if it is to be effective. After each meeting of the Audit Committee a report should be prepared for the Board and Accountable Officer to:

- summarise the business taken by the Committee, explaining if necessary why that business was regarded as important; and
- offer the views of, and advice from, the Committee on issues which they consider the Board and/or Accountable Officer should be taking action.

If the minutes of the Audit Committee meeting are used as the report, care should be taken in their presentation to highlight the advice being provided. These reports should normally be copied to the Head of Internal Audit and the External Auditor (especially if the report contains advice about or to the auditors).

ANNUAL REPORTS

6.2 The Audit Committee should also provide an Annual Report, as part of the annual review cycle of annual accounts and the wider governance framework, timed to support preparation of the Statement on Internal Control. This internal report needs to be open and honest in presenting the Audit Committee's views if it is to be of real benefit to the Board and Accountable Officer.

6.3 The Annual Report should summarise the Audit Committee's work for the year past, and present the Audit Committee's opinion about:

- the comprehensiveness of assurances in meeting the Board and Accountable Officer's needs;
- the reliability and integrity of these assurances;
- whether the assurance available is sufficient to support the Board and Accountable Officer in their decision taking and their accountability obligations;
- the implication of these assurances for the overall management of risk;
- any issues the Audit Committee considers pertinent to the Statement on Internal Control and any long term issues the Committee thinks the Board and/or Accountable Officer should give attention to;
- financial reporting for the year;
- the quality of both Internal and External Audit and their approach to their responsibilities; and
- the Audit Committee's view of its own effectiveness, including advice on ways in which it considers it needs to be strengthened or developed.

BILATERAL COMMUNICATIONS

6.4 There should be mutual rights of access among each of the Chair of the Audit Committee, the Chair of the Board, the Accountable Officer (where the Chair and the Accountable Officer are separate roles), the Head of Internal Audit and the External Auditor. Whether or not that right of access is exercised, there should be an annual bilateral meeting between the Chair of the Audit Committee and each of these parties to ensure that there is clear understanding of expectations and mutual understanding of current issues.

ANNEX A: THE ROLE OF THE CHAIR: GOOD PRACTICE

A.1 The role of the Chair of the Audit Committee goes beyond chairing meetings. Indeed it is key to achieving Committee effectiveness. The additional workload should be taken into account in the appointment of the Chair.

A.2 Exactly how a particular Chair manages the Audit Committee will vary depending on the character of the individual and the needs of the specific organisation. Key activities beyond Committee meetings should include the following:

1. Agenda Setting

Before each meeting the Chair and the Committee Secretary should meet to discuss and agree the business for the meeting. The Chair should take ownership of, and have final say in, the decisions about what business will be pursued at any particular meeting.

2. Communication

- The Chair should ensure that after each meeting appropriate reports are prepared from the Audit Committee to the Board and Accountable Officer.
- The Chair should ensure that the Audit Committee provides a suitable Annual Report to the Board and Accountable Officer.
- The Chair should have bilateral meetings at least annually with the Chair of the Board, the Accountable Officer (where the Chair and the Accountable Officer are separate roles), the Head of Internal Audit and the External Auditor.
- The Chair should meet any people newly appointed to these positions as soon as practicable after their appointment.
- The Chair should ensure that all Committee members have an appropriate programme of interface with the organisation and its activities to help them understand the organisation, its objectives, business needs and priorities.

3. Monitoring Actions

- The Chair should ensure that there is an appropriate process between meetings for action points arising from Committee business to be pursued appropriately.
- The Chair should ensure that members who have missed a meeting are appropriately briefed on the business conducted in their absence. Chairs may choose to rely on the Secretariat to take these actions.

4. Appraisal

- The Chair should take the lead in ensuring that Committee members are provided with appropriate appraisal of their performance as a Committee member and that training needs are identified and addressed. The Chair should themselves seek appraisal of their performance from the Chair of the Board (or Accountable Officer, as appropriate).

- The Chair should ensure that there is a periodic review of the overall effectiveness of the Audit Committee and of its Terms of Reference.

5. Appointments

The Chair should be involved in the appointment of new Committee members, including providing advice on the skills and experience being sought by the Committee.

6. Resources

The Chair is responsible for ensuring that the work of the Audit Committee is appropriately resourced.

ANNEX B: COMMITTEE SUPPORT: GOOD PRACTICE

B.1 A good secretariat function is more than a secretarial function. The secretariat should be able to support the Chair of the Committee in identifying business to be taken, and the relevant priorities of the business. For this reason, and as the Audit Committee is essentially a committee of the Board, the Audit Committee secretariat function should be supervised by the Board secretariat. The Chair of the Committee and the secretariat should agree procedures for commissioning briefing to accompany business items on the Committee's agenda and timetables for the issue of meeting notices, agendas, and minutes. The Chair of the Committee should always review and approve minutes of meetings before they are circulated.

B.2 The specific responsibilities of the Audit Committee secretariat should include:

- meeting with the Chair of the Committee to prepare agendas for meetings;
- commissioning papers as necessary to support agenda items;
- circulating meeting documents in good time before each meeting;
- arranging for executives to be available as necessary to discuss specific agenda items with the Committee during meetings;
- keeping a record of meetings and providing draft minutes for the Chair's approval;
- ensuring action points are being taken forward between meetings;
- support the Chair in the preparation of Audit Committee reports to the Board;
- arranging the Chair's bilateral meetings with the Chair of the Board (and/or Accountable Officer, as appropriate) the Head of Internal Audit and the External Auditor;
- keeping the Chair and members in touch with developments and relevant background information about developments in the organisation;
- maintaining a record of when members' terms of appointment are due for renewal or termination;
- ensuring that appropriate appointment processes are initiated when required;
- ensuring that new members receive appropriate induction training, and that all members are supported in identifying and participating in ongoing training; and
- managing budgets allocated to the Audit Committee.

B.3 Careful consideration should be given to ensuring that the secretariat function is able to demonstrate independence from operational and management issues. If the function is provided by Internal Audit or Finance there may be a risk of bias towards their interests.

B.4 When the Audit Committee decides to meet privately, the Chair should decide whether the secretariat members should also withdraw. If so, the Chair should ensure that an adequate note of proceedings is kept to support the Committee's conclusions and advice.

ANNEX C: MODEL LETTER OF APPOINTMENT OF AN AUDIT COMMITTEE MEMBER

APPOINTMENT AND PURPOSE

You are hereby appointed as a member of the Audit Committee of (*organisation*). As a member of the Audit Committee you are accountable to the Board (*or Accountable Officer where appropriate*) through the Chair of the Committee. Your appointment is for (*number*) years from (*date*). This appointment may be renewed (*number*) times (*by mutual agreement*) after the duration of this appointment.

The Audit Committee is a Committee of the Board of (*organisation*) and the purpose of the Audit Committee is to:

- review the comprehensiveness of assurances in meeting the assurance needs of the Board and Accountable Officer;
- review the reliability and integrity of these assurances; and
- advise the Board and Accountable Officer about how well assurances consequently support them in decision taking and in discharging their accountability obligations.

A copy of the Audit Committee's Terms of Reference is enclosed. The Committee is chaired by (*name*) and the other members are (*names*). [*It is recommended that new members be provided with a list of contact details*.]

SUPPORT AND TRAINING

The Secretary of the Audit Committee is (*name/contact details*) and he/she will shortly be in touch with you to discuss and arrange appropriate induction training.

To help you understand the governance arrangements and the role of Audit Committees in government, you should read the Audit Committee Handbook published by the Scottish Government.

COMMITMENT AND REMUNERATION

The Audit Committee meets at least four times each year, but additional meetings may be required from time to time. You will also be expected to undertake appropriate training and activities designed to keep you in touch with the organisation's activities and priorities. Your remuneration will be (*include details of daily rate and procedures for claims and payment*). All monies paid in connection with this appointment are taxable and it is your responsibility to make appropriate arrangements in respect of income tax.

EXPENSES AND SUBSISTENCE

Travel and subsistence costs will be paid in accordance with (*the organisation's*) standard arrangements. A copy of the current rates and conditions is enclosed for your information.

You are entitled to claim the following expenses and subsistence:

- travel expenses to and from home to the meeting venue;
- travel and subsistence expenses incurred as part of the work of the committee away from the normal venue; and
- dependant care costs.

You would be entitled to travel first class by rail and business class by air. Any further clarification on (*the organisation's*) arrangements should be sought via the Secretary of the Audit Committee. As a rule of thumb the aim is to use the most efficient and economic means of travel, taking into account sustainability, subsistence costs and savings in time.

CONFLICTS OF INTEREST

Any potential conflict of interest for you in your Audit Committee role, including any arising from a change in personal circumstances during your period of appointment, must be declared to the Chair of the Audit Committee.

APPRAISAL

As a member of the Audit Committee you will be subject to appraisal by the Audit Committee Chair (*include brief details of the appraisal process*).

CONDUCT

You are expected to conduct yourself in accordance with the principles of the *Seven Principles of Public Life* identified by the Committee on Standards in Public Life. A copy of the *Seven Principles of Public Life* is enclosed.

LIABILITY

Under the terms of the *Scottish Public Finance Manual* issued by the Scottish Ministers individual non-executive board members of public bodies and independent external members of board committees who have acted honestly and in good faith do not have to meet out of their own personal resources any personal civil liability which is incurred in the execution or purported execution of their board or committee functions, save where the person has acted recklessly.

TERMINATION

If you choose to resign from this appointment you will be expected to give (*number*) months notice, unless your circumstances have changed in a way that make it appropriate for you to resign immediately. If your performance as an Audit Committee member is decided to be unacceptable (see appraisal) or if your conduct (including conflicts of interests) is unacceptable your appointment may be terminated by the Board/Accountable Officer (*delete as appropriate*).

ANNEX D: MODEL TERMS OF REFERENCE FOR AN AUDIT COMMITTEE

The Board (and/or Accountable Officer – *delete as appropriate*) has established an Audit Committee as a Committee of the Board to support them in their responsibilities for issues of risk, control and governance and associated assurance through a process of constructive challenge.

MEMBERSHIP

The members of the Audit Committee are:

- non-executive directors: (*List those who are appointed to the Audit Committee*);
- independent external members: (*List those who are appointed to the Audit Committee; in all cases indicate the date of appointment and when the appointment is due to end/become eligible for renewal*).

The Audit Committee will be Chaired by .....

The Audit Committee will be provided with a secretariat function by .....

REPORTING

- The Audit Committee will formally report in writing to the Board and Accountable Officer after each meeting. A copy of minutes of the meeting may form the basis of the report.
- The Audit Committee will provide the Board and Accountable Officer with an Annual Report, timed to support finalisation of the accounts and the Statement on Internal Control, summarising its conclusions from the work it has done during the year.

RESPONSIBILITIES

The Audit Committee will advise the Board and Accountable Officer on:

- the strategic processes for risk, control and governance and the Statement on Internal Control;
- the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors;
- the planned activity and results of both internal and external audit;
- the adequacy of management response to issues identified by audit activity, including external audit's management letter/report;
- the effectiveness of the internal control environment;
- assurances relating to the corporate governance requirements for the organisation;
- (*where appropriate*) proposals for tendering for either internal or external audit services or for purchase of non-audit services from contractors who provide audit services; and
- anti-fraud policies, whistle-blowing processes, and arrangements for special investigations.

The Audit Committee will also periodically review its own effectiveness and report the results of that review to the Board and Accountable Officer.

RIGHTS

The Audit Committee may:

- co-opt additional members for a period not exceeding a year to provide specialist skills, knowledge and experience; and
- procure specialist ad-hoc advice at the expense of the organisation, subject to budgets agreed by the Board or Accountable Officer.

ACCESS

The Head of Internal Audit and the representative of External Audit will have free and confidential access to the Chair of the Audit Committee.

MEETINGS

The procedures for meetings are:

- the Audit Committee will meet at least four times a year. The Chair of the Audit Committee may convene additional meetings, as he/she deems necessary;
- a minimum of (*number*) members of the Audit Committee will be present for the meeting to be deemed quorate;
- Audit Committee meetings will normally be attended by the Accountable Officer, the Finance Director, the Head of Internal Audit, and a representative of External Audit (*add any others who may routinely attend such as representatives of sponsoring/sponsored bodies*);
- the Audit Committee may ask any other officials of the organisation to attend to assist it with its discussions on any particular matter;
- the Audit Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters;
- the Board or Accountable Officer may ask the Audit Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

INFORMATION REQUIREMENTS

For each meeting the Audit Committee will be provided with:

- a report summarising any significant changes to the organisation's Risk Register;
- a progress report from the Head of Internal Audit summarising:
  - work performed (and a comparison with work planned);
  - key issues emerging from Internal Audit work;
  - management response to audit recommendations;
  - significant changes to the audit plan;
  - any resourcing issues affecting the delivery of Internal Audit objectives;
- a progress report from the External Audit representative summarising work done and emerging findings.

As and when appropriate the Committee will also be provided with:

- proposals for the Terms of Reference of Internal Audit;
- the Internal Audit Strategy;
- the Head of Internal Audit's Annual Opinion and Report;
- quality assurance reports on the Internal Audit function;
- the draft accounts of the organisation;
- the draft Statement on Internal Control;
- a report on any changes to accounting policies;
- External Audit's management letter/report;
- a report on any proposals to tender for audit functions;
- a report on co-operation between Internal and External Audit.

The above list suggests minimum requirements for the inputs which should be provided to the Audit Committee. In some cases more may be provided.

ANNEX E: EXAMPLE CORE WORK PROGRAMME FOR AN AUDIT COMMITTEE MEETING FOUR TIMES A YEAR

Spring Meeting

- Review performance relating to risk management
- Review the Internal Audit strategy and the periodic work plan for the coming financial year
- Consider External Audit plans for the coming financial year
- Consider any reports from Internal Audit and management responses
- Consider a financial report, including relevant information about financial performance and achievement of financial targets

Summer Meeting

- Review performance relating to risk management
- Review and consider the accounts for the financial year just finished
- Consider (emerging) External Audit opinion for the financial year just finished
- Review assurances provided by senior staff
- Consider Internal Audit opinion for the financial year just finished
- Consider an annual report on fraud and security
- Advise the Accountable Officer on signing the accounts and Statement on Internal Control
- Consider any reports from Internal Audit and management responses
- Consider a financial report, including relevant information about financial performance and achievement of financial targets
- Consider an annual report to the Board and Accountable Officer

Autumn Meeting

- Review performance relating to risk management
- Review the performance management arrangements adopted by the body including, where appropriate, the timetable for reviewing such arrangements
- Consider any reports from Internal Audit and management responses
- Consider the External Audit management letter for the previous financial year and the response to/implementation of any recommendations
- Consider a financial report, including relevant information about financial performance and achievement of financial targets

Winter Meeting

- Review performance relating to risk management
- Consider any reports from Internal Audit and management responses
- Consider a financial report, including relevant information about financial performance and achievement of financial targets
- Consider the Committee's own effectiveness in its work
- Review the Committee's Terms of Reference

ANNEX F: KEY LINES OF ENQUIRY FOR AN AUDIT COMMITTEE

This list of questions is not intended to be exhaustive or restrictive nor should it be treated as a tick list substituting for detailed consideration of the issues it raises. Rather it is intended to act as a 'prompt' to help an Audit Committee ensure that their work is comprehensive.

