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 11 May 2017 at 9.30 within the Board Room, Conference Centre, King's Cross, Dundee.** Any apologies to be submitted to Lisa Green on ext. 36680, direct dial (01382) 496680 or via email to lisa.green7@nhs.net

AGENDA

ITEM NO.			LEAD OFFICER	REPORT NO AND ACTION REQUIRED
1.	**WELCOME**		S Hay	
2.	**APOLOGIES**		S Hay	
3.	**DECLARATION OF INTERESTS**		S Hay	
4.	**MINUTE OF PREVIOUS MEETING**			
	4.1	Minute of the Audit Committee Open Business - 9 March 2017	S Hay	Attached - For approval
	4.2	Action Points Update	L Bedford	Attached - to note update
	4.3	Work Plan 2017/18	L Bedford	Attached – to note update
	4.4	Matters Arising	S Hay	
5.	**AUDIT FOLLOW UP**			
	5.1	Audit Follow Up (AFU) – Mid Cycle Update Report	L Bedford	AUDIT38/2017 Attached - to note progress
6.	**FTF/INTERNAL AUDIT**			
	6.1	Internal Audit Progress Report	B Hudson	AUDIT40/2017 Attached - to note progress
	6.2	Follow Up of Financial Planning Audit Report No T22/17	L Bedford	AUDIT39/2017 Attached – to note progress
	6.3	Internal Audit T12/17 – Integration Joint Board (IJB) Governance Update	M Dunning	Verbal Update
7.	**EXTERNAL AUDIT**			
	7.1	NHS Tayside External Audit Interim Report 2016/17	B Crosbie	AUDIT37/2017 attached Attached - To note progress
8.	**RISK MANAGEMENT**			
	8.1	Annual Report of the Strategic Risk Management Group 2016-17	M Dunning	AUDIT27/2017 Attached – for information
	8.2	Risk Management Annual Report	H Walker	AUDIT28/2017 Attached – for approval
	8.3	Risk Management Work Plan 2017/18	H Walker	AUDIT29/2017 Attached – for approval
	8.4	Risk Management CIPFA Self Assessment and Audit Checklist	H Walker	AUDIT30/2017 Attached – to note progress

ITEM NO.		LEAD OFFICER	REPORT NO AND ACTION REQUIRED
9.	**AUDIT COMMITTEE TERMS OF REFERENCE AND WORKPLAN 2017/18**	L Bedford	AUDIT31/2017 Attached – for approval
10.	**PROPERTY TRANSACTIONS 2016/17**	L Lyall	AUDIT32/2017 Attached – for noting/approval
11.	**PAYMENT VERIFICATION: FAMILY HEALTH SERVICES (FHS) CONTRACTORS**	J Haskett	AUDIT33/2017 Attached –to note content
12.	**TAXATION OF WORKERS PROVIDED THROUGH INTERMEDIARIES (IR35) AND SELF EMPLOYED**	R MacKinnon	AUDIT34/2017 Attached – for noting/approval
13.	**COMPLIANCE WITH SCOTTISH GOVERNMENT WORKFORCE DIRECTORATE CIRCULARS AND NHS TAYSIDE EMPLOYMENT POLICIES**	G Doherty	AUDIT35/2017 Attached – to note progress
14.	**BEST VALUE FRAMEWORK ASSURANCE 2016/17 – TAYSIDE NHS BOARD**	M Dunning	AUDIT41/2017 Attached – to recommend approval by Tayside NHS Board
15.	**PAPERS/MINUTES FOR INFORMATION**		
	15.1 Minute of Strategic Risk Management Group - 2 February 2017	M Dunning	Attached – for information
	15.2 Audit Scotland Reports	L Bedford	Attached - for information
	• Technical Bulletin 2017/1		
	15.3 Record of Attendance	S Hay	Attached – for information
16.	**DATE OF NEXT MEETING:** **Thursday 22 June 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

17.	**MINUTES OF PREVIOUS MEETINGS**		
	17.1 Minute of the Audit Committee Reserved Business - 9 March 2017	S Hay	Attached – for approval
	17.2 Action Points Update	L Bedford	Attached – to note update
	17.3 Matters Arising	S Hay	

FOISA 33(1)
Commercial Interests and the Economy

18.	**NHS SCOTLAND COUNTER FRAUD SERVICES**		
	18.1 NHS Scotland Counter Fraud Services Update	R Mackinnon	AUDIT36/2017 Attached – to note report
19.	**PRIVATE DISCUSSION**		

Mr S Hay
Chair
May 2017

DISTRIBUTION

MEMBERS

Mr D Cross OBE
Ms L Dunion
Mrs J Golden
Mr S Hay (Chair)
Mr M Hussain

REGULAR ATTENDEES

Mr L Bedford
Mr D Colley
Mr B Crosbie
Mr G Doherty
Ms M Dunning
Mr T Gaskin
Mrs F Gibson
Mr B Hudson
Mrs J Lyall
Ms A Machan
Mr R MacKinnon
Ms F Mitchell-Knight
Mrs H Walker
Representative of Area Partnership Forum

FOR INFORMATION

Prof J Connell
Mrs G Costello
Miss D Howey
Ms L McLay
Dr R Peat
Mr H Robertson
Mrs A Rogers
Prof A Russell
Prof M Smith
Mrs S Tunstall-James
Dr D Walker
Communications Team

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 9 March 2017** in the Board Room, Kings Cross Hospital, Dundee

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

Chair, Chief Executive and Senior Officers
Mr L Bedford, Director of Finance, NHS Tayside
Ms L McLay, Chief Executive, NHS Tayside

External Auditors
Mr B Crosbie, Senior Audit Manager, Audit Scotland
Ms A Machan, Senior Auditor, 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
Prof J Connell, Chair, Tayside NHS Board
Dr A Cook, Medical Director – Operational Unit, NHS Tayside (for item 8.1)
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 J Haskett, General Manager – Primary Care Services, NHS Tayside (for item 9)
Miss D Howey, Head of Committee Administration, NHS Tayside
Ms M Kennedy, Practice Facilitator/H&S Lead Infection Control, NHS Tayside (for item 8.1)
Mr S Lyall, Head of Finance, NHS Tayside
Mr R Marshall, Representative of Area Partnership Forum
Mr R MacKinnon, Associate Director of Finance - Financial Services & Governance/FLO, NHS Tayside
Dr R Peat, Non Executive Member, Tayside NHS Board
Mrs H Walker, Risk Manager, NHS Tayside
Miss K Wilson, General Manager, PRI, NHS Tayside (for item 8.1)

Apologies
Ms L Dunion, Non Executive Member, Tayside NHS Board
Mr B Hudson, Regional Audit Manager, FTF Audit and Management Services

Mr S Hay in the Chair

1. WELCOME **ACTION**

Mr Hay welcomed all to the meeting including Dr Robert Peat. It was noted Dr Peat was recently appointed as a Non Executive Member of Tayside NHS Board and was not a Member of this Committee. 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 – 17 January 2017

The Audit Committee Minute of the meeting held on 17 January 2017 was approved on the motion of Mr Doug Cross and seconded by Cllr Glennis Middleton.

4.2 Action Points Update

Mr Bedford spoke to the Action Points Update.

External Review of all Mental Health Sites – It was noted an update would be provide to the 11 May 2017 meeting.

Risk Management Mid Year Report – It was noted the HIS one page summaries were being submitted to the Clinical Quality Forum at its meeting on 13 March 2017. Mrs Walker also advised that as part of the distribution the learning summaries were sent to the Integrated Joint Boards (IJBs), however, onward distribution and arrangements for discussion was the responsibility of each individual IJB. It was noted the learning summaries were also published on the Healthcare Improvement Scotland (HIS) Adverse Events Community of Practice website.

Adverse Events Management (AEM) Policy – Mrs Walker advised the Committee that an interim review of the AEM Policy was ongoing and it was intended this policy would be submitted to the Committee at its meeting in September 2017 for approval.

4.3 Work Plan 2016/17

The Committee was asked to note the Work Plan 2016/17.

Mr Bedford advised the Work Plan 2016/17 had been updated to reflect the current and forthcoming reporting arrangements. Mr Bedford informed the Committee that the current 2016/17 Work Plan noted Mr Robert MacKinnon as Lead Officer in respect of a number of reports either presented or to be presented to the Committee. It was noted this reflected the period in 2016/17 prior to Mr Bedford becoming Lead Officer and would be updated in the 2017/18 Work Plan.

The Committee

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

4.4 Matters Arising

There were no matters arising.

5. INTERNAL AUDIT

5.1 Internal Audit T22/17 – Follow Up of Financial Planning and Management (AUDIT25/2017)

Mr Gaskin advised the Committee the report was a complex report reviewing current and historical internal and external audit recommendations. It was noted the audit work was a long process due to a continual changing environment, however, improvements had been made.

Mr Gaskin highlighted para. 12 of the report which advised that the audit opinion reflected a D-grade. The grade reflected, in particular, the planned risk score of 25 in relation to Corporate Risk 36, Strategic Financial Plan 2016/17 – 2020/21 and NHS Tayside's ability to achieve its objectives, including the financial targets within the Local Delivery Plan (LDP). It was noted considerable work and improvements had been undertaken, however further improvements were required and Mr Gaskin emphasised the requirement for acceleration in the change of pace to ensure targets were achieved.

Mr Gaskin noted that the report addressed audit recommendations, some of which were historical, and whilst not all internal and external recommendations had been completed in full or within the given timescales there had been significant improvements and work was continuing

The Committee noted that whilst significant improvements had been recognised, further improvements were required and there was the need for NHS Tayside to adapt to a continual changing environment.

Mr Bedford re-iterated the complexities of the report which addressed both current and historical audit recommendations and noted the report recognised the continued progress and actions being taken.

The report demonstrated across the five themes identified within the report of Governance, Budgeting, Efficiencies, Benchmarking and Financial Planning, significant steps had been taken albeit further steps, equally as large, were still required.

There was recognition in terms of Governance that finance was now reported to a number of Committees and the Transformation Programme Board (TPB), reporting the most recent results verbally supported by a written report from the previous month. It was noted previously finance was only reported to the Finance and Resources Committee.

Mr Bedford advised in response to a previous audit recommendation the Terms of Reference for the Finance and Resources Committee had been reviewed in conjunction with Internal Audit providing more robust set of Terms and was approved by the Committee at its meeting in November 2016. It was noted the Corporate Finance Report would continue to evolve, with further enhancements, particularly in relation to the efficiency savings section, already in place. Mr Bedford advised that whilst every effort was made to ensure the report was easily digestible, language used in relation to complex or technical accounting terms was inevitable and there was the intention to provide a glossary within the report to address this.

The Committee noted as part of the Board Assurance Framework updates around Strategic Risks, there was now the inclusion of Operational Risks.

It was noted in relation to Budgeting a number of workshops had taken place and this would be formally documented within the Standing Financial Instructions.

Mr Bedford noted that whilst a truncated approach was in place for 2017/18, there was the intention for an earlier approach to Financial Planning for 2018/19 to ensure further alignment with Local Authorities.

The Financial Framework for 2017/18 detailed plans for a significant reduction in the level of Deferred Spend over the five year cycle, with a marked change in 2017/18, and would in part reflect greater allocation being directly governed by the Health and Social Care Partnerships (HSCPs).

The reporting of efficiencies, not only the impact in the current year but also the full year effect, was recognised with both being included within the Corporate Financial Report. A review of further enhancements would continue.

In terms of Benchmarking there was recognition that moving forward the active use of tools such as NSS Discovery would assist in driving out productive opportunities and this remained a key focus for the Committee and the TPB.

Mr Bedford concluded that it was evident significant steps had been taken, however, there was recognition further work was required.

Mr Cross noted his disappointment, as Chair of the Committee, with the report and the grading received, however, agreed the report reflected the current position and the improvements made in relation to historical and current issues.

Mr Bedford noted that along with the significant improvements made there was further clarity around governance and a better understanding of risks and challenges faced. Mr Bedford advised he would have liked to see more recognition of the improvements made within the report, however, noted the need to reflect on the current strategic risk score of 25 and advised it was a stated aim for further improvement, in the medium term, working towards the unbalanced Local Delivery Plan (LDP).

The Committee noted the requirement to monitor the changing dynamics, in relation to the Integrated Joint Boards (IJBs), and to track and monitor overall progress.

Mr Hussain raised concerns regarding the budget setting process as detailed within recommendation 5 and 6 of the action plan, noting a clear budget setting process was an expectation of all public sector bodies and queried the weakness in this area and whether there was confidence within the Finance Team in facing challenges and improving the audit opinion. Mr Hay agreed with these concerns and noted there was the need to ensure robust processes were in place. There was recognition of the progress made, however, the Committee noted that the acceleration of further work and a more detailed review of deferred revenue was required. The Chair asked the Finance and Resources Committee to monitor deferred expenditure to ensure that proper scrutiny was given to this issue.

Mr Bedford advised that the NHS Tayside Standing Financial Instructions (SFIs) would be updated to reflect the revised budgeting approach as discussed at the Budget Planning workshop and whilst a truncated approach had been adopted in 2017/18 that it would be fully implemented in 2018/19.

Mr Gaskin made reference to the national position, noted within recommendation 6 of the action plan, and highlighted the challenges were faced nationally with the requirement for new skills to be developed and engagement with NES. It was noted the NSS Discover tool would assist in identifying productive opportunities.

Ms McLay noted her agreement that the overall D- grading was correct, however, did not feel the report was reflective of actions taken and improvements made. Ms McLay advised there was the need to identify challenges which were specific to NHS Tayside and those which were corporate wide and recognise increasing wide spread pressures.

Mr Hay queried the capability of NHS Tayside and the expected timescales around the implementation of changes highlighted within Mr Shobhan Thakore's Realistic Medicine Consultation and Workshop Report and whether the finance team was adequately staffed.

Ms McLay advised there was the intention for this to be addressed within the one year plan with realistic medicines being a key component. It was noted this would be encouraged at a pace suitable to NHS Tayside and would be implemented in small areas, also to be identified within the one year plan.

Mr Bedford advised that a report around the structure of the finance directorate would be submitted to the Remuneration Committee at its meeting on 14 March 2017. Ms McLay noted there was a gap in the wider organisation in relation to finance which was part of the re-planning and re-structuring work ongoing.

Mr Cross noted NHS Tayside's obligation to meet SFI requirements and the need to ensure organisational support was re-aligned within individual departments and finance managers in addition to the finance department. It was noted there was the need to recognise in order to move forward from the current position further investment in resources and facilities was required.

Prof Connell raised concerns regarding implementation and the level of expertise around budget setting and noted assurance should only be given following approval of the new structure. Prof Connell highlighted para.27 of the report which noted a reliance on previous budget setting processes and advised that whilst the need to change budget setting processes was of highest priority in the action plan the new structure should also take priority.

10:17 Miss Jane Haskett arrived

Mr Hay noted that in order to set budgets a clear understanding of the Clinical Strategy was required. Ms McLay advised the Committee that it was the intention to submit the draft Strategic Five Year Plan to Tayside NHS Board at its meeting on 16 March 2017.

The Committee noted a formal update would be presented to each Committee meeting.

The Committee

- **Noted the content of the report**

10:20 Dr Alan Cook, Miss Kerry Wilson and Ms Margaret Kennedy arrived

5.2 Internal Audit T12/17 – Assurance Framework (AUDIT19/2017)

Ms Margaret Dunning was in attendance to present the report.

Ms Dunning advised the Committee that this audit report builds on the previous audit T11A/15 – Board Assurance Framework (BAF). It was noted the BAF was continually reviewed with assistance from Internal Audit to ensure systems and processes are adapted accordingly.

Ms Dunning noted that improvements had been made, however, there was the need for work to continue and evolve and this was reflected within the report.

It was noted the BAF highlights 22 strategic risks and assurances were being sought from Risk Owners in the approach to year end and preparation of the Governance Statement. Ms Dunning advised work was ongoing with the Chief Officers of each of the Integrated Joint Boards (IJBs) to review risks and agree which related to NHS Tayside, IJBs or were shared risks. It was noted a meeting with the Chief Officers to discuss the governance arrangements was scheduled for w/c 13 March 2017.

The Committee noted the BAF had been separated in to two areas in relation to the audit opinion. The audit opinion for the overall BAF was a B grading, however, the work in relation to describing the assurance process in relation to the IJBs received a D grading. Mr Gaskin advised the Committee the BAF was a robust system and a strength to NHS Tayside. It was noted the BAF would have received an A grading, however, it was found that whilst the information provided was excellent the format of the DATIX report required to be more user friendly, although it was recognised that approaches had already been made to the company.

Mr Gaskin noted that the BAF was now further complicated following the introduction of IJBs. There was the need to confirm the ownership of individual risks and ensure the governance and assurance processes were clear and applied. It was noted this change had not yet been reflected within the BAF, therefore the audit opinion on that particular area was a D grade.

With regard to the new assurance systems required it was noted that other Health Boards were facing similar challenges to that of NHS Tayside.

Mr Cross noted the difficulties faced in relation to the engagement of individuals around risk management and advised engagement was critical in determining where resources and efforts should be allocated. It was noted good governance arrangements were largely in place now and a number of improvements had been taken forward. Mr Cross agreed that good progress had been made over the last twelve months and there was now the opportunity to now review all strategic risks and risk ownership.

Mr Hay highlighted para.28 of the report and queried whether, as stated, the elements of the Integration Schemes and risk management systems in each organisation were consistent and if appropriate what measures were in place. Mr Gaskin advised this was indeed work in progress and this was progressing and moving forward. It was noted a Short Life Work Group (SLWG) had been established and a report would be submitted for consideration by the Committee at its meeting on 11 May 2017.

Mr Hay noted that there was no clearly articulated solution or timeline and queried how this would be resolved. Prof Connell advised challenges were reflected across all Health Boards in Scotland and noted that clinical accountability and governance was the responsibility of the Medical and Nurse Director and the Chief Executive.

The Committee noted the need for agreed processes, clear lines of communication, transparency and looked forward to a resolution within the next three months.

The Committee

- **Noted the content of the report**

5.3 Internal Audit Progress Report (AUDIT22/2017)

Mr Gaskin advised the Committee the purpose of the report was to provide an update on the 2016/17 internal audit plans.

Mr Gaskin advised the report detailed the completed audit work and noted all reports where Agenda items for this meeting.

The Committee noted Section 4.2 detailed the work in progress in relation to the 2016/17 plan including areas where a formal report was not produced. Mr Gaskin highlighted that a lot of work had been carried out and time allocated in respect of Health and Social Care Integration (HSCI).

Mr Gaskin advised the Committee there had been a number of changes to the Operational Audit Plan 2016/17, highlighted within Section 4.4 of the report, and audits would be incorporated into future audit plans. There was a variety of explanations in relation to these changes including ensuring efficiency and sustainability. Mr Gaskin gave a brief update on the following audits:

- **Clinical Governance – Mortality Reviews** – Agreed that at the request of management the audit would be refocused and included within the 2017/18 Internal Audit Plan
- **Staff and Patient Environment** – Focus was on external inspections and visits. However, action plans to address findings from inspections were in place and regularly reported through clinical governance structures. It was noted that internal audit T16/17 – Adverse Events Management would provide assurance in this area
- **Strategic Planning** – Following discussions with the Chief Executive it was agreed this would form part of 2017/18 audit in contributing to governance, visibility and risk environment
- **Infection Control** – This audit would feature in the 2017/18 Internal Audit Plan and was also covered in the Departmental Reviews
- **Savings Programme** – There was sufficient coverage provided in T22/17 – Follow Up of the Financial Planning & Management and this would be interlinked with the Transformation Programme Board (TPB) audit of specific workstreams
- **NDSI** – Through discussion with the Interim Head of Payroll this area was now considered to be low risk and the Director of Finance agreed that there was no added value in continuing with this check
- **Information Assurance** – This would be covered in year end work
- **NHS Scotland Waiting Times Methodology** - This would progress following the implementation of TrakCare
- **Departmental Reviews** – This would be included within the TPB, eRostering would be included as part of the Workforce and Care workstream

Mr Gaskin asked the Committee to note the progress on the 2016/17 internal audit plan and approve the changes to the Operational Audit Plan 2016/17.

The Committee

- **Noted the progress on the 2016/17 internal audit plan**
- **Approved the changes to the Operational Audit Plan 2016/17**

5.4 Internal Audit T08/17 – Interim Evaluation of Internal Control Framework (AUDIT26/2017)

Mr Gaskin advised the Committee that a new format of reporting had been used to provide a more concise and hopefully helpful and informative update.

The Committee noted the report detailed ongoing activities within NHS Tayside and any areas requiring further development. Mr Gaskin highlighted key areas, in moving forward, were understanding, NHS Tayside's capability and capacity and the need for acceleration. It was noted this report was similar to that presented last year, however, there had been progress.

Mr Gaskin highlighted the findings in relation to Clinical Governance, advised that progress was ongoing in remediating these issues and stated that following discussions with the Chief Executive, elements requiring further attention would be addressed.

Mr Hussain accepted the recommendations in relation to Staff Governance, noting there had been issues regarding non attendance at meetings. Mr Hussain raised concerns around the wording "ongoing failure" included in the Clinical Governance recommendation relating to the deaths in Moredun Ward. Mr Gaskin advised a lot of work had been undertaken, as notification had been received regarding potential prosecution, and there was the need to ensure a robust defence and the ability to demonstrate improvements. It was noted the Mental Health Performance Reviews had been re-established following the appointment of Mr Keith Russell, Associate Nurse Director – Mental Health & Learning Disabilities and these would commence 17 March 2017.

The Committee agreed this report should be circulated to all Standing Committees for information. LG

Ms McLay advised the Committee she had requested a formal review to be undertaken within the calendar year and assurance had been received from Chief Officers with details included within the Minutes of Directors meetings.

The Committee agreed an accelerated level of pace was required moving forward.

The Committee

- **Noted the content of the report**

6. EXTERNAL AUDIT

6.1 NHS Tayside External Audit Progress Report (AUDIT20/2017)

Mr Bruce Crosbie was in attendance to present the report.

Mr Crosbie provided the Committee with a brief overview of the report and advised that work was progressing well. It was noted the 2016/17 Interim Report would be submitted to management in March 2017 followed by submission to the May 2017 Audit Committee meeting.

Mr Crosbie advised that work was progressing in reviewing the Role of the Board and findings would be included in the Annual Audit Report submitted to the Committee in June 2017. It was noted Audit Scotland were undertaking work in relation to an Information and Communications Technology (ICT) overview, however, this was an exercise to inform Audit Scotland's understanding of the ICT environment in NHS Tayside and would not necessarily result in a report to management.

The Committee

- **Noted the content of the report**

7. RISK MANAGEMENT

7.1 Risk Appetite (AUDIT14/2017)

Ms Margaret Dunning and Mrs Hilary Walker were in attendance to present this report.

Ms Dunning advised the Committee that based on previous work the requirement for a model which described the risk appetite had been identified. It was noted following liaison with other NHS Boards a Short Life Working Group (SLWG) had been established to input into the development of the revised risk appetite statement and under pinning process.

Mrs Walker advised the Committee NHS Tayside currently had 22 Strategic Risks which were either delegated to a Standing Committee or reserved to Tayside NHS Board, there were currently six strategic risks delegated to Tayside NHS Board.

It was noted risk was expressed as a measure of Likelihood multiplied by Consequence and scored as both inherent (without control) or current (showing the effect of existing controls in place). The current risk score was then compared to the expressed appetite for risk. A score of 20 – 25 or above had a current risk exposure rating of very high and exceeded NHS Tayside's risk appetite.

Mrs Walker advised that it was now suggested the Board Assurance Framework (BAF) should be reported to Tayside NHS Board twice per year with Strategic Risks being reported to their relevant Standing Committees four times per year. It was noted all risks exceeding the risk appetite would be reported to each Tayside NHS Board meetings until the risk exposure rating was lowered to an acceptable level.

It was proposed that the current risk appetite, i.e. reporting on risk that fall into the very high category should be in place for 2017/18, beginning on 1 April 2017, however, it was anticipated the risk appetite would be reviewed with a view to this being lowered to high in future years.

Mr Gaskin noted this was a very good report and a sensible model which would not only reduce the level of reporting but should result in reports being more meaningful.

Mr Cross noted this report referred to NHS Tayside's performance though risk management and the importance of ensuring mitigating actions were developed to reduce current risk scores.

The Committee

- **Approved the Risk Appetite Statement for NHS Tayside**

8. POLICIES

8.1 Skin Health Surveillance Policy (AUDIT15/2017)

Dr Alan Cook, Miss Kerry Wilson and Ms Margaret Kennedy were in attendance to present the report.

The Committee was asked to review and approve the new Skin Health Surveillance Policy in relation to NHS Tayside's statutory requirements to comply with Health and Safety law.

Dr Cook advised the Committee that following a visit by the Health and Safety Executive (HSE) on 1 and 2 March 2016 it was identified that NHS Tayside did not meet all the requirements of health and safety law in relation to the management of skin health.

The Committee noted that in order to address the requirements and actions to be addressed identified by HSE, a full review of control measures, reporting of skin health surveillance and performance of the occupational health provided had been undertaken and a Skin Health Improvement Plan (SHIP) had been developed.

Dr Cook advised that a Skin Health Improvement Group had been established and noted the requirement for the development of a Skin Health Surveillance Policy. The Skin Health Surveillance Policy had been developed in collaboration with a wide range of groups, identified within the report. It was noted the policy had been updated to include feedback from the consultation and engagement process of all groups involved.

Dr Cook highlighted the appendices included within the policy and advised Appendix 4.6 would be updated to remove the word statutory from the heading.

The Committee was asked to adopt the Skin Health Surveillance Policy.

Ms McLay noted the excellent work and partnership in the development of this policy and advised NHS Tayside was now in a stronger position in relation to Skin Health.

The Committee

- **Reviewed and adopted the Skin Health Surveillance Policy**

9. PAYMENT VERIFICATION: FAMILY HEALTH SERVICE (FHS) CONTRACTORS (AUDIT16/2017)

Miss Jane Haskett was in attendance for this item.

Miss Haskett advised the Committee the purpose of the report was to provide assurance of the arrangements in place to comply with the national payment verification procedures and arrangements for payment verification for the four FHS Contractors. The four contractors were noted as being General Dental, Ophthalmic, Pharmaceutical and Medical Services.

It was noted this was an exception report and there were no areas of concern to highlight to the Committee.

The Committee

- **Noted the content of the report**

11:15am Dr Cook, Miss Wilson, Ms Kennedy and Miss Haskett left the meeting

10. AUDIT COMMITTEE HANDBOOK (AUDIT23/2017)

Mr Bedford advised the Committee the report was presented to the Committee as part of the Annual Audit Committee work plan with the check list included within the report being used to demonstrate the Committee was fulfilling its role.

It was noted the report and checklist had been shared with Mr Stephen Hay, Chair of the Audit Committee prior to this meeting as required.

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

The Committee

- **Noted the content of the report and confirmed that the completed checklist demonstrated adherence to good practice**

Mrs Frances Gibson was in attendance to present Items 11 and 12.

11. ANNUAL ACCOUNTS PROCESS UPDATE (AUDIT24/2017)

Mrs Gibson advised the report provided the Committee an overview of the Annual Accounts process and assurance the process remained on target.

Mrs Gibson advised that Appendix 1 of the report provided a high level summary of the accounts process timetable and noted a number of key dates within the timetable. It was noted Appendix 2 of the report provided details of responsible officers for each part of the accounts and the guidance letter received from the Scottish Government Health and Social Care Directorate (SGHSCD), which accompanied the issue of the Annual Accounts Manual, detailed a summary of the minimal changes required and was included within Appendix 3 of the report.

Mrs Gibson highlighted that the guidance letter received in December 2016 made reference to work which was ongoing at that point and confirmed work was now complete and would result in no significant changes to the final version of the manual.

Mrs Gibson highlighted that the manual contained the extant guidance on the preparation of the Governance Statement (GS) and that there were no changes from last year. As a result it was the intention to use the same process as last year to produce the draft GS which the Committee would review in June 2017.

The Committee

- **Noted the guidance received from SGHSCD in relation to the preparation of the 2016/17 accounts**
- **Noted the final version of the manual would be issued shortly and it was the intention to produce the Governance Statement (GS) using the same process as the previous year**
- **Noted that planning for the 2016/17 accounts process was well advanced and the accounts process was currently on target to be completed by 30 June 2017**

12. ACCOUNTING POLICIES (AUDIT21/2017)

Mrs Gibson advised the Committee the Audit Committee Terms of Reference required the Committee to review the accounting policies and approve changes made. It was noted the changes to the accounting policies, detailed within the report, were minimal and had no significant impact on the accounting policies.

It was noted the draft accounting policies note in respect of the 2016/17 annual accounts was included as Appendix 1 to the report.