On the strategic processes for risk, control and governance, how do we know:

- that the risk management culture is appropriate?
- that there is a comprehensive process for identifying and evaluating risk, and for deciding what levels of risk are tolerable?
- that the risk register is an appropriate reflection of the risks facing the organisation?
- that appropriate ownership of risk is in place?
- that management has an appropriate view of how effective internal control is?
- that risk management is carried out in a way that really benefits the organisation or is it treated as a box ticking exercise?
- that the organisation as a whole is aware of the importance of risk management and of the organisation's risk priorities?
- that the system of internal control will provide indicators of things going wrong?
- that the AO's annual 'Statement on Internal Control' is meaningful, and what evidence underpins it?
- that the SIC appropriately discloses action to deal with material problems?
- that the organisation is appropriately considering the results of the effectiveness review underpinning the SIC?

On risk management processes, how do we know:

- how senior management (and Ministers where appropriate) support and promote risk management?
- how well people are equipped and supported to manage risk well?
- that there is a clear risk strategy and policies?
- that there are effective arrangements for managing risks with partners?
- that the organisation's processes incorporate effective risk management?
- if risks are handled well?
- if risk management contributes to achieving outcomes?

On the planned activity and results of both internal and external audit, how do we know:

- that the Internal Audit strategy is appropriate for delivery of a positive reasonable assurance on the whole of risk, control and governance?
- that the periodic audit plan will achieve the objectives of the Internal Audit strategy, and in particular is it adequate to facilitate a positive, reasonable assurance?
- that Internal Audit has appropriate resources, including skills, to deliver its objectives?
- that Internal Audit recommendations that have been agreed by management are actually implemented?
- that any issues arising from line management not accepting Internal Audit recommendations are appropriately escalated for consideration?
- that the quality of Internal Audit work is adequate?
- that there is appropriate co-operation between the internal and external auditors?

On the accounting policies, the accounts, and the annual report of the organisation, how do we know:

- that the accounting policies in place comply with relevant requirements, particularly the *Financial Reporting Manual*?
- there has been due process in preparing the accounts and annual report and is that process robust?
- that the accounts and annual report have been subjected to sufficient review by management and by the Board and Accountable Officer?
- that when new or novel accounting issues arise, appropriate advice on accounting treatment is gained?
- that there is an appropriate anti-fraud policy in place and losses are suitably recorded?
- that suitable processes are in place to ensure accurate financial records are kept?
- that suitable processes are in place to ensure fraud is guarded against and regularity and propriety is achieved?
- that financial control, including the structure of delegations, enables the organisation to achieve its objectives with good value for money?
- if there are any issues likely to lead to qualification of the accounts?
- if the accounts have been qualified, that appropriate action is being taken to deal with the reason for qualification?
- that issues raised by the External Auditors are given appropriate attention?

On the adequacy of management response to issues identified by audit activity, how do we know:

- that the implementation of recommendations is monitored and followed up?
- that there are suitable resolution procedures in place for cases when management reject audit recommendations which the auditors stand by as being important?

On assurances relating to the corporate governance requirements for the organisation, how do we know:

- that the range of assurances available is sufficient to facilitate the drafting of a meaningful Statement on Internal Control?
- that those producing assurances understand fully the scope of the assurance they are being asked to provide, and the purpose to which it will be put?
- what mechanisms are in place to ensure that assurances are reliable?
- that assurances are 'positively' stated (i.e. premised on sufficient relevant evidence to support them)?
- that the assurances draw appropriate attention to material weaknesses or losses which should be addressed?
- that the Statement on Internal Control realistically reflects the assurances on which it is premised?

On the work of the Audit Committee itself, how do we know:

- that we are being effective in achieving our terms of reference and adding value to corporate governance and control systems of the organisation?
- that we have the appropriate skills mix?
- that we have an appropriate level of understanding of the purpose and work of the organisation?
- that we have sufficient time to give proper consideration to our business?
- that our individual members are avoiding any conflict of interest?
- what impact we are having on an organisation?

ANNEX G: AUDIT COMMITTEE COMPETENCY FRAMEWORK

All members of the Audit Committee should have, or acquire as soon as possible after appointment:

- understanding of the objectives of the organisation and current significant issues for the organisation;
- understanding of the organisation's structure, including key relationships such as that with a sponsoring directorate/portfolio or a major partner;
- understanding of the organisation's culture;
- understanding of any relevant legislation or other rules governing the organisation;
- broad understanding of the government environment, particularly accountability structures and current major initiatives.

The Audit Committee should corporately possess:

- knowledge/skills/experience (as appropriate and required) in:
  - accounting;
  - risk management;
  - audit;
  - technical or specialist issues pertinent to the organisation's business.
- experience of managing similar sized organisations;
- understanding of the wider relevant environments in which the organisation operates;
- detailed understanding of the government environment and accountability structures.

ANNEX H: AUDIT COMMITTEE SELF-ASSESSMENT CHECKLIST

Role and remit	YES/NO/NA	Comments/Action
Does the audit committee have written terms of reference?		
Do the terms of reference cover the core functions of an audit committee as identified in the *SG Audit Committee Handbook*?		
Are the terms of reference approved by the audit committee and reviewed periodically?		
Has the audit committee been provided with sufficient membership, authority and resources to perform its role effectively and independently?		
Does the body's statement on internal control mention the audit committee's establishment and its broad purpose?		
Does the audit committee periodically assess its own effectiveness?		
Membership, induction and training	**YES/NO/NA**	**Comments/Action**
Has the membership of the audit committee been formally agreed by the management board and or Accountable Officer and a quorum set?		
Are members appointed for a fixed term?		
Does at least one of the audit committee members have a financial background?		
Are all members, including the chair, independent of the executive function?		
Are new audit committee members provided with an appropriate induction?		
Has each member formally declared his or her business interests?		
Are members sufficiently independent of the other key committees of the Board?		
Has the audit committee considered the arrangements for assessing the attendance and performance of each member?		
Meetings	**YES/NO/NA**	**Comments/Action**
Does the audit committee meet regularly, at least four times a year?		
Do the terms of reference set out the frequency and broad timing of meetings?		
Does the audit committee calendar meet the body's business and governance needs, as well as the requirements of the financial reporting calendar?		
Are members attending meetings on a regular basis and if not, is appropriate action taken?		
Does the Accountable Officer attend all meetings and, if not, is he/she provided with a record of discussions?		
Does the audit committee have the benefit of attendance of appropriate officials at its meetings, including representatives from internal audit, external audit and finance?		

Internal control	YES/NO/NA	Comments/Action
Does the audit committee consider the findings of annual reviews by internal audit and others, on the effectiveness of the arrangements for risk management, control and governance?		
Does the audit committee consider the findings of reviews on the effectiveness of the system of internal control?		
Does the audit committee have responsibility for review of the draft Statement on Internal Control (SIC) and does it consider it separately from the accounts?		
Does the audit committee consider how accurate and meaningful the SIC is?		
Does the audit committee satisfy itself that the arrangements for risk management, control and governance have operated effectively throughout the reporting period?		
Has the audit committee considered how it should coordinate with other committees that may have responsibility for risk management and corporate governance?		
Has the audit committee satisfied itself that the body has adopted appropriate arrangements to counter and deal with fraud?		
Has the audit committee been made aware of the role of risk management in the preparation of the internal audit plan?		
Does the audit committee's terms of reference include oversight of the risk management process?		
Does the audit committee consider assurances provided by senior staff?		
Does the audit committee receive and consider stewardship reports from senior staff in key business areas such as Finance, HR and ICT?		
Financial reporting and regulatory matters	**YES/NO/NA**	**Comments/Action**
Is the audit committee's role in the consideration of the annual accounts clearly defined?		
Does the audit committee consider, as appropriate:		
• the suitability of accounting policies and treatments		
• major judgements made		
• large write-offs		
• changes in accounting treatment		
• the reasonableness of accounting estimates		
• the narrative aspects of reporting?		
Is an audit committee meeting scheduled to receive the external auditor's report to those charged with governance including a discussion of proposed adjustments to the accounts and other issues arising from the audit?		
Does the audit committee review management's letter of representation?		
Does the audit committee gain an understanding of management's procedures for preparing the body's annual accounts?		
Does the audit committee have a mechanism to keep it aware of topical legal and regulatory issues?		

Internal audit	YES/NO/NA	Comments/Action
Does the Head of Internal Audit attend meetings of the audit committee?		
Does the audit committee approve, annually and in detail, the internal audit plans including consideration of whether the scope of internal audit work addresses the body's significant risks?		
Does internal audit have a direct reporting line, if required, to the audit committee?		
As well as an annual report from the Head of Internal Audit, does the audit committee receive progress reports from the internal audit service?		
Are outputs from follow-up audits by internal audit monitored by the audit committee and does the committee consider the adequacy of implementation of recommendations?		
If considered necessary, is the audit committee chair able to hold private discussions with the Head of Internal Audit?		
Is there appropriate co-operation between the internal and external auditors?		
Does the audit committee review the adequacy of internal audit staffing and other resources?		
Are internal audit performance measures monitored by the audit committee?		
Has the audit committee considered the information it wishes to receive from internal audit?		
Do formal terms of reference exist defining internal audit's objectives, responsibilities, authority and reporting lines?		
External audit	**YES/NO/NA**	**Comments/Action**
Does the external audit representative attend meetings of the audit committee?		
Do the external auditors present and discuss their audit plans and strategy with the audit committee (recognising the statutory duties of external audit)?		
Does the audit committee chair hold periodic private discussions with the external auditor?		
Does the audit committee review the external auditor's annual report to those charged with governance?		
Does the audit committee ensure that officials are monitoring action taken to implement external audit recommendations?		
Are reports on the work of external audit presented to the audit committee?		
Does the audit committee assess the performance of external audit?		
Does the audit committee consider the external audit fee?		

Administration	YES/NO/NA	Comments/Action
Does the audit committee have a designated secretariat?		
Are agenda papers circulated in advance of meetings to allow adequate preparation by audit committee members?		
Do reports to the audit committee communicate relevant information at the right frequency, time, and in a format that is effective?		
Does the audit committee issue guidelines and/or a pro forma concerning the format and content of the papers to be presented?		
Are minutes prepared and circulated promptly to the appropriate people, including all members of the Board?		
Is a report on matters arising presented or does the chair raise them at the audit committee's next meeting?		
Do action points indicate who is to perform what and by when?		
Does the audit committee provide an effective annual report on its own activities?		
Overall	**YES/NO/NA**	**Comments/Action**
Does the audit committee effectively contribute to the overall control environment of the organisation?		
Are there any areas where the audit committee could improve upon its current level of effectiveness?		
Does the audit committee seek feedback on its performance from the Board and Accountable Officer?		

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RR Donnelley B55712 07/08

Appendix 2

AUDIT COMMITTEE HANDBOOK – NHS TAYSIDE SELF ASSESSMENT CHECKLIST 2016/17

Role and Remit	Yes	No	N/A	Comments/Action
Does the audit committee have written terms of reference?	✓			The Committee considered its Terms of Reference in May 2016. The terms of reference are incorporated in the Code of Corporate Governance. An annual report of the Committee has been incorporated into the Code of Corporate Governance terms of reference.
Do the terms of reference cover the core functions of an audit committee as identified in the *SG Audit Committee Handbook?*	✓			Core functions identified in Annex D to the SG Audit Committee Handbook, are covered in the terms of reference.
Are the terms of reference approved by the audit committee and reviewed periodically?	✓			The terms of reference of the Audit Committee are contained within the Code of Corporate Governance and are reviewed annually by the Audit Committee. The terms of reference for 2016/17 were reviewed and approved by the Audit Committee in May 2016. **(May 2016 Audit Committee – Item 11)**
Has the audit committee been provided with sufficient membership, authority and resources to perform its role effectively and independently?	✓			Role and remit including membership is set out in the Code of Corporate Governance.
Does the body's statement on internal control mention the audit committee's establishment and its broad purpose?	✓			The overall governance framework of the Board is described in the Governance Statement. The establishment, purpose and membership of the Audit Committee are specifically mentioned in the Directors' Report of the Annual Report and Accounts. **(June 2016 Audit Committee – Items 7.1, 7.5 and 8)**
Does the audit committee periodically assess its own effectiveness?	✓			An annual report of its activities is undertaken. This process inevitably requires the Committee to consider the effectiveness of the processes it undertakes on behalf of NHS Tayside. In addition, this self assessment checklist is an assessment of the Audit Committee's own effectiveness. **(June 2016 Audit Committee – Item 7.7)**
Membership, induction and training	**Yes**	**No**	**N/A**	**Comments/Action**
Has the membership of the audit committee been formally agreed by the management board and or Accountable Officer and a quorum set?	✓			The composition of the Audit Committee is included in the Code of Corporate Governance approved by the Board. Membership is included in the Terms of Reference approved at the May 2016 Audit Committee. Quorum set when at least three Members are present. **(May 2016 Audit Committee – Item 11)**

Membership, induction and training	Yes	No	N/A	Comments/Action
Are members appointed for a fixed term?	✓			Members of the Board are appointed by Scottish Ministers and the term of office is as Scottish Ministers specify, typically for a fixed term with the possibility of re-appointment. Non Executives are appointed to the Audit Committee by the Board Chairman. The term of office varies between members and cannot be longer than the maximum term specified by Scottish Government.
Does at least one of the audit committee members have a financial background?	✓			The current Chair has a MBA degree and 20 years experience in investment banking. One Member is also Fellow of the Chartered Institute of Management Accountants (FCMA).
Are all members, including the chair, independent of the executive function?	✓			In order to preserve its independence from operational management, the Audit Committee does not have executive membership. The Committee consists of 7 Non-Executive members of the Board.
Are new audit committee members provided with an appropriate induction?	✓			NHS Tayside provides new members of the Audit Committee with the following: • To date, the Audit Committee Lead Officer has circulated new members with an information pack to induct them in the workings of the NHS Tayside Audit Committee which contains : o Audit Committee Handbook and Checklist; o Annual Report; o Terms of Reference and Work Plan; o NHS Tayside's Non-Executive Membership Protocol.
Has each member formally declared his or her business interests?	✓			Each Member is obliged to declare their business interests annually. Additionally, members are invited to declare new or relevant interests at every meeting.
Are members sufficiently independent of the other key committees of the Board?	✓			Audit Committee membership is in line with the Code of Corporate Governance.
Has the audit committee considered the arrangements for assessing the attendance and performance of each member?	✓			Attendance at meetings is assessed on an ongoing basis. Members are assessed separately by the Board Chairman every year.
Meetings	**Yes**	**No**	**N/A**	**Comments/Action**
Does the audit committee meet regularly, at least four times a year?	✓			The Committee met five times in 2016/17 (including March 2017).
Do the terms of reference set out the frequency and broad timing of meetings?	✓			The terms of reference specifies that the Committee shall meet no fewer than four times each year. The Committee's workplan provides a timetable of meeting dates scheduled to be held for the year.
Does the audit committee calendar meet the body's business and governance needs, as well as the requirements of the financial reporting calendar?	✓			The timing and content discussed at each meeting is planned to meet NHS Tayside's business and governance needs as well as the requirements of the financial reporting calendar.

Are members attending meetings on a regular basis and if not, is appropriate action taken?	✓			The attendance record for 2016/17 confirms that members are attending meetings on a regular basis. The Code of Corporate Governance specifies that if a member does not attend three consecutive meetings of the Audit Committee, then the Chair of NHS Tayside shall terminate that person's appointment unless they are satisfied that : • the absence was due to illness or other reasonable cause; and • the member will be able to attend meetings within such period as the Chairman considers reasonable.
Does the Accountable Officer attend all meetings and, if not, is he/she provided with a record of discussions?	✓			A full set of Audit Committee papers was sent out for each meeting. When attendance of the Accountable Officer is not feasible a deputy attends.
Does the audit committee have the benefit of attendance of appropriate officials at its meetings, including representatives from internal audit, external audit and finance?	✓			Regular attendees include representatives from Finance and Internal and External Audit. Where appropriate a deputy attends the meetings. Attendance of appropriate officers for specific agenda items, as and when required.
Internal Control	**Yes**	**No**	**N/A**	**Comments/Action**
Does the audit committee consider the findings of annual reviews by internal audit and others, on the effectiveness of the arrangements for risk management, control and governance?	✓			Annual reports are submitted by Internal Audit, Risk Management and the Corporate Governance Review Group. **(Internal Audit Annual Report to June 2016 Audit Committee – Item 7.4, Risk Management Annual Report to May 2016 Audit Committee – Item 8.2 and Code of Corporate Governance Review Group Annual Report to June Audit Committee Item 7.2)**
Does the audit committee consider the findings of reviews on the effectiveness of the system of internal control?	✓			Internal and External Audit Annual Review reports submitted to the Audit Committee each year for consideration and discussion. **(Internal and External Audit Annual Review to June 2016 Audit Committee – Item 7.4 and Item 9 respectively)**
Internal Control	**Yes**	**No**	**N/A**	**Comments/Action**
Does the audit committee have responsibility for review of the draft Governance Statement and does it consider it separately from the accounts?	✓			Considered as agenda items at the May and June Audit Committees each year. **(May 2016 Audit Committee – Item12, June Audit Committee – Item 7.1 and Item 8)**
Does the audit committee consider how accurate and meaningful the Governance Statement is?	✓			Considered as a separate agenda item at the June Audit Committee each year. . **(June 2016 Audit Committee – Item 7)**
Does the audit committee satisfy itself that the arrangements for risk management, control and governance have operated effectively throughout the reporting period?	✓			Each year the Annual Report of the Audit Committee concludes on the adequacy and effectiveness of governance arrangements in place throughout NHS Tayside during the year. **(June 2016 Audit Committee – Item 7.7)**

Has the audit committee considered how it should coordinate with other committees that may have responsibility for risk management and corporate governance?	✓			The Committee considers minutes of the Strategic Risk Management and Corporate Governance Review Groups **(May 2016, January 2017 and March 2017 Audit Committees – Strategic Risk Management Group)** **(May 2016, September 2016, January 2017 and March 2017 Audit Committees - Corporate Governance Review Group)**
Has the audit committee satisfied itself that the body has adopted appropriate arrangements to counter and deal with fraud?	✓			Formal arrangements in place with Counter Fraud Services and within NHS Tayside. Regular updates are taken to Committee. **(Updates taken to May 2016, Sep 2016, Jan 2017 and March 2017 Audit Committees)**
Has the audit committee been made aware of the role of risk management in the preparation of the internal audit plan?	✓			The Audit Committee is presented each year with an updated Audit Plan which explains the basis used including the risk assessment model. **(May 2016 Audit Committee – Item 6.2)**
Does the audit committee's terms of reference include oversight of the risk management process?	✓			Yes, as included in the Code of Corporate Governance.
Internal Control	**Yes**	**No**	**N/A**	**Comments/Action**
Does the audit committee consider assurances provided by senior staff?	✓			As part of the Governance Statement assurance process, assurances are received from all Executive Directors. **(June 2016 Audit Committee – Items 7.5 and 10)**
Does the audit committee receive and consider stewardship reports from senior staff in key business areas such as Finance, HR and ICT?	✓			Principally, stewardship falls within the role and remit of the Finance & Resources Committee. The Audit Committee does however consider External Audit reviews.
Financial reporting and regulatory matters	**Yes**	**No**	**N/A**	**Comments/Action**
Is the audit committee's role in the consideration of the annual accounts clearly defined?	✓			Established over a number of years.
Does the audit committee consider as appropriate:				**The Audit Committee considers the points below as part of its scrutiny of the annual accounts and separately considers changes made to accounting policies:**
• the suitability of accounting policies and treatments	✓			Paper to Committee each year to review and approve any changes to accounting policies. **(May 2016 Audit Committee – Item 13)**
• major judgements made	✓			Included in accounting policies note **(May 2016 Audit Committee – Item 13)**
• large write-offs	✓			Losses report considered each year at the June Audit Committee meeting. **(June 2016 Audit Committee – Item 16)**

• changes in accounting treatment	✓			The Committee is provided with a summary of key changes in respect of accounts each year **(May 2016 Audit Committee – Item 13)**
• the reasonableness of accounting estimates	✓			Considered each year at the June Audit Committee meeting. **(June 2016 Audit Committee – Item 8)**
• the narrative aspects of reporting?	✓			Key changes were applied in the 2015/16 accounts approved in June 2016. The changes required were contained in a report considered in March 2016 and the detailed narrative in June 2016 as part of the Accounts approval process. **(March Audit Committee - Item 7 and June 2016 Audit Committee – Item 8)**
Is an audit committee meeting scheduled to receive the external auditor's report to those charged with governance including a discussion of proposed adjustments to the accounts and other issues arising from the audit?	✓			Report considered each year at the June Audit Committee meeting. **(June 2016 Audit Committee – Item 9)**
Financial reporting and regulatory matters	**Yes**	**No**	**N/A**	**Comments/Action**
Does the audit committee review management's letter of representation?	✓			Considered each year at the June Audit Committee meeting. **(June 2016 Audit Committee – Item 9)**
Does the audit committee gain an understanding of management's procedures for preparing the body's annual accounts?	✓			The Financial Statements Checklist is brought to Committee each year. **(May 2016 Audit Committee Item 19)**
Does the audit committee have a mechanism to keep it aware of topical legal and regulatory issues?	✓			The Committee receives as agenda items, copies of External Audit's Technical Bulletins and relevant CELs. **(Technical Bulletins to Sep 2016 and Jan 2017, Audit Committees.)**
Internal Audit	**Yes**	**No**	**N/A**	**Comments/Action**
Does the Head of Internal Audit attend meetings of the audit committee?	✓			The Chief Internal Auditor has attended three of the four Audit Committee meetings to January 2017. A deputy is sent to any meeting that the Chief Internal Auditor is unable to attend.
Does the audit committee approve, annually and in detail, the internal audit plans including consideration of whether the scope of internal audit work addresses the body's significant risks?	✓			Internal Audit Plan considered and approved in relation to Internal Audit year commencing 1 May. Plan based on the Corporate risks for NHS Tayside which determines the frequency of coverage during the five year period. The 2016/17 Internal Audit Annual Plan was approved in May 2016. **(May 2016 Audit Committee – Item 6.2)**

Does internal audit have a direct reporting line, if required, to the audit committee?	✓			Under the terms of the SFIs (Section F of the Code of Corporate Governance Paragraph 20.8), the Chief Internal Auditor (CIA) is accountable to the Director of Finance. The Audit Committee's terms of reference incorporates a requirement to ensure that there is direct contact between the Committee and Internal Audit, and to meet with the CIA at least once per year, and as required, without the presence of Executive Directors.
As well as an annual report from the Head of Internal Audit, does the audit committee receive progress reports from the internal audit service?	✓			The annual report is submitted to the June Audit Committee meeting each year. **(June 2016 Audit Committee – Item 7.4)** Progress updates are provided to each meeting. **(Progress updates to May 2016, Sept 2016 and Jan 2017 Audit Committees)**
Internal Audit	**Yes**	**No**	**N/A**	**Comments/Action**
Are outputs from follow-up audits by internal audit monitored by the audit committee and does the committee consider the adequacy of implementation of recommendations?	✓			Audit Follow Up reports are regularly considered by the Audit Committee comprising detail on the adequacy of implementation of recommendations. **(Audit Follow Up reports to May 2016, Sept 2016 Jan 2017)**
If considered necessary, is the audit committee chair able to hold private discussions with the Head of Internal Audit?	✓			This facility is timetabled for all meetings within the agenda item entitled 'Private Discussion'. To January 2017 private discussions were held during three meetings. **(May 2016, June 2016 and September 2016 Audit Committees)**
Is there appropriate co-operation between the internal and external auditors?	✓			
Does the audit committee review the adequacy of internal audit staffing and other resources?	✓			Internal Audit reports regularly on this to the Committee within progress update reports. The Service Specification sets out the role and composition of the team. The requirement is for 50% qualified input. **(Progress updates to May 2016, Sept 2016 and Jan 2017 Audit Committees)**
Are internal audit performance measures monitored by the audit committee?	✓			Progress against the Audit Plan is regularly monitored by the Audit Committee within progress update reports. Key performance indicators are included in the Internal Audit Annual Report. **(Progress updates to May 2015, Sept 2015, Nov 2015, Feb 2016 and March 2016 Audit Committees. Annual Report considered June 2016 Audit Committee – Item 7.4)**
Has the audit committee considered the information it wishes to receive from internal audit?	✓			Unified reporting protocol periodically considered. Although protocol was last considered and approved in March 2012.

Do formal terms of reference exist defining internal audit's objectives, responsibilities, authority and reporting lines?	✓			Contained in Standing Financial Instructions (Section 20 FTF Service Specification.
External Audit	**Yes**	**No**	**N/A**	**Comments/Action**
Does the external audit representative attend meetings of the audit committee?	✓			External Audit representatives attends each meeting of the Audit Committee.
Do the external auditors present and discuss their audit plans and strategy with the audit committee (recognising the statutory duties of external audit)?	✓			External Audit Plan discussed each year at Audit Committee meeting. (**January 2017 Audit Committee – Item 7.1)**
Does the audit committee chair hold periodic private discussions with the external auditor?	✓			Opportunity for 'private discussion' without the presence of Executive Directors and other staff, is timetabled for each meeting of the Audit Committee. To January 2017 private discussions were held during three meetings. **(May 2016, June 2016 and September 2016 Audit Committees)**
Does the audit committee review the external auditor's annual report to those charged with governance?	✓			This is reviewed each year at the June Audit Committee meeting. **(June 2016 Audit Committee – Item 9)**
Does the audit committee ensure that officials are monitoring action taken to implement external audit recommendations?	✓			Audit Follow Up reports are regularly considered by the Audit Committee which report on action taken to implement external audit recommendations. **(Audit Follow Up reports to May 2016, Sept 2016 Jan 2017)**
Are reports on the work of external audit presented to the audit committee?	✓			Regular reports on the work of External Audit are presented to the Audit Committee. **(Progress reports to May 2015, Sept 2015, Nov 2015, Feb 2016 and March 2016**
Does the audit committee assess the performance of external audit?	✓			External Audit attends all Audit Committee meetings and can be challenged on their performance either during the meeting or at the end of the meeting within the agenda item entitled 'Private Discussion'.
Does the audit committee consider the external audit fee?	✓			The Audit Committee considers the external audit fee each year. **(January 2017 Audit Committee – Item 7.2)**
Administration	**Yes**	**No**	**N/A**	**Comments/Action**
Does the audit committee have a designated secretariat?	✓			The administrative function is undertaken by the Committee Support Officer.
Are agenda papers circulated in advance of meetings to allow adequate preparation by audit committee members?	✓			All papers are sent to Members circa 1 week prior to date of meetings.
Do reports to the audit committee communicate relevant information at the right frequency, time, and in a format that is effective?	✓			A standard report template is used for all Standing Committees. Frequency and timing of reports considered and approved in the Terms of Reference and Work Plan paper taken to Committee, for approved by the Committee at the start of each year. **(May 2016 Audit Committee – Item 11)**

Does the audit committee issue guidelines and/or a pro forma concerning the format and content of the papers to be presented?	✓			The Board Secretary issues guidance notes and a template for Standing Committee reports. Latest guidance and template issued in March 2017.
Administration	**Yes**	**No**	**N/A**	**Comments/Action**
Are minutes prepared and circulated promptly to the appropriate people, including all members of the Board?	✓			All members of the Board receive a copy of the Audit Committee minutes within the papers to be considered by the Board.
Is a report on matters arising presented or does the chair raise them at the audit committee's next meeting?	✓			An action points update paper on matters arising together with the status of the action taken is presented to the next meeting of the Audit Committee. **(Reserved and Open Action Point Update papers taken to each Audit Committee meeting)**
Do action points indicate who is to perform what and by when?	✓			Name of officer noted. No due date set although the majority of actions are completed by the next Audit Committee meeting.
Does the audit committee provide an effective annual report on its own activities?	✓			Annual report presented to the June Audit Committee each year. **(June 2016 Audit Committee – Item 7.7)**
Overall	**Yes**	**No**	**N/A**	**Comments/Action**
Does the audit committee effectively contribute to the overall control environment of the organisation?	✓			The Audit Committee ensures the Board's activities are within the law and regulations governing the NHS and that an effective internal control system is maintained, and ensures that suitable arrangements are in place to provide formal assurance to the Accountable Officer by providing an opinion on the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources.
Are there any areas where the audit committee could improve upon its current level of effectiveness?	✓			Audit is a continuously evolving process where 'Best Practice' is frequently changing and the Internal and External Auditors combined with Management regularly make suggestions for enhancing and improving processes.
Does the audit committee seek feedback on its performance from the Board and Accountable Officer?	✓			The Audit Committee is a Standing Committee of the Board and submits minutes to the Board from which an action point on poor performance could be developed by the Board. The Accountable Officer attends both the Audit Committee and the Board.

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

Item Number 11

AUDIT24/2017
Audit Committee
9 March 2017

ANNUAL ACCOUNTS PROCESS UPDATE

1. SITUATION AND BACKGROUND

The Audit Committee will be asked on 22 June, 2017 to recommend that Tayside NHS Board sign off the 2016/17 NHS Tayside Annual Report and Accounts (the Accounts). This paper provides the Audit Committee with an update on the planning and progress made to date in relation to the process of producing the accounts. In addition, it provides an update on guidance received in relation to preparing the accounts and Governance Statement.

2. ASSESSMENT

The planning cycle for the production of the annual accounts starts almost immediately the preceding years accounts are signed with the workload increasing as more detailed planning is undertaken through December to March. The bulk of the workload falls between 1 April and early May, at which point the draft accounts are presented to the External Auditors. Thereafter the process moves into the audit and accounts finalisation phase through May and June, with the accounts requiring to be signed by 30 June each year.

Planning for the 2016/17 accounts is almost complete. A high level summary of the accounts process timetable is included at Appendix 1 to provide an overview of the process and to allow Non Executive colleagues to note key dates for their diaries. The timetable has been agreed with the External Auditors of both our Exchequer and Endowments Funds. The process is on target so far.

The timetable is supported by more detailed documents detailing the tasks requiring to be completed, responsible officers and related deadlines that assist in ensuring the overall process remains on track. A list of the responsible officers for each part of the accounts is included for information at Appendix 2.