The Committee

- **Reviewed and approved the changes made to the accounting policies**

13. COMPLIANCE WITH SCOTTISH GOVERNMENT WORKFORCE DIRECTORATE CIRCULARS AND NHS TAYSIDE EMPLOYMENT POLICIES (AUDIT17/2017)

Mr Bedford advised the Committee that due to unforeseen circumstances Mr Christopher Smith, Associate Director of Human Resources & Organisational Development, was no longer available to attend to present this report and this item would be deferred to the May 2017 meeting.

The Committee

- **Noted this item would be deferred to the May 2017 meeting**

14. PAPERS/MINUTES FOR INFORMATION

14.1 Strategic Risk Management Group Minute – 24 November 2016

The Strategic Risk Management Group (SRMG) Minute of 24 November 2016 was presented to the Committee for information.

Mr Gaskin raised concerns regarding the number of risk reports being submitted to the SRMG without attendance from the relevant Risk Owner/Manager and queried what actions were being taken to address non attendance.

Ms Dunning advised the Committee this was an ongoing issue and there were challenges due to heavy diary commitments of Risk Owners/Managers. It was noted various options in terms of timings of meetings had been explored and where possible a deputy was sought or a written assurance statement was requested. The Committee noted the requirement for deputies to be well informed.

Mr Cross highlighted the importance of attendance, in relation to risk management, and noted the requirement to find an appropriate and consistent level of attendance at these meetings.

The Committee acknowledged the challenges faced and requested Ms Dunning and Mrs Walker explored further options to improve attendance at meetings and provide the Committee with a verbal update. **MD/HW**

The Committee

- **Noted the Strategic Risk Management Group Minute – 24 November 2016**
- **Requested Ms Dunning and Mrs Walker explored further options to improve attendance and provide the Committee with a verbal update**

14.2 Corporate Governance Review Group Action Note – 30 November 2016 (unapproved)

The unapproved Corporate Governance Review Group Action Note of **30 November 2016** was presented to the Committee for information.

The Committee

- **Noted the unapproved Corporate Governance Review Group Action Note – 30 November 2016**

14.3 Attendance Record

The Committee

- **Noted the Attendance Record**

15. DATE OF NEXT MEETING

The next meeting of the Audit Committee will take place on Thursday 11 May 2017 at 9:30am in the Board Room, Kings Cross 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 9 March 2017, and approved by the Committee at its meeting held on 11 May 2017.

....

CHAIR **DATE**

NHS Tayside Audit Committee – 11 May 2017 Open Business
Action Points Update

New Actions arising from meeting on 9 March 2017

MEETING	MINUTE REF.	HEADING	ACTION POINT	RESPONSIBILITY	STATUS
9 March 2017	14.1	Strategic Risk Management Group Minute – 24 November 2016	Ms Dunning and Mrs Walker to explore further options to improve attendance at SRMG meetings and provide a verbal update to the Committee	Margaret Dunning/ Hilary Walker	Early notification of forthcoming meetings and regular reminders will be put in place. Risk Managers will be required to attend to talk to their respective risks if the Risk Owner cannot be present. Group Terms of Reference will be updated to incorporate this deputising arrangement
9 March 2017	5.4	Internal Audit T08/17 – Interim Evaluation of Internal Control Framework	Internal Audit Report T08/17 – Interim Evaluation of Internal Control Framework to be circulated to all Standing Committees for information	Lisa Green	Report circulated to all Standing Committee Chairs and Committee Support Officers. Email issued 19 April 2017.
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 Committee meeting included as **Appendix 1** of the Action Points Update. It was noted the Finance and Resources Committee gave approval of Phase 1 of the window replacement

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.	Hilary 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

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	Completed

Appendix 1

Audit and Assurance Committee

Action Point Update - External Review of Mental Health Sites

The HSE Improvement Notice which was issued on 4th December 2015 had a required compliance date of 7th January 2016. The requirement was to produce a time bound action plan with named individuals responsible for actions to mitigate or control the known ligature points in the ward environment. Two investigators from HSE attended Murray Royal Hospital on the morning of the 7th January and were satisfied that NHS Tayside complied with the Improvement Notice.

The HSE Action Plan is detailed and was planned to be delivered in 2 phases. Phase 1 was to address the immediate issues identified within Moredun ward as per the HSE Improvement Notice. Phase 2 was to support the roll out of learning and safety improvement to the wider Mental Health inpatient estate.

Environmental Improvements initially identified for Moredun ward client group of acute General Adult Psychiatry, were recognised as an equal risk to other services such as GAP services within Mulberry ward, Susan Carnegie Centre; Ward 1, Decant ward, IPCU, Carseview Centre; Carseview Centre and the CAMHS within the Young Peoples Unit, Dudhope House. Additionally it became apparent that within some localities, that the application of environment improvements required extension to Psychiatry of Old Age and Learning Disabilities Services.

This resulted in the adoption of a broader approach to resolving risks from environmental factors to secure a standardised approach, economies of scale and to meet the expectation of the HSE Improvement Notice that NHST would roll out improvements to other areas as a matter of urgency.

A series of immediate actions were taken to identify and control the risks to patients from environmental ward features. This includes a review of the ward environment and working practices by the OHSAS Health and Safety Team. Risk Controls have been introduced / fitted until such times as permanent solutions are secured. A programme of environmental review visits are currently underway to benchmark against 2014 OHSAS assessments and future improvement actions.

A robust and practical evidence based approach has been undertaken to produce environment improvements that ensures an evidence file of actions and decision making processes is available.

Environment Improvement actions are tracked through weekly huddles and Phase 2 of the Environment Programme has been commenced to support the continued roll out of learning, provide standardization across the estate and inform future work plans.
With the complex nature of the roll out improvement programme, a detailed project plan has been produced to provide direction, a standardised approach and highlight progression to date.

A matrix of work items is kept along with the creation of a HSE Phase 2 shared folder to ensure robust record keeping and archiving of actions, decisions and outcomes and completed works.

A standardised guidance document will be developed to provide guidance to property services, estates staff and clinical staff on reducing ligature risk within the inpatient environment.

The scope and current status of the improvement works are as follows;

BEDS

All Kings Fund Beds replaced by Cabin style beds within GAP inpatient areas, CAMHS inpatient areas, Profile beds have been provided in storage for use when a clinical need is identified.

Within POA ward of Murray Royal Hospital and Susan Carnegie Centre, Stracathro all Kings Fund beds have been removed and replaced with safer models of profile beds.

Remaining beds will be reviewed under Phase 2 of the Environment Programme.

DOORS

Ensuite Doors: A control measure for the management of risk from full height, full width, and ensuite doors of locking the door off remains in place. An option appraisal event is scheduled for the week commencing 22nd May 2017 to run for 3 weeks to provide staff of all grades and services to appraise the options for future model of en suite doors provision and management of risk.

Options are

- Full Height and width door with locking control (current provision in MRH and Susan Carnegie Centre)
- Break away track and curtain (Current provision in CVC)
- Sloping door option (current provision in YPU)
- New to Market ensuite doors

Bedroom Doors: A solution to the incompatibility of DTA installation with the building fabric of CVC is under review and will be concluded in June 2017. On completion of this process a final decision on the installation of DTAs to GAP Bedroom Doors can be undertaken for feasibility of rollout across all gap inpatient sites.

WINDOWS

Bedroom Windows: Anti ligature windows are due to commence installation in May 2017 within MRH bedrooms.

Common area windows are currently being reviewed for modification to locking mechanism to reduce risk to patients and provide staff with control.

Interim measures of locking off windows remains in place until windows identified as high risk are replaced.

FIXTURES AND FITTINGS

Sinks: Change of use for some wards has required the replacement of sink units to anti ligature models.

Toilets: Change of use for some wards has required the replacement of sink units to anti ligature models.

Exposed piping: All exposed piping under sinks is currently being reviewed with a view to boxing in or replacement of unit where additional risks from taps and flush handles exist.

Exposed cables: Cables especially for wall mounted televisions present a risk and these will be addressed within phase 2.

Observation Mirrors: To facilitate improved sightlines within inpatient areas observation mirrors have been trailed within Moredun ward and the roll out of these within GAP wards in MRH are underway.

FURNITURE

All wardrobe doors: (including cupboard doors) have been removed from inpatient bedrooms within GAP inpatient wards, POA wards within MRH and SCC, SMS and Forensic medium secure wards.

Drawer Units: Are currently being reviewed for level of ligature risk and for replacement with a standard specification of safe storage within bedrooms.

Chairs: All chairs have been removed from bedrooms and are risk assessed against clinical need of individual patient if they are returned to a bedroom.

Soft Furnishings: Curtains are all breakaway models however non mental health approved curtains with string pulls have been noted. Work is in progress to remove this risk.

OUTSIDE AREAS

Observation of internal courtyards has been increased with the introduction of dusk to dawn lighting as a control measure from ligature points on outdoor benches and lighting.

Access to high level ligature points and the roof line has been mitigated by application of anti climb paint to upper sections of down pipes within internal courtyards.

CONCLUDING STATEMENT

Reporting on status and actions is being reported to the Strategic Risk Management Group and the Clinical Care & Governance Committee.

The Environmental Programme seeks to secure an executive clinical lead to co chair the group.

Current clinical input is from Clinical Team Managers through attendance at meetings, distribution lists, and one on one contact with both Clinical Team Managers and Head of Services for issues specific to their areas.

Partnership working with PFPI contracted services and external contracted services to deliver environmental outcomes where required is ongoing.

Item Number 4.3

AUDIT COMMITTEE

Audit Committee Workplan 2017/18

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

	Responsible Officer	Comment	Meeting 11 May 2017	Meeting 22 Jun 2017	Meeting 24 Aug 2017	Meeting 14 Dec 2017	Meeting 15 Mar 2018	Meeting May 2018	Meeting June 2018
Regular reports submitted to the Audit Committee									
Audit Follow Up									
Full Cycle Reports	L Bedford	**6 Monthly**	**X**			**X**			
Mid Cycle Reports	L Bedford	**6 Monthly**			**X**		**X**		
Update of Audit Follow Up	L Bedford	**As & when available**							
Annual Accounts									
Accounting Policies	F Gibson	**Annual**					**X**		
Annual Accounts Guidance (incl Financial Statements Checklist)	F Gibson	**Annual**					**X**		
Governance Statement	F Gibson	**Annual**		**X**					**X**
Review of Annual Accounts for Exchequer	L Bedford	**Annual**		**X**					X
Review of Annual Accounts for Endowments	L Bedford	**Annual**		**X**					X
Review of Annual Accounts for Patient Funds	L Bedford	**Annual**		**X**					X
Losses and Compensation Payments	L Bedford	**Annual**		**X**					X

	Responsible Officer	Comment	Meeting 11 May 2017	Meeting 22 Jun 2017	Meeting 24 Aug 2017	Meeting 14 Dec 2017	Meeting 15 Mar 2018	Meeting May 2018	Meeting June 2018
Risk Management									
Strategic Risk Management Group Annual Report	**M Dunning**	**Annual**	**X**						
Risk Management Mid Year Report	**H Walker**	**6 monthly**		**X**					
Risk Management Annual Report	**H Walker**	**Annual**	**X**						
Risk Management Workplan	**H Walker**	**Annual**	**X**						
Risk Management Strategy (last presented 3/9/15)	**H Walker**	**5 yr document (last presented 03/09/15)**	**-**	**-**		**-**	**-**	**-**	**-**
Risk Management CIPFA Self Assessment and Audit Checklist	**H Walker**	**Annual**	**X**						
Review on Internal Controls									
Committee Annual Report s and Assurances incl. Best Value Assurance	**L Bedford**	**Annual**		**X**					**X**
Review Framework of Internal Controls and Corporate Governance	**L Bedford**	**Annual**		**X**					**X**
Lead Officer Statement on Governance Statement on Internal Control to Chief Internal Officer	**L Bedford**	**Annual**		**X**					**X**
Chief Internal Auditors Annual Report & Assurance Statement	**T Gaskin**	**Annual**		**X**					**X**
Code of Corporate Governance									
Updates to Code of Corporate Governance	M Dunning	**As & when available**		**X**					
Governance Review Group Annual Report	M Dunning	**Annual**		**X**					**X**

	Responsible Officer	Comment	Meeting 11 May 2017	Meeting 22 Jun 2017	Meeting 24 Aug 2017	Meeting 14 Dec 2017	Meeting 15 Mar 2018	Meeting May 2018	Meeting June 2018
Internal Audit									
Internal Audit Progress Report	B Hudson	**Standing Item**	**X**		**X**	**X**	**X**	**X**	
Internal Audit Interim Review	T Gaskin	**Annual**				**X**			
Internal Audit Annual Report (incl report on previous years Internal Control)	T Gaskin	**Annual**		**X**					**X**
Internal Audit Annual Plan	T Gaskin	**Annual**	**X**					**X**	
Private Discussions	T Gaskin	**Standing Item**							
External Audit – Audit Scotland									
Annual Audit Plan **(last presented 17/01/17)**	B Crosbie	**Annual**				**X**			
External Audit Plan Progress Report	B Crosbie	**Quarterly**			**X**				
External Audit Interim Report	B Crosbie	**Annual**	**X**						
Audit Scotland Annual Report on NHS Scotland	L Bedford	**Annual**			**X**				
Audit Scotland Reports (incl Technical Bulletins)	L Bedford	**As & when available**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Notification from Sponsored Body Audit Committees	L Bedford	**Annual**		**X**					**X**
Annual Report on the previous year audit to the Board and the Auditor General for Scotland	B Crosbie	**Annual**		**X**					**X**

	Responsible Officer	Comment	Meeting 11 May 2017	Meeting 22 Jun 2017	Meeting 24 Aug 2017	Meeting 14 Dec 2017	Meeting 15 Mar 2018	Meeting May 2018	Meeting June 2018
External Audit - Other									
Review withExternal AuditorAudit Planning Memorandum , Fees & Reporting Arrangements	L Bedford	**Annual**		**X**					**X**
Review of Audit Plan of Endowment Funds – External Audit Report (MMG Archbold)	P Crichton	**Annual**		**X**					**X**
Review of Audit Plan of Patients' Funds – External Audit Report (Henderson Loggie)	D Taylor	**Annual**		**X**					**X**
Appointment of External Auditors Endowment & Patients Funds & approval of fees	R MacKinnon	**As & when required**				**X**			
Counter Fraud Services									
Counter Fraud Services Update	R MacKinnon	**Standing item**	**X**		**X**	**X**	**X**	**X**	
National Fraud Initiatives (& Bribery Act) Progress Report	R MacKinnon	**Standing item**	**X**		**X**	**X**	**X**	**X**	
Patient Exemption Checking (PECS) Annual Report	R MacKinnon	**Annual**		**X**					**X**
Payment Verification									
Payment Verification Update • General Pharmaceutical Svs • General Ophthalmic Svs • General Dental Svs • General Medical Svs	J Haskett	**Standing item**	**X**		**X**	**X**	**X**	**X**	

	Responsible Officer	Comment	Meeting 11 May 2017	Meeting 22 Jun 2017	Meeting 24 Aug 2017	Meeting 14 Dec 2017	Meeting 15 Mar 2018	Meeting May 2018	Meeting June 2018
Annual Reports									
Audit Committee Annual Report	L Bedford	**Annual**	**X**					**X**	
Audit Committee Terms of Reference & Workplan	L Bedford	**Annual**	**X**					**X**	
Audit Committee Handbook & Checklist	L Bedford	**Annual**					**X**		
Other Reports									
Property Transactions Monitoring	L Lyall	**Annual**	**X**			**X**		**X**	
Litigation Monitoring	R MacKinnon	**Quarterly**	**X**			**X**			**X**
Minutes for Information									
Strategic Risk Management Group	M Dunning	**As & when available**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Governance Review Group	M Dunning	**As & when available**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Policies to be endorsed by the Committee as and when required									
Adverse Event Management Policy	H Walker	**Annually**			**X**				
Health and Safety/Risk Management Policies	Policy Managers	**As & when available**							

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

Item number 5.1

AUDIT 38/2017
Audit Committee
11 May 2017

AUDIT FOLLOW UP (AFU) – MID CYCLE UPDATE REPORT

1. PURPOSE OF THE REPORT

The purpose of this report is to present to the Audit Committee a progress update on the action taken since January 2017, relating to recommendations made in NHS Tayside Internal/External Audit reports.

2. RECOMMENDATIONS

The Committee is asked to note further progress made during the period from January 2017.

3. EXECUTIVE SUMMARY

This report is a mid-cycle update report and covers progress on D opinion Internal Audit Reports, and External Audit Reports. Comments are included in Appendix 1.

i. Internal Audit

- **T21/14, Medical Equipment and Devices** (taken in draft to Audit Committee November 2014) – Actions reported to Audit Committee January 2017. Action Points now complete, and
- **T22/17 Follow Up of Financial Planning and Management** (presented to Audit Committee March 2017) – to be considered separately under Agenda Item 5.

ii. External Audit

- **CFE2/16 Endowment Fund from MMG Archbold** (first presented to Audit Committee June 2015);
- **CFE3/17 Annual Report from PwC** (first presented to Audit Committee June 2016) - work has been undertaken and Director of Finance is leading on the outstanding points, and
- **CFE4/17 National Fraud Initiative from Audit Scotland** (first presented to Audit Committee September 2016) - Fraud Liaison Officer presented paper to January 2017 Audit Committee. Action complete.

iii. Internal Audit Interim Evaluation of Internal Control Framework Report

Progress on **T08/17, Interim Evaluation of Internal Control Framework 2016/17** (presented to Audit Committee March, 2017). The Interim Review highlighted areas for improvement which will enhance the Board's governance arrangements going forward. No grade was attached to this audit, but the importance of the report is recognised through the identification within this update.

For ease of reference, a definition of terms used is included at Appendix 2.

4. MEASURES FOR IMPROVEMENT

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

5. RESOURCE IMPLICATIONS

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

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

6. RISK ASSESSMENT

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

7. LEGAL IMPLICATION

There are no direct legal implications arising from this report.

8. IMPLICATIONS FOR HEALTH

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

9. EQUALITY AND DIVERSITY IMPACT ASSESSMENT

Not applicable.

10. DELEGATION LEVEL

The lead officer is the Director of Finance.

11. TIMETABLE FOR IMPLEMENTATION AND LEAD OFFICER

Regular update reports are provided to the Audit Committee.

The lead officer is the Director of Finance.

Lindsay Bedford
Director of Finance

May 2017

NHS TAYSIDE

AUDIT FOLLOW UP - MID CYCLE UPDATE REPORT - TO MAY 2017

APPENDIX 1

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

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

Report Ref	Report Title	Responsible Officer	Report Category	Original Due Date	Expected completion Date	Priority	Action Point No	Agreed Management Action to Audit Recommendation	Comment from Responsible Officer
T08/17	Interim Evaluation of Internal Control Framework	Chief Executive	Internal Audit					The report recommended further issues for consideration across the spectrum of Workforce & Care Assurance, Clinical Governanace, Staff Governance, Financial Governance, and Information Governance.	**Comment received May 2017**: Work progresses on all action points with the most pressing action relating to the the key principles for HSCI and year end assurance between the Board and the IJBs being formally agreed and documented, presently being worked through.

Report Ref	Report Title	Responsible Officer	Author	Original Due Date	Expected completion Date		Action Point No	Agreed Management Action to Audit Recommendation	Comment from Responsible Officer
CFE 2/16	Endowment Fund	Associate Director of Finance - Financial Services & Governance	MMG Archbold	Jun-15			4.2	A number of old funds remain unspent. Reserves policy would benefit from a timeframe for spending of old balances.	**Comment received May 2017:** The Assiciate Diirector of Finance is progressiing a Fund Reorganisation Scheme Proposal in respect of small dormant funds through Board of Trustees and Endowment Advisory Group and review the Policy & Procedures by Sept 2017.
CFE 3/17	Annual Report	Director of Finance	PWC	Sep-16			1.1	The Board should consider the implications of not setting a balanced budget for 2016/17 and the ranifications for future service provision. The Board should seek formal clarification from the Scottish Government of the implications of the Board being unable to manage the current gap in the budget resulting form the deficit at year end.	**Comment received May 2017**: An unbalanced LDP has been submitted for 2017/18. An efficiency programme has been set out to deliver £45.8m in 2017/18 against a breakeven target of £49.8m. An Advisory and Assurance Group has been invited by Scottish Government to provide comment on the Board's plans to return to a financially stable position in the medium term recognising the Transformation programme and assiociated workstreams in place to drive overall efficiency of the organisation and securing optimal service delivery models within resourcing limits.
CFE 3/17	Annual Report	Director of Finance	PWC	Aug-16			1.4	The Board should review its CNORIS accounting practices to ensure that reversal of unutilised provisions is recognised against annually managed expenditure.	**Comment received January 2017**: Accounting practices have been reviewed and updated as part of 15/16 audit. In year review of spreadsheets has been undertaken to ensure issue does not reoccur.

APPENDIX 2

AUDIT FOLLOW UP

DEFINITION OF TERMS

1. INTERNAL AUDIT OPINIONS AND PRIORITIES

Audit Opinions

Audit opinions are defined as follows:-

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

Audit Priorities

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

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

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

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

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

2. EXTERNAL AUDIT PRIORITIES

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

3. AUDIT FOLLOW UP – ACTION POINT STATUS

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

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

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

Item Number 6.1

AUDIT40/2017
Audit Committee
11 May 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 plan.

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. A summary of each report is included for information within Appendix 1 'Summary of Report Content'.

		Opinion	Draft Issued	Finalised
2016/17				
T01/17	Audit Risk Assessment and Planning	N/A	N/A	N/A
T20/17	Standards of Business Conduct	N/A	7 Apr 2017	10 May 2017
T24/17	Financial Process Compliance	N/A	3 Apr 2017	10 May 2017
T25/17	National Payroll System	A+	27 Apr 2017	10 May 2017

4.2 Draft Reports Issued

		Draft Issued
T26/17	Tayside Health Fund	4 May 2017

4.3 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	Aug 2017
T18/17	Food, Fluid & Nutrition	Aug 2017
T28/17	Information Security Framework	Aug 2017
2017/18		
T07/18	Governance Statement and Annual Report	June 2017

The following are projects for which we do not produce a formal report. Year end summaries are provided under Appendix 2.

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)
T12b/17	Assurance Framework/Risk Management
T20/17	Deputy FLO

4.4 Planning Commenced

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

2017/18	
T23/18	Post Transaction Monitoring

4.5 Changes to Operational Audit Plan 2016/17

At the request of the Chief Executive and Director of Finance and, following detailed discussion on priorities, risks, resources and planned external audit reviews, the following audits will be amended/replaced to allow time for work which is deemed to impart greater added value at this time.

T14/17	Organisational Performance Management
T19/17	Medicines Management – Realistic Medicines Workstream
T31/17	Workforce & Care Assurance Workstream

The Director of Finance will provide full details at the Audit Committee to allow discussion/approval.

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 30 April, 2017, actual input against the 2016/17 NHS Tayside plan stood at 425 days (97%) of the 438 days planned audit input for 2016/17 (overall days reflects section 4.4 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 under the supervision of the Chief Internal Auditor. Audit work is planned to allow the Chief Internal Auditor to provide the necessary assurances prior to the signing of the accounts.

Barry Hudson BAcc CA
Regional Audit Manager

Lindsay Bedford
Director of Finance

Jocelyn Lyall BAcc CPFA
Acting Regional Audit Manager

May 2017

Tayside NHS Board
Summary of Report Contents

Ref	Audit	Grade	Report Summary
T01/17	Audit Risk Assessment and Planning	N/A	The 2017/18 plan has been agreed with management and is presented as a separate agenda item.
T20/17	Standards of Business Conduct	N/A	On 15 June 2016 the Scottish Government Director for Health Finance wrote to Board Chief Executives regarding an NHS Scotland Counter Fraud Services (CFS) ongoing investigation into allegations that NHS Scotland staff may have received gifts and hospitality exceeding that allowed under standard financial instructions. The letter required Boards to carry out whatever processes were considered necessary to provide assurance that Standing Financial Instructions (SFIs) are being adhered to, and suggested that the following actions should be considered: • Commission internal audit to review processes for notification and recording of gifts and hospitality; • Confirm that the hospitality register across the Board is up to date and that entries conform to the SFIs; • Provide a reminder to all staff of the need to comply with SFIs in regards to the acceptance of gifts and hospitality and ensure that SFIs are read and understood; • Invite CFS to present to key staff on the provisions of the Bribery Act. The Standards of Business Conduct (SoBC) guidance in place within NHS Tayside reflects the overall legislative requirements, but could be further enhanced by the use of flowcharts, both to help all staff recognise Bribery and Corruption and to provide guidance on the management of gifts and hospitality. Examples of these flowcharts have been provided to the Board Secretary for consideration. We commend the approach taken by the Board Secretary within NHS Tayside by annually reminding managers *"to confirm that you understand and accept the principles of the Standards of Business Conduct for NHS Staff. You may wish to confirm this as evidence in*

			your eKSF." A Vital Signs communication issued to all staff via the NHS Tayside Intranet in December 2016 covered SoBC specifically. A report of all returns is held by the Board Secretary and is available if requested. Internal Audit reviewed the completed interest/gift/hospitality forms held and we recommended that the process could be further enhanced by recording the name of the line manager giving approval for the gift/hospitality to provide a clearer audit trail. Counter Fraud Services provided a presentation on Bribery and Corruption, and specifically the Bribery Act 2010, to the Senior Management Team on 21 February 2017**.**
T24/17	Financial Process Compliance	N/A	This review was limited to high level compliance testing on input and output controls within the central payroll, travel expenses, accounts receivable, accounts payable and banking systems. Based on the testing undertaken, we found no evidence to suggest that the systems were failing to meet business objectives. Controls were found to be operating well and in accordance with NHS Tayside's extant Financial Operating Procedures. The report highlighted some minor control issues (priority 3 & 4) and management have agreed actions to address these. Work has also commenced on a review of the Travel/Accommodation Policy and Car Lease Policy. Procedures will be reviewed in light of these policy reviews and management have agreed to address our findings in this area. We commented positively on Maryfield Financial Service's performance in the areas of Accounts Payable invoice processing cost, Accounts Receivable invoice/credit note processing cost, as well as prompt payment of invoices and the accuracy of payroll data against national targets, and in participation in national focus groups which aim to deliver service improvements and efficiencies and review benchmarking data to share good practice and identify efficiencies.
T25/17	National ePayroll Maintenance	A+	Throughout the year the NHSScotland (NHSS) National Payroll project team based at Maryfield House South, Dundee make updates to payscale - job description masterfiles, Agenda for Change paybands, post descriptors and Allowance/Deduction Codes. This audit provided assurance on the accuracy of these updates. The amendments to the Pay Band files notified in the updates for April 2016 to March 2017 were checked to supporting records and we tested the input details of Allowance/Deduction Code File Amendments for the same period. Amendments include changes to salaries, job descriptions, detail codes, allowance/deduction codes and changes to conditioned hours.

			This represented 1012 individual amendments to the system. Internal Audit concluded that amendments were as notified in the update letters and only appropriate authorised amendments were processed.

Tayside NHS Board
Internal Audit Year End Position Statements

T02/17	Audit Management and Liaison with Directors	Meetings were held with the Director of Finance to discuss audit issues and review progress against the audit plan. Other meetings with the Chief Executive, Executive Directors and Non Executives were held as required and reflected the increased need for pro-active interaction in the current year.
T03/17	Liaison with External Auditors	Ongoing liaison and sharing of audit reports with Audit Scotland.
T04/17	Audit Committee	Attendance at each Audit Committee and agenda planning meetings, including preparation of required papers. The Chief Internal Auditor (CIA) presented the issues raised in the Internal Audit Interim Review 2016/17 to the March 2017 Audit Committee. The CIA has liaised with and advised the Audit Committee lead officer and the Board Secretary on the requirements of Annex F of the Audit Committee Handbook.
T05/17	Clearance of Prior Year	Time spent to clear outstanding reports from the previous year's audit plan.
T10a/17	Code of Corporate Governance	During 2016/17 the Governance Review Group continued, under the Chairmanship of the Board Secretary, to review and update the Code of Corporate Governance and discuss other governance issues. The Regional Audit Manager (RAM) attended this group, contributed to the debate, and contributed to the updates to the Code of Corporate Governance.
T11b/17	CIA Attendance at Board meetings	The CIA has attended Board meetings throughout the year and provided information, advice and opinions to the Board and its members as appropriate. The CIA attended quarterly meetings with the Board Chair and provided ad-hoc advice to members and officers on a range of issues. The RAM has similarly liaised with senior officers. Internal Audit routinely reviews all Standing Committee minutes and papers to highlight areas for inclusion within relevant audit reviews.

Tayside NHS Board
Internal Audit Year End Position Statements

T12b/17	Assurance Framework / Risk Management	Throughout 2016/17 regular meetings with Clinical Governance & Risk colleagues continued. Standing Agenda items included the Board Assurance Framework (BAF), strategic risk reporting, Adverse Event Management and risk management arrangements for Health & Social Care Integration. Throughout the year, Internal Audit assisted and advised on governance aspects of NHS Tayside risk management. During 2016/17 the CIA provided advice to Risk Owners and Managers on the content of individual BAFs as well as the BAF template.
T26a/17	Deputy FLO	The RAM in his role as Deputy Fraud Liaison Officer (FLO), provided support to the FLO, deputised where required and attended meetings with Counter Fraud Services.

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

Item Number 6.2

AUDIT39/2017
Audit Committee
11 May, 2017

FOLLOW UP OF FINANCIAL PLANNING
AUDIT REPORT NO. T22/17

1. PURPOSE

To provide the Audit Committee with an update with regard to the implementation of the Audit Recommendations as a consequence of Internal Audit Report T22/17, Follow Up of Financial Planning.

2. RECOMMENDATION

The Committee is requested to note the current position.

3. EXECUTIVE SUMMARY

Appendix 1 provides an update on the status of the audit recommendations and the consequent management actions arising from the Follow Up of Financial Planning presented to the Audit Committee by the Chief Internal Auditor at its meeting in March 2017.

Text highlighted in **bold** in the appendix reflects revised information from that presented to the March Audit Committee.

4. MEASURES FOR IMPROVEMENT

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

5. RESOURCE IMPLICATIONS

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

6. DELEGATION LIMIT

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

7. RISK ASSESSMENT

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

8. IMPLICATIONS FOR HEALTH

There are no direct implications for health.

9. TIMETABLE FOR IMPLEMENTATION AND LEAD OFFICER

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

10. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

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

Lindsay Bedford
Director of Finance

May 2017

Appendix

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
1.	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 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 Committee."* 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 Finance and Resources Committee 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 May 2017 **Discussion with Chair of the Finance and Resources Committee taken place.** **Informal Finance and Resources Committee meetings will be arranged during May 2017. Finance and Resources Committee meetings for 2018/19 will be arranged to be held towards the end of a month.** **Informal meetings will alternate with the formal Finance and Resources Committee and Board meetings.**

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. 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.	**2** **3**	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. A glossary will be developed	Director of Finance April 2017 **The Corporate Financial Report for 2017/18 will build on the improvements introduced last year, taking cognisance of the audit points raised.** Director of Finance April 2017 **A glossary will feature as part of the 2017/18 Corporate Finance Report.**
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	**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 Finance & Resources Committee to monitor its status throughout the year	Director of Finance April 2017 **NHS Tayside Board approved Financial Framework in March 2017.** **Enhanced reporting will feature in the Finance and Resources**

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
		Committee can monitor its status throughout the year and understand its underlying impact on the year-end financial position and on future years.			**Committee reports in 2017/18.**
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 […] 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.	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
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

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
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	**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 **The year end report once produced will take cognisance of any impact flowing through to 2017/18**

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
		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.			
8.	The Corporate Financial Report considered by the NHST 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. 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	The layout of the Corporate Financial Report should be further revisited to include: • a breakdown of recurring and non-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 target to ensure accuracy and transparency. • A projected savings position as at 31 March split by recurring and non-recurring.	**2**	Reports to the most recent standing committees have already incorporated this enhanced level of reporting.	Actioned

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
	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.	• 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 **Update to Strategic Financial Plan Risk reported to NHS Tayside Board 4th May**
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 out of synch 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

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

Item Number 7.1

AUDIT37/2017
Audit Committee
11 May 2017

AUDIT SCOTLAND
NHS TAYSIDE EXTERNAL AUDIT INTERIM REPORT 2016/17

Bruce Crosbie
Senior Audit Manager

Lindsay Bedford
Director of Finance

May 2017

NHS Tayside

Interim Audit Report 2016/17

AUDIT SCOTLAND

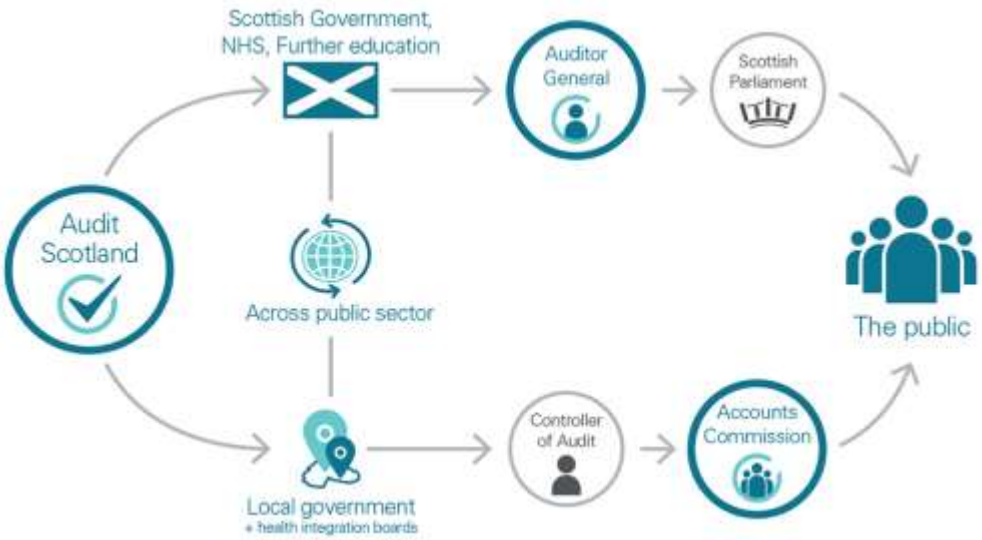
Prepared for NHS Tayside

April 2017

Who we are

The Auditor General, the Accounts Commission and Audit Scotland work together to deliver public audit in Scotland:

- The Auditor General is an independent crown appointment, made on the recommendation of the Scottish Parliament, to audit the Scottish Government, NHS and other bodies and report to Parliament on their financial health and performance.
- The Accounts Commission is an independent public body appointed by Scottish ministers to hold local government to account. The Controller of Audit is an independent post established by statute, with powers to report directly to the Commission on the audit of local government.
- 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.

Contents

Audit findings

Introduction

1. This report contains a summary of the key issues identified during the interim audit work carried out at NHS Tayside. This work included testing of key controls within financial systems to gain assurance over the processes and systems used in preparing the financial statements. We will use the results of this testing to determine our approach during the 2016/17 financial statements audit.

2. Our responsibilities under the Code of Audit Practice require us to assess the system of internal control put in place by management. We seek to gain assurance that the audited body:

- has systems of recording and processing transactions which provide a sound basis for the preparation of the financial statements
- has systems of internal control which provide an adequate means of preventing and detecting error, fraud or corruption
- complies with established policies, procedures, laws and regulations.

3. Under the Code of Audit Practice (2016) we are also carrying out work on the wider dimension audit.

Conclusion

4. We found that overall, the systems of internal control are generally sound. We did identify some control weaknesses from our interim audit work which we have summarised in Exhibit 1 . Where appropriate we will be carrying out additional work in response to these findings. This will enable us to take planned assurance for our audit of the 2016/17 financial statements.

5. In terms of our wider dimension audit work, this focuses on financial management, financial sustainability, governance and transparency and value for money. Findings from this work will be reported separately in our Annual Audit Report in June 2017. Some preliminary findings from our work to date are included in Exhibit 1.

Work summary

6. Our 2016/17 testing covered key controls in a number of areas including bank reconciliations, payroll validation and exception reporting, authorisation of journals, change of supplier bank details and ledger access controls. Additionally, our testing covered budget monitoring and control, feeder system reconciliations and family health service expenditure.

Bank reconciliations

Payroll controls

IT access

Budgets

7. In accordance with *ISA 330: the auditor's response to assessed risk*, we have designed and performed tests of controls to obtain sufficient appropriate audit evidence as to the operating effectiveness of relevant controls in the current year. Our risk based audit approach also requires us to, where possible, place reliance on the work of internal audit to avoid duplication of effort.

8. The contents of this report have been discussed with relevant officers to confirm factual accuracy. The co-operation and assistance we received during the course of our audit is gratefully acknowledged.

Risks identified

9. The key control and wider dimension risks identified during the interim audit are detailed in Exhibit 1. These findings will inform our approach to the financial statements audit where relevant.

10. Any weaknesses identified represent those that have come to our attention during the course of normal audit work and therefore are not necessarily all the weaknesses that may exist. It is the responsibility of management to decide on the extent of the internal control system appropriate to NHS Tayside.

Additional follow-up work

11. Based on our audit work to date, we have concluded that overall, the systems of internal controls are generally sound. We identified some control weaknesses as set out in Exhibit 1, which mean that additional audit work is required to allow us to obtain the necessary assurances for the audit of the 2016/17 financial statements. Specifically this will focus on substantively testing changes in suppliers' bank details.

Exhibit 1

Key findings and action plan 2016/17

Issue identified/ Risk	Management response	Responsible officer and target date
Audit findings		
Payroll - exception reports Exception reports are reviewed by a payroll officer to identify any potential errors in the payroll run. We were advised that a second spot check is undertaken by a senior payroll officer but a review of a sample of 10 exception reports showed no evidence of this spot check. **There is a risk that payroll errors and frauds go undetected.**	All warning and errors exception reports are generated by ePayroll. They are all checked by Payroll staff at 1st Pre Payroll, 2nd Pre Payroll or payroll input close deadline and the actions taken to address the exception is noted on CALCY. This database allows checks to be done by Team Leaders to ensure all messages are checked prior to payroll input close deadline. This is an enhanced method of checking exception reports; is auditable in terms of who has undertaken the check and the reason or action taken. The necessary spot checks are undertaken on a random basis in terms of selecting an exception message. However Team Leaders have noted their checks as an over-write of the Payroll Officer check, rather an addition to the Payroll Officer check. A reminder of the correct procedure has been issued.	Already actioned

Issue identified/ Risk	Management response	Responsible officer and target date
Family health service expenditure - reconciliations Monthly ledger reconciliations for the General Pharmaceutical Services (prescribing) stream were not completed for periods 2 and 5. We were advised that this was due to work pressures and subsequent period reconciliations would have identified any issues from previous un-reconciled periods. **Although later period reconciliations should subsequently identify any issues of reconciliation, there is a risk that errors and irregularities are not detected timeously.**	Reconciliations will be completed on a monthly basis for Months 2 to 12.	Primary Care Accountant 30 June 2017
Accounts payable - changes to supplier bank details When notified of bank detail changes, officers are required to contact the supplier directly using the existing contact details stored in the eFinancials financial ledger to confirm the change. This control guards against fraudulent changes. We tested a sample of 15 supplier bank detail changes in 2016/17 and identified that 4 showed no evidence of checking and 5 showed some evidence of checking, but had not been signed to fully evidence the check.	The Team are well aware of the importance of these checks. The Accounts Payable Team have been reminded that the checks performed need to be evidenced so that a clear audit trail is available.	Already actioned
We were also advised that Finance Process Manager (FPM), the tool used to upload standing data amendments to eFinancials, does not prevent changes being input and approved by the same officer. This creates a weakness in segregation of duties controls. We identified 6 of the 15 samples tested where the change had been input and approved on FPM by the same officer. We were advised that NHS Tayside have recognised this issue and in December 2016 put in place a manual process which required one officer to input the change and a second officer to approve the change. As a result we tested a further 10 cases from December 2016 and found that in all but one instance, the process had been properly applied. **The absence of checks of bank account detail changes and of segregation of duties increases the risk of fraudulent payments. We are**	NHS Tayside has now allocated separate input and authoriser roles within the Accounts Payable Team to ensure that the absence of a system validation check does not lead to a weakness in segregation of duties. Team Leaders will not input and rely on other Team Leaders to authorise those requests in the FPM system. They will only now authorise requests in FPM.	Already actioned

Issue identified/ Risk	Management response	Responsible officer and target date
pleased to note that improved segregation has been put in place, although we would recommend that this process be re-emphasised to accounts payable officers (due to the one 'failure' of this control identified in our additional testing).		
Wider dimension issues and risks		
Transparency - Register of Hospitality NHS Tayside's Code of Conduct requires a Register of Hospitality to be maintained and published on the website. We could find no evidence of the register on the Board's website. **NHS Tayside may be unable to demonstrate openness in the receipt of gifts and hospitality, receipt of which could be interpreted as an attempt to gain preferential treatment.**	NHS Tayside will publish this information for 2017/18 onwards. The information that will be published will be as follows: • designation • date received • nature of hospitality	Board Secretary 31 October 2017
Transparency - Public Sector Reform The Public Services Reform (Scotland) Act 2010 requires prescribed categories of information to be made available on the board's website. The information on the board's website is not up to date for some of the prescribed categories. **NHS Tayside may be unable to demonstrate that it is compliant with Public Services Reform legislation.**	We will update the website as soon as practicable in line with the following timetable: • all information for prescribed categories up to 2015/16. • all information for prescribed categories for 2016/17.	Board Secretary 30 June 2017 31 October 2017

Source: Audit Scotland

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

NHS Tayside

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Item Number 8.1

AUDIT27/2017
Audit Committee
11 May 2017

ANNUAL REPORT OF THE STRATEGIC RISK MANAGEMENT GROUP 2016/17

Margaret Dunning
Board Secretary

Lindsay Bedford
Director of Finance

May 2017

ANNUAL REPORT OF THE STRATEGIC RISK MANAGEMENT GROUP 2016-2017

1. PURPOSE

The purpose of the report is to provide an assurance to the Audit Committee on the work undertaken by the Strategic Risk Management Group during 1 April 2016 to 31 March 2017.

2. STRATEGIC RISK MANAGEMENT GROUP

2.1 Composition

During the financial year ended 31 March 2017 membership of the Strategic Risk Management Group comprised:

Chairperson: Ms Margaret Dunning

Ms K Anderson	Director of Allied Health Partnerships (AHPs)	
Mr K Armstrong	Director of Operations	
Mr L Bedford	Director of Finance	
Ms J Bodie	Director of eHealth	
Mrs G Costello	Nurse Director	
Mr G Doherty	Director of Human Resources and Organisational Development	
Ms M Dunning	Board Secretary **(Chair)**	
Mrs J Golden	Employee Director	
Ms L McLay	Chief Executive	
Mr B Nicoll	Director of Strategic Change	to August 2016
Dr K Ozden	Director of Mental Health, Associate Nurse Director	to Dec 2017
Ms F Rooney	Director of Pharmacy	
Prof A Russell	Medical Director	
Dr D Walker	Director of Public Health	
Dr M Watts	Associate Medical Director, Primary Care	
Ms L Wiggin	Director of Acute Services	
Dr P Williamson	Director of Health and Care Strategy	to Dec 2017
In attendance		
Ms D Clark	Health and Safety Manager	to April 2016
Miss D Howey	Head of Committee Administration	
Ms E Leslie	Head of Resilience	
Ms A Napier	Associate Director, Clinical Governance and Risk	
Dr G Phillips	Lead Infection Control Doctor	
Mrs H Walker	Risk Manager	

Support to the group is provided by Alison Hodge.

2.2 Meetings

The Committee has met on 4 occasions during the period 1 April 2016 to 31 March 2017 on the undernoted dates:

7 April 2016

15 August 2016

24 November 2016

2 February 2017

The record of attendance is attached as Appendix 1.

2.3 Business

Details of the business items considered are attached at Appendix 2.

Minutes of the meetings of the Strategic Risk Management Group have been submitted to the Audit Committee for its information at the next possible meeting.

3. OUTCOMES

Outcomes in relation to each item of business have been recorded in the Strategic Risk Management Group's Minutes.

4. CONCLUSION

As Chair of the Strategic Risk Management Group during the financial year 2016-2017, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken, and the range of attendees at meetings of the Strategic Risk Management Group has allowed us to fulfil our remit as detailed in the Terms of Reference. As a result of the work undertaken during the year I can confirm that adequate and effective risk management arrangements were in place throughout NHS Tayside during the year.

I would again pay tribute to the dedication and commitment of fellow members of the Committee and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings of the Strategic Risk Management Group and express my thanks to Alison Hodge for her support.

(signed)……..

Ms Margaret Dunning
Board Secretary

CHAIRPERSON (2016 - 2017)
On behalf of the Strategic Risk Management Group

Appendix 1

Record of attendance

Strategic Risk Management Group 1 April 2016 – 31 March 2017

Name Designation		April 2016	August 2016	November 2016	February 2017
Members					
Ms K Anderson	Director of Allied Health Partnerships (AHPs)	apologies	apologies	present	apologies
Mr K Armstrong	Director of Operations	apologies	apologies	apologies	_
Mr L Bedford	Director of Finance	present	present	present	present
Ms J Bodie	Director of eHealth	apologies	F Stewart	apologies	F Stewart
Mrs G Costello	Nurse Director	present	present	present	present
Mr G Doherty	Director of Human Resources and Organisational Development	present	present	apologies	J Mudie
Ms M Dunning	Board Secretary (Chair)	present	present	present	present
Mrs J Golden	Employee Director	present	apologies	apologies	apologies
Ms L McLay	Chief Executive	apologies	apologies	apologies	apologies
Mr B Nicoll	Director of Primary and Community Services	present	present	_	_
Dr K Ozden	Director of Mental Health Services and Associate Nurse Director	present	present	apologies	_
Ms F Rooney	Director of Pharmacy	apologies	present	apologies	apologies
Prof A Russell	Medical Director	A Cook	present	present	apologies
Dr D Walker	Director of Public Health	H Scott	present	apologies	apologies

Name	Designation	April 2016	August 2016	November 2016	February 2017
Members					
Dr M Watts	Associate Medical Director, Primary Care	apologies	apologies	apologies	G McClure
Ms L Wiggin	Director of Acute Services	K Wilson	present	apologies	A Warden
In attendance					
Mrs D Clark	Health and Safety Manager	present	_	_	_
Miss D Howey	Head of Committee Administration	apologies	present	apologies	present
Ms E Leslie	Head of Resilience Planning	present	present	present	present
Ms A Napier	Associate Director, Clinical Governance and Risk	apologies	apologies	apologies	present
Dr G Phillips	Lead Infection Control Doctor	present	present	present	present
Mrs H Walker	Risk Manager	present	apologies	present	present

STRATEGIC RISK MANAGEMENT GROUP (SRMG)

SCHEDULE OF BUSINESS CONSIDERED DURING YEAR 1 APRIL 2016 TO 31 MARCH 2017

7 APRIL 2016

Clinical Governance and Risk Management Update Period 5

Risk Management CIPFA Self Assessment and Audit Checklist

Risk Management Annual Report 2015/16

Risk Management Workplan 2016/17

Board Committee Report and Assurance Report Template

New strategic risks – update on progress
- NHS Tayside Estates Infrastructure
- Capacity and Flow (Winter Plan)
- Primary Care

Strategic risks aligned to the Tayside NHS Board
- Control of Infection
- Waiting Times and RTT
- Health Equity
- Health and Social Care Partnerships

Strategic risks aligned to the Finance and Resource Committee
- Strategic Financial Plan
- Reduction in Capital
- Information Governance

Strategic risks aligned to the Staff Governance Committee
- Workforce Optimisation
- Medical Workforce
- Nursing Workforce

Strategic risks aligned to the Clinical and Care Governance Committee
- Older People
- Clinical Governance
- Children and Young People
- Mental Health
- Person Centred Care
- Maternity Services
- PRI/ Patient Flow

Risk horizon scanning and emerging themes

Update on Health and Safety Reporting

Health, Safety and Fire Quarterly Update

Resilience Planning Quarterly Update

Policy Management Report

Annual Report of the Strategic Risk Management Group 2015/16

Strategic Risk Management Group Terms of Reference 2016/17

Strategic Risk Management Group Membership 2016/17

Strategic Risk Management Group Workplan 2016/17

Strategic Risk Management Group meeting dates 2016/17

15 AUGUST 2016

Clinical Governance and Risk Management Update 1/2/16 – 31/3/16

Clinical Governance and Risk Management Update 1/4/16 – 31/5/16

Operational Risks

New risks

- Health and Safety
- Implementation of TrakCare
- Managed/2c Practices

Assurance update on progress reports

- NHS Tayside Estates Infrastructure
- Capacity and Flow (Winter Plan)
- Primary Care
- Health and Social Care Partnerships

Exception reporting updates

Strategic risks aligned to the Tayside NHS Board

- Control of Infection
- Waiting Times and RTT
- Health Equity

Strategic risks aligned to the Finance and Resource Committee

- Strategic Financial Plan
- Reduction in Capital
- Information Governance

Strategic risks aligned to the Staff Governance Committee

- Workforce Optimisation
- Medical Workforce
- Nursing Workforce

Strategic risks aligned to the Clinical and Care Governance Committee

- Older People
- Clinical Governance
- Children and Young People
- Mental Health
- Person Centred Care
- Maternity Services
- PRI/ Patient Flow

Risk horizon scanning and emerging themes

Health and Safety

- Update on Health and Safety Reporting
- Health and Safety Quarterly Report
- Fire Safety Update

Resilience Planning

- Resilience Planning Quarterly Update
- Resilience Planning Annual Report 2015/16

Policy Management

- Policy Management Quarterly Report

Governance

- Strategic Risk Management Group Workplan 2016/17
- Strategic Risk Management Group meeting dates 2016/17
    - Thursday 3 November 2016
    - Thursday 2 February 2017

Items for information

- Action note NHS Tayside Incident Feedback and Risk Management Datix Implementation Group 7 June 2016

24 NOVEMBER 2016

Risk Management

- Risk Management Mid Year report

Strategic risks aligned to the Tayside NHS Board

- Infection Management
- Waiting Times and RTT Targets
- Health Equity
- NHS Tayside Estates Infrastructure Condition
- Capacity and Flow (Winter Plan)
- Sustainable Primary Care Services

Strategic risks aligned to the Finance and Resource Committee

- Strategic Financial Plan 2015/16 - 2019/20
- Impact of Reduction in Capital Resources
- Information Governance
- Implementation of TrakCare

Strategic risks aligned to the Staff Governance Committee

- Workforce Optimisation
- Medical Workforce
- Nursing and Midwifery Workforce
- Health and Safety

Strategic risks aligned to the Clinical and Care Governance Committee

- Delivering Care for Older People
- Clinical Governance
- Health Protection of Children and Young People
- Person Centredness
- Maternity Services
- PRI/ Patient Flow
- Mental Health Services – Sustainability of Safe and Effective Services
- Managed/ 2C Practices

Risk horizon scanning and emerging themes

Health and Safety

- NHS Tayside Health and Safety Support

Resilience Planning

- Resilience Planning Quarterly Update

Policy Management

- Policy Management Quarterly Report

Governance

- Strategic Risk Management Group Workplan 2016/17

2 FEBRUARY 2017

Risk Management

- Risk Appetite Statement
- Internal Audit Report T12/16 Assurance Framework Recommendation 6

Strategic risks aligned to the Tayside NHS Board

- Infection Management
- Waiting Times and RTT Targets
- Health Equity
- NHS Tayside Estates Infrastructure Condition
- Capacity and Flow (Winter Plan)
- Sustainable Primary Care Services

Strategic risks aligned to the Finance and Resource Committee

- Strategic Financial Plan 2015/16 - 2019/20
- Impact of Reduction in Capital Resources
- Information Governance
- Implementation of TrakCare

Strategic risks aligned to the Staff Governance Committee

- Workforce Optimisation
- Medical Workforce
- Nursing and Midwifery Workforce
- Health and Safety

Strategic risks aligned to the Clinical and Care Governance Committee

- Delivering Care for Older People
- Clinical Governance
- Health Protection of Children and Young People
- Person Centredness
- Maternity Services
- PRI/ Patient Flow
- Mental Health Services – Sustainability of Safe and Effective Services
- Managed/ 2C Practices

Risk horizon scanning and emerging themes

Health and Safety

- NHS Tayside Health and Safety Support

Resilience Planning

- Resilience Planning Quarterly Update
- Core Competencies for Major Incidents and Emergencies

Policy Management

- Policy Management Quarterly Report

Governance

- Strategic Risk Management Group Workplan 2016/17

Items for information

- Datix Implementation Group meeting 13 December 2016
- Sharps Management Committee 26 August 2016
- Sharps Management Committee 26 October 2016
- Strategic Risk Management Meeting Dates for 2017/18

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

Item Number 8.2

AUDIT28/2017
Audit Committee
11 May 2017

RISK MANAGEMENT ANNUAL REPORT

1. PURPOSE OF THE REPORT

To provide the Audit Committee with an annual report in relation to Risk Management activities which have been undertaken during 2016/17.

2. RECOMMENDATIONS

The Committee is asked to:

- Review and approve the report attached in Appendix 1.
- Recommend any further action/reports it considers necessary.

3. EXECUTIVE SUMMARY

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 an annual Governance Statement.

As part of the minimum requirements an assessment of the effectiveness of risk management arrangements should be conducted and it is recommended that this is evidenced by a Mid and Year End Risk Management report confirming whether adequate and effective risk management arrangements were in place throughout the financial year.

Within NHS Tayside the Audit Committee has delegated responsibility from Tayside NHS Board for reviewing the organisations risk management arrangements, systems and processes.

The presentation of this report demonstrates adequate and effective arrangements for Risk Management are in place and the contribution, in governance terms, that the systems in place to manage risk make throughout NHS Tayside.

4. REPORT DETAIL

Please refer to report 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, IT Training and the Clinical Governance and Risk Management Team to produce this paper. The Strategic Risk Management Group were consulted on in relation to the content of the report.

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/Red (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 M Dunning, Board Secretary, is the Executive Lead for Strategic Risk Management and the delegated Chair of the Strategic risk management Group.

Dr A Russell, Medical Director and Mrs G Costello, Nurse Director are the Executive Leads for Clinical Governance.

Mrs Hilary Walker, Risk Manager is responsible for the implementation of risk management plans and the 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. Work in relation to the changes and improvements outlined within this paper, are in progress. Implementation of any actions will be immediate following approval by the Audit Committee

Hilary Walker
Risk Manager

Lindsay Bedford
Director of Finance

Margaret Dunning
Board Secretary

May 2017

Appendix 1

RISK MANAGEMENT

ANNUAL REPORT

2016/17

Ms L McLay
Chief Executive
NHS Tayside

Introduction

The Chief Executive, as Accountable Officer, has responsibility for maintaining a sound system of Internal Control and reviewing the effectiveness of the system within the organisation culminating in the preparation of an annual Governance Statement. In addition, NHS Scotland bodies are subject to the requirements of the Scottish Public Finance Manual and must operate a risk management strategy.

Within NHS Tayside the Audit Committee has delegated responsibility from Tayside NHS Board for evaluating the organisations risk management arrangements, systems and processes.

As part of the governance reporting arrangements for risk management it has been agreed that the Audit Committee will receive and review the:

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

to provide assurance to the public, patients and staff that the organisation is doing its very best to manage risk adequately and effectively.

The management of risk is a key organisational responsibility and a strategy has been has agreed that aims to control risk to an acceptable level by creating a culture of risk management that focuses on assessment and prevention rather than reaction and remedy. Risk extends much further than solely harm to patients, staff and the public and NHS Tayside sets out its objectives in its Local Delivery Plan. Risk management also concerns itself with managing the threats to the achievement of those objectives and the opportunities risk analysis offers.

NHS Tayside ensures that arrangements for managing risk are fully embedded within the day-to-day management processes. To support this, there is a need to ensure that a progressive, honest and open environment exists, where mistakes and untoward adverse events are identified quickly and acted upon in a positive and constructive way without fear of blame.

Risk Management

Strategic Risk Management Group

Throughout 2016/17 the Strategic Risk Management Group met in April, August and November 2016 and February 2017 under the Chairmanship of the Board Secretary. Approved minutes have been submitted timeously to the Audit Committee for information and discussion.

Board Assurance Framework/Strategic Risk Profile

During 2016/17 the Strategic Risk Management Group have reviewed the strategic risk profile and received updates in relation to progress against each of the risks on a quarterly basis as detailed above. Through provision of horizon scanning they have agreed the addition of strategic risks in relation to Health and Safety, Implementation of Trakcare and Managed/2c Practices. They have also endorsed the archiving of the strategic risk pertaining to Health and Social Care Integration. This has resulted in the number of Strategic risks increasing to 22.

The strategic risk profile was presented to NHS Tayside Board in June and October 2016 and February 2017.

It was recognised in Internal Audit Report T13B/16 (Follow Up of T13B/14 – Risk Maturity) which was published on 12 November 2015 that a substantial amount of work had been undertaken since the issue of the original risk maturity report on 29 May 2014.