The preparation of the accounts is undertaken in line with guidance in the Financial Reporting Manual (FReM), the Scottish Government Health and Social Care Directorate (SGHSCD) NHS Boards manual for annual report and accounts (the manual) and any further guidance issued by SGHSCD. The manual is updated annually to reflect changes in the FReM by a national Technical Accounting Group on which the Board has representation.

The first version of the 2016/17 manual was issued to all Boards before Christmas with the final version expected imminently. There are no significant changes to the financial statements this year.

The guidance letter issued with the manual contains a useful summary of the changes for this year and has been included for information at Appendix 3. Whilst it makes reference to work ongoing at that point, work is now concluded and will result in no significant changes to the final version of the manual.

Guidance on the preparation of the Governance Statement is incorporated into the manual and has not changed since last year. It is the intention to produce the Governance Statement using the same process as last year which adopted best practice identified in the Audit Scotland publication 'Improving the quality of NHS annual report and accounts: Governance Statements'.

3. RECOMMENDATIONS

The Committee is asked to:-

i. note the guidance received from SGHSCD in relation to the preparation of the 2016/17 accounts, and

ii. note that planning for the 2016/17 accounts process is well advanced and the accounts process is currently on target to be completed by the 30 June, 2017, deadline.

Frances Gibson
Head of Financial Services

Lindsay Bedford
Director of Finance

March 2017

Appendix 1

NHS Tayside - Timetable for production of 2016/17 Annual Accounts - Key Dates (close of play unless otherwise indicated)

Draft accounting policies – papers issued for Audit Committee	Thursday 2 March
Draft accounting policies approved by Audit Committee	Thursday 9 March
Final version revaluation available from Barr's consortium	Tuesday 4 April (TBC)
Nurse and Medical Bank	Tuesday 4 April
All standard journal entries (Maryfield normal month end input)	Thursday 6 April
Revenue Account & Endowments reviewed for capital items	Tuesday 11 April
Entries impacting on other Directorates(thereafter inform Team affected)	Tuesday 11 April
SFR 30 letters issued	Tuesday 11 April
Capital entries completed	Wednesday 12 April
Management accounts entries (Incl D017) /financial services non standard entries completed	Thursday 13 April
Completed CNORIS Provision Template to SGHSCD	Monday 17 April (TBC)
Endowments Team all entries complete	Tuesday 18 April
SFR balances agreed	Wednesday 19 April
Finalise T forms/Agree outturn	Wednesday 19 April
Scottish Government March 2016 monitoring returns - March Allocation Letter	**Monday 24 April**
Draft March Corporate Financial Report to ET	Monday 1 May
Scottish Government March 2016 monitoring returns - Revised March Allocation Letter	**Tuesday 2 May**
Analytical review (v1) completed and accounts changed if necessary	Wednesday 3 May
Template input completed excluding consolidation, SFR 18 and staff report information	Wednesday 3 May
Accounting policies (amendments) – papers issued for Audit Committee	Thursday 4 May
Completed templates (Board) (excl, SFR 18 and consolidation) passed to Audit	**Monday 8 May 10am**
Working papers saved in shared directory	Monday 8 May
Accounting policies(amendments) approved by Audit Committee	Thursday 11 May
Data Extraction submission to Audit	Friday 12 May
Draft Performance and Accountability Report (incls draft Governance Statement, staff and remuneration report)	Wednesday 17 May
SFR 18 passed to Audit	Thursday 18 May
Endowments Accounts to External Auditors (MMGArchbold)	Thursday 18 May
IJB Accounts Received	**Friday26 May 10am**
Draft Consolidated Accounts (typed version) passed to auditors	Monday 29 May 10am
Completed draft templates to SGHSCD Finance	Wednesday 31 May
Endowment Clearance Meeting	Thursday 1 June
Audit Clearance meeting	Thursday 8 June 10 am
Revised accounts (templates and typed version) returned to Audit for checking	Monday 12th June 10 am
Analytical review (v2) with explanations for Audit Committee completed	Mon 12 June
Executive Team meeting - review draft accounts	Monday 12 June (tbc)
Accounts distributed to Non Execs for Briefing (Electronic Copies)	Monday 12 June
Accounts copied for Non Execs Briefing – Finance Senior Team copies only	Monday 12 June

contd./

Audit check of revised accounts completed	Wednesday 14 June
Final version of typed set of accounts including audit amendments	Wed 14 June
Accounts copied for Audit Committee (electronic versions only)	Thurs 15 June
Non Executive Directors Meeting	Thursday 15 June
Annual Audit Report issued (includes draft opinion and draft letter of rep)	Friday 16 June
Papers sent out for Audit Committee (excludes Annual Accounts)	Friday 16 June
Annual Accounts sent out for Audit Committee (electronic copies)	Monday 19 June
Audit Committee Meeting	**Thursday 22 June**
Papers sent out for Board meeting	Thursday 22 June
Board Meeting to adopt accounts	**Thursday 29 June**

NHS Tayside Annual Accounts 2016/17		
Financial Statements Preparation responsible officers	**Annual Accounts Lead Officer**	**Responsible Officer**
Performance Report		
Chief Exececutive's Statement	Director of Finance	Board Secretary
Performance Analysis:	Director of Finance	
Financial Performance and Position	Head of Financial Services	Head of Financial Services
Outturn	Head of Financial Services	Head of Financial Services
memorandum for in year outturn	Head of Financial Services	Head of Financial Services
Efficient Government	Head of Financial Services	Head of Financial Services
Trade and other revievables	Head of Financial Services	Head of Financial Services
Outstanding Liabilities	Head of Financial Services	Head of Financial Services
Legal obligations	Head of Financial Services	Head of Financial Services
Significant Changes in Non Current Assets	Head of Financial Services	Capital Finance Manager
PFI/PPP/NPD	Head of Financial Services	Capital Finance Manager
Performance Against Key Non Financial Targets	Chief Operating Officer	Business Unit
Sustainability and Environmental Reporting	Head of Financial Services	Head of Environmental Management
Payment Performance	Head of Financial Services	Head of Financial Services
Accountability Report	Head of Financial Services	
Corporate Governance Report -	Head of Financial Services	
Directors Report - Board Membership and Committees	Head of Financial Services	Head of Committee Administration
Directors Report - balance of narrative	Head of Financial Services	Head of Financial Services
Statement of Accountable Officer's Duties	Head of Financial Services	Head of Financial Services
Governance Statement	Director of Finance	Board Secretary
Remuneration and Staff Report -	Head of Financial Services	
Board Members Remuneration	Head of Financial Services	Financial Accountant
Board Members Remuneration (for IJB accounts disclosure)	Head of Financial Services	Financial Accountant
Remuneration Arrangements	Head of Financial Services	Director of Human Resources & Organisational Development
Fair Pay Disclosure	Head of Financial Services	Financial Accountant
Staff Report -	Head of Financial Services	Head of Financial Services
Staff Costs	Head of Financial Services	Management Accountant
Staff Numbers	Head of Financial Services	Management Accountant/Corporate Senior Management Accountant
Staff Composition	Head of Financial Services	Director of Human Resources & Organisational Development
Sickness Absence Data	Head of Financial Services	Director of Human Resources & Organisational Development
Staff Policies	Head of Financial Services	Director of Human Resources & Organisational Development
Exit Packages	Head of Financial Services	Director of Human Resources & Organisational Development
Parliamentary Accountabiilty Report	Head of Financial Services	
Losses	Head of Financial Services	Head of Financial Services
Fees and Charges	Head of Financial Services	Head of Financial Services/Head of Finance - Financial Planning & Operational Services
Audit Report	Head of Financial Services	Audit Scotland
Primary Statements		
Statement of Comprehensive Expenditure (SOCNE)	Head of Financial Services	Corporate Senior Management Accountant
Statement of Resource Outturn (SORO)	Head of Financial Services	Corporate Senior Management Accountant

NHS Tayside Annual Accounts 2016/17		
Financial Statements Preparation responsible officers	**Annual Accounts Lead Officer**	**Responsible Officer**
Balance Sheet	Head of Financial Services	Corporate Senior Management Accountant
Cashflow Statement	Head of Financial Services	Corporate Senior Management Accountant
Statement of Changes in Taxpayers' Equity (SOCTE)	Head of Financial Services	Corporate Senior Management Accountant
Notes to the Accounts		
Note 1 - Accounting Policies	Head of Financial Services	Head of Financial Services
Note 2 - Higher Paid Employees	Head of Financial Services	S McDonald
Note 3 - Other Operating Costs	Corporate Senior Management Accountant	Corporate Senior Management Accountant
Note 4 - Hospital and Community Health Services (By Provider)	Corporate Senior Management Accountant	Corporate Senior Management Accountant
Note 5 - Family Health Services Expenditure	Senior Management Accountant	automatic
Note 6 - Adminstration Costs		Management Accountant
Note 7 - Other Non Clinical Services	Corporate Senior Management Accountant	Management Accountant
Note 8 - Operating Income	Corporate Senior Management Accountant	Senior Management Accountant
Note 9 - Analysis of Capital Expenditure		
Analysis of Capital Expenditure	Head of Financial Services	Financial Accountant
Summary of Capital Resource Outturn	Head of Financial Services	Financial Accountant
Note 10 - Intangible Assets	Head of Financial Services	Financial Accountant
Note 11a - Property, Plant & Equipment (Purchased Assets)	Head of Financial Services	Financial Accountant
Note 11b - Property, Plant & Equipment (Donated Assets)	Head of Financial Services	Financial Accountant
Note 11c - Assets held for sale	Head of Financial Services	Financial Accountant/Capital Finance Manager
Note 11d - Property, Plant & Equipment Disclosures	Head of Financial Services	Financial Accountant/Capital Finance Manager
Note 12 - Inventories	Head of Financial Services	Finance Officer
Note 13 - Trade and Other Receivables	Corporate Senior Management Accountant	Corporate Senior Management Accountant
Note 14 - Available for Sale Financial Assets	Corporate Senior Management Accountant	Corporate Senior Management Accountant
Note 15 - Cash and Cash Equivalents	Corporate Senior Management Accountant	Corporate Senior Management Accountant
Note 16 - Trade and Other Payables	Corporate Senior Management Accountant	Corporate Senior Management Accountant
Note 17 - Provisions	Corporate Senior Management Accountant	Management Accountant/Head of Financial Services
Note 18 - Movement on Working Capital Balances	Corporate Senior Management Accountant	automatic
Note 19 - Contingent Liabilities	Corporate Senior Management Accountant	Management Accountant
Note 20 - Events after the end of the Reporting Period	Head of Financial Services	Head of Financial Services
Note 21 - Commitments	Capital Finance Manager	Capital Finance Manager
Note 22 - Leases	Corporate Senior Management Accountant	Finance Manager/Management Accountant/Capital Finance Manager
Note 23a - PFI Contracts - Off Balance Sheet	Capital Finance Manager	Capital Finance Manager
Note 23b - PFI Contracts - On Balance Sheet	Capital Finance Manager	Capital Finance Manager
Note 24 - Pension Costs	Head of Financial Services	Business Support Officer
Note 25 - Exceptional Items and Prior Year adjustments	Head of Financial Services	Management Accountant
Note 26 - Restated Operating Cost Statement, Balance Sheet and Cash Flow Statement	Corporate Senior Management Accountant	Corporate Senior Management Accountant

NHS Tayside Annual Accounts 2016/17		
Financial Statements Preparation responsible officers	**Annual Accounts Lead Officer**	**Responsible Officer**
Note 27 - Financial Instruments	Capital Finance Manager	Capital Finance Manager
Note 28 - Derivative Financial Instruments	Head of Financial Services	Head of Financial Services
Note 29 - Related Party Transactions		
Endowments	Endowment Accountant	Endowment Accountant
Board members/Related Parties	Head of Financial Services	Business Support Officer
IJBs	Head of Financial Services	Head of Finance - Financial Planning & Operational Services/3 Chief Finance Officers
Note 30 - Segmental Information	Head of Financial Services	Corporate Senior Management Accountant
Note 31 - Third Party Assets	Head of Financial Services	automatic
Note 33 - Consolidation/Endowments	Head of Financial Services	Head of Financial Services/Endowment Accountant
-Consolidation/IJBs	Head of Financial Services	3 Chief Financial Officers
Accounts Direction	Head of Financial Services	
SFRs		
SFR 1.0 - Allocations from Scottish Executive	Head of Finance - Financial Planning & Operational Services	Corporate Senior Management Accountant
SFR 4.0 - Family Health Service Income	Senior Management Accountant	Senior Management Accountant
SFR 9.0 - Total Primary Medical Services	Senior Management Accountant	Senior Management Accountant
SFR 10.0 - Pharmaceutical Services	Senior Management Accountant	Senior Management Accountant
SFR 11.0 - General Dental Services	Senior Management Accountant	Senior Management Accountant
SFR 12.0 - General Ophthalmic Services	Senior Management Accountant	Senior Management Accountant
SFR 15.0 - Salaries & Wages Summary	Head of Financial Services	Financial Accountant
SFR 18.0 - Summary of Losses and Special Payments	Head of Financial Services	Finance Officer
SFR 18.1a - Details of Delegated Authority for Losses and Special Payments	Head of Financial Services	Management Accountant
SFR 18.1b - Details of Losses and Special Payments above Delegated Authority of NHS Board	Head of Financial Services	Management Accountant
SFR 18.1c - Details of Fraud, Embezzlement and other irregularities	Head of Financial Services	Head of Financial Services
SFR 19.0 - Patients Private Funds	Head of Financial Services	Financial Governance Accountant
SFR 30.0 - Balances with Other NHSScotland Bodies	Corporate Senior Management Accountant	Management Accountant
SFR 30.1 - Balances with Central Government Bodies	Corporate Senior Management Accountant	Management Accountant
SFR 30.2 - Balances with Whole of Government Bodies	Corporate Senior Management Accountant	Management Accountant
SFR 36.0 - Private Patients and Amenity Beds	Corporate Senior Management Accountant	Senior Management Accountant
SFR 37.0 - Disclosure on Leases	Head of Financial Services	Financial Accountant
Payment Policy	Head of Financial Services	Head of Financial Services
Resource and Cash Outturn	Head of Finance - Financial Planning & Operational Services	Corporate Senior Management Accountant
Sickness Absence	Head of Financial Services	Director of Human Resources & Organisational Development
Note		
Preparation of above notes includes responsibility for comparing prior year figures		
and providing explanations for any significant variances.		

Health Finance Directorate
Health Finance and Infrastructure Division

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Scottish Government
Riaghaltas na h-Alba
gov.scot

NHS Directors of Finance
Territorial Health Boards
Special Health Boards
Mental Welfare Commission

Issued by email

Our ref: A15920927

21 December 2016

Dear Colleague,

NHS Scotland Accounting Manuals 2016-17

I attach the Annual Accounts and Capital Accounting Manuals for 2016-17 as approved by the Technical Accounting Group at their meeting on 8 December 2016. These manuals interpret the accounting guidance contained in the Financial Reporting Manual (FReM) issued by HM Treasury. Please note that the manuals do not supersede the FReM and it is the responsibility of Boards to ensure that accounts are compliant with the FReM.