Since then further work to embed risk management systems and processes has concluded. This includes increased and more robust strategic and operational risk reporting arrangements, the introduction of horizon scanning as a standing agenda item at the SRMG, the development of an additional assurance reporting template and the review and further development of risk appetite. As a result, following

discussion and consultation with the Board Secretary and colleagues from Internal Audit, it was agreed at Tayside NHS Board in February 2017 to reduce the reporting of the Board Assurance Framework in full from 4 times per annum to biannually with assurance also being received through Committee Chairs Assurance Reports and the minutes and committee report from the Audit Committee which has delegated authority for risk management.

Risk Appetite
Internal Audit Report T13B/16 published on 12 November 2015 recommended further articulation of risk appetite in numerical terms. 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. This was presented to the Strategic Risk Management Group for endorsement and the Audit Committee for approval in February and March 2017 respectively.

Risk Management Strategy/Risk Management Guidance Note
The Risk Management Strategy was presented to and approved by Tayside NHS Board on 29 October 2015 following endorsement by the Strategic Risk Management Group and Audit Committee on 20 August and 3 September 2015 respectively. The strategy sets out the direction NHS Tayside will take in delivering Risk Management over the next 5 years but is subject to an annual review to ensure that it reflects the dynamic nature of the organisation.

The Risk Management Guidance Note underpins the Risk Management Strategy was presented to and approved by the Strategic Risk Management Group on 20 August 2015.

During 2016/17 updates to both documents took place in June and November 2016 at which times minimal changes were made.

Internal Audit Report – T12/16 – Assurance Framework
Internal Audit Report T12/16 was finalised on 16 December 2016 and presented to the Audit Committee on 9 March 2017. This was graded as Category B and concluded that the Board Assurance Framework had moved forward since its last review, particularly with the introduction of the assurance report template and Committee Chairs reports. However, the report also highlighted that there is currently no agreed, formal setting out of the precise responsibilities of the Health Board, Councils and the IJB in relation to operational activities and reflected this with a D grade. In response to this, and as a result of discussion and agreement at the Finance and Resources Committee, it was recognised that there was a requirement for a high level meeting to take place. An initial meeting took place on 12 January 2017 and a further meeting of the Chief Officers, Board Secretary and Internal Audit then took place on 8 February 2017 with a view to developing/scoping out recommendations. This will provide a framework for Year End Governance Arrangements and inform further work to be progressed in relation to risk registers ensuring risks are appropriately aligned and managed.

Datix Risk Group/Service Level Risk
The Datix Risk Group, which is a sub group of the Datix Implementation Group, was re-convened under the Chairmanship of Head of Nursing, Sean McArtney. The group has developed and issued a survey monkey questionnaire to all service level risk owners and managers whose responses will inform developments within the Datix risk module for service level risk.

Adverse Event Management

NHS Tayside Adverse Event Management Policy
Due to a number of pieces of work being taken forward both at local and national level that it was recognised would impact on the NHS Tayside Adverse Event Management Policy agreement was sought from the Nurse and Medical Directors as Executive Leads to defer the annual review of the Adverse Event Management Policy scheduled for September 2016 to September 2017.

Review of the Policy is now well underway and will include updates in respect of Learning Summaries, Multi Board Approach, Suicide Reviews, Review Timescales, SCEA process review, Sharing Local Adverse Event Reviews, Redaction, Community of Practice and Family Involvement.

In addition, 21 people attended a Participatory Learning Session as part of the Clinical Quality Forum on the 16 January 2017 where a presentation was made before the session was opened up for discussion.

This method of engagement used generated a deep discussion and valuable feedback and a second participatory session with Clinical Governance Chairs and Leads from across the whole system being invited to attend is scheduled for the 13 March 2017.

The Clinical Governance and Risk Management Team will oversee a work plan to action the feedback received with a commitment for the revised Policy to be presented to Directors for approval and Audit Committee for adoption nearer August/September 2017.

Duty of Candour
In response to correspondence received by the Chief Executive from the Scottish Government dated 8 February 2017, a self assessment report has been prepared to identify prepared NHS Tayside is for the introduction of Duty of Candour and to assist in the identification of any areas for inclusion in planning for local implementation. This report will be presented to the Clinical Risk Management Group on Monday 20 March 2017 and thereafter will progress to the Clinical Quality Forum and Clinical and Care Governance Committee.

Adverse Event Reporting
Adverse event reporting is a measure of the organisations' culture of disclosure. The aim within NHS Tayside is to minimise the risk of adverse events and maximise our opportunities to learn.

The Datix Adverse Event Module was introduced to the organisation on 4 September 2012 and so far there have been c71000 adverse events recorded. During the period 1 April 2016 to 31 March 2017 c18000 adverse events were recorded.

The operational detail of adverse event reporting is considered as a Standing Agenda Item by the Clinical Quality Forum and Clinical and Care Governance Committee.

Learning outcomes from adverse event reporting are disseminated across the organisation in a number of ways including:-

- Getting it Right Newsletter which was been circulated on a monthly basis from June 2016 to March 2017
- Risk Alerts of which there have been 4 during the time period 1 April 2016 to 31 March 2017
- Local Adverse Event Review (LAER) and Significant Clinical Event Analysis (SCEA)
- Discussion and reporting at Department and Directorate Clinical Governance and Risk meetings

Never Events
During the period 1 April 2016 to 31 March 2017 there was 1 never event reported in NHS Tayside. This pertained to Wrong Site Surgery, a Local Adverse Event Review was carried out on 18 July 2016 and learning was discussed and shared by the Consultant Team and the Specialist Registrars at the Plastic Surgery Clinical Governance meeting on the 15 September 2016.

Education and Training Activity for April 2016 – March 2017
The Learn Pro Module for Datix Risk Management went live on 26 January 2015. To date 170 members of staff have completed the module, 77 of whom did so during the period 1 April 2016 to 31 March 2017, which is aimed only at those staff who, through risk workshops, are identified as either risk owners or managers.

Since the launch of the module in September 2012 c8100 individuals have completed the Datix Adverse Event User Learn Pro Module. During the period 1 April 2016 to 31 March 2017 c990 individuals have completed the Datix Adverse Event User Learn Pro Module.

In addition work was undertaken in relation to:

- Operational Risk Reporting
- Service Level Risk Reporting
- Health and Social Care Integration
- Adverse Event and Near Miss Definitions
- Review of Local Adverse Event Review Timescales
- Sharing Local Adverse Event Review Reports
- Learning Summaries
- Redaction Workshop
- External Visits

the detail of which was captured in the mid year report.

Conclusion

In summary, the risk management activities detailed throughout the course of this report demonstrate that adequate and effective risk management arrangements exist and have been fulfilled by NHS Tayside throughout the course of 2016/17.

As such we have created an environment where we effectively manage the risks associated with provision of healthcare, making best use of available resources to provide a service that is as safe as possible for patients and staff whilst seeking opportunity for continuous review and improvement.

Item Number 8.3

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

AUDIT29/2017
Audit Committee
11 May 2017

RISK MANAGEMENT WORKPLAN 2017/18

1. PURPOSE OF THE REPORT

The purpose of this report is to seek approval of the attached Risk Management Workplan for 2017/18 and provide an update in relation to work undertaken during 2016/17.

2. RECOMMENDATIONS

The Strategic Risk Management Group is asked to:

- review and agree the risk management workplan for 2017/18 in (Appendix A)
- note progress and work undertaken during 2016/17 (Appendix B)

3. EXECUTIVE SUMMARY

Each year, all Standing Committees and Sub Committees are required to produce, no later than 30 June, an annual workplan. While the workplan for risk management is not a statutory requirement it is recognised as being an element of good practice in providing assurances to the Audit Committee.

Failure to provide information to the Audit Committee that enables them to conduct an assessment that there were adequate and effective arrangements in place for Risk Management would have a detrimental impact on the assessment of internal control and the Governance Statement.

The workplan is largely cyclical, rather than being specific to individual financial years and has been prepared accordingly.

4. 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 contribute to these to be achieved.

5. MEASURES FOR IMPROVEMENT

The measures are as detailed within the Risk Management Key Performance Indicators section of the Risk Management Strategy.

6. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

The Board Secretary as Strategic Lead for Risk Management was consulted in relation to the content of this report.

Members of the Strategic Risk Management Group were also consulted on the content of the annual workplan prior to its presentation to the Audit Committee.

7. PATIENT EXPERIENCE

Risk management systems and processes are embedded across NHS Tayside. This ultimately contributes to the patient experience by minimising risk exposures across all services.

8. RESOURCE IMPLICATIONS

Financial
The system arrangements for Risk Management are contained within current resource.

Workforce
The system arrangements for Risk Management are contained within current resource.

9. 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).

10. LEGAL IMPLICATION

There are no legal implications associated with this paper.

11. INFORMATION TECHNOLOGY IMPLICATIONS

There are no information technology implications associated with this paper.

12. HEALTH AND SAFETY IMPLICATIONS

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

13. HEALTHCARE ASSOCIATED INFECTION (HAI)

There are no HAI arising from this report.

14. DELEGATION LEVEL

Ms Lesley McLay is the Chief Executive and Accountable Officer.

Ms Margaret Dunning, Board Secretary, is the Executive Lead for Strategic Risk Management Systems and the delegated Chair of the Strategic Risk Management Group.

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

11. TIMETABLE FOR IMPLEMENTATION AND LEAD OFFICER

Implementation will be immediate following approval of the Audit Committee.

Hilary Walker
Risk Manager

Lindsay Bedford
Director of Finance

Margaret Dunning
Board Secretary

May 2017

Appendix A

Risk Management Workplan 2017-2018

Every two months the following business shall be transacted:

Business	Frequency	Responsible Officer
Meetings with Representative from Internal Audit	Commencing April 2017 and two monthly thereafter	Risk Management and Acting Regional Audit Manager
Meeting of the Datix Risk Group	Commencing May 2017 and two monthly thereafter	Head of Nursing, Renal Services and Risk Manager

On a quarterly basis:

Business	Frequency	Responsible Officer
Meeting of Strategic Risk Management Group	April, September and November 2017 and February 2018	Board Secretary

On a 6 month frequency:

Business	Frequency	Responsible Officer
2016/17 Annual Report and 2017/18 Mid Year Report submitted to Audit Committee	May and December 2017	Risk Manager
Strategic Risk Profile/Board Assurance Framework will be presented to Tayside NHS Board	June 2017 and February 2018	Board Secretary/Risk Manager

Annually:

Business	Frequency	Responsible Officer
Review Strategic Risk Management Group Terms of Reference	April 2017 (for meetings 2017/18)	Board Secretary/Risk Manager/Committee Support Officer
Review of Risk Management Guidance Note will be conducted	April 2017 (for 2017/18)	Risk Manager
Review of Risk Management Strategy	April 2017 (for 2017/18)	Risk Manager
Review & set the Risk Appetite Statement	April 2017 (for 2017/18)	Risk Manager
Contribution to Annual Review Process	August 2017	Risk Manager
Review of Adverse Event Management (AEM) Policy	September 2017	Clinical Governance and Risk Management Team
CIPFA Self Assessment and Audit Checklist	March 2018 (retrospective for 2017/18)	Risk Manager
Contribution to Governance Statement	March 2018 (retrospective for 2017/18)	Risk Manager
Strategic Risk Management	March 2018 (for meetings 2017/18)	Board Secretary/Risk

Group Committee Annual Report		Manager/Committee Support Officer

Minutes:

Minutes of the Strategic Risk Management Group will be regularly considered by the Audit Committee

Ongoing Work:

Review of Health and Social Care Integration Risk Management Policy and Strategy
Develop NHS Tayside approach to Duty of Candour Legislation as a Member of the Scottish Government Duty of Candour Implementation Advisory Group and incorporate into AEM Policy
Complete review of Risk Management Key Performance Indicators

Appendix B

Progress Against Risk Management Workplan 2016-2017

Every two months the following business shall be transacted:

Business	Frequency	Status Update
Meetings with Representative from Internal Audit	Commencing April 2016 and two monthly thereafter	Complete. Meetings held in person or by telephone.
Clinical Governance and Risk Management report submitted to Strategic Risk Management Group	Commencing May 2016 and two monthly thereafter	Completed until August 2016. Following discussion and agreement with Board Secretary and Internal Audit, going forward the SRMG will receive a mid-year and annual report on Risk Management for endorsement prior to presentation for approval by the Audit Committee. This change will be reflected in both the SRMG and risk management workplans for 2017/18. Report continues to be considered by Clinical Quality Forum and Clinical and Care Governance Committee.

On a quarterly basis:

Business	Frequency	Status Update
Meeting of Strategic Risk Management Group	April, August and November 2016 and February 2017	Complete. Meetings held April, August and November 2016 and February 2017.
Strategic Risk Profile will be presented to Tayside NHS Board	June, October and December 2016 and February 2017	Due to the reconfiguration of the frequency of Tayside NHS Board and Standing Committee meetings, Strategic Risk Profile was presented to Tayside NHS Board June and October 2016 and February 2017.

On a 6 month frequency:

Business	Frequency	Status Update
Biannual report submitted to Audit Committee	May 2016 (Annual for 2015/16) and November 2016 (Mid Year 2016/17)	Complete. Risk Management Annual Report for 2015/16 presented to Audit Committee May 2016. Thereafter Clinical Governance and Risk Management Report (Period 1 – April/May) presented August 2016.

		Following discussion and agreement with Board Secretary and Internal Audit, going forward the SRMG will receive a mid-year and annual report on Risk Management for endorsement prior to presentation for approval by the Audit Committee. This change will be reflected in both the SRMG and risk management workplans for 2017/18. Risk Management Mid Year Report considered by SRMG November 2016 and Audit 17 January 2017. CGRM Report continues to be considered by Clinical Quality Forum and Clinical and Care Governance Committee.

Annually:

Business	**Frequency**	**Status Update**
CIPFA Self Assessment and Audit Checklist	March 2017 (Retrospective view for 2016/17)	Complete. Will be presented to SRMG 21 April 2017 and Audit Committee 11 May 2017.
Risk Management Section of Annex F of Audit Committee Handbook	March 2017 (Retrospective view for 2016/17)	During meeting held on 10 June 2016 with Board Secretary, Chief Internal Auditor and Associate Director of Finance it was agreed that: • An Audit Committee BDE will be scheduled for January 2017. • Annex F will be discussed at the BDE and it will be completed and presented to Audit Committee on a 2 year cycle. • The CIPFA tool will continue to be completed on an annual basis, and will underpin the work on Annex F. • This arrangement will be included in the Audit Committee Terms of Reference and workplan.
Contribution to Governance Statement	March 2017 (retrospective for 2016/17)	Complete. Submission provided to Head of Financial Services 16 March 2017
Review Strategic Risk Management Group Terms of Reference	April 2016 (for meetings 2016/17)	Updated and approved 5 May 2016.

Strategic Risk Management Group Committee Annual Report	April 2016 (for meetings held 2015/16)	Complete. SRMG 21 April 2016 and Audit Committee 5 May 2016.
Review of Risk Management Guidance Note will be conducted	March 2016 (for 2016/17)	Complete. 2016/17 update and refresh conducted and revised document with minimal changes reposted on staffnet 20 June and 25 November 2016.
Review of Risk Management Strategy	April 2016 (for 2016/17)	Complete. Risk Management Strategy which is a 5 year document was presented to SRMG 20 August 2015, Audit Committee 3 September 2015 and Tayside NHS Board 29 October 2015. 2016/17 update and refresh conducted and revised document with minimal changes reposted on staffnet 20 June and 25 November 2016.
Board Development Event on Risk Management	April 2016	Annual Board Development Event for risk management was primarily held to formulate strategic risk profile for the coming year. However, due to increased monitoring and reporting arrangements for strategic risks and the introduction of horizon scanning as a standing agenda item at the Strategic Risk Management Group this has superceded previous arrangements.
Review of Strategic Risk Profile to ensure underpinning of Corporate Objectives	March 2016	Complete. Strategic Risk Profile presented to SRMG and TNHSB as detailed above. Every Strategic Risk as part of the Datix record is linked to a Corporate Objective.
Contribution to Annual Review Process	August 2016	Complete. Submission provided for self assessment 18 August 2016.
Review of Adverse Event Management Policy	December 2016	Following approval from Nurse and Medical Director on 23 June 2016 extension was sought and granted to the review of the AEM Policy until September 2017 to allow significant areas of work to emerge and be given the appropriate time to conclude and then be incorporated into the revised version Policy.

Ongoing Work:

Business	Status Update
Enhance and upgrade Datix Risk Management Software	Work is continuously taken forward by Clinical Governance and Risk Management Co-ordinator – Datix. Governance is provided by the Datix Implementation Group (now known as the Datix Steering & Development Group), the minutes of which are submitted to the Strategic Risk Management Group.
Health and Social Care Integration	The NHS Tayside Risk Manager delivered risk management training for Angus IJB in October 2016 thereafter continued to support the Head of Community Health and Care Services, Angus IJB in establishing systems and processes for risk management. With regard to HSCP Governance and Assurance it was noted that it had been agreed at a meeting of the Finance and Resources Committee in November 2016 that there was a requirement for a high level meeting to take place. As a result an initial meeting took place on 12 January 2017. A further meeting of the Chief Officers, Board Secretary and Internal Audit will now be scheduled with a view to developing/scoping out recommendations before being submitted to the larger group for approval. This will provide a framework for Year End Governance Arrangements and inform further work to be progressed in relation to risk registers ensuring risks are appropriately aligned and managed.
Review of Risk Management Key Performance Indicators	An exercise has be undertaken to review current KPIS to identify improvements and additions through review of available best practice and guidance. Revised Key Performance Indicators will be presented to SRMG
Further develop NHS Tayside approach to Risk Appetite in numerical terms	The risk appetite statement has been reviewed and updated following liaison with other NHS

	Boards. The revised risk appetite was presented to the SRMG for endorsement in February 2017 and Audit Committee in March 2017 and thereafter incorporated into the Risk Management Strategy.
Develop NHS Tayside approach to Duty of Candour Legislation as a Member of the Scottish Government Duty of Candour Implementation Advisory Group	The NHS Tayside Risk Manager is an active member of the Scottish Government Duty of Candour Implementation and Advisory Group which meets on an ad hoc basis but is supported by 3 working groups. Regular updates have been provided to the Clinical and Care Governance Committee to ensure NHS Tayside is a prepared as possible for the introduction now scheduled for April 2018. Vital Signs was distributed to organisation in November 2016. Workshops and training for staff are being developed and will be running over the course of next year and in the run up to the introduction of the Act.

Item Number 8.4

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

AUDIT/2017
Audit Committee
11 May 2017

RISK MANAGEMENT
CIPFA SELF ASESSMENT AND AUDIT CHECKLIST

1. PURPOSE OF THE REPORT

The purpose of this report is:

- To provide members with an assurance in relation to the systems and processes established and in place for risk management within NHS Tayside.
- To establish whether the measures taken during 2016/17 allowed the Audit Committee to operate effectively in reviewing the systems and processes for risk management as part of the framework of Internal Control and Corporate Governance.

2. RECOMMENDATIONS

The Audit Committee is asked to:

- Review progress against the CIPFA Self Assessment and Audit Tool (Appendix A)
- Be aware that a further review against the standard will be undertaken during 2017/18
- To ensure a commonality of approach and as part of the overall governance process between the Health Board and the IJBs, recommend that assurance from the HSCPs incorporates an assessment against the requirements of the CIPFA guidance or equivalent.

3. EXECUTIVE SUMMARY

As part of the governance reporting arrangements for risk management it has been agreed that the Audit Committee will receive and review:

- Annual Workplan in respect of Risk Management
- Annual Report from Strategic Risk Management Group
- Annual Report on effectiveness, adequacy and robustness of risk management
- CIPFA Self Assessment and Audit Checklist for Risk Management
- Minutes of the Strategic Risk Management Group during 2016/17

The CIPFA Self Assessment and Audit Checklist is used to identify the contribution risk management makes to a successful public sector organisation by presenting the components of risk management in a structured framework.

The CIPFA Self Assessment and Audit Checklist has been completed (Appendix A) to enhance the above requirements and is commended to the organisation as a tool to test the effectiveness of the Board's risk management arrangements as an essential and integral part of effective corporate governance.

The framework consists of twelve separate elements with the level of compliance for NHS Tayside and updates on the 2015/16 assessment shown in brackets:

- Risk Management Strategies – 100% (100%)
- Risk Management Structures and Processes – 100% (100%)
- Risk Identification and Evaluation – 100% (100%)
- Risk Recording, Tracking and Reporting – 100% (100%)
- Risk Financing – 100% (100%)
- Risk Management Communication and Training – 100% (100%)
- The Corporate Risk Management Group – 100% (100%)
- The Corporate Risk Officer – 100% (100%)
- Managers' Accountability for Risk Management – 100% (100%)
- Testing the Embedding of Risk Management within the Organisation – 100% (100%)
- Projects and Partnerships – 58% (100%)
- Risk Management Information Systems (Risk Registers etc) – 100% (100%)

It is acknowledged that we have reduced the self assessment score within the project and partnerships section from 100% to 58%. This is to reflect the changing landscape in terms of Health and Social Care Partnerships and Internal Audit report T12/16 which was finalised on 16 December 2016 and presented to the Audit Committee on 9 March 2017. This was graded as Category B and concluded that the Board Assurance Framework had moved forward since its last review, particularly with the introduction of the assurance report template and Committee Chairs reports. However, the report also highlighted that there is currently no agreed, formal setting out of the precise responsibilities of the Health Board, Councils and the IJB in relation to operational activities and reflected this with a D grade. A short life working group is currently progressing these issues.

4. REPORT DETAIL

Please refer to report 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.

Internal Audit Colleagues and the Board Secretary considered the content of the paper as did Members of the Strategic Risk Management Group prior to its presentation to the Audit Committee.

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/Red (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

The Chief Executive, as Accountable Officer, has the responsibility for maintaining a sound system of Internal Control and reviewing the effectiveness of the system within the organisation culminating in the preparation of an annual Statement on Internal Control. In NHS Tayside the Audit Committee has delegated responsibility for reviewing the organisation's risk management arrangements, systems and processes.

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 the follow up process.

16. TIMETABLE FOR IMPLEMENTATION

Implementation of any actions will be immediate following approval by the Audit Committee

Hilary Walker
Risk Manager

Lindsay Bedford
Director of Finance

Margaret Dunning
Board Secretary

May 2017

APPENDIX A

CIPFA RISK MANAGEMENT SELF ASSESMENT AND AUDIT CHECKLIST
NHS TAYSIDE SELF ASSESSMENT 2015/16

Risk Management Strategies	Yes	No	N/A	Comments/Action
Has a formal, written risk management strategy document been drawn up?	✓			Risk Management Strategy which is a 5 year document was presented to SRMG 20 August 2015, Audit Committee 3 September 2015 and Tayside NHS Board 29 October 2015. 2016/17 update and refresh conducted and revised document with minimal changes reposted on staffnet 20 June and 25 November 2016.
Does the strategy document make it clear that "risk" is not just something that will impact negatively on objectives but includes risk as an opportunity as well as a threat?	✓			This is contained within the risk management strategy and is also documented in the risk management guidance note.
Does the strategy define who within the organisation is responsible for ensuring that it is effectively implemented?	✓			Section 4 - Roles and Responsibilities within Risk Management Strategy
Does the strategy make it clear that risk will be managed at both a strategic and operational level?	✓			Information contained within both Risk Management Strategy and Risk Management Guidance Note.
Does the strategy outline the organisation's choice of risk categories to be used?	✓			Information contained within both Risk Management Strategy and Risk Management Guidance Note.
Does the strategy define the corporately adopted risk identification process?	✓			Information contained within Risk Management Guidance Note for NHS Tayside approach and for Strategic Risks this is within the Terms of Reference for the Strategic Risk Management Group.
Does the strategy contain the organisation's definitions of risk measurement (risk criteria) for both probability and consequences?	✓			This is contained within the Risk Management Guidance Note and a link to this document is given within the Risk Management Strategy.
Does the strategy contain an undertaking that the organisation will identify key risk indicators and how these are to be tracked?	✓			A set of key performance indicators for risk management were developed and included within the Strategy. An exercise has been undertaken to review current KPIS to identify improvements and additions through review of available best practice and guidance. Revised Key Performance Indicators will be presented to SRMG for approval.
Does the strategy document contain an undertaking to report on risk?	✓			Information contained within Risk Management Strategy also Governance Reporting Chart for risk management also developed separately.
Does the strategy make it clear that risk should be formally considered at the commencement of any major organisational change or project?	✓			Information contained within Risk Management Guidance Note (Section 7 – Arrangements for Projects) and incorporates a link to the NHS Tayside Capital Approval and Business Case Guide.

Does the strategy make it clear that risk assessment should become an integral part of the annual planning process?	✓			Guidance Note highlights that all strategic risks are linked to NHS Tayside Corporate Objectives.
Does the strategy outline realistic and achievable milestones and deadlines?	✓			Section 4 of the Risk Management Strategy covers this in respect of reporting requirements. This is also referred to in Section 7, Section 10 and the Risk Review Matrix.
Is the strategy specific about the outcomes and benefits the organisation expects to achieve from risk management?	✓			Risk Management of Strategy outlines as does Risk Management Guidance Note.
Has the strategy been reviewed and updated systematically and regularly and within the last 12 months?	✓			Risk Management Strategy which is a 5 year document was presented to SRMG 20 August 2015, Audit Committee 3 September 2015 and Tayside NHS Board 29 October 2015. 2016/17 update and refresh conducted and revised document with minimal changes reposted on staffnet 20 June and 25 November 2016.
Has the strategy been reported on and endorsed at political and management board level?	✓			Risk Management Strategy presented to SRMG 20 August 2015, Audit Committee 3 September 2015 and Tayside NHS Board 29 October 2015.
Has the strategy been widely publicised and distributed amongst staff?	✓			Strategy is available on NHS Tayside staff intranet.
Has a risk management policy statement been prepared?	✓			Risk Management Strategy and Risk Management Guidance Note.
Has the policy been endorsed at political and management board level?	✓			Risk Management Strategy presented to SRMG 20 August 2015, Audit Committee 3 September 2015 and Tayside NHS Board 29 October 2015. Guidance Note approved by SRMG 20 August 2015.
Has the policy been widely publicised and distributed amongst staff?	✓			Strategy and Guidance Note both available on NHS Tayside Intranet Safe and Effective Working pages.
In defining the strategy and policy were the views of stakeholders such as trade union representatives, employees at all levels, internal experts such as auditors taken into account?	✓			Risk Management Strategy which is a 5 year document was prepared by the Risk Manager on behalf of NHS Tayside. As part of consultation and approval process this was presented to SRMG on 20 August 2015 where membership includes staff side colleagues. Thereafter this was taken to the Audit Committee on 3 September 2015 and Tayside NHS Board 29 October 2015 where membership is inclusive of Staff Side and Non-Executive Board Members. The views of Internal Audit colleagues were also sought. Since the Strategy was approved, due to unforeseen circumstances, staff side attendance at the Strategic Risk Management Group has been intermittent. As a result the Employee Director is currently seeking nominations for additional staff side representation for attendance at the meetings.
Have the views of the organisation's external auditors on the policy and strategy been obtained and taken into account?	✓			The Risk Management Strategy and Guidance Note were shared with the External Auditors via the Head of Financial Services on 25 February 2016.

Risk Management Structures & Processes	Yes	No	N/A	Comments/Action
Is risk management seen as a key priority at senior management board level?	✓			Reporting of strategic risk profile to Tayside NHS Board continued during 2016/17. However due to the reconfiguration of the frequency of Tayside NHS Board and Standing Committee meetings, the strategic risk profile was presented to Tayside NHS Board June and October 2016 and February 2017. The Strategic Risk Management Group (Membership consisting of Executive Directors) meets 4 times per year. Minimum of quarterly presentation of Strategic Risks, prepared by risk owner who is Executive Director, to Standing Committees (Chaired by Non Executives) continued and this was further enhanced during 2016/17 with the agreement at the SRMG in August 2016 to include a progress update in relation to the underpinning operational risks.
Is risk management seen as a key priority at elected member/non executive board member/board level?	✓			Reporting of strategic risk profile to Tayside NHS Board continued during 2016/17. However due to the reconfiguration of the frequency of Tayside NHS Board and Standing Committee meetings, the strategic risk profile was presented to Tayside NHS Board June and October 2016 and February 2017. Minimum of quarterly presentation of Strategic Risks to Standing Committees (Chaired by Non Executives) continued and this was further enhanced during 2016/17 with the agreement at the SRMG in August 2016 to include a progress update in relation to the underpinning operational risks. In addition Non Executive Board Members have requested a further risk management development event to take place during 2017/18.
Is there evidence that elected Member/non executive board member/board members consider risk in making decisions?	✓			Risk Assessment is a mandatory section required for papers going to any Standing Committee within NHS Tayside. Submissions are reviewed by Committee Chairs (Non-Executive Board Members).
Has a senior manager been formally nominated to "champion" risk management?	✓			The Board Secretary is the Executive Lead for Risk Management. However, the Board Secretary is not responsible for the risk management function and does not line manage the NHS Tayside Risk Manager. Internal Audit colleagues have intelligence that other NHS Boards have moved to a system where the risk management function is separate to clinical governance.
Does the organisation have a corporate risk officer with no responsibilities except for risk management?	✓			There is a clear organisational focus on risk management with mitigating controls in place in that Board Secretary is Executive Lead for Strategic Risk. In addition, the organisation employs a Risk Manager. However, the Board Secretary is not responsible for the risk management function and does not line manage the NHS Tayside Risk Manager.

				Internal Audit colleagues have intelligence that other NHS Boards have moved to a system where the risk management function is separate to clinical governance.
Have the resource requirements been defined and have sufficient resources been applied to the implementation of the risk management system throughout the organisation?	✓			Risk Management Systems within the Organisation have been in place since December 2000 and a budget is in place.
Are there any groups, risk panels or forums to ensure the co-ordination of the risk management system?	✓			Department and Directorate Clinical Governance and Risk Management Fora. Performance Review Meetings and Strategic Risk Management Group. Audit Committee has delegated responsibility from Tayside NHS Board to review the systems and process in place for risk management.
Are any groups, risk panels or forums also used as a platform for sharing risk experiences?	✓			Department and Directorate Clinical Governance and Risk Management Fora, Performance Review Meetings, Strategic Risk Management Group and Clinical Quality Forum.
Have the roles and responsibilities for risk management been defined at all levels in the organisation?	✓			Information on this is contained within the Risk Management Strategy.
Have risk management responsibilities been written into the job descriptions for operational managers and above?	✓			Either contained in objectives/job description for Chief Executive, Board Secretary, Associate Director of Clinical Governance and Risk Management, Risk Manager, Clinical Governance and Risk Co-ordinators and Facilitators. Corporate objective in relation to risk management agreed for 2016/17: ***Effective Management of Risk – Weighting 4*** *Lead the organisations risk management strategy and principles, and be accountable for managing the process of adverse event management at directorate/department level to enable evidencing of continued service improvement.*
Is risk management performance included within personal targets for operational managers and above?	✓			Contained in objectives for Board Secretary, Associate Director of Clinical Governance and Risk Management, Risk Manager and Clinical Governance and Risk Co-ordinators. Corporate objective in relation to risk management included for 2016/17: ***Effective Management of Risk – Weighting 4*** *Lead the organisations risk management strategy and principles, and be accountable for managing the process of adverse event management at directorate/department level to enable evidencing of continued service improvement.*
Does the senior management board carry out periodic reviews on the risk management system to ensure its continued suitability and effectiveness?	✓			The role of the Strategic Risk Management Group is to evaluate they systems and process in place for risk management and the role of the Audit Committee is to review these. The SRMG meets quarterly and the Audit Committee regularly receive minutes from the Strategic RMG and a Mid Year and Annual Report on risk

				management are presented at 6 monthly intervals. Audit Committee also annually receive risk management workplan and CIPFA Self Assessment and Audit Tool.
Does the senior management board agree any inputs required to support risk management work corporately?	✓			Through discussion with Board Secretary as Lead for Strategic Risk and Chair of Strategic Risk Management Group and at Strategic Risk Management Group.
Do the organisation's internal auditors carry out periodic reviews of the risk management system and report on its continued suitability and effectiveness?	✓			Reviews of the risk management arrangements are contained within the Internal Audit 5 Year Plan. Representatives from Internal Audit meet Risk Manager on a 2 monthly basis and all of this information together forms part of the Internal Audit Interim and Annual Review.
Is risk management considered in the annual business planning process?	✓			Risk Assessment is also a mandatory section required for papers going to any Standing Committee within NHS Tayside. Submissions are reviewed by Committee Chairs (Non-Executive Board Members). Strategic risks are recorded within Datix these must be linked to a Corporate Objective and this is also highlighted within the risk management guidance note.
Is risk management embedded in change programmes?	✓			See Projects and Partnerships section. In addition Risk Management Guidance Note Section 7 provides details on Arrangements for Projects.
Does internal audit have a role in and provide advice about risk management?	✓			A Representative from Internal Audit meets with Risk Manager on a 2 monthly basis and reviews of the risk management arrangements are contained within the Internal Audit 5 Year Plan. All of this information together forms part of the Internal Audit Interim and Annual Review
Is the organisation active in terms of sharing information, networking and has membership or relevant organisations such as Alarm?	✓			NHS Tayside is a member of the Healthcare Improvement Scotland (HIS) Liaison Coordinators Network and Risk Managers Network. Information sharing exercises are regularly pursued and undertaken with other Health Boards and Partner Organisations.

Risk Identification and Evaluation	Yes	No	N/A	Comments/Action
Have systematic procedures for risk identification been agreed?	✓			Risk Management Guidance Note outlines procedures.
Have these been communicated to all staff involved in the risk identification process?	✓			Guidance Note available to all staff via NHS Tayside Staff Intranet and was distributed to all those who attend risk management workshops. LearnPro Risk Module also available and completed by those members of staff identified as Risk Owners or Managers
Have systematic procedures for risk evaluation been agreed?	✓			Risk Management Guidance Note identifies.
Have these been communicated to all staff involved in the risk identification process?	✓			Guidance Note available to all staff via NHS Tayside Staff Intranet and was distributed to all those who attend risk management workshops. LearnPro Risk Module also available and completed by those members of staff identified as Risk Owners or Managers
Have the number of probability and consequence measures on the risk matrix been agreed?	✓			Risk Management Guidance Note identifies. Guidance Note last approved by Strategic Risk Management Group 20 August 2015. 2016/17 update and refresh conducted and revised document with minimal changes reposted on staffnet 20 June and 25 November 2016.
Have these been communicated to all staff involved in the risk identification process?	✓			Guidance Note available to all staff via NHS Tayside Staff Intranet and was distributed to all those who attend risk management workshops. LearnPro Risk Module also available and completed by those members of staff identified as Risk Owners or Managers
Has the organisation's risk appetite been defined?	✓			The risk appetite statement was reviewed and updated during 2016/17 by a short life working group following liaison with other NHS Boards. The revised risk appetite was presented to the SRMG for endorsement in February 2017 and Audit Committee for approval in March 2017 and thereafter incorporated into the Risk Management Strategy and Guidance Note. It is of note that the organisations risk appetite level was set at 20 thus ensuring that not every strategic risk sat above the appetite. However, the risk appetite statement is scheduled for annual review.
Are both internal and external experiences also used to inform risk identification?	✓			Staff are advised and educated that this should be the case and information and examples are contained within the Risk Management Guidance Note.
Does the organisation make use of other internal statistical information such as health and safety statistical analyses, analyses of liability insurance claims to inform the risk identification process?	✓			Staff are advised that this should be the case and information and examples are contained within the Risk Management Guidance Note. At ward level historical Adverse Event Reporting and Health and Safety Information along with that of Complaints and Claims for example should be taken into consideration.
Does the organisation make use of other internal sources of information such as budgetary statements, annual reports and best value performance plans to identify	✓			Individual Strategic Risk Owners (Executive Directors) are responsible for Horizon Scanning and this is a Standing Agenda Item at the SRMG, as per Risk Management Guidance Note. This will include consideration of annual reports etc.
Does the organisation make use of benchmarks and good practice guidance in the identification of areas where risk management may need to be	✓			Best Value Reviews. CIPFA Self Assessment and Audit Tool. Annex F of the Audit Committee Handbook. Institute of Internal Auditors and Internal and External Audit Reports.

strengthened?				
Does the organisation have an incident recording and reporting arrangement that is used to inform the risk identification process?	✓			NHS Tayside Adverse Event Management Policy and Datix Risk Management Software system. Adverse Event Management Policy is currently under review and is scheduled for presentation for approval to Audit Committee in September 2017.
Are group sessions such as workshops used to determine high risk areas and evaluate their impact?	✓			Strategic and Operational Risks are generally identified and agreed at meetings of Strategic Risk Management Group, Tayside NHS Board or its Standing Committees and through provision of Board Development Events. Risk management workshops which aim to raise awareness of risk management activities and help Directorates identify their key risks and develop service level risk registers has been developed and are available on request. The risks are then monitored through Directorate Clinical Governance and Risk Management Fora and scrutinised during the performance review process. If it is felt that any operational or service level risk should be altered in status to strategic or operational level a written proposal detailing the risk and the reasons behind them must be presented to the Strategic Risk Management Group for approval and allocation.
Does the organisation carry out site inspections where appropriate to enhance the process of risk identification?	✓			Internal Audit Departmental Audits. Fire Safety Visits.
Does the organisation make use of feedback from tenants/citizens forums to identify the public perception and attitude to risk and help identify risks.	✓			Complaints are regularly reviewed to identify any safety or risk issues emerging. The implementation of Datix has seen this enhanced to cover comments and compliments also.
Does the organisation involve functional specialists (e.g. internal auditors, health and safety officers) in the risk identification process where appropriate?	✓			Internal Audit and Health and Safety staff, Fire Safety Advisors and Infection Control are utilised to enhance process.

Risk Recording, Tracking and Reporting	Yes	No	N/A	Comments/Action
Is a risk register maintained to record all the identified risks?	✓			Electronically within Datix Risk Management Software system. Key risks recorded at Strategic, Operational and Service level.
Does the register contain a description of the risk?	✓			Yes, colleagues are given the opportunity to provide details and there is a preferred methodology which captures cause, risk and effect.
Does the risk register link risks to organisational objectives?	✓			Strategic risks are recorded within Datix these must be linked to a Strategic Objective. Operational risks must link to a strategic risk and service level risks to an operational risk.
Does the risk contain measures of the probability and consequences of gross risk (i.e the level of risk, assuming no controls or risk mitigation is in place)?	✓			**Inherent Risk Exposure Rating**, Current Risk Exposure Rating and Planned risk Exposure Rating all recorded within Datix system based on Likelihood x Consequence.
Does the risk register contain measures of the likelihood and severity of residual risk (i.e. the level of risk remaining after existing controls and risk mitigation is taken into account)?	✓			Inherent Risk Exposure Rating, Current Risk Exposure Rating and **Planned risk Exposure Rating** all recorded within Datix system based on Likelihood x Consequence.
Does the risk register contain action plans for further risk mitigation work?	✓			Datix system requires risk owner/manager to record individual mitigating actions for improvement and anticipated completion dates.
Does the register contain dates by which risk mitigation action should be taken?	✓			Datix system requires risk owner/manager to record individual actions for improvement and anticipated completion date. Also date for full risk review is required.
Does the register record the risk owner?	✓			In Datix name of risk owner is required as opposed to a job title and there is also a requirement to identify a risk manager with the expectation that the risk owner and manager will not be the same individual.
Is there evidence that there is a follow up to check that risk mitigation action is delivered by the due date?	✓			Datix system issues automatic reminders and these are manually checked and followed up by a member of Clinical Governance and Risk Management staff. Performance review data set round 7 now contains a number of measures in relation to Service Level Risks including: % of number of service level risk actions completed within timeframe % or number of breached service level risk actions
Are operational managers responsible for maintaining their part of the risk register?	✓			Individual risk owners/managers are responsible for maintaining and updating their risks within the Datix system. Progress on Strategic risks is reported and monitored at each meeting of the Strategic Risk Management Group and through strategic risk reports to Standing Committees. Service level risks monitored through departmental and directorate clinical

				governance and risk management fora and also performance review meetings.
Have key risk indicators been identified?	✓			Key Performance Indicators are contained within Risk Management Strategy. An exercise has been undertaken during 2016/17 to review current KPIs to identify improvements and additions through review of available best practice and guidance. Revised Key Performance Indicators will be presented to SRMG during 2017/18.
Are steps taken to monitor key risks on a regular basis?	✓			Progress on Strategic risks is reported and monitored at each meeting of the Strategic Risk Management Group and through strategic risk reports to Standing Committees which now also include a progress update in relation to the underpinning operational risks. Service level risks monitored through departmental and directorate clinical governance and risk management fora and also performance review meetings.
Are there arrangements in place for the regular reporting of key risks to senior management board?	✓			Strategic Risk Management Group Meetings quarterly, strategic risk reports to standing committees and quarterly presentation of Strategic Risk Profile to Tayside NHS Board.
Are there arrangements in place for the regular reporting of key risks to elected Member/non-executive board members/board members?	✓			Strategic risk reports to standing committees (chaired by Non Executive) and presentation of Strategic Risk Profile to Tayside NHS Board.
Does the annual internal audit plan flow from the risk register?	✓			The annual internal audit plan is not generated from the risk register but is based upon risk management methodology and elements of the risk register are incorporated into the Internal Audit strategic and annual planning process, both at the control risk stage and in evaluating the final high/medium/low scores. For example Internal Audit include a review of the strategic risk register in detailed audit assignment planning for each audit and where possible, assignment plans include a link to a relevant risk. Moving forward into 2017/18, while the planning process will be largely the same as in previous years, the intention is to carry out a detailed mapping exercise to ensure that the annual internal audit plan is more closely aligned to the strategic risk register than in previous years. The outcomes of this mapping exercise will also be detailed in the strategic plan appendix to the annual plan which will be presented to the May Audit Committee.
Is there a procedure in place for immediately reporting any serious emerging risks to the senior management board?	✓			Through Risk Escalation Process as identified in Risk Management Guidance Note.

Risk Financing	Yes	No	N/A	Comments/Action
Is there evidence that the organisation's arrangements for risk financing are monitored and reviewed?	✓			Clinical Negligence and Other Risks Indemnity Scheme (CNORIS).
Does the organisation have a policy to self-insure some or all of its risk?	✓			CNORIS
Are the limited legal requirements for external insurance being met?	✓			CNORIS
If self-insurance funds are maintained are they subject to a regular actuarial valuation?			✓	Not applicable.
Has external advice been sought in relation to the organisation's risk financing strategy?	✓			National
Are insurance claims managed in accordance with 'Woolfe' principles?			✓	The Woolfe Principles apply in England and Wales but are not relevant within Scotland and currently there is no equivalent standard.

Risk Management Communication and Training	Yes	No	N/A	Comments/Action
Is risk management training included as part of induction training for new employees?	✓			Arrangements were put in place for Risk Management Quick Guide is distributed to all new starts during induction. In addition, Risk Management Workshops remain available throughout the organisation on request and Learn Pro Module is available to those staff identified as being risk owners or risk managers.
Is risk management training offered to existing employees with risk management responsibilities?	✓			Risk Management Workshops remain available throughout the organisation on request and Learn Pro Module is available to those staff identified as being risk owners or risk managers.
Is the quality of training well regarded and does feedback inform content and style?	✓			Each workshop allows participants to provide feedback in the form of an evaluation form and regular review and analysis informs updates of courses. In addition the Datix Risk Group, which is a sub group of the Datix Implementation Group, has been re-convened with immediate effect under the Chairmanship of Head of Nursing, Sean McArtney. The group has a multidisciplinary membership inclusive of representation from front line staff who, in conjunction with the NHS Tayside Risk Manager, will review key pieces of work including service level risk workshop and the risk learnpro module during 2017/18. This has commenced in 2016/17 with the distribution of a survey monkey questionnaire to all service level risk owners and managers.
Are there facilities for self training and reference e.g. learning on line?	✓			Learn Pro Module on Datix Adverse Event Module and Datix Risk Module available.
Is training part of the response when things go wrong?	✓			Individual tailored workshops are provided when required.
Does the organisation have a regular risk management newsletter or other means of communicating risk management issues to staff?	✓			Monthly Getting It Right Newsletter and Risk Alerts which are produced on an ongoing basis when required. These are also posted on the Safe and Effective pages of staffnet.
Are individuals' risk management training needs reviewed regularly?	✓			This is a local line management responsibility but should be considered as part of individual staff members' appraisal and personal development plan.
Has there been a corporate risk management training needs assessment?	✓			Not formally but this is kept under regular review through fora such as the Strategic Risk Management Group and Tayside NHS Board. Requests for a further board Development Event on Risk Management were acknowledged during the March 2016 Tayside NHS Board meetings and this request is being planned into the schedule for 2017/18.
Are risk management strategy, policy, systems and processes communicated, followed and understood by all relevant staff?	✓			These are all available on Staff Intranet and amendments and/or updates are communicated through provision of newsletter articles and other communication vehicles such as Vital Signs and Inbox. Datix also has provision to include login pop up alerts and individual section guidance where required. Internal Audit check compliance during interviews with staff as part of departmental

				audits and if deficiencies are found these are addressed by risk management staff.
Can advice and guidance be sought on line e.g. the Intranet?	✓			All key documents are available on the Clinical Governance and Risk Management pages within the Safe and Effective Care section of the NHS Tayside intranet.
Is there guidance on the issues (e.g. risk identification techniques) where advice is required?	✓			Risk Management Guidance Note.
Do reports for decision contain risk management implications written/or approved by the corporate risk officer?	✓			Section is contained within all papers to Standing Committees and Risk Manager drafted guidance for completion of this. However, submissions are reviewed by Committee Chairs and Lead Officers as opposed to Strategic Risk Officer.
Are risk management staff roles and contact details accessible and up to date?	✓			Clinical Governance and Risk Management Who's Who (staff contact details) is available on the Clinical Governance and Risk Management pages within the Safe and Effective Care section of the NHS Tayside intranet
Do staff know how to access risk management guidance?	✓			Clinical Governance and Risk Management pages within the Safe and Effective Care section of the NHS Tayside intranet.
Are staff aware of when and whom to consult?	✓			Clinical Governance and Risk Management Who's Who (staff contact details) is available on the Clinical Governance and Risk Management pages within the Safe and Effective Care section of the NHS Tayside intranet
Are there formally defined levels of generic risk management competencies for managers and staff?	✓			Risk management workshops which aim to raise awareness of risk management activities and help Directorates identify their key risks and develop service level risk registers has been developed and are available on request. Learn Pro Module is also available to those staff identified as being risk owners or risk managers within the organisation. Corporate objective in relation to risk management agreed for 2016/17: ***Effective Management of Risk – Weighting 4*** *Lead the organisations risk management strategy and principles, and be accountable for managing the process of adverse event management at directorate/department level to enable evidencing of continued service improvement.*
Are these reviewed and tested through performance appraisal?	✓			Corporate objective in relation to risk management agreed for 2016/17: ***Effective Management of Risk – Weighting 4*** *Lead the organisations risk management strategy and principles, and be accountable for managing the process of adverse event management at directorate/department level to enable evidencing of continued service improvement.*
Are there forums to enable staff within business groups who are responsible for managing risk to network and exchange good practice?	✓			Local Directorate and Departmental Clinical Governance and Risk Fora; Performance Review and Clinical Quality Forum

The Corporate Risk Management Group	Yes	No	N/A	Comments/Action
Does the organisation have a risk management group(s) operating at either a corporate or service level?	✓			Strategic Risk Management Group, Chaired by Board Secretary, as Strategic Lead for Risk, as delegated responsibility from Accountable Officer. Service level risks monitored through local Clinical Governance Structures and scrutiny and assurance takes place at Performance Review.
Does the group provide advice and support to the corporate management team on risk management strategies, policy and processes?	✓			All risk management strategic documents and reports are considered by the Strategic Risk Management group for endorsement and approval before escalation/distribution.
Does the group identify areas of overlapping risk?	✓			SRMG consider Strategic Risk Profile at every meeting and Horizon Scanning is a Standing Agenda Item for the group.
Does the group drive new risk management initiatives within the organisation?	✓			SRMG consider Strategic Risk Profile at every meeting and Horizon Scanning is a Standing Agenda Item for the group. Proposals for additions to the Strategic Risk Profile would be suggested or endorsed by this group, Tayside NHS Board or any of the Standing Committees.
Does the group communicate risk management and share good practice?	✓			Individual strategic risk owners (Executive Directors) are responsible for Horizon Scanning as per Risk Management Guidance Note and this is a Standing Agenda Item at the Strategic Risk Management Group.
Does the group drive the process of risk identification and assessment?	✓			Strategic Risk Profile is considered at every meeting of SRMG where addition, removal and alterations to risks can be agreed. However, this can also take place at any of the Standing Committees to whom Strategic risks are aligned or Tayside NHS Board.
Does the group provide, review and monitor risk management training?	✓			Role of Clinical Governance and Risk Management Department on behalf of Strategic Risk Management Group.
Does the group undertake a regular review of the risk register?	✓			SRMG considered Strategic Risk Profile at every meeting. In addition, strategic risk profile was presented to and considered by Tayside NHS Board in June and October 2016 and February 2017. Minimum of quarterly presentation of Strategic Risks, prepared by risk owner who is Executive Director, to Standing Committees (Chaired by Non Executives) continued and this was further enhanced during 2016/17 with the agreement at the SRMG in August 2016 to include a progress update in relation to the underpinning operational risks.
Does the group co-ordinate the results for reporting on risk to the corporate management team and elected Members/non executive directors/board members?	✓			This is the role of the Risk Manager on behalf of the Strategic Risk Management Group.
Does the group provide advice and support on prioritising risk treatment action based on the organisation's risk appetite?	✓			NHS Tayside Risk Appetite Statement was contained in Section 10 of Risk Management Strategy during 2016/17. However, the risk appetite statement was reviewed and updated during 2016/17 by a short life working group following liaison with other NHS Boards. The revised

				risk appetite was presented to the SRMG for endorsement in February 2017 and Audit Committee for approval in March 2017 and will be implemented during 2017/18 and the updated information incorporated into the Risk Management Strategy and Guidance Note. SRMG consider Strategic Risk Profile at every meeting inclusive of individual Risk Exposure Ratings, Controls and Mitigating Actions. SRMG will also consider and advise on any risk issue escalated to them.

The Corporate Risk Officer	Yes	No	N/A	Comments/Action
Does the Corporate Risk Officer support decision making and policy formulation?	✓			Risk Manager/Clinical Governance and Risk Management Department is responsible for maintaining and updating Risk Management Strategy, Risk Management Guidance Note and producing all required reports to TNHSB, Standing Committees and Risk Management Groups. The Risk Manager has also prepared the Guidance and Fields within the Risk Assessment Section of the Board Paper Template and is an active member of the Governance Review Group.
Does the corporate risk officer provide advice and support in the identification, analysis and evaluation of risk?	✓			Contained within Risk Manager and Clinical Governance & Risk Co-ordinators and Facilitators Job Descriptions. Support can be provided through training, telephone calls or one to one meetings.
Does the corporate risk officer provide advice and support in prioritising action based on the organisation's risk appetite?	✓			This is part of the role of the Strategic Risk Management Group where the Risk Manager is in attendance at each meeting and Tayside NHS Board. NHS Tayside Risk Appetite Statement was contained in Section 10 of Risk Management Strategy during 2016/17. However, the risk appetite statement was reviewed and updated during 2016/17 by a short life working group following liaison with other NHS Boards. The revised risk appetite was presented to the SRMG for endorsement in February 2017 and Audit Committee for approval in March 2017 and will be implemented during 2017/18 and the updated information incorporated into the Risk Management Strategy and Guidance Note.
Does the corporate risk officer provide advice and support on determining risk treatment and mitigation action?	✓			Contained within Risk Manager and Clinical Governance & Risk Co-ordinator and Facilitators Job Descriptions. Support can be provided through training, telephone calls or one to one meetings.
Does the corporate risk officer provide advice and support on risk control techniques?	✓			Contained within Risk Manager and Clinical Governance & Risk Co-ordinators and Facilitators Job Descriptions. Support can be provided through training, telephone calls or one to one meetings.
Does the corporate risk officer co-ordinate the results of risk monitoring and reporting to the management board and elected members/non-executive directors/board members?	✓			Reporting of strategic risk profile to Tayside NHS Board continued during 2016/17. However due to the reconfiguration of the frequency of Tayside NHS Board and Standing Committee meetings, the strategic risk profile was presented to Tayside NHS Board June and October 2016 and February 2017. Mid Year and Annual Report to Audit Committee; Risk Management Workplan and CIPFA Self Assessment and Audit Tool; Committee Annual Report for Strategic Risk Management Group.
Does the corporate risk officer prepare draft reports for the corporate management team to	✓			Reporting of strategic risk profile to Tayside NHS Board continued during 2016/17. However due to the reconfiguration of the frequency of Tayside NHS Board and

issue to stakeholders on the organisation's risk management strategy, policy and processes?				Standing Committee meetings, the strategic risk profile was presented to Tayside NHS Board June and October 2016 and February 2017. Mid Year and Annual Report to Audit Committee; Risk Management Workplan and CIPFA Self Assessment and Audit Tool; Committee Annual Report for Strategic Risk Management Group.
Can the corporate risk officer call on skills in communication, presentation, diplomacy and mediation?	✓			Main duty/responsibility contained within Risk Manager and Clinical Governance & Risk Co-ordinator Job Description. Risk Manager regularly in communication with Executive and Non-Executive Directors and presents at Board Meetings and Standing Committees and is regular attendee at Audit Committee.
Is the corporate risk officer professionally qualified in risk management?	✓			Risk Manager holds an MSc in Risk Management.
Is the corporate risk officer welcome in project development because he or she can take a broad view?	✓			Risk Management is embraced within project structure at outset and if required risk Manager or Clinical Governance and Risk Co-ordinator would attend.
Do managers have confidence in the advice of the corporate risk officer and is this evidenced?	✓			Evidence of this can be provided through returns to the Risk Manager contained within Personal Development Portfolio.
Does the corporate risk officer have unlimited access to the organisation's records or scope of activities?	✓			Risk Manager, for example, routinely receives copies of all Internal Audit Reports.

Managers' Accountability for Risk Management	Yes	No	N/A	Comments/Action
Are managers involved in the risk identification and assessment process?	✓			NHS Tayside operates a 3 tier system of risk management capturing Strategic, Operational and Service Level Risks. Executive Directors are Owners of all Strategic and Operational Risks. Risk Management Workshops take place at Departmental and Directorate Level on request to identify Service Level Risks. Risk Assessment and Management is advocated as being a group activity and not one which should be conducted in isolation therefore managers are part of this process.
Do they take ownership of the risk in their service area?	✓			Strategic Risk Owners/Managers are responsible for reviewing all operational risks aligned to their Strategic Risk. Departmental managers as part of their departmental and directorate Clinical Governance and Risk Meetings should be discussing service level risks and this is also considered and monitored through Performance Review.
Are managers' responsibilities for risk management clearly documented?	✓			Risk Management Strategy defines.
Are managers held accountable for any significant risk management failures in their area?	✓			Monitored through Performance Review Meetings.
Is there guidance for service managers (for example a risk management manual, timetable for risk identification)?	✓			Risk Management Guidance Note is available and applicable to all staff within NHS Tayside.
Is their risk management performance included as part of their performance assessment?	✓			Corporate objective in relation to risk management agreed for 2016/17: ***Effective Management of Risk – Weighting 4*** *Lead the organisations risk management strategy and principles, and be accountable for managing the process of adverse event management at directorate/department level to enable evidencing of continued service improvement.*
Are managers able to explain how they manage their risks?	✓			Strategic Risk Owners/Managers are required to provide progress/status updates on their risks quarterly to the Strategic Risk Management Group, the relevant Standing Committee of the Board and Tayside NHS Board itself. Departmental managers are required to do this as part of their departmental and directorate Clinical Governance and Risk Meetings when discussing service level risks and this is also considered and monitored through Performance Review.
Are risks identified, assessed and documented in accordance with the timetable?	✓			Appendix A of Risk Management Guidance Note contains a Flowchart which is the Process for Risk Management Training and Service Level Risks.

				Review of all risks is a forcing function within Datix system and this must be done on either a monthly, 3 monthly, 6 monthly, 9 monthly or annual basis and requires a full review of the risk including description, exposure ratings, controls and mitigating actions.
Do managers review their risks at least annually?	✓			Review of risk is a forcing function within Datix system and this must be done on either a monthly, 3 monthly, 6 monthly, 9 monthly or annual basis.
Is evidence of this annual re-assessment of risk collated?	✓			Audit trail within Datix.
Are risks presented in sufficient, but not excessive, detail?	✓			Key Risks should be recorded within Datix system which provides a consistent framework for presentation across the organisation.