Summary of Changes

The Annual Accounts Manual has been reviewed and updated against the 2016-17 FReM, as published by HM Treasury in December 2015. There have been relatively few changes to the FReM and wider financial reporting requirements, and the main amendments to the Accounts Manual are as follows:

- Revision of the 'Sustainability and Environmental Reporting' guidance contained within the Performance Report. The new guidance makes reference to national reporting as mandated in the Climate Change (Scotland) Act 2009 and the subsequent order in 2015;
- Removal of requirement to report staff numbers and costs within note 2, in order to avoid duplication with the Remuneration and Staff Report;
- Insertion of a Parliamentary Accountability Statement into the Accountability Report in accordance with the FReM and requirements of the Scottish Public Finance Manual (SPFM); and
- Clarification on the number of signed copies of accounts to be provided to Scottish Government Health and Social Care Directorates – reduced to two from four.

INVESTOR IN PEOPLE
POSITIVE ABOUT DISABLED PEOPLE

There have been no significant amendments to the Capital Accounting Manual for 2016-17.

Final review of manuals – January 2017
A further meeting of the Annual Accounts Subgroup will be held in January 2017 to ensure that the manuals reflect all amendments set out in the FReM amendment record due to be published by HM Treasury this month. Boards will be advised as appropriate of any revisions to the manual or associated guidance.

Off-payroll Engagements
Please note that there is currently a review being carried out by Scottish Government regarding disclosure requirements to be made for off-payroll engagements. Boards will be advised as appropriate of the conclusion of this review and the disclosures to be set out in annual accounts.

Advice and Guidance
Advice and guidance on preparing accounts for 2016-17 is available to Boards through the Technical Accounting Group.

Pre-2010 provisions
The letter sent to Directors of Finance by Christine McLaughlin on 28 October requested notification of pre-2010 provisions which are currently held on Boards' balance sheets as DEL provisions and which Boards intend to score to AME in 2016-17. It has been noted as part of the work of the Technical Accounting Group that confirmation should be given by the Scottish Government that this accounting treatment is appropriate. This letter confirms the appropriateness of this accounting treatment, and that AME funding will be provided by the Scottish Government in 2016-17.

Issue of Template and Prior Year Figures
The Annual Accounts template will be issued in February 2017 once it has been reviewed and tested by members of the Annual Accounts sub-group.

SFR 30 – agreement of balances – contact details
As in previous years, the manual contains contact details for each Board to support the agreement of intra-NHSScotland (SFR 30) balances by communicated deadlines. To ensure that contact information is up-to-date for the final version of the manual to be issued in January, can I ask you to send any amendments to Bethany.Grieve@gov.scot by **20 January 2017.**

Yours sincerely

Richard McCallum
Deputy Director, Health Finance
cc: Christine McLaughlin, NHS Board Leads, NHSScotland Technical Accounting Group (TAG), Accounts Manual Review Group

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

Item Number 12

NHS Tayside

AUDIT21/2017
Audit Committee
9 March 2017

ACCOUNTING POLICIES

1. PURPOSE OF THE REPORT

The Audit Committee Terms of Reference require the Audit Committee to review, at least annually, the accounting policies and approve changes made. This report highlights the changes made to accounting policies for 2016/17.

2. RECOMMENDATIONS

The Audit Committee is asked to review and approve changes made to the accounting policies.

3. EXECUTIVE SUMMARY

The draft accounting policies note in respect of the 2016/17 annual accounts is attached at Appendix 1.

There are very few changes to the accounting policies note in the annual accounts. None are major. The changes applied are:-

- Section 1 - Disclosure of new Accounting Standards. The section should disclose Accounting Standards that have been issued or amended in the year but are not yet effective. As guidance is awaited on the final list the listing of Standards affected has been left blank at this stage.
- Section 2 – Basis of Consolidation. The note has been updated to reflect the consolidation into the accounts of the Integrated Joint Boards.
- Section 6.2 - Fixed Assets - Measurement – Revaluation. Sentence added to correct omission of treatment of temporary decreases in asset values.
- Section 7.2 - Intangible Fixed Assets - Measurement - Revaluation - two sentences removed as was repetition of previous two paragraphs and not required.

4. MEASURES FOR IMPROVEMENT

Not applicable.

5. CONTRIBUTION TO NHS TAYSIDE'S STRATEGIC AIMS

Not applicable.

6. HEALTH EQUITY

There are no direct implications arising from this report.

7. MEASURES FOR IMPROVEMENT

Not applicable.

8. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

The Director of Finance was consulted on the content of this paper prior to it being considered by the Audit Committee.

9. PATIENT EXPERIENCE

There are no direct implications arising from this report.

10. RESOURCE IMPLICATIONS

Financial
There are no financial implications to report.

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

11. RISK ASSESSMENT

No significant risks have been identified from the changes required.

12. LEGAL IMPLICATION

There are no direct implications arising from this report.

13. IMPLICATIONS FOR HEALTH

There are no direct implications arising from this report.

14. INFORMATION TECHNOLOGY IMPLICATIONS

There are no direct implications arising from this report.

15. HEALTH & SAFETY IMPLICATIONS

There are no direct implications arising from this report.

16. HEALTHCARE ASSOCIATED INFECTION (HAI)

There are no direct implications for healthcare associated infection arising from this report.

17. DELEGATION LEVEL

Not applicable.

18. TIMETABLE FOR IMPLEMENTATION AND LEAD OFFICER

The Lead Officer is the Director of Finance. Implementation of changes is effective from 1 April, 2016.

Frances Gibson
Head of Financial Services

Lindsay Bedford
Director of Finance

March 2017

TAYSIDE HEALTH BOARD

DRAFT ACCOUNTING POLICIES

NOTE 1

1. Authority

In accordance with the accounts direction issued by Scottish Ministers under section 19(4) of the Public Finance and Accountability (Scotland) Act 2000 appended, these Accounts have been prepared in accordance with the Government Financial Reporting Manual (FReM) issued by HM Treasury, which follows International Financial Reporting Standards as adopted by the European Union (IFRSs as adopted by the EU), International Financial Reporting Interpretations Committee (IFRIC) interpretations and the Companies Act 2006 to the extent that they are meaningful and appropriate to the public sector. They have been applied consistently in dealing with items considered material in relation to the accounts.

The preparation of financial statements in conformity with IFRS requires the use of certain critical accounting estimates. It also requires management to exercise its judgement in the process of applying the accounting policies. The areas involving a higher degree of judgement or complexity, or areas where assumptions and estimates are significant to the financial statements are disclosed in section 29 below.

(a) Disclosure of new accounting standards, amendments and interpretations

To be updated

(b) Standards, amendments and interpretation early adopted in 2016-17

There are no new standards, amendments or interpretations early adopted in 2016-17.

2. Basis of Consolidation

As directed by the Scottish Ministers and in accordance with International Accounting Standard 27, Separate Financial Statements, the financial statements consolidate the results of Tayside NHS Board Endowment Fund (operating as Tayside Health Fund). The basis of the consolidation used is merger accounting. Transactions between the Board and Tayside Health Fund are eliminated on consolidation as set out in Note 30 to the financial statements.

Tayside NHS Board Endowment Fund was established by the NHS (Scotland) Act 1978. The legal framework under which charities operate in Scotland is the Charities and Trustee Investment (Scotland) Act 2005. Under the 1978 Act Endowment Trustees are also members of the NHS Board. The Board members (who are also Trustees) are appointed by Scottish Ministers.

Tayside NHS Board Endowment Fund is registered with the Office of the Charity Regulator (OSCR). The accounts of the charity are prepared in accordance with the applicable UK accounting standards, the Statement of Recommended Practice – Accounting and Reporting by Charities (SORP 2015) and comply with the Charities and Trustee Investment (Scotland) Act 2005 and the Charities Accounts (Scotland) Regulations 2006.

The integration of health and social care services under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014 and associated secondary legislation impacts on Health Board disclosure requirements in the annual accounts.

In accordance with IAS 28 – Investments in Associates and Joint Arrangements, the primary financial statements have been amended for the additional disclosure required to accurately reflect the interest of IJBs using the equity method of accounting.

Note 33 to the Annual Accounts, details how these consolidated Financial Statements have been calculated.

3. Going Concern

The accounts are prepared on the going concern basis, which provides that the entity will continue in operational existence for the foreseeable future.

4. Accounting Convention

The Accounts are prepared on a historical cost basis, as modified by the revaluation of property, plant and equipment, intangible assets, inventories, available-for-sale financial assets and financial assets and liabilities (including derivative instruments) at fair value.

5. Funding

5.1 Tayside Health Board

Most of the expenditure of the Health Board as Commissioner is met from funds advanced by the Scottish Government within an approved revenue resource limit (RRL). Cash drawn down to fund expenditure within this approved revenue resource limit is credited to the general fund. All other income receivable by the Board that is not classed as funding is recognised in the year in which it is receivable. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Brokerage is additional funding advanced to the Board by the Scottish Government, but which is repayable in future years. The cash drawn down is credited to the general fund.

Income from the sale of non-current assets is recognised only when all material conditions of the sale have been met, and is measured as the sums due under the sale contract.

Non discretionary funding outwith the RRL is allocated to match actual expenditure incurred for the provision of specific pharmaceutical, dental or ophthalmic services identified by the Scottish Government. Non discretionary expenditure is disclosed in the accounts and deducted from operating costs charged against the RRL in the Statement of Resource Outturn.

Funding for the acquisition of capital assets received from the Scottish Government is credited to the general fund when cash is drawn down.

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in the Statement of Comprehensive Net Expenditure except where it results in the creation of a non-current asset such as property, plant and equipment in which case it is recognised in the Balance Sheet.

5.2 Tayside Health Fund

Voluntary income from donations, gifts and legacies is recognised when Tayside Health Fund is entitled to regard such income as receivable. Investment income is stated gross of taxation recoverable and is accounted for on an accruals basis.

Expenditure is accounted for on an accruals basis and is recognised once there is a legal or constructive obligation committing the charity to the expenditure.

6. Property, Plant and Equipment

The treatment of non-current assets in the financial statements (capitalisation, valuation, depreciation, particulars concerning donated assets) is in accordance with the NHS Capital Accounting Manual.

Title to properties included in the accounts is held by Scottish Ministers.

6.1 Recognition

Property, Plant and Equipment is capitalised where: it is held for use in delivering services or for administrative purposes; it is probable that future economic benefits will flow to, or service potential be provided to, the Board; it is expected to be used for more than one financial year; and the cost of the item can be measured reliably.

All assets falling into the following categories are capitalised:-

1) Property, plant and equipment assets which are capable of being used for a period which could exceed one year, and have a cost equal to or greater than £5,000.
2) In cases where a new hospital would face an exceptional write off of items of equipment costing individually less than £5,000, the Board has the option to capitalise initial revenue equipment costs with a standard life of 10 years.

3) Assets of lesser value may be capitalised where they form part of a group of similar assets purchased at approximately the same time and cost over £20,000 in total, or where they are part of the initial costs of equipping a new development and total over £20,000.

6.2 Measurement

Valuation:
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are subsequently measured at fair value as follows:-

Specialised NHS land, buildings, equipment, installations and fittings are stated at depreciated replacement cost, as a proxy for fair value as specified in the FReM.

Non specialised land and buildings, such as offices, are stated at fair value.

Valuations of all land and buildings assets within Tayside Health Board have been reassessed as at 31 January 2016 by a consortium of independent professional valuers appointed by the Board. The valuers have stated that there will only be a nominal difference in valuation between 31 January 2016 and 31 March 2016. The valuations are carried out in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Scottish Government.

Non specialised equipment, installations and fittings are valued at fair value. The Board values such assets using the most appropriate valuation methodology available (for example, appropriate indices). A depreciated historical cost basis is used as a proxy for fair value in respect of such assets which have short useful lives or low values (or both).

Assets under construction are valued at current cost. This is calculated by the expenditure incurred to which an appropriate index is applied to arrive at current value. These are also subject to impairment review.

To meet the underlying objectives established by the Scottish Government the following accepted variations of the RICS Appraisal and Valuation Manual have been required:

Specialised operational assets are valued on a modified replacement cost basis to take account of modern substitute building materials and locality factors only. Operational assets which are in use delivering front line services or back office functions, and surplus assets with restrictions on their disposal, are valued at current value in use. Assets have been assessed as surplus where there is no clear plan to bring the asset back into future use as an operational asset.

Subsequent expenditure:
Subsequent expenditure is capitalised into an asset's carrying value when it is probable the future economic benefits associated with the item will flow to the Board and the cost can be measured reliably. Where subsequent expenditure does not meet these criteria the expenditure is charged to the Statement of Comprehensive Net Expenditure. If part of an asset is replaced, then the part it replaces is de-recognised, regardless of whether or not it has been depreciated separately.

Revaluations and Impairment:
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in the Statement of Comprehensive Net Expenditure, in which case they are recognised as income. Movements on revaluation are considered for individual assets rather than groups of land/buildings together.

Permanent decreases in asset values and impairments are charged gross to the Statement of Comprehensive Net Expenditure. Any related balance on the revaluation reserve is transferred to the General Fund.

Temporary decreases in asset values or impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to the Statement of Comprehensive Net Expenditure.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Net Expenditure.

6.3 Depreciation

Items of Property, Plant and Equipment are depreciated to their estimated residual value over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Depreciation is charged on each main class of tangible asset as follows:-

1) Freehold land is considered to have an infinite life and is not depreciated.

2) Assets in the course of construction and residual interests in off-balance sheet PFI contract assets are not depreciated until the asset is brought into use or reverts to the Board, respectively.

3) Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification.

4) Buildings, installations and fittings are depreciated on current value over the estimated remaining life of the asset, as advised by the appointed valuer. They are assessed in the context of the maximum useful lives for building elements.

5) Equipment is depreciated over the estimated life of the asset.

6) Property, plant and equipment held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

Depreciation is charged on a straight line basis. The following asset lives have been used:

Asset Category/Component	Useful Life (years)
Structure	25-100
Engineering	25-70
External Plant	25-50
Medical Equipment	3-15
Catering Equipment	5-15
General Equipment	4-15
Furniture	8-12
Fire Prevention Equipment	12-18
Mainframe information technology installations	2-8
Medical furniture	7-15
Telecommunication system	3-8
Vehicles	4-17
Initial Revenue Miscellaneous Equipment	10
Landscaping	15-30
Services	10-31
Surfacing	5-15
Fixed Plant	10-25
Internal upgrade to fabric of building	12-25

7. Intangible Assets

7.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Board's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Board and where the cost of the asset can be measured reliably.

Intangible assets that meet the recognition criteria are capitalised when they are capable of being used in a Board's activities for more than one year and they have a cost of at least £5,000.

The main classes of intangible assets recognised are software licences and information technology software.

Internally generated intangible assets
Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Board intends to complete the asset and sell or use it;
- the Board has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Board to complete the development and sell or use the asset; and
- the Board can measure reliably the expenses attributable to the asset during development.

Expenditure so deferred is limited to the value of future benefits.

Software
Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Software licences
Purchased computer software licences are capitalised as intangible assets where expenditure of at least £5,000 is incurred.

7.2 Measurement

Valuation:
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Where an active (homogeneous) market exists, intangible assets are carried at fair value. Where no active market exists, the intangible asset is revalued, using indices or some suitable model, to the lower of depreciated replacement cost and value in use where the asset is income generating. Where there is no value in use, the intangible asset is valued using depreciated replacement cost. These measures are a proxy for fair value.

Revaluation and impairment:
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in the Statement of Comprehensive Net Expenditure, in which case they are recognised in income.

Permanent decreases in asset values and impairments are charged gross to the Statement of Comprehensive Net Expenditure. Any related balance on the revaluation reserve is transferred to the General Fund.

Temporary decreases in asset values or impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to the Statement of Comprehensive Net Expenditure.

Intangible assets held for sale are reclassified to ‘non-current assets held for sale’ measured at the lower of their carrying amount or ‘fair value less costs to sell’.

7.3 Amortisation

Intangible assets are amortised to their estimated residual value over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Amortisation is charged to the Statement of Comprehensive Net Expenditure on each main class of intangible asset as follows:-

1) Software. Amortised over their expected useful life

2) Software licences. Amortised over the shorter term of the licence and their useful economic lives.

3) Intangible assets which has been reclassified as ‘Held for Sale’ ceases to be amortised upon the reclassification.

Amortisation is charged on a straight line basis. The following asset lives have been used:-

Asset Category/Component	Useful Life (years)
Software	5
Software Licences	5

8. Non-current Assets Held for Sale

Non-current assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:-

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales, and
- the sale must be highly probable, i.e.
    - management are committed to a plan to sell the asset;
    - an active programme has begun to find a buyer and complete the sale;
    - the asset is being actively marketed at a reasonable price;
    - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale', and
    - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.
-

Immediately before reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

9. Donated Assets

Non-current assets that are donated or purchased using donated funds are included in the Balance Sheet initially at the current full replacement cost of the asset. The accounting treatment, including the method of valuation, follows the rules in the NHS Capital Accounting Manual.

Properties held for investment by Tayside NHS Board Endowment Fund are stated at current market value and are revalued annually by professional independent valuers with any resulting surplus or deficit credited or charged to income or expenditure.

10. Sale of Property, Plant and Equipment, Intangible Assets and Non-current Assets Held for Sale

Disposal of non-current assets is accounted for as a reduction to the value of assets equal to the net book value of the assets disposed. When set against any sales proceeds, the resulting gain or loss on disposal will be recorded in the Statement of Comprehensive Net Expenditure. Non-current assets held for sale will include assets transferred from other categories and will reflect any resultant changes in valuation.

11. Leasing

Finance Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Board, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are initially recognised is the lower of the fair

value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability. Assets held under finance leases are valued at their fair values and are depreciated over the remaining period of the lease in accordance with IFRS.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to interest payable in the Statement of Comprehensive Net Expenditure.

Operating Leases
Other leases are regarded as operating leases and the rentals are charged to expenditure on a straight-line basis over the term of the lease.

Leases of Land and Buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease unless title to the land is expected to transfer.

Leasing of Board Assets to Other Bodies
Income received from leasing assets to other bodies is accounted for as it falls due.

12. Impairment of Non-financial Assets

Assets that are subject to depreciation and amortisation are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use. Where an asset is not held for the purpose of generating cash flows, value in use is assumed to equal the cost of replacing the service potential provided by the asset, unless there has been a reduction in service potential. For the purposes of assessing impairment, assets are grouped at the lowest levels for which there are separately identifiable cash flows (cash-generating units). Non-financial assets that suffer an impairment are reviewed for possible reversal of the impairment. Impairment losses charged to the Statement of Comprehensive Net Expenditure are deducted from future operating costs to the extent that they are identified as being reversed in subsequent revaluations.

13. General Fund Receivables and Payables

Where the Health Board has a positive net cash book balance at the year end, a corresponding creditor is created and the general fund debited with the same amount to indicate that this cash is repayable to SGHSCD. Where the Health Board has a net overdrawn cash position at the year end, a corresponding debtor is created and the general fund credited with the same amount to indicate that additional cash is to be drawn down from SGHSCD.

14. Inventories

Inventories are valued at the lower of cost and net realisable value. Taking into account the high turnover of NHS inventories, the use of average purchase price is deemed to represent current cost. Work in progress is valued at the cost of the direct materials plus the conversion costs and other costs incurred to bring the goods up to their present location, condition and degree of completion.

15. Losses and Special Payments

Operating expenditure includes certain losses which would have been made good through insurance cover had the NHS not been bearing its own risks. Had the NHS provided insurance cover, the insurance premiums would have been included as normal revenue expenditure.

16. Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the year in which the service is received from employees. The cost of annual leave and flexible working time entitlement earned but not taken by employees at the end of the year is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following year.

Pension Costs

The Board participates in the NHS Superannuation Scheme for Scotland providing defined benefits based on final pensionable pay, where contributions are credited to the Exchequer and are deemed to be invested in a portfolio of Government Securities. The Board is unable to identify its share of the underlying notional assets and liabilities of the scheme on a consistent and reasonable basis and therefore accounts for the scheme as if it were a defined contribution scheme, as required by IAS 19 'Employee Benefits'. As a result, the amount charged to the Statement of Comprehensive Net Expenditure represents the Board's employer contributions payable to the scheme in respect of the year. The contributions deducted from employees are reflected in the gross salaries charged and are similarly remitted to Exchequer. The pension cost is assessed every five years by the Government Actuary and determines the rate of contributions required. The most recent actuarial valuation is published by the Scottish Public Pensions Agency and is available on their website.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the Statement of Comprehensive Net Expenditure at the time the Board commits itself to the retirement, regardless of the method of payment.

17. Clinical and Medical Negligence Costs

Employing health bodies in Scotland are responsible for meeting medical negligence costs up to a threshold per claim. Costs above this threshold are reimbursed to Boards from a central fund held as part of the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) by the Scottish Government.

The Board provides for all claims notified to the NHS Central Legal Office according to the value of the claim and the probability of settlement. Claims assessed as 'Category 3' are deemed most likely and provided for in full, those in 'Category 2' as 50% of the claim and those in 'Category 1' as 10%. The balance of the value of claims not provided for is disclosed as a contingent liability. This procedure is intended to estimate the amount considered to be the liability in respect of any claims outstanding and which will be recoverable from the Clinical Negligence and Other Risks Indemnity Scheme in the event of payment by an individual health body. The corresponding recovery in respect of amounts provided for is recorded as a debtor and that in respect of amounts disclosed as contingent liabilities are disclosed as contingent assets. The Board also provides for its respective share of the total liability of NHS Scotland as advised by the Scottish Government, based on information prepared by NHS Boards and the Central Legal Office.

18. Related Party Transactions

Material related party transactions are disclosed in the Note 27 in line with the requirements of IAS 24. Transactions with other NHS bodies for the commissioning of health care are summarised in Note 4.

19. Value Added Tax

Most of the activities of the Board are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

20. PFI/HUB/NPD Schemes

Transactions financed as revenue transactions through the Private Finance Initiative or alternatives, such as HUB or the Non Profit Distributing Model (NPD) are accounted for in accordance with IFRIC 12, *Service Concession Arrangements,* which sets out how they should be accounted for in the private sector and outlined in the FReM.

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-balance sheet' by the Board. The underlying assets are recognised as Property, Plant and Equipment and Intangible Assets at their fair value. An equivalent liability is recognised in accordance with IAS 17. Where it is not possible to separate the finance element from the service element of unitary payment streams this has been estimated from information provided by the operator and the fair values of the underlying assets. Assets are subsequently revalued in accordance with the treatment specified for their applicable asset categories.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The finance cost is calculated using the implicit interest rate for the scheme.

The service charge and the finance cost interest element are charged in the Statement of Comprehensive Net Expenditure.

21. Provisions

The Board provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated cash flows are discounted using the discount rate prescribed by HM Treasury.

22. Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Board's control) are not recognised as assets, but are disclosed in Note 19 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 19, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:-

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control, or

- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

23. Corresponding Amounts

Corresponding amounts are shown for the primary statements and notes to the financial statements. Where the corresponding amounts are not directly comparable with the amount to be shown in respect of the current financial year, IAS 1 'Presentation of Financial Statements', requires that they should be adjusted and the basis for adjustment disclosed in a note to the financial statements.

24. Financial Instruments

Financial Assets
Classification

The Board classifies its financial assets in the following categories: at fair value through profit or loss, loans and receivables, and available for sale. The classification depends on the purpose for which the financial assets were acquired. Management determines the classification of its financial assets at initial recognition.

(a) Financial assets at fair value through profit or loss

Financial assets at fair value through profit or loss comprise derivatives. Assets in this category are classified as current assets. The Board does not trade in derivatives and does not apply hedge accounting.

(b) Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. They are included in current assets, except for maturities greater than 12 months after the balance sheet date. These are classified as non-current assets. Loans and receivables comprise trade and other receivables and cash at bank and in hand in the balance sheet.

(c) Available-for-sale financial assets

Available-for-sale financial assets are non-derivatives that are either designated in this category or not classified in any of the other categories. They are included in non-current assets unless management intends to dispose of the investment within 12 months of the balance sheet date. Available for sale financial assets comprise investments.

Recognition and measurement

Financial assets are recognised when the Board becomes party to the contractual provisions of the financial instrument.

Financial assets are derecognised when the rights to receive cash flows from the asset have expired or have been transferred and the Board has transferred substantially all risks and rewards of ownership.

(a) Financial assets at fair value through profit or loss

Financial assets carried at fair value through profit or loss are initially recognised at fair value, and transaction costs are expensed in the Statement of Comprehensive Net Expenditure.

Financial assets carried at fair value through profit or loss are subsequently measured at fair value. Gains or losses arising from changes in the fair value are presented in the Statement of Comprehensive Net Expenditure.

(b) Loans and receivables

Loans and receivables are recognised initially at fair value and subsequently measured at amortised cost using the effective interest method, less provision for impairment. A provision for impairment of loans and receivables is established when there is objective evidence that the Board will not be able to collect all amounts due according to the original terms of the receivables. Significant financial difficulties of the debtor, probability that the debtor will enter bankruptcy or financial reorganisation, and default or delinquency in payments (more than 30 days overdue) are considered indicators that the loan and receivable is impaired. The amount of the provision is the difference between the asset's carrying amount and the present value of estimated future cash flows, discounted at the original effective interest rate. The carrying amount of the asset is reduced through the use of an allowance account, and the amount of the loss is recognised in the Statement of Comprehensive Net Expenditure. When a loan or receivable is uncollectible, it is written off against the allowance account. Subsequent recoveries of amounts previously written off are credited in the Statement of Comprehensive Net Expenditure.

(c) Available-for-sale financial assets

Available-for-sale financial assets are initially recognised and subsequently carried at fair value. Changes in the fair value of financial assets classified as available for sale are recognised in equity in other reserves. When financial assets classified as available for sale are sold or impaired, the accumulated fair value adjustments recognised in equity are included in the Statement of Comprehensive Net Expenditure. Dividends on available-for-sale equity instruments are recognised in the Statement of Comprehensive Net Expenditure when the Board's right to receive payments is established.

Investments in equity instruments that do not have a quoted market price in an active market and whose fair value cannot be reliably measured are measured at cost less impairment.

The Board assesses at each balance sheet date whether there is objective evidence that a financial asset or a group of financial assets is impaired. In the case of equity securities classified as available for sale, a significant or prolonged decline in the fair value of the security below its cost is considered as an indicator that the securities are impaired. If any such evidence exists for available-for-sale financial assets, the cumulative loss – measured as the difference between the acquisition cost and the current fair value, less any impairment loss on that financial asset previously recognised in profit or loss – is removed from equity and recognised in the Statement of Comprehensive Net Expenditure. Impairment losses recognised in the Statement of Comprehensive Net Expenditure on equity instruments are not reversed through the income statement.

Financial Liabilities

Classification

The Board classifies its financial liabilities in the following categories: at fair value through profit or loss, and other financial liabilities. The classification depends on the purpose for which the financial liabilities were issued. Management determines the classification of its financial liabilities at initial recognition.

(a) Financial liabilities at fair value through profit or loss

Financial liabilities at fair value through profit or loss comprise derivatives. Liabilities in this category are classified as current liabilities. The NHS Board does not trade in derivatives and does not apply hedge accounting.

(b) Other financial liabilities

Other financial liabilities are included in current liabilities, except for maturities greater than 12 months after the balance sheet date. These are classified as non-current liabilities. The NHS Board's other financial liabilities comprise trade and other payables in the balance sheet.

Recognition and measurement
Financial liabilities are recognised when the NHS Board Scotland becomes party to the contractual provisions of the financial instrument.

A financial liability is removed from the balance sheet when it is extinguished, that is when the obligation is discharged, cancelled or expired.

(a) Financial liabilities at fair value through profit or loss

Financial liabilities carried at fair value through profit or loss are initially recognised at fair value, and transaction costs are expensed in the income statement.

Financial liabilities carried at fair value through profit or loss are subsequently measured at fair value. Gains or losses arising from changes in the fair value are presented in the Statement of Comprehensive Net Expenditure.

(b) Other financial liabilities

Other financial liabilities are recognised initially at fair value and subsequently measured at amortised cost using the effective interest method.

25. Segmental reporting

Operating segments are reported in a manner consistent with the internal reporting provided to the chief operating decision-maker, who is responsible for allocating resources and assessing performance of the operating segments. This has been identified as the senior management of the Board.

Operating segments are unlikely to directly relate to the analysis of expenditure shown in notes 4 to 7 for Hospital & Community, Family Health and Other Service and Administration Costs, the basis of which relates to Scottish Government funding streams and the classification of which varies depending on Scottish Government reporting requirements.

26. Cash and Cash Equivalents

Cash and cash equivalents includes cash in hand, deposits held with banks, cash balances held with the Government Banking Service, balances held in commercial banks and other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts. Bank overdrafts are shown within borrowings in current liabilities on the balance sheet. Where the Government Banking Service is using Citibank and Royal Bank of Scotland Group to provide the banking services, funds held in these accounts should not be classed as commercial bank balances.

27. Foreign Exchange

The functional and presentational currencies of the Board are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Board has assets or liabilities denominated in a foreign currency at the balance sheet date:-

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;

- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction, and

- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the balance sheet date) are recognised in income or expenditure in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

28. Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Board has no beneficial interest in them. However, they are disclosed in Note 29 to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

29. Key Sources of Judgement and Estimation Uncertainty

Estimates and judgements are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

The Board makes estimates and assumptions concerning the future. The resulting accounting estimates will, by definition, seldom equal the related actual results. The Board makes judgements in applying accounting policies. The estimates, assumptions and judgements that have a significant risk of a causing material adjustment to the carrying amounts of assets and liabilities within the financial statements within the next financial year are addressed below.

Clinical and Medical Negligence Costs
The Board's accounting policy relating to the provisions for clinical and medical negligence and other claims is described in section 17 above.

Pension Provision
The pension provision is calculated using information received from the Scottish Public Pension Agency (SPPA) relating to former Board employees for whom the Board has an ongoing pension liability. The provision is calculated using information obtained from SPPA and applicable discount rates for future payments are provided by HM Treasury.

Pay Accruals
The holiday pay and flexible working hours accrual is based on an historic analysis of payroll data adjusted for in year movements in staff numbers, pay awards and the amount of leave taken in the year as recorded in the payroll system. The general pay accrual recognises the Board's commitment to future payments in respect of Agenda for Change reviews, public holidays during maternity leave and unsocial hours entitlement during periods of annual leave.