Testing the Embeddedness of Risk Management Within the Organisation	Yes	No	N/A	Comments/Action
Are the managing board and elected Members/non executive directors/board members sincere about their beliefs that effective risk management can enhance organisational performance?	✓			Regular reports to TNHSB, Audit Committee, Strategic Risk Management Group and Standing Committees of the Board. Demonstrated through requests for Development Event on Risk Management. New assurance template developed to assist in risk report and Committee Chairs Assurance Report.
Do managers understand and take responsibility for managing risk in their service areas?	✓			Evidenced through attendance at Departmental and Directorate Clinical Governance and Risk Management Fora, through entries of Service Level Risks on Electronic risk register which are monitored through Performance Review meetings.
Is there a general culture of risk management, at all levels?	✓			Education and training is delivered at all levels throughout the organisation to support the creation of Strategic, Operational and Service Level Risks. Education and Training is provided through provision of Risk Management Workshop, Risk LearnPro and individual 121 training sessions. Also can be evidence through minutes of discussions at Departmental and Directorate Clinical Governance and Risk Management For a, management committees, Standing Committees and Tayside NHS Board.
Do managers understand the risk management performance of their own area of work and have a general appreciation of those in the wider organisation?	✓			Through attendance at Departmental and Directorate risk management meetings and Performance Review.
Are risk management accountabilities and performance embedded in managers' recruitment and in performance appraisal?	✓			This is included within either the objectives or job descriptions for individuals such as the Board Secretary, Associate Director of Clinical Governance and Risk and other key members of risk management staff. Corporate objective in relation to risk management agreed for 2016/17: ***Effective Management of Risk – Weighting 4*** *Lead the organisations risk management strategy and principles, and be accountable for managing the process of adverse event management at directorate/department level to enable evidencing of continued service improvement.*
Is competency in managing risk recognised and important for career progression?	✓			Implicit within the culture of the organisation as attendance at Departmental/Directorate Clinical Governance and Risk Management Meetings, Performance Review Meetings; receipt, review and verification of Adverse Event Reports and preparation of committee reports will be required.

Is training and development in risk management, including background briefing, provided for Board members?	✓			Education and training is delivered at all levels throughout the organisation to support the creation of Strategic, Operational and Service Level Risks. Education and Training is provided through provision of Risk Management Workshop, Risk LearnPro and individual 121 training sessions. Requests for a further board Development Event on Risk Management were acknowledged during the March 2016 Tayside NHS Board meeting and this request is being planned into the schedule for 2017/18.
Is a culture of risk awareness sustained by regularly involving managers in the risk management aspects of business planning?	✓			The Governance Statement ensures that risk management processes are embedded in the planning, operational, monitoring and review activities of the Board. Senior Managers also regularly attend Senior Leadership Team Meetings and Performance Review Meetings. Risk Assessment is also a mandatory section within "Reports that require decisions to be made" going to any Standing Committee within NHS Tayside. Submissions are reviewed by Committee Chairs (Non-Executive Board Members).
Are managers over-dependent on the corporate risk officer in managing their risks?		✓		Managers will contact the Clinical Governance and Risk Management Team for advice and assistance where required.
Are service managers attuned to the risk management implications of their decisions?	✓			Through attendance at Departmental/Directorate Clinical Governance and Risk Management Meetings, Performance Review Meetings; Through receipt, review and verification of Adverse Event Reports and also through submission of committee reports.
Do managers think about the risk management implications of the way they do business?	✓			Through attendance at Departmental/Directorate Clinical Governance and Risk Management Meetings, Performance Review Meetings; Through receipt, review and verification of Adverse Event Reports and also through submission of committee reports.
Has consideration been given to whether control strategies are appropriate?	✓			Service Level Risks are regularly considered as part of Directorate and Department Clinical Governance and Risk Management and Performance Review meetings and focus should be applied to scrutinising the controls detailed. For Strategic Risks control strategies are discussed, reviewed and scrutinised by Strategic Risk Management Group, Standing Committees of Tayside NHS Board and Tayside NHS Board itself. In addition during 2016/17 Internal Audit Report T12/16 provided a review of the Board Assurance Framework (Strategic Risks)
Is the subject of risk management a regular part of team meeting agendas?	✓			Regularly considered as part of Directorate and Department Clinical Governance and Risk Management meetings. Also as part of performance review meetings

				and Standing Committees and Tayside NHS Board.
Is the subject of risk management incorporated into quality measures e.g. Investors in People programme, quality arrangements under ISO?	✓			Incorporated into NHS Healthcare Improvement Scotland reviews, many Best Value Reviews and reviews undertaken for example within the Laboratory service.
Are departmental managers required to self certify the performance of risk management and internal control in their department?	✓			Through Departmental/Directorate Clinical Governance and Risk Management meetings and as part of performance review meetings.
Do departmental management teams agree budgets for risk control projects?	✓			This would be taken from and managed within overall departmental budget as and if necessary.
Does the organisation have a fully developed business/service continuity plan covering all its services?	✓			This is led and managed by the Resilience Planning Department who have a number of Emergency and Business Continuity Plans in place.
Does the organisation have an IT recovery plan?	✓			Produced, maintained and held by the E-Health department.
Are cost benefit analyses carried out on proposed risk control measures?	✓			These are normally contained within current resource otherwise a proposal inclusive of cost benefit analysis would be taken to the relevant committee of the board.
Are early warning mechanisms adequate?	✓			A risk escalation pyramid exists within the risk management structure of NHS Tayside for communication of emergent risks. Section 5 of Risk Management Guidance note refers. In addition, to ensure risks within the electronic risk management system remain fit for purpose and up to date the system operates a reminder framework.

Projects and Partnerships	Yes	No	N/A	Comments/Action
Is a risk assessment carried out before the commencement of every major project?	✓			Risk Management Guidance Section 7 details expectations and arrangements and provides a link to the Capital Approvals Process and Business Case Guide.
Is the risk assessment fully documented?	✓			Risk Management Guidance Section 7 details expectations and arrangements and provides a link to the Capital Approvals Process and Business Case Guide
Is the risk assessment reviewed at regular intervals during the life of the project to determine changes to risk and identify new and emerging risks?	✓			Risk Management Guidance Section 7 details expectations and arrangements and provides a link to the Capital Approvals Process and Business Case Guide
Is a risk assessment carried out before entering into new partnership arrangements?	✓			For capital projects these are completed both internally and externally. Each project has at least one risk workshop. If it is an internal risk register NHS Tayside methodology utilised. If external Health Facilities Scotland proformas and methodology adopted.
Is the risk assessment fully documented?	✓			Within Capital Projects this is completed as per National Scottish Capital Investment Manual and NHS Tayside Capital Approval and Business Case Guide. If it is an internal risk register NHS Tayside methodology utilised. If external Health Facilities Scotland proformas and methodology adopted.
** Are potential partners required to produce and submit risk assessments?	✓			Completed jointly.
** Is the risk management performance of the partnership regularly reviewed?	✓			Each project has at least one risk workshop which is completed jointly.
** Are partnership arrangements regularly reviewed?	✓			As part of risk assessment process.
** Are there effective arrangements on risk sharing?	✓			Risk assessments completed jointly and each project has at least one risk workshop which is completed jointly.
** Have existing contracts been reviewed to highlight areas of risk retained by the organisation?	✓			This is completed on a Project by project basis.
Is a risk assessment carried out when entering into new contractual arrangements?	✓			Only if contractor changed mid project e.g. through receivership but seek to avoid where possible.
Is the risk assessment fully documented?	✓			For capital projects these are completed both internally and externally. Each project has at least one risk workshop. If it is an internal risk register NHS Tayside methodology utilised. If external Health Facilities Scotland proformas and methodology adopted.

This section of the self assessment has largely been completed in respect of capital projects with the exception of the 5 areas/questions marked **. Although these have been marked as compliant, it is recognised that Internal Audit report T12/16 was finalised on 16 December 2016 and presented to the Audit Committee on 9 March 2017. This was graded as Category B and concluded that the Board Assurance Framework within NHS Tayside had moved forward since its last review, particularly with the introduction of the assurance report template and Committee Chairs reports. However, the report also highlighted that there is currently no agreed, formal setting out of the precise responsibilities of the Health Board, Councils and the IJB in

relation to operational activities and reflected this with a D grade. In response to this, and as a result of discussion and agreement at the Finance and Resources Committee, it was recognised that there was a requirement for a high level meeting to take place. An initial meeting took place on 12 January 2017 and a further meeting of the Chief Officers, Board Secretary and Internal Audit then took place on 8 February 2017 with a view to developing/scoping out recommendations. This will provide a framework for Year End Governance Arrangements and inform further work to be progressed in relation to risk registers ensuring risks are appropriately aligned and managed. As a result the overall compliance for this section has been reduced at this point in time until this work has concluded and a process is fully implemented.

Risk Management Information Systems (Risk Registers etc)	Yes	No	N/A	Comments/Action
Does the risk management system provide reliable outputs?	✓			Datix risk management system has been configured to meet organisational requirements and reports have been designed and generated internally. In addition tailored reports can be designed and set up to meet specific area/department/directorate requirements.
Is risk information updated promptly?	✓			Risk Owners/Managers specify review dates within system which automatically issues reminders and these are also followed up manually by members of the Clinical Governance and Risk Management Team.
Are risk management information systems documented?	✓			Information and link contained within Guidance Note. Also training notes/manuals available for individual modules of Datix and Learn Pro Module training available for Adverse Event and Risk Modules.
Are the risk management information systems appropriately supported and maintained?	✓			Clinical Governance and Risk Management Co-ordinator (Datix), Clinical Governance Support Officer (Datix) and Datix Administrator appointed and in post.
Is the system adequate for risk reporting?	✓			Datix risk management system has been configured to our requirements and reports have been designed and generated internally. In addition tailored reports can be designed and set up to meet specific area/department/directorate requirements.
Are managers equipped with the tools and skills to use risk information systems effectively and to access the information they need?	✓			Training notes/manuals available for individual modules of Datix and all staff are required to undertake a risk management workshop and complete the Risk Learn Pro module prior to access being granted.
Does the risk management information system used by the organisation meet users' needs?	✓			Datix enablement structure in place and Datix Steering & Development Group review any proposals for enhancements.
Are users' needs regularly reviewed to ensure that risk management systems remain 'fit for purpose'?	✓			Datix enablement structure developed. Survey Monkey Questionnaires undertaken and results made available to staff through communications such as Vital Signs. Improvements agreed and progress monitored though Datix Steering & Development Group.
Are users consulted on developments?	✓			Datix enablement structure developed. Survey Monkey Questionnaires undertaken and results made available to staff through communications such as Vital Signs. Improvements agreed and progress monitored though Datix Steering & Development Group.
Are managers able to update risk information held the system on line?	✓			Only risk owners/risk managers can update information on line but can do this at either review date or any time in between review date. Risks are also monitored at

				Directorate and Departmental Clinical Governance and Risk Management Fora and through Performance Review.
Are there flexible reporting tools so specialist reports can be designed?	✓			Datix risk management system has been configured to our requirements and reports have been designed and generated internally. Clinical Governance and Risk management Staff working on Datix have completed successful projects in developing specific reporting forms for e.g. Control Drugs, 2222 calls & GP forms. In addition Datix Administrator regularly assists service areas/individuals in establishing reports that they will use on a frequent basis to generate outputs from the system.

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

Item Number 9

AUDIT31/2017
Audit Committee
11 May 2017

AUDIT COMMITTEE TERMS OF REFERENCE AND WORK PLAN 2017/18

1. PURPOSE OF THE REPORT

The purpose of this report is to seek the Committee's approval for the attached Terms of Reference and Work Plan.

2. RECOMMENDATIONS

The Committee is requested to review and agree the attached Terms of Reference and Work Plan 2017/18.

3. EXECUTIVE SUMMARY

Each year, all Standing Committees and Sub-Committees are required to produce annual work plans. Such plans must be produced by 30 June each year.

The Terms of Reference of the Audit Committee are contained within the Code of Corporate Governance and a summary exists on the Committee intranet site.

The detailed Terms of Reference is included in Appendix 1 while the Work Plan for the coming year is set out at Appendix 2.

The Work Plan of the Committee is largely cyclical, rather than being specific to individual financial years and has been drafted accordingly.

4. REPORT DETAIL

As per Executive Summary

5. CONTRIBUTION TO NHS TAYSIDE'S STRATEGIC AIMS

The purpose of the Audit Committee is to assist the Board to deliver its responsibilities for the conduct of public business and the stewardship of funds under its control.

6. HEALTH EQUITY

The Audit Programme covers the Health of the Population.

7. MEASURES FOR IMPROVEMENT

The Work Plan seeks to assist the Committee in aiming to function with the highest standards of governance.

8. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

As the attached paper is in draft for the Committee's approval, it has not been subject to prior consultation.

9. PATIENT EXPERIENCE

There is no patient experience arising from this report.

10. RESOURCE IMPLICATIONS

There are no financial or workforce implications arising from this report.

11. RISK ASSESSMENT

There are no risks arising as a consequence of this report.

12. LEGAL IMPLICATION

Not applicable

13. INFORMATION TECHNOLOGY IMPLICATIONS

Not applicable

14. HEALTH & SAFETY IMPLICATIONS

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

15. HEALTHCARE ASSOCIATED INFECTION (HAI)

Not applicable

16. DELEGATION LEVEL

Not applicable.

17. TIMETABLE FOR IMPLEMENTATION

Implementation will be immediate following Committee approval. The lead officer is the Director of Finance.

18. REPORT SIGN OFF

Lindsay Bedford
Director of Finance

May 2017

19. SUPPORTING DOCUMENTS

Appendix 1 – Audit Committee Terms of Reference 2017/18
Appendix 2 – Audit Committee Work Plan 2017/18

Appendix 1

AUDIT COMMITTEE
TERMS OF REFERENCE AND 2017/18 WORK PLAN

1. Introduction

This paper outlines the terms of reference for the Audit Committee (as contained within the NHS Tayside Code of Corporate Governance) and the Committee's 2017/18 Work Plan.

2. Executive Lead Officer

The executive lead officer for this committee is Mr Lindsay Bedford Director of Finance.

3. Support Officer

Items for the agenda should be submitted to the Committee Support Officer,
Ms Lisa Green, Committee Support Officer, NHS Tayside HQ, Level 10, Ninewells Hospital & Medical School, Dundee DD1 9SY on tel 01382 496680, ext 36680 or via email lisa.green7@nhs.net

4. Purpose of Committee

The purpose of the Audit Committee is to assist the Board to deliver its responsibilities for the conduct of public business and the stewardship of funds under its control. In particular, the Committee will seek to provide assurance to the Board that an appropriate system of internal control is in place to ensure that:

- Business is conducted in accordance with the law and proper standards.
- Public money is safeguarded and properly accounted for.
- Financial Statements are prepared timeously and give a true and fair view of the financial position of the Board for the period in question.
- Affairs are managed to secure economic, efficient and effective use of resources.
- Reasonable steps are taken to prevent and detect fraud and other irregularities.

5. Membership

Mr Stephen Hay, Non Executive Member, NHS Tayside is the Chair of the Committee.
The Vice Chair position is presently vacant.

Members

Mr D Cross, Non Executive Member
Mrs L Dunion, Non Executive Member
Mrs J Golden, Non Executive Member and Employee Director
Mr S Hay, Non Executive Member
Mr M Hussain, Non Executive Member
Non Executive Member (vacant)
Non Executive Member (vacant)

In Attendance
Mr L Bedford, Director of Finance (Lead Officer)
Ms M Dunning, Board Secretary, NHS Tayside

The External Auditor and the Chief Internal Auditor shall also receive a standing invitation to attend.

In order to preserve its independence from operational management, the Audit Committee does not have executive membership. It is also the only Standing Committee for which the Chair of the Board does not have ex-officio status.

The under noted groups have a right of attendance at the meetings of the Committee as follows:

- The Public Partnership Groups shall be invited to send a maximum of two representatives.
- The Area Clinical Forum and Area Partnership Forum shall be invited to send a maximum of two representatives.

The Chair of the meeting will have the discretion to decide if the representatives will not be issued with reserved business and will be required to leave due to the nature of business to be discussed in Reserved Business.

Persons attending in this capacity shall be entitled to speak but not to propose or second any motion or to vote.

Regular Attendees

Mr D Colley, Finance Governance Accountant, NHS Tayside
Mr B Crosbie, Senior Audit Manager, Audit Scotland
Mr G Doherty, Director of Human Resources, NHS Tayside
Mr T Gaskin, Chief Internal Auditor, FTF Audit and Management Services
Mrs F Gibson, Head of Financial Services, NHS Tayside
Miss D Howey, Head of Committee Administration, NHS Tayside
Mr B Hudson, Regional Audit Manager, FTF Audit and Management Services
Mrs J Lyall, Regional Audit Manager, FTF Audit and Management Services
Ms A Machan, Senior Auditor, Audit Scotland
Mr R Marshall, Representative Area Partnership Forum
Mr R MacKinnon, Associate Director of Financial Services and Governance/FLO
Ms F Mitchell-Knight, Assistant Director, Audit Services, Audit Scotland
Ms H Walker, Risk Manager, NHS Tayside
Representative Area Clinical Forum

6. Quorum

Meetings of the Committee will be quorate when at least three members are present.

7. Frequency of Meetings

The Committee shall meet no fewer than four times a year.

8. Remit

The main objectives of the Audit Committee are to ensure compliance with NHS Tayside's Code of Corporate Governance and that an effective system of internal control is maintained. The duties of the Audit Committee are in accordance with the NHS Audit Committee Handbook and are as detailed below.

Risk Reporting

The Committee has a duty

- To review the organisation's risk management arrangements, systems and processes;
- To review biannual reports from corporate risk owners with risks aligned to this Committee;
- To review and approve the risk management work plan;

- To approve the Terms of Reference and Committee Annual Report of the Strategic Risk Management Group;

- To receive the Minutes and Action Points Update from the Strategic Risk Management Group and Operational Unit Risk/Health and Safety Management Group;

- To approve the mid year and annual risk management/health and safety reports on effectiveness, adequacy and robustness of the risk management systems.

Policy Adoption

- Adopt Health & Safety/Risk Management (including Fire Safety) policies.

Internal Control and Corporate Governance

To review the framework of internal control and corporate governance comprising the following components:

- Control environment.
- Information and communication.
- Risk management.
- Control procedures.
- Monitoring and corrective action.

To review the system of internal financial control, which includes:

- The safeguarding of assets against unauthorised use and disposition.
- The maintenance of proper accounting records and the reliability of financial information used within the organisation or for publication.
- To ensure that the Board's activities are within the law, regulations, Ministerial Direction and the Board's Code of Corporate Governance.
- To present an annual Statement of Assurance on the above to the Board, in support of the Governance Statement by the Chief Executive.

Internal Audit

- To review and approve the Internal Audit Strategic and Annual Plans.
- To receive and review Internal Audit reports in line with the Internal Audit Protocol.
- To receive and review management reports on action taken in response to audit recommendations in line with the agreed follow-up Protocol.
- To consider the Chief Internal Auditor's annual report and Assurance Statement.
- To review the operational effectiveness of Internal Audit by considering the audit standards, resources, staffing, technical competency and performance measures.
- To ensure that there is direct contact between the Audit Committee and Internal Audit and to meet with the Chief Internal Auditor at least once per year and as required, without the presence of Executive Directors.

External Audit

To review the annual Audit Planning Memorandum including the Performance Audit programme;

- To review the terms of reference, appointment and remuneration of external auditors for the Board Endowment Funds.
- To review the Audit Plan produced by the external auditors appointed in relation to the Board Endowment Funds.

- To consider all statutory audit material for the Board, in particular:-
  - Audit reports (including Performance Audit studies and Best Value toolkits).
  - Annual report.
  - Chief Executive Letters.
  - Matters relating to the certification of Annual Accounts (Exchequer Funds); Annual Patients' Funds Accounts and Annual Endowment Funds Accounts.
  - To monitor management action taken in response to all External Audit recommendations, including VFM studies.
  - To hold meetings with the External Auditors at least once per year and as required, without the presence of the Executive Directors.
  - To review the extent of co-operation between External and Internal Audit.
  - Annually appraise the performance of the External Auditors.
  - To note the appointment and remuneration of the External Auditors and to examine any reason for the resignation or dismissal of the Auditors.
  - To appoint the External Auditors of Patients' Funds and approve the remuneration.

Code of Corporate Governance

- To review the Code of Corporate Governance which includes Standing Orders, Schemes of Reservation and Delegation, Standing Financial Instructions and recommend amendments to the Board.
- To examine the circumstances associated with each occasion when Standing Orders have been waived or suspended.
- To monitor compliance with the Members' Code of Conduct.

Annual Report and Accounts

- To review the Annual Report for the Board.
- To review and recommend for approval the Annual Accounts for Exchequer Funds.
- To review and recommend for approval the Annual Accounts for Endowment Funds to the Endowment Trustees of the Board.
- To review and recommend for approval the Annual Accounts for Patients' Funds.
- To review at least annually the accounting policies and approve any changes thereto;
- To review schedules of losses and compensation payments.

Risk Management

- To review and approve the Risk Management Mid Year Report
- To review and approve the Risk Management Annual Report
- To review and approve the Risk Management Work Plan
- To review and approve the Risk Management Strategy (5 yearly report)
- To review the Risk Management CIPFA Self Assessment and Audit Checklist

Other Matters

- The Committee has a duty to review its own performance and effectiveness, including its running costs, and terms of reference on an annual basis;
- It also has a duty to keep up to date by having a mechanism to ensure topical legal and regulatory requirements are brought to Members' attention;
- The Committee shall monitor how the Board controls risk and possible litigation;
- The Committee shall agree the level of detail it wishes to receive from the Internal and External Auditors.

Best Value

The Committee is responsible for reviewing those aspects of the Best Value work plan which are delegated to it from Tayside NHS Board. The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Tayside has systems and processes in place to secure best value for these delegated areas.

9. Authority

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

10. Reporting Arrangements

- The Audit Committee reports to Tayside NHS Board;
- Following a meeting of the Audit Committee, the minutes of that meeting should be presented at the next Tayside NHS Board meeting;
- The Audit Committee should annually and within three months of the start of the financial year, provide a work plan detailing the work to be taken forward by the Audit Committee;
- The Audit Committee will produce an Annual Report for presentation to Tayside NHS Board. The Annual Report will describe the outcomes from the Committee during the year and provide an assurance to the Board that the Committee has met its remit during the year.
- The Annual Report must be presented to the Board meeting following the Audit Committee considering the Annual Accounts.

11. Work Plan

At each meeting of the Committee, the following business shall be transacted:

- Minutes and any matters arising from the previous meeting of the Committee.
- Minutes for the Strategic Risk Management Group.
- Minutes for the Governance Review Group.
- Reports from the Chief Internal Auditor against the Annual Internal Audit Plan.
- Consideration of specific Internal and External Audit Reports and Action Plans.
- Review of audit publications relevant to economy, efficiency and effectiveness of services.
- Update reports on all Counter Fraud Service investigations and consideration of their potential impact on NHS Tayside taken by management under Reserved Business.
- Consider progress reports around National Fraud Initiative work.
- Consideration of detailed Payment Verification reports and updates on Primary Care Contractors and considered actions taken by management

On a quarterly basis, the Committee shall consider progress reports on:

- Audit follow up – full progress reports to 2 meetings and mid-cycle update reports to 2 other meetings
- Progress reports from the appointed External Auditor together with consideration of specific reports

Every six months, the Committee shall consider progress and exception reports on:

- Risk Management/Health and Safety.
- Litigation monitoring.

Annually, the Committee shall consider and make recommendations to the Board where necessary, with regard to:

- Approval of terms of reference and a work plan for all Committee meetings for the forthcoming year
- Approval of Risk Management Annual Report
- Approval of Risk Management Work Plan
- Review of Risk Management CIPFA Self Assessment and Audit Checklist
- Annual Report for the Strategic Risk Management Group Review with the appointed External Auditor, the Audit Planning Memorandum including fees and reporting arrangements.
- Review of Annual Accounts for Exchequer, Endowments and Patients Funds.
- Review of Audit Plan of Endowment Funds – External Audit Report
- Review of Audit Plan of Patients' Funds – External Audit Report
- Review of Patient Exemption Checking (PECS) Annual Report
- Review of NHS Tayside Losses and Compensation payments.
- Review the effectiveness of co-operation between Internal and External Audit.
- Review of Internal Audit Interim Review
- Approval of the Annual Report from the Chief Internal Auditor relating to the previous year
- Approval of Internal Audit Plan
- Review of the External Audit Annual Audit Plan
- Review of the External Audit Interim Report
- Review previous year Annual Report to Members on the audit of NHS Tayside.
- Review of the changes to the Code of Corporate Governance.
- Approval of Annual report of the Audit Committee.
- .
- Review compliance with Property Transaction Monitoring requirements for onward submission to Scottish Government Health and Social Care Directorates (SGHSCD).

The last item included on the Reserved Business Agenda for each Audit Committee Meeting is entitled 'Private Discussion', this provides the members of the Committee and the Internal/External auditors an opportunity for private discussion without other regular attendees being present.

This information has been tabularised. See Appendix 1.

12. Timetable for submitting agenda items and papers

The Audit Committee meetings are held on a Thursday, at 9.30 a.m. in the Board Room, King's Cross.