Assessment of Leases
Leases are assessed under IFRS as being operating or finance leases, which determines their accounting treatment. The criteria for assessment are to a certain extent subjective, but a consistent approach has been taken through use of a standard template which sets out the relevant criteria.

Valuation of Estate
The land and buildings held by the Board are revalued annually by independent valuers. Judgements are made about the status of property which affects the valuation methodology.

Item Number 13

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

AUDIT17/2017
Audit Committee
9 March 2017

COMPLIANCE WITH SCOTTISH GOVERNMENT WORKFORCE DIRECTORATE CIRCULARS AND NHS TAYSIDE EMPLOYMENT POLICIES

1. SITUATION AND BACKGROUND

This paper seeks to provide some detail for the Audit Committee as to how NHS Tayside will assure itself in relation to compliance with circulars issued by the Health Workforce and Strategic Change Directorate of the Scottish Government and compliance with existing NHS Tayside employment policies.

2. ASSESSMENT

It has been highlighted that NHS Tayside requires a process which confirms that suitable arrangements are in place to ensure compliance with recently issued workforce circulars. In addition once Human Resource policies are implemented following their issue by circular that there is a process to ensure organisational compliance with the policy requirements.

The Human Resource Directorate has tested audit processes to address these separate issues. Attached to this paper, as Appendix 1, is the HR Audit Assessment Form. When a relevant circular is issued by the Workforce Directorate of the Scottish Government this form would be completed by the Director of Human Resources & Organisational Development, or senior Human Resources & OD representative. This Form would enable any changes to current employment practice to be highlighted and allow consideration of how any changes will be communicated. In addition the Form identifies risks to the organisation if adherence to the circular is not achieved and how implementation will be audited. This Form would be implemented with immediate effect. Copies of the completed Form would be retained by the Director of Human Resources & Organisational Development.

In relation to employment policy the Director of Human Resources & Organisational Development will agree a programme of policy compliance audit via the Staff Governance Committee. This programme will allow NHS Tayside to seek demonstrable evidence that managers are discharging their people management duties in compliance with the relevant employment policy. The outcomes of the compliance audit will be shared with the Area Partnership forum and the Staff Governance Committee. A separate paper detailing the areas for audit will be submitted to the March meeting of the Staff Governance Committee.

3. RECOMMENDATIONS

The Audit Committee are asked to note progress in relation to the actions detailed in the Report.

A further update on progress on implementation will be brought to a future Staff Governance Committee meeting.

4. REPORT SIGN OFF

Christopher J Smith
Associate Director of Human Resources
& Organisational Development

Lindsay Bedford
Director of Finance

George Doherty
Director of Human Resources
& Organisational Development

March 2016

HR Audit Assessment Form

To be completed by HR Director or delegated responsibility prior to communicating changed terms and conditions or employment law to line managers. This is in order to assess whether subsequent audit of line manager practice is required.

State the changed legislation or terms and conditions. (For terms and conditions consider DLs, STAC (TCS), PIN Policies, CELs and PCS)

1) Does implementation of the new t&cs or employment legislation require a new practice from line managers or a change to current practice of line managers? **Yes/No**

   If "No" then no further action is required in relation to audit of line manager practice.
   If "Yes" complete questions 2) to 7)

2) State the specific line manager practice that will be necessary for the t&cs or legislation to be correctly implemented. Complete questions 2) to 7) for each separate line manager practice

3) What process will be in place to ensure that all line managers responsible for implementation of changed t&cs or legislation are **informed** of the new/changed practice and how will it be verified that managers have been informed?

   _____

4) What process will be in place to ensure that all line managers responsible for implementation of new or changed t&cs or legislation **understand** the revised t&cs or legislation and how will it be verified that managers understand?

   _____

5) What are the risks, including financial risk, of any line manager failure to implement the t&cs/legislative change?

   _____

6) Is audit of line manager practice both necessary and possible in order to verify implementation of the t&cs/legislation? **Yes/No**

7) If no audit of line manager practice required why not?

   _____

   If yes what system or process of audit will be implemented to provide assurance that a new line manager practice or a changed line manager practice has happened?

T&Cs or Legislation	How to verify t&cs or legislation is being applied by line managers	Timescale/Frequency

Signed.....Date.....

Minute NHS Tayside

STRATEGIC RISK MANAGEMENT GROUP

Minute of the above meeting held at 1pm on Monday 24 November 2016 in the Board Room, Ninewells Hospital.

Present

Members

Ms Karen Anderson	Director of Allied Health Professions (AHPs), NHS Tayside
Mr Lindsay Bedford	Director of Finance, NHS Tayside
Mrs Gillian Costello	Nurse Director, NHS Tayside
Ms Margaret Dunning	Board Secretary, NHS Tayside **(Chair)**
Professor Andrew Russell	Medical Director, NHS Tayside
Mrs Hilary Walker	Risk Manager, NHS Tayside

In Attendance

Ms Alison Hodge	Committee Support Officer, NHS Tayside
Miss Donna Howey	Head of Committee Administration, NHS Tayside
Dr Gabby Phillips	Lead Infection Control Doctor, NHS Tayside
Ms Lesley Wilson	Clinical Governance and Risk Management Administrator, NHS Tayside

Apologies

Ms Jenny Bodie	Director of eHealth, NHS Tayside
Mr George Doherty	Director of Human Resources and OD, NHS Tayside
Mrs Judith Golden	Employee Director, NHS Tayside
Ms Elisabeth Leslie	Head of Resilience, NHS Tayside
Ms Lesley McLay	Chief Executive, NHS Tayside
Ms Arlene Napier	Associate Director, Clinical Governance and Risk, NHS Tayside
Mr Bill Nicoll	Director of Strategic Change, NHS Tayside
Mrs Karen Ozden	Director of Mental Health /Associate Nurse Director, NHS Tayside
Ms Frances Rooney	Director of Pharmacy, NHS Tayside
Dr Drew Walker	Director of Public Health, NHS Tayside
Dr Michelle Watts	Associate Medical Director, Primary Care, NHS Tayside
Ms Lorna Wiggin	Chief Operating Officer, NHS Tayside
Dr Peter Williamson	Director of Health and Care Strategy, NHS Tayside

Ms Margaret Dunning in the Chair

1 Welcome and Introduction **ACTION**

Ms Dunning welcomed everyone to the meeting. She thanked those present for their attendance acknowledging that the meeting scheduled for 3 November 2016 had been postponed.

Ms Dunning advised that Item 10.1 had been removed, as on reflection, this report was a summary of workshop and not a minute from a meeting of the Datix Implementation Group.

2 Apologies

Apologies were noted as above.

3 Minute of the last meeting

3.1 Minute of the Strategic Risk Management Group 15 August 2016

There were no comments relating to the minute of the meeting held on 15 August 2016.

The SRMG:

- Agreed the Minute of the Strategic Risk Management Group 7 April 2016 was an accurate record of the meeting

3.2 Action Points Update Strategic Risk Management Group 24 November 2016

1. Clinical Governance and Risk Management Update
Confirmation required on the relevance of this update to the SRMG

Ms Walker advised that the Clinical Governance and Risk Management Update had been discussed with Internal Audit. It was agreed that the report contained a degree of operational detail that was not required by the SRMG. Going forward the SRMG would receive a mid-year and annual report on Clinical Governance and Risk Management for endorsement prior to presentation for approval by the Audit Committee. This change will be reflected in both the SRMG workplan and risk management workplan for 2017-18. **Committee Support Officer**

2. Operational Risks
The template for reporting strategic risk to be updated to include Operational risks

Ms Walker confirmed that the template and associated guidance would be updated. The Finance and Resources Committee had included an update on operational risks within the risk assurance reports at their last meeting on 17 November 2016. Ms Walker advised that the Finance and Resources Committee risk assurance reports would be provided as an example when the template was updated.

The SRMG:

- Noted the action points update

3.3 Matters Arising

There were no matters arising.

4 RISK MANAGEMENT

4.1 Risk Management Mid Year Report

Ms Walker introduced this report and advised that this report was presented to the SRMG today for comments prior to being considered at the Audit Committee on 20 December 2016.

Ms Walker highlighted a minor amendment to section 3 in the executive summary, final paragraph should state '... demonstrates adequate and effective arrangements for **Risk Management** have remained in place within NHS Tayside'.

Within the report there were references to CHP's Mrs Walker agreed to update this with Health and Social Care Partnerships. **H Walker**

There were no further comments in relation to this report.

The SRMG:

- Reviewed and approved the Risk Management Mid Year Report 2016
- Requested amendments as described above

5 STRATEGIC RISKS

It was noted that strategic risks were currently reported at each meeting of the Board Standing Committees and the Board Assurance Framework (BAF) was presented to the Tayside NHS Board quarterly. Also that the format of the BAF was currently being updated to ensure it provided the right level of information but in a more succinct format. Ms Walker commented that she was working with the Board Secretary, Mr Doug Cross, Non Executive member of Tayside NHS Board and Internal Audit on the risk appetite statement and to agree a risk appetite model that would work for NHS Tayside. This work is based on information shared from other NHS Boards. When the work is complete, a report will be produced for the SRMG for discussion and agreement prior to presentation the Audit Committee requesting approval for Tayside NHS Board adoption.

Ms Dunning advised that the approach being considered was an approach based on only providing Risk Assurance reports on those risks that fall out with the agreed Risk Appetite. It was acknowledged that the portfolio of risks was growing and the intention would be to reduce the number of risks that were reported to Standing Committees.

Professor Russell commented that the Maternity Risk was considered in Reserved Business of the Clinical and Care Governance Committee due to the level of detail and management data included in the report. It was agreed that further work was required on the level of detail contained in the Risk Assurance reports. Ms Dunning and Ms Walker agreed to take this forward and would use the Maternity Risk Assurance Report as an example in training sessions. **M Dunning/ H Walker**

It was recognised that there might be a requirement for further training in relation to the completion of risk assurance reports and awareness of the importance of the Standing Committee process in the overall risk management assurance system.

The Chair requested the risk owners/ managers provide a brief exception report on their strategic risk(s)

Strategic Risks aligned with the Tayside NHS Board

14 Infection Management

Owner – G Costello, A Russell
Manager – D Weir

Dr Gabby Phillips was in attendance. She highlighted concern that the information contained within the BAF was too generic.

Following discussion it was agreed that:

- The concerns raised by Dr Phillips should be reported at the HAI Infrastructure Risks Short Life Working Group
- It may be necessary for the Terms of Reference for this group to be revisited
- Consideration should be given to work being commissioned by the Short Life Working Group
- Any further strategic risks identified would be agreed by the SRMG

There was a further short discussion on options on the preferred format of a group to consider infection control. Dr Phillips was in favour of the reinstatement of the Infection Control Committee with the addition of a project team and workstreams. It was acknowledged that there would be resource requirements, which would need to be agreed. It was noted that other NHS Boards had an Infection Control Committee. Mrs Costello agreed to update Ms Wiggin regarding this discussion. **G Costello**

26 Waiting Times and RTT Targets

Owner – L Wiggin
Manager – S Lowry

There was no representative at the meeting to provide an exception report.

The Chair requested that a written update was obtained from the risk owner and circulated to the SRMG for information. **Committee Support Officer**

201 Health Equity

Owner – D Walker
Manager – H Scott

There was no representative at the meeting to provide an exception report however a written update had been provided and the most recent major activity was as follows:

- The Directorate of Public Health has been fully engaged with each of the three IJB's to ensure that the Strategic and Commissioning Plans address the issue of health inequality.
- Each of these plans in have now been presented and signed off by their respective IJB's
- Perth and Kinross IJB are currently drafting a supplementary Health Inequalities Action Plan. The Perth and Kinross IJB senior planning officers are to agree the content of this with Drew Walker and Hazel Scott in December before it is presented to both the Perth and Kinross HSC Integrated Joint Board and the Perth and Kinross Council Housing and Health Committees in January for their agreement.
- The Public Health Directorate have been fully engaged to support the production of Dundee Partnership Fairness Commission Action Plan 2017-2020
- The Benefit Reform agenda is been closely considered to assess the impact on the local population and its potential impact on widening the health inequality gap

312 NHS Tayside Estates Infrastructure Condition

Owner – L Wiggin
Manager – M Anderson
There was no representative at the meeting to provide an exception report.

The Chair requested that a written update was obtained from the risk owner and circulated to the SRMG for information. **Committee Support Officer**

313 Capacity and Flow (Winter Plan)

Owner – L McLay
Manager – L Wiggin

There was no representative at the meeting to provide an exception report.

The Chair requested that a written update was obtained from the risk owner and circulated to the SRMG for information.

Committee Support Officer

353 Sustainable Primary Care Services

Owner – V Irons
Manager – J Galloway
There was no representative at the meeting to provide an exception report.

The Chair requested that a written update was obtained from the risk owner and circulated to the SRMG for information.

Committee Support Officer

Strategic Risks aligned with the Finance and Resources Committee

36 Strategic Financial Plan 2015/16 - 2019/20

Owner – L McLay
Manager – L Bedford

37 Impact of Reduction in Capital Resources

Owner – L McLay
Manager – L Bedford

Mr Bedford provided an update on both risks.

He advised that the most up to date position with both of these risks had been reported at the Finance and Resources Committee (F&R) on 16 November 2016. The assurance reports also included an update on the relevant operational risks and this format for reporting on operational risks would now be rolled out to the other Standing Committees.

38 Information Governance Risk

Owner – M Dunning
Manager – A Dailly

Ms Dunning advised that this strategic risk had also been reported to the Finance and Resources Committee on 16 November 2016. She noted that there had been a full discussion on the recent gap analysis undertaken and that there was a commitment to develop an improvement plan which would be monitored by the Information Governance Team and reported on through the strategic risk reporting to the Finance and resources Committee.

415 Implementation of TrakCare

Owner – J Bodie
Manager – A Graham

Mr Bedford advised that this risk would be reported at the next Finance and Resources Committee on 19 January 2017. Ms Dunning commented that Ms Leslie was trying to seek assurance from the TrakCare Programme Board regarding the required Business Continuity Planning for this project.

Strategic Risks aligned with the Staff Governance Committee

58 Workforce Optimisation

Owner – G Doherty
Manager – J Mudie

95 Medical Workforce

Owner – G Doherty
Manager – J Mudie

There was no representative at the meeting to provide an exception report.

By way of an update Mr Doherty had provided Risk Assurance reports for the Workforce Optimisation and Medical Workforce risks that had been presented to the Staff Governance Committee on 21 June 2016.

Ms Dunning requested a more contemporary update and this would be circulated to the SRMG for information. **Committee Support Officer**

280 Nursing and Midwifery Workforce

Owner – G Costello
Manager – E McKenna

Mrs Costello advised:

- Work was under way to address the use of supplementary and agency staff
- A report on Nursing and Midwifery Workforce would go to the Tayside NHS Board 1 December 2016.

TBC Health and Safety

Owner – L Wiggin
Manager – S Muir (interim)

Mrs Walker advised that there was an existing Health and Safety Operational Risk currently in the Datix system and work was in progress to establish a risk owner and risk manager for the Strategic Risk

December 2016 – risk owner and manager agreed.

Strategic Risks aligned with the Clinical and Care Governance Committee

Noted that last since the last SRMG on 15 August 2016 all Strategic Clinical Risks were discussed at the following meetings:

- Clinical Quality Forum (CQF) 12 September 2016
- Clinical and Care Governance Committee (CCGC)10 November 2016
- Clinical Quality Forum (CQF) 14 November 2016

15 Delivering Care for Older People

Owner – G Costello, A Russell
Manager – C Rodriguez

Mrs Costello advised that Dr Cesar Rodriguez had attended the Clinical and Care Governance Committee on 10 November 2016 and provided a comprehensive update. Ms Sarah Dickie, Associate Nurse Diretcor, will be supporting the Older

People Clinical Board (OPCB) on behalf of Mrs Costello.

16 Clinical Governance

Owner – G Costello, A Russell
Manager – A Napier

There were no issues to highlight to the SRMG.

22 Health Protection of Children and Young People

Owner – G Costello
Manager – K Fowlie, (J Wilson)

Mrs Costello advised that Ms Kay Fowlie, Risk Manager, had retired and Mrs Joan Wilson, Chief Nurse, Children and Families would be the new Risk Manager. Steps were being taken to reframe this risk. It was noted that the information contained in the report to the CCGC had not been accurate and this would be resolved in the next Assurance Report.

121 Person Centredness

Owner – G Costello, A Russell
Manager – E McKenna

There were no issues to highlight to the SRMG.

144 Maternity Services

Owner – G Costello, A Russell
Manager – C Goodman, J Craig

It was noted that there had been a detailed discussion at the last CCGC regarding this risk.

302 PRI/Patient Flow

Owner – A Cook
Manager – K Wilson

There was no representative at the meeting to provide an exception report.

The Chair requested that a written update was obtained from the risk owner and circulated to the Group for information.

Committee Support Officer

395 Mental Health Services – Sustainability of Safe and Effective Services

Owner – A Russell
Manager – R Packham

The Medical Director advised that the risk rating had increased and it had been reported at the last Area Partnership Forum (APF) that in February 2017 that there was the possibility that the service would move to invoking Business Continuity arrangements due insufficient numbers of junior doctors to populate the rota.

The SRMG also noted that the manager of this risk had changed and was now Mr Robert Packham.

414 Managed/ 2C Practices

Owner – A Russell
Manager – M Watts

There were no issues to highlight to the SRMG.

The SRMG:

- Noted the updates

5.2 Risk Horizon Scanning and Emerging Risks

Forthcoming General Medical Council (GMC) visit to NHS Tayside
Professor Russell advised that he was content with the operational arrangements in place and being progressed, which were monitored through ongoing performance reviews. He also advised that the Clinical and Care Governance Committee were aware of the work progressing so there was no need to develop a strategic risk in this area.

Health and Social Care Partnership (HSCP) Governance and Assurance

The meeting was advised that internal audit had raised a concern that the assurance and governance arrangements between the bodies involved had not been fully described.

Ms Dunning advised that there had been a discussion at the November 2016 Finance and Resources Committee meeting and it was agreed that there was a requirement for a high level meeting to take place to discuss as a priority the year end assurance and governance arrangements to ensure robust governance statements can be provided for all the organisations involved in these partnerships

The meeting would involve the Tayside NHS Board Chairman, the Chief Executive, the Board Secretary, the IJB Chief Officers and Chairs and also Internal Audit.

Noted that the Clinical Quality Forum Terms of Reference had been updated to include attendance by Clinical Directors from the Health and Social Care Partnership (HSCP). There was a requirement for further work regarding the range of measures and understanding of the framework also the identification of risks that were owned/ shared

An update on progress in relation to HSCP Governance and Assurance arrangements to come to the next meeting. **??**

6 HEALTH AND SAFETY

6.1 NHS Tayside Health and Safety Support

There was no representative in attendance to speak to the report.

The Chair requested an updated position from Ms Wiggin and Ms Muir in relation to: **Committee Support Officer**

- Section 4:
  - Environmental issues
  - Respiratory Protection, Skin Health, Sharps Management
  - RIDDOR reporting
  - Risk assessments at Murray Royal Hospital

- Section 6 :
    - Recruitment of a Health and Safety Manager and Compliance Officer
    - Review of Health and Safety training and mandatory training

This update to be circulated to the SRMG for information.

7 RESILIENCE PLANNING

7.1 Resilience Planning Quarterly Update

Ms Dunning provided an update on behalf of Ms Leslie. Ms Dunning advised that the Resilience Planning team was operating with only the Head of Resilience Planning and a short term secondment post and there was now an urgent need to fill the Deputy and part-time support posts. These were being progressed as a priority.

The group noted from the report that there had been a number of training exercises including an Incident Control Room Awareness session.

It was highlighted that Lead Officers names contained in the workplan in Appendix 2 required to be updated. **E Leslie**

The SRMG:

- Noted the report

8 POLICY MANAGEMENT

8.1 Policy Management Report

Ms Dunning advised that work was now complete to allow policies to be available on the NHS Tayside external website.

Ms Walker provided an update on the review of the Adverse Event Management Policy:

- There would be a 6 week consultation period starting this week
- The intention would be that this policy would go to the Audit Committee in March 2017

Mrs Costello requested that the policy also went to the CQF for comments.

Duty of Candour:

- The implementation of these guidelines has been extended from 2017 to 2018
- Vital signs has been prepared and is ready to be circulated
- NHS Grampian has held an awareness day for the Duty of Candour guidelines and NHS Tayside will have a similar approach

Mrs Costello provided an update to Appendix 2 Breached Policies as at end of October 2016:

Caring for In-patient After Death Policy

- This has been delayed due to liaison with national groups and funeral directors

Rostering Policy for Nursing and Midwifery Staff

- An extension has been requested to enable Partnership Groups to consider this policy

There were no further comments in relation to this report.

The SRMG:

- Noted the report and the updates

9 GOVERNANCE

9.1 Strategic Risk Management Group Workplan 2016/17

There were no comments in relation to this report.

The SRMG:

- Noted the Strategic Risk Management Group Workplan 2016/17

10. ITEMS FOR INFORMATION

10.1 Item removed.

10.2 RECORD OF ATTENDANCE

The SRMG:

- Noted the record of attendance

11. ANY OTHER COMPETENT BUSINESS

There were no items for discussion.

12. DATE OF THE NEXT MEETING

Thursday 2 February 2017, 2:00pm – 3:30pm in the Board Room Ninewells Hospital.

CORPORATE GOVERNANCE REVIEW MEETING

Action note from above meeting held at 0930am on Wednesday 30 November 2016 in Committee Room 1, Level 10, Ninewells Hospital

Present
Ms Valerie Aitken, Corporate Services/Business Support Manager, Perth & Kinross (teleconference)
Ms Jackie Bayne, HR Manager
Mr Derek Colley, Financial Governance Accountant
Miss Donna Howey, Head of Committee Administration
Ms Margaret Dunning, Board Secretary
Mrs Alison Hodge, Committee Support Officer
Mr Barry Hudson, Regional Audit Manager
Mrs Nicki Owen, Committee Support Officer
Mrs Judith Triebs, Regional Audit Manager, FTF Audit Services
Apologies
Mrs Judith Golden, Employee Director
Mrs Lisa Green, Committee Support Officer
Mrs Jocelyn Lyall, Principal Auditor
Mrs Hilary Walker, Risk Manager, NHS Tayside

Miss D Howey in the Chair

ACTION

1. Apologies and Welcome

The apologies were as noted above.

Donna welcomed new members to the Group – Valerie Aitken, representing the IJBs. Judith Triebs was in attendance on behalf of Internal Audit.

Action Note of Last Meeting

Action Note – 19 May 2016

The Action Note of the meeting held on 19 August 2016 was approved. The Action Note was forwarded to the Audit Committee 20 December 2016.

3. Action Points Update

1. **19 August 2016** – **UK Bribery Action 2010 – Gifts, Gratuities, and Hospitality** – A presentation was being undertaken to the Senior Management Team on 21 February 2017. Vital Signs were being published regularly on Counter Fraud Services

2. **19 August 2016** – **UK Bribery Action 2010 – Gifts, Gratuities, and Hospitality –** the Vital Signs was forwarded to the Committee 23 November 2016 for final approval.

3. **National Fraud - Self Assessment Checklist** – this was not presented to the Audit Committee 20 December 2016.

4. **19 August 2016 – APBI Disclosure of Payments** – this was ongoing - action now complete.

5. **19 August 2016 – Updated Decision Report Template and Guidance** – this has been updated and distributed and would be used by Committees from January 2017.

The Action Points Update was noted

4. Other Matters Arising

Section E Code of Corporate Governance

Section E of the Code was to be reviewed by 19 May 2017. A meeting was to be convened with Internal Audit, Chief Officers, Chief Executive to include H&SCI Governance. It was noted that the review was contained within the Work Plan and would therefore be taken forward. **DH**

Vital Signs – Gifts, Gratuities, and Hospitality

In relation to Gifts and Gratuities Vital Signs the publication was timely due to an issue being discussed in Angus. Wendy Aichison was currently in discussion with Margaret Dunning regarding gifts, gratuities, and hospitality.

5. Draft Vital Signs re Code of Corporate Governance

Concerns were raised around misinterpretation of Section C of the Code of Corporate Governance and this would again be revised. **DH**

6. Updates to the Code of Corporate Governance

- **Draft report for Audit Committee 20 December 2016**

Amended structures were to be agreed as the posts of Director of Acute Care, Director of Operation and Director of Mental Health had been removed from the Organisational Structure.

The Director of Human Resources has added Organisational Development to the portfolio and will forthwith be known as the Director of HR & OD. The Director of Finance would not be a member of Tayside NHS Board however would remain in attendance.

Discussions were ongoing around whether the Chief Officers of the 3 Integrated Joint Boards would become members of the Board or Executive Leads.

The post of Chief Operating Officer has been renewed. The post holder will undertake the duties including those of the Operations Directorate.

The Staff Governance Committee will be submitting a revised Terms of Reference to the Board on 13 December 2016.

Acceptance of Gifts, Hospitality, and Prizes

It was highlighted that conflicting advice was being given to groups of staff who had received gifts from families who could not envisage an issue for staff. There was conflicting advice from the NMC as their code was not clear as to what Nurses could and could not accept. Wards had received vouchers etc and as this was not cash it was deemed acceptable. Clarity had to be sought as the Code is clear that no gifts are acceptable however this does not relate to chocolates/biscuits. Verbal advice from Corporate Services is always available should there be any issues.

The Group agreed that wording should be explicit that staff should try to refuse gifts but may accept low value donations such as chocolates and biscuits. The current wording within the Code was based on the Code from 1994. Donna Howey would reflect, revise the Code, and provide a further update to the Group.

Concerns were raised that the Code of Conduct for the IJB's advised that staff could accept gifts up to value of £50. It was noted that NHS Tayside employees were accountable through the NHS Tayside Code of Corporate Governance. Discussions would have to be undertaken with the IJB's in relation to this.

Health Fund

Derek Colley advised he had produced a form of words relating to the removal of differences between contractors, patients, and relatives. He would forward this to be discussed further. Jackie Bayne would look at other Codes to provide an update and would forward to the group by the 7 December 2016 and an update would be made to the Vital Signs being produced would be updated accordingly.

Section C

The paragraph numbers required amending around Member of Staff – General Comments from 18.6.2 to 20.6.2. **This would be amended accordingly**.

Section F - SFI

The Scottish Government has issued guidance around the Procurement Act 2016 around the use of contract services. Contracts should not be awarded on cost/price only. If a bid was not the lowest, a report for approval had to be remitted to the Finance & Resources Committee. These criteria have now been removed. The remit now states the following: - Most Economical Advanced Tender (MEAT) with any bid submitted should abide by the criteria set out.

The Finance & Resources Committee remit would have to be amended and a further update to the Code would be required. Derek Colley would email Donna Howey in relation to this matter contained in Section E&F of the Code of Corporate Governance. A draft amendment would be circulated to the Group.

The Highland board had clear and concise information relating to the review of SFI's. Derek Colley had spoken with Frances Gibson in relation to this matter and would put forward proposals in due course.

7. Work Plan

Discussion at the finance & Resources had taken place 7 September 2016 to discuss the invitation of the Chairs of the IJB's to Tayside NS Board

Mr Colley highlighted that the authorised signatory list would require to be amended however it was noted that this was not the remit of the Governance Review Group and would be forwarded to the correct meeting for review.

8. Any Other Competent Business

There was no further business

9. Date of Next Meeting

The dates for 2017 would be published in due course.

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	17 Jan 2017	9 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	Present	Present	
Cllr D Doogan	Non Executive Member (Vice Chair)	NHS Tayside	Apologies	Apologies	Present	Apologies	
Mrs L Dunion	Non Executive Member	NHS Tayside	Present	Apologies	Present	Present	
Mrs J Golden	Non Executive Member & Employee Director	NHS Tayside	Apologies	Present	Present	Apologies	
Mr S Hay	Non Executive Member (Chair)	NHS Tayside	Present	Present	Present	Present	
Mr M Hussain	Non Executive Member	NHS Tayside	Present	Present	Present	Apologies	
Cllr Middleton	Non Executive Member	NHS Tayside	Apologies	Present	Present	Present	
In Attendance							
Mr L Bedford	Director of Finance	NHS Tayside	Present	Present	Present	Present	
Ms M Dunning	Board Secretary	NHS Tayside	Present	Present	Present	Present	
Mr T Gaskin	Chief Internal Auditor	FTF Audit & Management Services	Present	Present	Apologies	Present	
Regular Attendees							
Mr D Colley	Financial Governance Accountant	NHS Tayside	Present	-	Present	Present	
Ms G Collin	Senior Manager	PricewaterhouseCoopers	Present	Present	-	-	-
Mr B Crosbie	Senior Audit Manager	Audit Scotland	-	-	Present	Present	
Mr G Doherty	Director of Human Resources	NHS Tayside	Present	Present	Apologies	Apologies	
Mrs F Gibson	Head of Financial Servicew	NHS Tayside	Present	Present	Present	Present	
Mr B Hudson	Regional Audit Manager	FTF Audit & Management Services	-	-	Present	Apologies	

Record of Attendance

NHS Tayside

Mrs J Lyall	Principal Auditor	FTF Audit & Management Services	Present	Present	Present	Present	
Mr R MacKinnon	Associate Director of Finance, Financial Svs & Governance/FLO	NHS Tayside	Present	Present	Present	Present	
Mr D Mills	Representative Area Clinical Forum	NHS Tayside	Apologies	Present	-	-	-
Ms F Mitchell-Knight	Asst Director, Audit Services	Audit Scotland	-	-	Apologies	Apologies	
Mrs H Walker	Risk Manager	NHS Tayside	Present	Apologies	Apologies	Apologies	
Mr K Wilson	Partner	PricewaterhouseCoopers	-	Present	-	-	-
Mr R Marshall	Representative Area Partnership Forum	NHS Tayside	-	-	-	Present	
For Information							
Prof J Connell FMedSci FRSE	Chair, Tayside NHS Board	NHS Tayside	Present	Present	Present	Apologies	
Mrs G Costello	Nurse Director	NHS Tayside	-	-	-	-	
Mrs L Green	Committee Support Officer	NHS Tayside	Present	Present	Present	Present	
Miss D Howey	Head of Committee Administration	NHS Tayside	Present	Present	Present	Present	
Ms L McLay	Chief Executive	NHS Tayside	Apologies	Present	Apologies	Apologies	
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	-	-	-	-	