The dates of the Committee meetings for 2017/18 are set out below. Final papers must be submitted, electronically, to Mrs Lisa Green, lisa.green7@nhs.net, Committee Support Officer, by the due date noted in column four below:

Draft Reports to be submitted to Lisa Green for Pre-Agenda Planning	Papers to be agreed at Agenda Planning Meeting on:	Final Papers to be submitted by 12pm on:	Agenda & Papers to be issued:	**Date of Committee Meeting**
Friday 14 April 2017	Wednesday 19 April 2017 14:00pm Break Out Room 5	Monday 1 May 2017	Thursday 4 May 2017	**Thursday 11 May 2017** 9.30am Board Room, Kings Cross

Friday 26 May 2017	Tuesday 30 May 2017 11:00am Break Out Room 5	Monday 12 June 2017	Thursday 15 June 2017	**Thursday 22 June 2017** **Annual Accounts** 9.30am Board Room, Kings Cross
Friday 28 July 2017	Tuesday 1 August 2017 11:00am Break Out Room 5	Monday 14 August 2017	Thursday 17 August 2017	**Thursday 24 August 2017** 9.30am Board Room, Kings Cross
Friday 24 November 2017	Tuesday 28 November 2017 11:00am Break Out Room 5	Monday 4 December 2017	Thursday 7 December 2017	**Thursday 14 December 2017** 9.30am Board Room, Kings Cross
Friday 23 February 2018	Tuesday 27 February 2018 11:00am Break Out Room 5	Monday 5 March 2018	Thursday 8 March 2018	**Thursday 15 March 2018** 9.30am Board Room, Kings Cross

Appendix 2

AUDIT COMMITTEE

Audit Committee Workplan 2017/18

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

	Responsible Officer	Comment	Meeting 11 May 2017	Meeting 22 Jun 2017	Meeting 24 Aug 2017	Meeting 14 Dec 2017	Meeting 15 Mar 2018	Meeting May 2018	Meeting June 2018
Regular reports submitted to the Audit Committee									
Audit Follow Up									
Full Cycle Reports	L Bedford	**6 Monthly**	**X**			**X**			
Mid Cycle Reports	L Bedford	**6 Monthly**			**X**		**X**		
Update of Audit Follow Up	L Bedford	**As & when available**							
Annual Accounts									
Accounting Policies	F Gibson	**Annual**					**X**		
Annual Accounts Guidance (incl Financial Statements Checklist)	F Gibson	**Annual**					**X**		
Governance Statement	F Gibson	**Annual**		**X**					**X**
Review of Annual Accounts for Exchequer	L Bedford	**Annual**		**X**					X
Review of Annual Accounts for Endowments	L Bedford	**Annual**		**X**					X
Review of Annual Accounts for Patient Funds	L Bedford	**Annual**		**X**					X
Losses and Compensation Payments	L Bedford	**Annual**		**X**					X

	Responsible Officer	Comment	Meeting 11 May 2017	Meeting 22 Jun 2017	Meeting 24 Aug 2017	Meeting 14 Dec 2017	Meeting 15 Mar 2018	Meeting May 2018	Meeting June 2018
Risk Management									
Strategic Risk Management Group Annual Report	M Dunning	**Annual**	**X**						
Risk Management Mid Year Report	H Walker	**6 monthly**		**X**					
Risk Management Annual Report	H Walker	**Annual**	**X**						
Risk Management Workplan	H Walker	**Annual**	**X**						
Risk Management Strategy (last presented 3/9/15)	H Walker	**5 yr document (last presented 03/09/15)**	**-**	**-**		**-**	**-**	**-**	**-**
Risk Management CIPFA Self Assessment and Audit Checklist	H Walker	**Annual**	**X**						
Review on Internal Controls									
Committee Annual Report s and Assurances incl. Best Value Assurance	L Bedford	**Annual**		**X**					**X**
Review Framework of Internal Controls and Corporate Governance	L Bedford	**Annual**		**X**					**X**
Lead Officer Statement on Governance Statement on Internal Control to Chief Internal Officer	L Bedford	**Annual**		**X**					**X**
Chief Internal Auditors Annual Report & Assurance Statement	T Gaskin	**Annual**		**X**					**X**
Code of Corporate Governance									
Updates to Code of Corporate Governance	M Dunning	**As & when available**		**X**					
Governance Review Group Annual Report	M Dunning	**Annual**		**X**					**X**

	Responsible Officer	Comment	Meeting 11 May 2017	Meeting 22 Jun 2017	Meeting 24 Aug 2017	Meeting 14 Dec 2017	Meeting 15 Mar 2018	Meeting May 2018	Meeting June 2018
Internal Audit									
Internal Audit Progress Report	B Hudson	**Standing Item**	**X**		**X**	**X**	**X**	**X**	
Internal Audit Interim Review	T Gaskin	**Annual**				**X**			
Internal Audit Annual Report (incl report on previous years Internal Control)	T Gaskin	**Annual**		**X**					**X**
Internal Audit Annual Plan	T Gaskin	**Annual**	**X**					**X**	
Private Discussions	T Gaskin	**Standing Item**							
External Audit – Audit Scotland									
Annual Audit Plan **(last presented 17/01/17)**	B Crosbie	**Annual**				**X**			
External Audit Plan Progress Report	B Crosbie	**Quarterly**			**X**				
External Audit Interim Report	B Crosbie	**Annual**	**X**						
Audit Scotland Annual Report on NHS Scotland	L Bedford	**Annual**			**X**				
Audit Scotland Reports (incl Technical Bulletins)	L Bedford	**As & when available**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Notification from Sponsored Body Audit Committees	L Bedford	**Annual**		**X**					**X**
Annual Report on the previous year audit to the Board and the Auditor General for Scotland	B Crosbie	**Annual**		**X**					**X**

	Responsible Officer	Comment	Meeting 11 May 2017	Meeting 22 Jun 2017	Meeting 24 Aug 2017	Meeting 14 Dec 2017	Meeting 15 Mar 2018	Meeting May 2018	Meeting June 2018
External Audit - Other									
Review withExternal AuditorAudit Planning Memorandum , Fees & Reporting Arrangements	L Bedford	**Annual**		**X**					**X**
Review of Audit Plan of Endowment Funds – External Audit Report (MMG Archbold)	P Crichton	**Annual**		**X**					**X**
Review of Audit Plan of Patients' Funds – External Audit Report (Henderson Loggie)	D Taylor	**Annual**		**X**					**X**
Appointment of External Auditors Endowment & Patients Funds & approval of fees	R MacKinnon	**As & when required**				**X**			
Counter Fraud Services									
Counter Fraud Services Update	R MacKinnon	**Standing item**	**X**		**X**	**X**	**X**	**X**	
National Fraud Initiatives (& Bribery Act) Progress Report	R MacKinnon	**Standing item**	**X**		**X**	**X**	**X**	**X**	
Patient Exemption Checking (PECS) Annual Report	R MacKinnon	**Annual**		**X**					**X**
Payment Verification									
Payment Verification Update • General Pharmaceutical Svs • General Ophthalmic Svs • General Dental Svs • General Medical Svs	J Haskett	**Standing item**	**X**		**X**	**X**	**X**	**X**	

	Responsible Officer	Comment	Meeting 11 May 2017	Meeting 22 Jun 2017	Meeting 24 Aug 2017	Meeting 14 Dec 2017	Meeting 15 Mar 2018	Meeting May 2018	Meeting June 2018
Annual Reports									
Audit Committee Annual Report	L Bedford	**Annual**	**X**					**X**	
Audit Committee Terms of Reference & Workplan	L Bedford	**Annual**	**X**					**X**	
Audit Committee Handbook & Checklist	L Bedford	**Annual**					**X**		
Other Reports									
Property Transactions Monitoring	L Lyall	**Annual**	**X**			**X**		**X**	
Litigation Monitoring	R MacKinnon	**Quarterly**	**X**			**X**			**X**
Minutes for Information									
Strategic Risk Management Group	M Dunning	**As & when available**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Governance Review Group	M Dunning	**As & when available**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Policies to be endorsed by the Committee as and when required									
Adverse Event Management Policy	H Walker	**Annually**			**X**				
Health and Safety/Risk Management Policies	Policy Managers	**As & when available**							

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

Item Number 10

AUDIT32/2017
Audit Committee
11 May 2017

PROPERTY TRANSACTIONS 2016/17

1. PURPOSE OF THE REPORT

In return for the operational independence NHS Boards have in relation to property transactions, the Scottish Government Health and Social Care Directorate (SGHSCD) requires that Boards follow procedures laid out in the Property Transactions Handbook, (the Handbook). It is a requirement of the Handbook that the Audit Committee be advised of all property transactions by May of each year, and receive copies of all relevant proformas and certificates. This report advises the Audit Committee of any completed relevant property transactions identified within the scope of the Handbook for 2016/17.

2. RECOMMENDATIONS

The Committee is asked to:-

- note that there were six completed property transactions during 2016/17 (Appendix 1);
- approve a draft return for 2016/17, and note that the report will be submitted to the SGHSCD by the deadline of 30 October, 2017, and
- note the copies of the relevant proformas and certificates (Appendix 2).

3. EXECUTIVE SUMMARY

The Property Transactions Handbook requires that:-

- The Audit Committee is responsible for monitoring property transactions. Monitoring is carried out on the basis of an annual cycle. This cycle should normally commence no later than May each year when NHS Tayside staff responsible for property transactions should provide the Audit Committee with the details of property transactions completed during the previous financial year. The details should include completed monitoring proformas for every transaction together with any appropriate certification required.

- Annually, a sample of completed property transactions are measured against the Handbook by the Internal Audit Department. Up to 50% of transactions should be inspected, or all, if there have been only a few transactions.

4. REPORT DETAIL

The Committee is advised that there were six certificated property transactions in 2016/17, which were as follows:-

i. Sale of Dundonnachie House, Aberfeldy;
ii. Sale of the former Sunnyside Royal Hospital, Montrose;
iii. Sale of the former Murray Royal Hospital, Perth;
iv. Sale of surplus land at the former Douglas Clinic, Dundee;
v. Sale of the former Orleans Day Hospital, Dundee, and
vi. Sale of the former Longcroft Clinic, Dundee.

Internal Audit has been asked to undertake an inspection of the Sunnyside and Murray Royal transactions, along with one further transaction. Following discussion between Internal Audit and senior management, it was agreed that the third transaction to be reviewed would be Dundonnachie House.

The sale proceeds from the sale of the former Sunnyside Hospital amount to £1.079 million, plus further overage payments. The £1.079 million will be received by NHS Tayside on a phased basis, with an initial payment of £0.3 million received in 2016/17 and 10 further guaranteed payments of £77,900 in future financial years, commencing in 2018.

5. CONTRIBUTION TO NHS TAYSIDE'S STRATEGIC AIMS

Rationalisation of estate and consequent avoidance of unnecessary expenditure would release funding for frontline healthcare. It is also important that we ensure healthcare is delivered from appropriate facilities to enable us to deliver on the 2020 vision.

6. HEALTH EQUITY

Not applicable.

7. MEASURES FOR IMPROVEMENT

Not applicable.

8. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

Internal Audit was consulted on the content of the paper prior to it being considered by the Audit Committee.

9. PATIENT EXPERIENCE

There is no patient experience arising directly from this report. The disposal of surplus property is an essential part of the Property and Financial Strategies to fund improvements to healthcare throughout Tayside.

10. RESOURCE IMPLICATIONS

Financial

The financial implications were included in reports to the Finance and Resources Committee and Tayside NHS Board.

Workforce

There are no workforce implications arising from this report.

11. RISK ASSESSMENT

There are no major risks specific to the property transaction process, provided it is carried out in accordance with the appropriate guidance. The Property Asset Management Team has been strengthened in 2016/17 to ensure compliance with Property Transaction Handbook guidance and timescales are adhered to. Changes to the process of completion for the PTHB Certificates have been addressed with Central Legal Office and all transactions completed in 2016/17 have signed certificates.

12. LEGAL IMPLICATION

All specialist legal advice and conclusion of sale documents will be managed by the Central Legal Office.

13. INFORMATION TECHNOLOGY IMPLICATIONS

Not applicable.

14. HEALTH & SAFETY IMPLICATIONS

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

15. HEALTHCARE ASSOCIATED INFECTION (HAI)

Not applicable.

16. DELEGATION LEVEL

Not applicable.

17. TIMETABLE FOR IMPLEMENTATION

Post Transaction Monitoring is a cyclical process with proformas produced in May and annual certification reported to the Audit Committee in August/September. The Audit Committee's approval of the transaction procedures is then reported to SGHSCD by 30 October, 2017.

The lead officer is the Capital Finance Manager.

18. REPORT SIGN OFF

Louise Lyall
Capital Finance Manager

Lindsay Bedford
Director of Finance

May 2017

Appendix 1

Tayside Health Board

Completed Property Transactions 2016/17

A.	**Sales Under £100,000**	**Amount**
	Dundonnachie House, Aberfeldy	£0.100m
	Land at Douglas Clinic	£0.020m
	Orleans Day Hospital	£0.075m
	Longcroft Clinic	£0.055m
B.	**Sales Over £100,000**	
	Sunnyside Royal Hospital	£1.079m
	Murray Royal Hospital	£0.550m
C.	**Sales of NHS Houses/Residential Accommodation**	
	Nil	
D.	**Granting of Leases**	
	Nil	
E.	**Acquisition of Property**	
	1. By Purchase	
	Nil	
	2. By Lease	
	Nil	

PROPERTY TRANSACTION CERTIFICATION: CHIEF EXECUTIVE

DISPOSAL BY SALE, EXCAMBION OR LEASE

A. Holding Body

Tayside Health Board

B. Property

Dundonnachie House, Bank Street, Aberfeldy PH15 2BB

C. Nature of Disposal (e.g. sale, ~~excambion or lease~~)

Sale

\+ D. *Proceeds/~~excambion value, annual lease value and term~~
(*please delete as appropriate)

£ £99,667

E. Date of Settlement of Transaction (when available) Not known at acceptance

F. I am satisfied that this transaction has been dealt with:

F1 in accordance with in-force mandatory requirements contained in the Health and Social Care Directorates' NHSScotland Property Transactions Handbook and any other relevant general guidance issued by the Health and Social Care Directorates;

\# F2 taking proper and reasonable account of guidance related specifically to this transaction issued by the Health and Social Care Directorates before, or after, any notification to the Accountable Officer;

F3 taking proper and reasonable account of the advice received from professional advisers,

and that consequently the *proceeds/~~excambion value/annual lease value~~ (*delete as appropriate), and the conditions attached thereto, are the best obtainable for the public interest at this time having regard for the price and other conditions.

SIGNED: (reflecting position as at stage of selection of preferred bidder/or before transaction is notified to the Accountable Officer.)

.....Chief Executive (1)

DATE: 25th April 2016

SIGNED: (reflecting position as at the date of settlement of the transaction)

.....Chief Executive

DATE: 21st September 2016

CHANGES: (Please describe here and initial (a): any material changes in the transaction between selection of preferred bidder and settlement of the transaction and, (b): any dates for scheduled post-settlement payments to be made to the Holding Body)

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Notes:

+ Show separately any balancing receipt or payment by Holding Body necessary to complete any excambion.

Cross-out F2 only if no guidance specifically related to this transaction was issued by the Health and Social Care Directorates.

PROPERTY TRANSACTION CERTIFICATION:
CONFIRMATION OF ADVICE TO CHIEF EXECUTIVE

DISPOSAL BY SALE, EXCAMBION OR LEASE

DETAILS

1. Holding Body

Tayside Health Board

2. Address and Property Involved

Dundonnachie House, Bank Street, Aberfeldy PH15 2BB

3. Nature of Disposal (e.g. sale, ~~xxxxxxxxxxxxxxxx~~

Sale

+ 4. *Proceeds/~~xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx~~
(*delete as appropriate)

£ £99,667

5. Date of Settlement of Transaction (when available) Not known at acceptance

6. **Property Adviser's Advice**

TO CHIEF EXECUTIVE

I am satisfied that:

the chosen disposal method has where appropriate been identified by an acceptable appraisal of practical disposal alternatives;

- all appropriate steps have been taken to enhance the proceeds from the disposal of the above property by taking advantage of the property's potential for development or change of use.

- the property has been given the maximum possible exposure to the market and that further marketing within the foreseeable future will not yield a *better price/*~~lease value~~ (*delete as appropriate);

- our investigation of the future planning potential of the above property has completely clarified the issue in terms conveyed to the Holding Body;

- (for sales) in the light of the planning position, and other factors, clawback or other provision for further payment to the Holding Body above the purchase price after *disposal ~~is~~/*is not (*delete as appropriate) required and that suitable advice on this issue has been given to the Holding Body;

- the *proceeds/*~~exchange/lease/premium~~(*delete as appropriate) and conditions of disposal obtained in the above transaction are the best obtainable for the public interest at this time in terms of the Health and Social Care Directorates NHSScotland Property Transactions Handbook;

** (in the case of off-market sales other than for health related or Scottish Government functions) it is clear beyond doubt that one purchaser has submitted the best bid which will not be obtained by open tender.

(in circumstances where the final price is at a price below the guide price) the price is the best offer reasonably obtainable.

SIGNED: (reflecting the position as at stage of selection of preferred bidder/or before transaction is notified to the Accountable Officer)

..... Property Adviser (1)

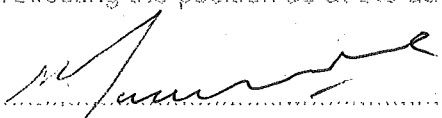
DATE: 22/4/16

Adviser's Name and Address

BALLANTYNES SCOTLAND LIMITED

28 YORK PLACE, PERTH PH2 8EH

SIGNED: (reflecting the position as at the date of settlement of transaction)



..... Property Adviser

CHANGES: (Please describe here and initial (a): any material changes in the transaction between selection of preferred bidder and settlement of the transaction and, (b): any dates for scheduled post-settlement payments to be made to the Holding Body)

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7. **Advice of Legal Adviser**

TO CHIEF EXECUTIVE

I, the Legal Adviser, confirm that the legal advice tendered to you in respect of this transaction:

7.1 was consistent with your instructions;

7.2 took proper and reasonable account of in-force mandatory requirements contained in the Health and Social Care Directorates NHSScotland Property Transactions Handbook and any other relevant general guidance issued by the Health and Social Care Directorates;

++ 7.3 took proper and reasonable account of guidance (related specifically to this transaction) issued to you by the Health and Social Care Directorates, and copied to me as part of my instructions, before (or after) any referral to the Accountable Officer.

SIGNED: (reflecting position as at stage of conclusion of missives/or before transaction is notified to the Accountable Officer).

..... Legal Adviser (1)

DATE: 7/2/17

SIGNED: (reflecting position as at date of settlement of transaction)

..... Legal Adviser

DATE: 7/2/17

PROPERTY TRANSACTION CERTIFICATION: CHIEF EXECUTIVE

DISPOSAL BY SALE, EXCAMBION OR LEASE

A. Holding Body

Tayside Health Board

B. Property

Sunnyside Hospital, Hillside, Montrose DD10 9JP

C. Nature of Disposal (e.g. sale, ~~excambion or lease~~)

Sale

\+ D. *Proceeds/~~excambion value/ annual lease value and term~~
(*please delete as appropriate)

£ £300,000 and 10no. annual payments of £77,900 and further Clawback on further land sales

E. Date of Settlement of Transaction (when available) Not known at acceptance

F. I am satisfied that this transaction has been dealt with:

F1 in accordance with in-force mandatory requirements contained in the Health and Social Care Directorates' NHSScotland Property Transactions Handbook and any other relevant general guidance issued by the Health and Social Care Directorates;

\# F2 taking proper and reasonable account of guidance related specifically to this transaction issued by the Health and Social Care Directorates before, or after, any notification to the Accountable Officer;

F3 taking proper and reasonable account of the advice received from professional advisers,

and that consequently the *proceeds/~~excambion value/lease value~~ (*delete as appropriate), and the conditions attached thereto, are the best obtainable for the public interest at this time having regard for the price and other conditions.

SIGNED: (reflecting position as at stage of selection of preferred bidder/or before transaction is notified to the Accountable Officer.)

.....Chief Executive (1)

DATE: 26th April 2016

SIGNED: (reflecting position as at the date of settlement of the transaction)

.....Chief Executive

DATE: 21st September 2016

CHANGES: (Please describe here and initial (a): any material changes in the transaction between selection of preferred bidder and settlement of the transaction and, (b): any dates for scheduled post-settlement payments to be made to the Holding Body)

.....

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.....

Notes:

+ Show separately any balancing receipt or payment by Holding Body necessary to complete any excambion.

Cross-out F2 only if no guidance specifically related to this transaction was issued by the Health and Social Care Directorates.

PROPERTY TRANSACTION CERTIFICATION:
CONFIRMATION OF ADVICE TO CHIEF EXECUTIVE

DISPOSAL BY SALE, EXCAMBION OR LEASE

DETAILS

1. Holding Body

Tayside Health Board

2. Address and Property Involved

Sunnyside Hospital, Hillside, Montrose DD10 9JP

3. Nature of Disposal (e.g. sale, ~~excambion or lease~~)

Sale

+ 4. *Proceeds/~~*excambion value/ annual lease value~~

(*delete as appropriate)

£ £300,000 and 10no. annual payments of £77,900 and further Clawback on further land sales

5. Date of Settlement of Transaction (when available) Not known at acceptance

6. Property Adviser's Advice

TO CHIEF EXECUTIVE

I am satisfied that:

the chosen disposal method has where appropriate been identified by an acceptable appraisal of practical disposal alternatives;

- all appropriate steps have been taken to enhance the proceeds from the disposal of the above property by taking advantage of the property's potential for development or change of use.
- *the property has been given the maximum possible exposure to the* market and that further marketing within the foreseeable future will not yield a *better price/*lease value (*delete as appropriate);
- our investigation of the future planning potential of the above property has completely clarified the issue in terms conveyed to the Holding Body;
- (for sales) In the light of the planning position, and other factors, clawback or other provision for further payment to the Holding Body above the purchase price after *disposal is/*is not (*delete as appropriate) required and that suitable advice on this issue has been given to the Holding Body;
- the *proceeds/*~~exchange price/lease value~~ (*delete as appropriate) and conditions of disposal obtained in the above transaction are the best obtainable for the public interest at this time in terms of the Health and Social Care Directorates NHSScotland Property Transactions Handbook;

** (in the case of off-market sales other than for health related or Scottish Government functions) it is clear beyond doubt that one purchaser has *submitted the best bid which will not be obtained by open tender.*

(in circumstances where the final price is at a price below the guide price) the price is the best offer reasonably obtainable.

SIGNED: (reflecting the position as at stage of selection of preferred bidder/or before transaction is notified to the Accountable Officer)

..... Property Adviser (1)

DATE: 25/4/16

Adviser's Name and Address

Rory Ballantyne, FRICS, Ballantynes

30 Stafford Street, Edinburgh EH3 7BD

SIGNED: (reflecting the position as at the date of settlement of transaction)

..... Property Adviser

CHANGES: (Please describe here and initial (a): any material changes in the transaction between selection of preferred bidder and settlement of the transaction and, (b): any dates for scheduled post-settlement payments to be made to the Holding Body)

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7. **Advice of Legal Adviser**

TO CHIEF EXECUTIVE

I, the Legal Adviser, confirm that the legal advice tendered to you in respect of this transaction:

7.1 was consistent with your instructions;

7.2 took proper and reasonable account of in-force mandatory requirements contained in the Health and Social Care Directorates NHSScotland Property Transactions Handbook and any other relevant general guidance issued by the Health and Social Care Directorates;

++ 7.3 took proper and reasonable account of guidance (related specifically to this transaction) issued to you by the Health and Social Care Directorates, and copied to me as part of my instructions, before (or after) any referral to the Accountable Officer.

SIGNED: (reflecting position as at stage of conclusion of missives/or before transaction is notified to the Accountable Officer).

..... Legal Adviser

DATE: 19/4/17

SIGNED: (reflecting position as at date of settlement of transaction)

..... Legal Adviser

DATE: 19/4/17

9. **Advice of Independent Valuer (if appointed)**

TO CHIEF EXECUTIVE

I am satisfied that:

9.1 the proceeds and conditions of disposal in the above transaction are the best obtainable for the public interest at this time in terms of the Health and Social Care Directorates NHSScotland Property Transactions Handbook;

9.2 (in circumstances where the final price is at a price below the guide price) the price is the best offer reasonably obtainable.

SIGNED: (reflecting position as at stage of selection of preferred bidder/or before transaction is notified to the Accountable Officer)

.....

DATE: 19/4/17

Independent Valuer's Name and Address

ALASTAIR C WATSON MRICS, DISTRICT VALUER SERVICES, RIVER HOUSE, YOUNG STREET, INVERNESS IV3 5BN

SIGNED: (reflecting position as at date of settlement of transaction)

..... Independent Valuer

DATE: .....

CHANGES: (Please describe here and initial (a): any material changes in the transaction between selection of preferred bidder and settlement of the transaction and, (b): any dates for scheduled post-settlement payments to be made to the Holding Body)

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PROPERTY TRANSACTION CERTIFICATION: CHIEF EXECUTIVE

DISPOSAL BY SALE, EXCAMBION OR LEASE

A. Holding Body

Tayside Health Board

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B. Property

Land and Buildings at Murray Royal Hospital, Perth, PH2 7BH

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C. Nature of Disposal (e.g. sale, excambion or lease)

Sale

.....

\+ D. *Proceeds/~~excambion *value/*annual lease value and term~~
(*please delete as appropriate)

£550,000

.....

E. Date of Settlement of Transaction (when available)

.....**Not Known at Acceptance**.....

F. I am satisfied that this transaction has been dealt with:

F1 in accordance with in-force mandatory requirements contained in the Health and Social Care Directorates' NHS Scotland Property Transactions Handbook and any other relevant general guidance issued by the Health and Social Care Directorates;

\# F2 taking proper and reasonable account of guidance related specifically to this transaction issued by the Health and Social Care Directorates before, or after, any notification to the Accountable Officer;

F3 taking proper and reasonable account of the advice received from professional advisers,

and that consequently the *proceeds/*~~excambion value/*lease value~~ (*delete as appropriate), and the conditions attached thereto, are the best obtainable for the public interest at this time having regard for the price and other conditions.

SIGNED (at stage of acceptance of offer/or before transaction is notified to the Accountable Officer.)

Lesley McGhee

.....Chief Executive

DATE ....21st September 2016..... LMcL

SIGNED (when proceeds received)

Lesley McGhee

.....Chief Executive

DATE ....12th April 2017.....

CHANGES (Please describe here and initial any changes in the transaction between acceptance of offer and receipt of proceeds)

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Notes:

+ Show separately any balancing receipt or payment by Holding Body necessary to complete any excambion.

Cross-out F2 only if no guidance specifically related to this transaction was issued by the Health and Social Care Directorates.

PROPERTY TRANSACTION CERTIFICATION:
CONFIRMATION OF ADVICE TO CHIEF EXECUTIVE

DISPOSAL BY SALE, EXCAMBION OR LEASE

DETAILS

1. Holding Body

.....Tayside Health Board.....

2. Address and Property Involved

.....Land and Buildings at Murray Royal Hospital, Perth, PH2 7BH.....

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3. Nature of Disposal (e.g. sale, excambion or lease)

.....Sale.....

+ 4. *Proceeds/~~*excambion value/*annual lease value~~
(*delete as appropriate)

£.550,000.....

5. Date of Settlement of Transaction (when available)

.....23rd February 2017.....

6. **Property Adviser's Advice**

TO CHIEF EXECUTIVE

I am satisfied that:

the chosen disposal method has where appropriate been identified by an acceptable appraisal of practical disposal alternatives;

- all appropriate steps have been taken to enhance the proceeds from the disposal of the above property by taking advantage of the property's potential for development or change of use.
- the property has been given the maximum possible exposure to the market and that further marketing within the foreseeable future will not yield a *better price/*lease value (*delete as appropriate);
- our investigation of the future planning potential of the above property has completely clarified the issue in terms conveyed to the Holding Body;
- (for sales) in the light of the planning position, and other factors, clawback or other provision for further payment to the Holding Body above the purchase price after *disposal is/*is not (*delete as appropriate) required and that suitable advice on this issue has been given to the Holding Body;
- the *proceeds/*exchange value/*lease value (*delete as appropriate) and conditions of disposal obtained in the above transaction are the best obtainable for the public interest at this time in terms of the Health and Social Care Directorates NHSScotland Property Transactions Handbook;

** (In the case of off-market sales other than for health related or Scottish Government functions) it is clear beyond doubt that one purchaser has submitted the best bid which will not be obtained by open tender.

(In circumstances where the final price is at a price below the guide price) the price is the best offer reasonably obtainable.

SIGNED: (reflecting the position as at stage of selection of preferred bidder/or before transaction is notified to the Accountable Officer)

..... RYDEN LLP ..... Property Adviser

DATE: 5/4/17

Adviser's Name and Address

RYDEN 7 EXCHANGE CRESCENT

EDINBURGH EH3 8AN

SIGNED: (reflecting the position as at the date of settlement of transaction)

..... for RYDEN LLP 4/4/17 ..... Property Adviser

CHANGES: (Please describe here and initial (a): any material changes in the transaction between selection of preferred bidder and settlement of the transaction and, (b): any dates for scheduled post-settlement payments to be made to the Holding Body)

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7. **Advice of Legal Adviser**

TO CHIEF EXECUTIVE

I, the Legal Adviser, confirm that the legal advice tendered to you in respect of this transaction:

7.1 was consistent with your instructions;

7.2 took proper and reasonable account of in-force mandatory requirements contained in the Health and Social Care Directorates NHSScotland Property Transactions Handbook and any other relevant general guidance issued by the Health and Social Care Directorates;

~~7.3 took proper and reasonable account of guidance (related specifically to this transaction) issued to you by the Health and Social Care Directorates, and copied to me as part of my instructions, before (or after) any referral to the Accountable Officer.~~

SIGNED: (reflecting position as at stage of conclusion of missives/or before transaction is notified to the Accountable Officer).

..... Legal Adviser

DATE: 25/4/17

SIGNED: (reflecting position as at date of settlement of transaction)

..... Legal Adviser

DATE: 25/4/17

9. **Advice of Independent Valuer (if appointed)**

TO CHIEF EXECUTIVE

I am satisfied that:

9.1 the proceeds and conditions of disposal in the above transaction are the best obtainable for the public interest at this time in terms of the Health and Social Care Directorates NHSScotland Property Transactions Handbook;

9.2 (in circumstances where the final price is at a price below the guide price) the price is the best offer reasonably obtainable.

SIGNED: (reflecting position as at stage of selection of preferred bidder/or before transaction is notified to the Accountable Officer)

.....

DATE: 25/4/17

Independent Valuer's Name and Address

ALASTAIR C WATSON MRICS DISTRICT VALUER SERVICES, RIVER HOUSE, YOUNG STREET, INVERNESS IV3 5BN

SIGNED: (reflecting position as at date of settlement of transaction)

..... Independent Valuer

DATE: .....

CHANGES: (Please describe here and Initial (a): any material changes in the transaction between selection of preferred bidder and settlement of the transaction and, (b): any dates for scheduled post-settlement payments to be made to the Holding Body)

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PROPERTY TRANSACTION CERTIFICATION: CHIEF EXECUTIVE

DISPOSAL BY SALE, EXCAMBION OR LEASE

A. Holding Body

Tayside Health Board

B. Property

Douglas Clinic, Balmoral Avenue,Dundee DD4 8SQ

C. Nature of Disposal (e.g. sale, ~~excambion or lease~~)

Sale

+ D. *Proceeds/~~excambion value/annual lease value and term~~
(*please delete as appropriate)

£20,000

E. Date of Settlement of Transaction (when available)

8th February 2017

F. I am satisfied that this transaction has been dealt with:

F1 in accordance with in-force mandatory requirements contained in the Health and Social Care Directorates' NHS Scotland Property Transactions Handbook and any other relevant general guidance issued by the Health and Social Care Directorates;

F2 taking proper and reasonable account of guidance related specifically to this transaction issued by the Health and Social Care Directorates before, or after, any notification to the Accountable Officer;

F3 taking proper and reasonable account of the advice received from professional advisers,

and that consequently the *proceeds/*excambion value/*lease value (*delete as appropriate), and the conditions attached thereto, are the best obtainable for the public interest at this time having regard for the price and other conditions.

SIGNED (at stage of acceptance of offer/or before transaction is notified to the Accountable Officer.)

.....Chief Executive

DATE .....

SIGNED (when proceeds received)

.....Chief Executive

DATE ..... 1st March 2017.

CHANGES (Please describe here and initial any changes in the transaction between acceptance of offer and receipt of proceeds)

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Notes:

+ Show separately any balancing receipt or payment by Holding Body necessary to complete any excambion.

Cross-out F2 only if no guidance specifically related to this transaction was issued by the Health and Social Care Directorates.

PROPERTY TRANSACTION CERTIFICATION:
CONFIRMATION OF ADVICE TO CHIEF EXECUTIVE

DISPOSAL BY SALE, EXCAMBION OR LEASE

DETAILS

1. Holding Body

TAYSIDE HEALTH BOARD

2. Address and Property Involved

SITE OF FORMER DOUGLAS CLINIC, BALMORAL AVENUE, DUNDEE DD4 8SQ

3. Nature of Disposal (e.g. sale, excambion or lease)

SALE

+ 4. *Proceeds/*~~excambion value~~/*~~annual lease value~~
(*delete as appropriate)

£ 20,000

5. Date of Settlement of Transaction (when available)

8th FEBRUARY 2017

6. Property Adviser's Advice

TO CHIEF EXECUTIVE

I am satisfied that:

the chosen disposal method has where appropriate been identified by an acceptable appraisal of practical disposal alternatives;

- all appropriate steps have been taken to enhance the proceeds from the disposal of the above property by taking advantage of the property's potential for development or change of use.
- the property has been given the maximum possible exposure to the market and that further marketing within the foreseeable future will not yield a better price/lease value (delete as appropriate);
- our investigation of the future planning potential of the above property has completely clarified the issue in terms conveyed to the Holding Body;
- (for sales) in the light of the planning position, and other factors, clawback or other provision for further payment to the Holding Body above the purchase price after disposal is/is not (delete as appropriate) required and that suitable advice on this issue has been given to the Holding Body;
- the proceeds/excambion value/lease value (delete as appropriate) and conditions of disposal obtained in the above transaction are the best obtainable for the public interest at this time in terms of the Health and Social Care Directorates NHS Scotland Property Transactions Handbook;

  ** (in the case of off-market sales other than for health related or Scottish Government functions) it is clear beyond doubt that one purchaser has submitted the best bid which will not be obtained by open tender.

  (in circumstances where the final price is at a price below the guide price) the price is the best offer reasonably obtainable.

Signed (at stage of acceptance of offer/or before transaction is notified to the Accountable Officer)

..... Property Adviser

Date 10/2/17

Adviser's Name and Address

GARTH DAWSON c/o GLAHAMS SIBBALD, 1 GREENMARKET

DUNDEE DD1 4QB

7. **Advice of Legal Adviser**

TO CHIEF EXECUTIVE

I, the Legal Adviser, confirm that the legal advice tendered to you in respect of this transaction:

7.1 was consistent with your instructions;

7.2 took proper and reasonable account of in-force mandatory requirements contained in the Health and Social Care Directorates NHSScotland Property Transactions Handbook and any other relevant general guidance issued by the Health and Social Care Directorates;

~~7.3 took proper and reasonable account of guidance (related specifically to this transaction) issued to you by the Health and Social Care Directorates, and copied to me as part of my instructions, before (or after) any referral to the Accountable Officer.~~

SIGNED: (reflecting position as at stage of conclusion of missives/or before transaction is notified to the Accountable Officer).

..... Legal Adviser

DATE: 8/2/17

SIGNED: (reflecting position as at date of settlement of transaction)

..... Legal Adviser

DATE: 9/2/17

PROPERTY TRANSACTION CERTIFICATION: CHIEF EXECUTIVE

DISPOSAL BY SALE, EXCAMBION OR LEASE

A. Holding Body

Tayside Health Board

B. Property

Orleans Day Hospital, Orleans Place Dundee

C. Nature of Disposal (e.g. sale, ~~excambion~~)

Off Market Sale

\+ D. *Proceeds/~~excambion value/ annual lease value and term~~
(*please delete as appropriate)

£ £75,000

E. Date of Settlement of Transaction (when available) March 2017

F. I am satisfied that this transaction has been dealt with:

F1 in accordance with in-force mandatory requirements contained in the Health and Social Care Directorates' NHSScotland Property Transactions Handbook and any other relevant general guidance issued by the Health and Social Care Directorates;

\# F2 taking proper and reasonable account of guidance related specifically to this transaction issued by the Health and Social Care Directorates before, or after, any notification to the Accountable Officer;

F3 taking proper and reasonable account of the advice received from professional advisers,

and that consequently the *proceeds/~~excambion value/lease value~~ (*delete as appropriate), and the conditions attached thereto, are the best obtainable for the public interest at this time having regard for the price and other conditions.

SIGNED: (reflecting position as at stage of selection of preferred bidder/or before transaction is notified to the Accountable Officer.)

.....Chief Executive (1)

DATE: 3 March 2017

SIGNED: (reflecting position as at the date of settlement of the transaction)

.....Chief Executive

DATE: 16 March 2017

CHANGES: (Please describe here and initial (a): any material changes in the transaction between selection of preferred bidder and settlement of the transaction and, (b): any dates for scheduled post-settlement payments to be made to the Holding Body).

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Notes:

+ Show separately any balancing receipt or payment by Holding Body necessary to complete any excambion.

Cross-out F2 only if no guidance specifically related to this transaction was issued by the Health and Social Care Directorates.

PROPERTY TRANSACTION CERTIFICATION:
CONFIRMATION OF ADVICE TO CHIEF EXECUTIVE

DISPOSAL BY SALE, EXCAMBION OR LEASE

DETAILS

1. Holding Body

.....Tayside Health Board.....

2. Address and Property Involved

..... Orleans Day Hospital, Orleans Place, Dundee.....

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3. Nature of Disposal (e.g. sale, excambion or lease)

.....Off Market Sale.....

+ 4. *Proceeds/~~*excambion value/*annual lease value~~
(*delete as appropriate)

£..75,000.00.....

5. Date of Settlement of Transaction (when available)

.....14th March 2017.....

7. Advice of Legal Adviser

TO CHIEF EXECUTIVE

I, the Legal Adviser, confirm that the legal advice tendered to you in respect of this transaction:

7.1 was consistent with your instructions;

7.2 took proper and reasonable account of in-force mandatory requirements contained in the Health and Social Care Directorates NHSScotland Property Transactions Handbook and any other relevant general guidance issued by the Health and Social Care Directorates;

~~7.3 took proper and reasonable account of guidance (related specifically to this transaction) issued to you by the Health and Social Care Directorates, and copied to me as part of my instructions, before (or after) any referral to the Accountable Officer.~~

SIGNED: (reflecting position as at stage of conclusion of missives/or before transaction is notified to the Accountable Officer).

..... Legal Adviser

DATE: 25/4/17

SIGNED: (reflecting position as at date of settlement of transaction)

..... Legal Adviser

DATE: 28/4/17

9. **Advice of Independent Valuer (if appointed)**

TO CHIEF EXECUTIVE

I am satisfied that:

9.1 the proceeds and conditions of disposal in the above transaction are the best obtainable for the public interest at this time in terms of the Health and Social Care Directorates NHSScotland Property Transactions Handbook;

9.2 (in circumstances where the final price is at a price below the guide price) the price is the best offer reasonably obtainable.

SIGNED: (reflecting position as at stage of selection of preferred bidder/or before transaction is notified to the Accountable Officer)

.....

DATE: 25/4/17

Independent Valuer's Name and Address

ALASTAIR C WATSON MRICS DISTRICT VALUER SERVICES, RIVER HOUSE YOUNG STREET INVERNESS IV3 5BA

SIGNED: (reflecting position as at date of settlement of transaction)

..... Independent Valuer

DATE: .....

CHANGES: (Please describe here and initial (a): any material changes in the transaction between selection of preferred bidder and settlement of the transaction and, (b): any dates for scheduled post-settlement payments to be made to the Holding Body)

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PROPERTY TRANSACTION CERTIFICATION: CHIEF EXECUTIVE

DISPOSAL BY SALE, EXCAMBION OR LEASE

A. Holding Body

.....**Tayside Health Board**.....

B. Property

.....**Former Longcroft Clinic,**.....

.....**Inglefield Street, Dundee DD4 8JA**.....

.....

C. Nature of Disposal (e.g. sale, ~~excambion or lease~~)

.....**Sale**.....

\+ D. *Proceeds/~~excambion *value/*annual lease value and term~~
(*please delete as appropriate)

.....**£55,000**.....

E. Date of Settlement of Transaction (when available)

.....**31/03/2017**.....

F. I am satisfied that this transaction has been dealt with:

F1 in accordance with in-force mandatory requirements contained in the Health and Social Care Directorates' NHSScotland Property Transactions Handbook and any other relevant general guidance issued by the Health and Social Care Directorates;

\# F2 taking proper and reasonable account of guidance related specifically to this transaction issued by the Health and Social Care Directorates before, or after, any notification to the Accountable Officer;

F3 taking proper and reasonable account of the advice received from professional advisers,

and that consequently the *proceeds/*excambion value/*lease value (*delete as appropriate), and the conditions attached thereto, are the best obtainable for the public interest at this time having regard for the price and other conditions.

SIGNED: (reflecting position as at stage of selection of preferred bidder/or before transaction is notified to the Accountable Officer.)

.....Chief Executive

DATE: .....

SIGNED: (reflecting position as at the date of settlement of the transaction)

.....Chief Executive

DATE: 21 — 4 — 17

CHANGES: (Please describe here and initial (a): any material changes in the transaction between selection of preferred bidder and settlement of the transaction and, (b): any dates for scheduled post-settlement payments to be made to the Holding Body)

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Notes:

+ Show separately any balancing receipt or payment by Holding Body necessary to complete any excambion.

Cross-out F2 only if no guidance specifically related to this transaction was issued by the Health and Social Care Directorates.

PROPERTY TRANSACTION CERTIFICATION:
CONFIRMATION OF ADVICE TO CHIEF EXECUTIVE

DISPOSAL BY SALE, EXCAMBION OR LEASE

DETAILS

1. Holding Body

..... **Tayside Health Board**.....

2. Address and Property Involved

.....**Former Longcroft Clinic,**.....

.....**Inglefield Street, Dundee DD4 8JA**.....

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3. Nature of Disposal (e.g. sale, ~~excambion or lease~~)

.....**Sale**.....
.....

+ 4. *Proceeds/*excambion value/*annual lease value
(*delete as appropriate)

.....**£55,000**.....

5. Date of Settlement of Transaction (when available)

.....**31/03/2017**.....

6. Property Adviser's Advice

TO CHIEF EXECUTIVE

I am satisfied that:

the chosen disposal method has where appropriate been identified by an acceptable appraisal of practical disposal alternatives;

- all appropriate steps have been taken to enhance the proceeds from the disposal of the above property by taking advantage of the property's potential for development or change of use.

- the property has been given the maximum possible exposure to the market and that further marketing within the foreseeable future will not yield a *better price/*~~lease value~~ (*delete as appropriate);

- our investigation of the future planning potential of the above property has completely clarified the issue in terms conveyed to the Holding Body;

- (for sales) in the light of the planning position, and other factors, clawback or other provision for further payment to the Holding Body above the purchase price after *disposal is/~~*is not~~ (*delete as appropriate) required and that suitable advice on this issue has been given to the Holding Body;

- the *proceeds/*~~excambion value/*lease value~~ (*delete as appropriate) and conditions of disposal obtained in the above transaction are the best obtainable for the public interest at this time in terms of the Health and Social Care Directorates NHSScotland Property Transactions Handbook;

** (in the case of off-market sales other than for health related or Scottish Government functions) it is clear beyond doubt that one purchaser has submitted the best bid which will not be obtained by open tender.

(in circumstances where the final price is at a price below the guide price) the price is the best offer reasonably obtainable.

SIGNED: (reflecting the position as at stage of selection of preferred bidder/or before transaction is notified to the Accountable Officer)

GARTH DAVISON | GRAHAM + SIBBALD ..... Property Adviser

DATE: 18/4/17

Adviser's Name and Address

GARTH DAVISON

GRAHAM + SIBBALD, 1 GREENMARKET, DUNDEE, DD1 4QB

SIGNED: (reflecting the position as at the date of settlement of transaction)

ASSOCIATE ..... Property Adviser

CHANGES: (Please describe here and initial (a): any material changes in the transaction between selection of preferred bidder and settlement of the transaction and, (b): any dates for scheduled post-settlement payments to be made to the Holding Body)

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7. **Advice of Legal Adviser**

TO CHIEF EXECUTIVE

I, the Legal Adviser, confirm that the legal advice tendered to you in respect of this transaction:

7.1 was consistent with your instructions;

7.2 took proper and reasonable account of in-force mandatory requirements contained in the Health and Social Care Directorates NHSScotland Property Transactions Handbook and any other relevant general guidance issued by the Health and Social Care Directorates;

~~7.3 took proper and reasonable account of guidance (related specifically to this transaction) issued to you by the Health and Social Care Directorates, and copied to me as part of my instructions, before (or after) any referral to the Accountable Officer.~~

SIGNED: (reflecting position as at stage of conclusion of missives/or before transaction is notified to the Accountable Officer).

..... Legal Adviser

DATE: 25/4/17

SIGNED: (reflecting position as at date of settlement of transaction)

..... Legal Adviser

DATE: 28/4/17

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

Item Number 11

AUDIT33/2017
Audit Committee
11 May 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

Quarter 3 (Oct 2016 – Dec 2016)

Post Treatment Referral Analysis

Referral for appointments	128
Reports received	12
Failed appointments	25
Referrals cancelled	11
Outcomes awaited	80

Of the 128 referrals 10 % were non random (PV level 3 & 4).

The report breakdown for post and pre treatment reports is as follows:

Post Treatment Reports

	No of Dentists	No. of Patients
Code 1	40	51
Code 2	7	7
Code 3	1	1
Code 4	0	0

Pre Treatment Reports

	No. of Dentist	No of Patients
Code A	4	4
Code B	2	2
Code C	0	0
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 24

No of active investigations	4
New cases under investigation	3
Closed cases	1

Monies recovered to date £16,050.00

4.2 General Ophthalmic Services

Quarter 3 (Oct 2016 to Dec 2016)

i) Level 1: No further action required.

ii) Level 2: Random Sampling – Random sampling was undertaken on GOS4 optical replacement claims across Scotland. 39 claims from six contractors were checked across NHS Tayside.

- One contractor achieved a high level of assurance.
- Recoveries to the value of £238.90 and £116.10 were made in respect of two contractors as the records did not state the reason for the replacement. Advice has been provided and a further sample will be taken in six months time to assess compliance, in accordance with due process.
- A recovery to the value of £130.70 was made against one contractor for two reasons: the records did not state the reason for replacement and in two cases whilst the reason for dispensing could be verified the practice not could verify that glasses were dispensed as no record was provided.
- Records are still awaited from two of the contractors.

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

iv) Level 3: The data in respect of ongoing level 3 investigations was reviewed. 35 cases were discussed, three of which have been closed and the remaining 32 are ongoing.

v) Level 4: Four practice visits were undertaken in this quarter. A high level of assurance was achieved in two practices and an adequate level was achieved in two practices.

4.3 Pharmaceutical Services:

Quarter 2 (July – September 2016)

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. No further action was required.

ii) Level 2: The new Tableau reports were discussed with the Board highlighting the ability to review costs per NHS Board / service type / average cost per item & rank accordingly. The payment verification team highlighted where community pharmacy contractors were outliers in the targeted categories. Further action was requested in two areas:

- Minor Ailments Service: One contractor will be contacted to highlight the low CHI capture rate.

- Gluten Free Food Service: Any high cost items from two contractors will be investigated.

iii) Level 3: Further investigation is being undertaken with respect to the following two items

- Gluten Free Food Service: Patient Medication Record (PMR) to be requested from one contractor following receipt of an unsatisfactory patient letter.

- Random Sample – e-Pharmacy team to contact one contractor to update them on the correct endorsing procedures following receipt of an unsatisfactory patient letter.

iv) Level 4: Further investigation is being undertaken with respect to the following two items.

- Explanation and a copy of the controlled drugs register to be sought following an omitted PMR entry for a methadone prescription.

- Treatment of an aspirin prescription item with ePharmacy to be investigated to establish why the electronic claim was paid from paper.

4.4 General Medical Services

Details of the new contract and information in respect of future payment verification processes are still awaited. In the interim payment verification visits in respect of 2016/17 continue to be made. The detail of the visits for Quarter 4 is provided below.

Quarter 4 (Jan 2017 to Mar 2017)

Five payment verification visits took place in Quarter 4. Three were random, one was non random and one was a follow up from November 2016

A high level of assurance was obtained for two practices.

An adequate level of assurance was obtained for one practice. A small recovery was made of £212.13 in respect of incorrect exception coding. This will be addressed by further training.

A non random visit was arranged to a practice following a significant increase in claims in relation to the Alcohol Brief Intervention local enhanced service. In order to gain adequate assurance, a more extensive verification exercise is underway.

A follow up visit had been arranged to one practice following a limited level of assurance during their random payment verification visit. The follow up visit established that an incorrect search criterion, picking up historical reviews, had resulted in a significant over claim. The incorrect search criterion had a cumulative effect over a five year period leading to a significant inadvertent over claim of £21,911.30. Given the practice size, an assessment of income was undertaken to determine an appropriate recovery period in order to maintain practice stability. A recovery period of 18 months, commencing in April 2017 has been agreed. The practice has amended the search criterion with the assistance of the IMT Facilitators.

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

May 2017

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

Item Number 12

AUDIT34/2017
Audit Committee
11 May 2017

TAXATION OF WORKERS PROVIDED THROUGH INTERMEDIARIES (IR35) AND SELF EMPLOYED

1. PURPOSE OF THE REPORT

The purpose of this report is to update the Committee on the impact of the Finance Act 2017 in respect of the taxation of workers provided through intermediaries. As the taxation of self employed workers is unavoidably impacted by the Board's compliance with these provisions within this draft legislation, the report also addresses similar issues relating to these workers.

2. RECOMMENDATIONS

The Audit Committee is asked to:-

i. note the key legislative changes from 6 April 2017;
ii. note the actions being progressed by management, and
iii. agree in principle to amendments to the Code of Corporate Governance in respect of "**off payroll engagements**" and **taxation of workers** which will be brought back to the Committee for approval upon the recommendation of the Board Secretary and Director of Finance through the Governance Review Group.

3. EXECUTIVE SUMMARY

3.1 Legislation and Guidance

The recent changes to legislation regarding the taxation of workers provided through intermediaries (IR35) set out in the Finance Act 2017 places responsibility on public sector bodies who contract directly for a worker through a third party, referred to as an intermediary, to check if the nature of the work would fall within HMRC's definition of employment for tax purposes. This responsibility applies regardless of the contractual circumstances between the individual and the agency, i.e. whether they operate as an individual or through an intermediary such as a Limited Company, Personal Service Company or Partnership.

IR35 legislation was first introduced in April 2000. It is widely seen as being ineffective and it has been estimated that as much as £400 million will have been underpaid in 2016/17 in Income Tax and NICs as a result of the rules not being properly operated by the intermediaries. In addition, there have been various high profile challenges involving *off-payroll* working in the public sector which HMRC have won. However, until now it has been the intermediary businesses and the individuals behind them that have had to suffer the high costs of putting it right.

HMRC/HM Treasury published policy guidance, draft legislation for the Finance Bill 2017, and a Technical Guide describing how the legislation would affect public bodies from 6 April, 2017.

The NHS Scotland Management Steering Group (MSG) also issued guidance to NHS boards.

From 6 April, 2017, where workers are engaged by the Board through their own limited company, personal service company, partnership or as a self employed contractor,

responsibility to apply the intermediaries' rules will fall to NHS Tayside, and the Board will be liable to pay over Income Tax and NICs. This means that where an individual provides services to NHS Tayside and is doing a similar job in a similar manner to an employee, both the individual and the Board will be required to comply with tax rules as if they were an employee (for tax purposes only).

3.2 Use of Third Party Agencies

For agency staff who are recruited from a third party, i.e. recruitment agency, it is the agency's responsibility to apply these rules and deduct Income Tax and NICs, if appropriate, and incur additional employers costs. The Board will not be held liable for these deductions in the first instance. However, NHS Tayside now has a duty to inform the agency or individual if the contract falls within the IR 35 rules, i.e. to determine the employment status of the worker supplied by the agency or other third party intermediary. Thereafter, if asked in writing to explain the basis of decision, the Board will have 31 days to inform the agency or NHS Tayside will become liable for the tax due.

3.3 Existing Employment v Self Employment Tax Rules

The new tax changes do not affect existing responsibilities the Board has to determine the tax status of individuals with whom we directly contract, however, they do bring into sharp focus the need for stricter compliance, particularly as the same on-line assessment tool must be used for both IR35 intermediaries and the self employed. The expectation is that this existing compliance risk will be better addressed by consistently adopting the processes required to be compliant with the IR35 changes.

3.4 Management Actions

An Action Plan is being progressed with input from senior staff in Finance and Payroll, Human Resources and Procurement. The Team has also been meeting with colleagues from other NHSS Boards on a weekly or fortnightly basis throughout the implementation period, and has taken forward actions aimed at ensuring compliance from 6 April, 2017, and that robust arrangements are in place on an ongoing basis.

The key aspects of the Action Plan are as follows:-

- Assess the scale of impact upon suppliers previously/currently on the finance system and identify those that may fall to be treated as employees for tax purposes under IR35 or employed/self employed purposes;

- Communication with existing agencies and other suppliers to determine the tax treatment of those appointments likely to be in place on 6 April, 2017;

- Amend the existing engagement process for agency staff to ensure that the IR35 treatment is clarified for each individual appointment on an ongoing basis within the regulatory timescales;

- Develop an appropriate weekly payroll process within the standard national payroll system, ePayroll, for all IR35 and self employed "deemed employees for tax purposes" to enable deduction of Income Tax, NICs and Apprentice Levy;

- Develop/amend Finance and Payroll Operating procedures (FOPs), including the basis of calculation of remuneration, for the processing and retention of information, e.g. invoice details and the authorisation of appointments/ amendments to Payroll for all IR35 and self employed deemed employees;

- Clarify all accounting adjustments, including VAT treatment;

- Develop clear guidance and for managers regarding the process to be followed for all staff engagements without employment rights and communicate across the

organisation, ensuring that all relevant managers are fully briefed and aware of the implications;

- Propose amendments to the Code of Corporate Governance to ensure robust governance and internal control, e.g. in respect of "off payroll engagements".

4. MEASURES FOR IMPROVEMENT

This report seeks to address the main issues.

5. RESOURCE IMPLICATIONS

Financial
Cost pressures may increase as follows:-

- Agencies and workers engaged through them and the self employed may press for higher fees, in part to compensate for higher National Insurance Contributions (NICs) and partly as compensation for exposure to taxation at source through Pay As You Earn (PAYE), or even in an attempt to secure higher fees in a period of turbulence. Nonetheless, every effort is being made to contain costs.

- Payments processed via Payroll from now on and subject to PAYE will incur Employer's NICs at 13.8%.

Along with better VAT efficiency, the extra Employer's NICs on medical locum payments can be mitigated by engaging all such doctors via NHS Tayside's Medical Services Direct Engagement contractor, without detriment to the individual locum.

An initial assessment of impacted organisations and expenditure with whom the Board does business is as follows:-

Category	**No.**	**£m**
Agencies	56	8.4
Companies	115	1.0
Individuals	158	0.7
Total	**328**	**10.1**

Workforce
Many of the agency staff engaged by NHS Tayside and the agencies that provide them have been impacted by this legislation. Similarly, a high proportion of self employed workers engaged by the Board now have to be paid and taxed via Payroll. These changes, which have been widely trailed in the media, may adversely affect resourcing, particularly in the early months until it becomes known by all that the Board has little choice in the matter.

Implementation of these legislative changes has been resource intensive across Finance and Payroll, HR and Procurement and will require to be factored in to organisational redesign plans, particularly in Finance and Payroll which faces the biggest challenge.

6. DELEGATION LEVEL

The Associate Director of Finance – Financial Services/FLO works to provide professional tax advice to NHS Tayside and its senior officers, and reports on significant issues to the Audit Committee.

The Director of Finance is the executive lead for tax matters and the Director of HR & Organisational Development is the executive lead for workforce.

7. RISK ASSESSMENT

There are very significant risks to NHS Tayside should the organisation be found not to be compliant with the tax rules. HMRC operate a Fines and Penalties regime, and could

impose penalties amounting to 100% of the payments assessed as due in the worst case scenario.

Ensuring compliance with the regulations may lead to some service implications in circumstances of challenge by those providing temporary medical cover otherwise threatening a withdrawal of their service. This circumstance has, for example, already arisen within the Medicine and Occupational Health directorates.

8. IMPLICATIONS FOR HEALTH

Not applicable.

9. IMPACT ASSESSMENT AND INFORMING, ENGAGING AND CONSULTING

The Associate Director of Finance Financial Services /FLO has worked with colleagues from Human Resources and Procurement and has provided briefing notes for the Chief Executive and Directors. Collaborative working has also taken place with counterparts from other NHS Boards with the aim of developing consistent best practice nationally.

10. EQUALITY AND DIVERSITY IMPACT ASSESSMENT

Not applicable.

11. PATIENT EXPERIENCE

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

Robert MacKinnon
Associate Director of Finance - Financial Services/FLO

Lindsay Bedford
Director of Finance

George Doherty
Director of HR & Organisational Development

May 2017

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

AUDIT35/2017
Audit Committee
11 May 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

George Doherty
Director of Human Resources & Organisational Development

Lindsay Bedford
Director of Finance

Christopher J Smith
Associate Director of Human Resources & Organisational Development

May 2017

Appendix 1

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.....

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

Item number 14

AUDIT41/2017
Audit Committee
11 May 2017

BEST VALUE
FRAMEWORK ASSURANCE 2016/17 – TAYSIDE NHS BOARD

1. PURPOSE OF THE REPORT

The purpose of the report is to provide an assurance on the business considered by Tayside NHS Board during 2016/17 against the current Best Value Framework

2. RECOMMENDATIONS

The Committee is asked to recommend approval the Assessment of Tayside NHS Board's Best Value Characteristics (Framework Assurance) 2016/17 contained in Appendix 1.

3. EXECUTIVE SUMMARY

Annually, as part of its overall governance processes, the Board develops a Framework for allocating the Best Value characteristics. Aspects of the Best Value characteristics are delegated to the Board's Standing Committees. This report details the assessment of those Best Value characteristics reserved for the Board.

4. REPORT DETAIL

Tayside NHS Board approved the Best Value Framework for allocating the Best Value Characteristics at the Board meeting held on 27 October, 2016.

The Framework delegates the various aspects of the Best Value characteristics to the Board's Committees. The Committees are expected to consider and schedule into their business/workplans, agenda items to provide overt assurance on Best Value in their Annual Reports.

The Board Secretary reviews the areas reserved to Tayside NHS Board and provides an assurance report on the business considered by the Board against the Best Value Framework.

The Board's Committees required to provide assurance through their Annual Reports that they have reviewed those aspects of the Best Value Framework delegated to them by Tayside NHS Board during the year 2016/17 are as follows:-

- Audit Committee;
- Finance and Resources Committee;
- Improvement and Quality Committee;
- Remuneration Committee, and
- Staff Governance Committee.

The Annual Reports are an essential part of the internal control process and the conclusions on assurance are considered in June each year by the Audit Committee as part of the Annual Accounts process. The Annual Reports also provide assurance to the Accountable Officer regarding the Governance Statement.

The Annual Report conclusions will be considered by the Audit Committee at its meeting on 22 June, 2017.

Attached in Appendix 1 is the Best Value Framework Tayside NHS Board Assurance Report 2016/17.

5. CONTRIBUTION TO NHS TAYSIDE'S STRATEGIC AIMS

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

6. HEALTH EQUITY

There are no health equity implications.

7. MEASURES FOR IMPROVEMENT

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

8. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

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

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

9. PATIENT EXPERIENCE

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

10. RESOURCE IMPLICATIONS

Financial
There are no financial implications.

Workforce
There are no workforce implications.

11. RISK ASSESSMENT

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

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

12. LEGAL IMPLICATION

There are no legal implications.

13. INFORMATION TECHNOLOGY IMPLICATIONS

There are no IT implications.

14. HEALTH & SAFETY IMPLICATIONS

There are no Health & Safety implications.

15. HEALTHCARE ASSOCIATED INFECTION (HAI)

There are no Healthcare Associated Infection implications.

16. DELEGATION LEVEL

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

17. TIMETABLE FOR IMPLEMENTATION

Not applicable

18. REPORT SIGN OFF

Margaret Dunning
Board Secretary

Lindsay Bedford
Director of Finance

May 2017

18. SUPPORTING DOCUMENTS

Appendix 1- Best Value Framework Assurance 2016/17 – Tayside NHS Board

Best Value Framework
Tayside NHS Board Assurance 2016/17

CHARACTERISTIC 1 - VISION AND LEADERSHIP

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

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned)
Executive and Non-Executive leadership demonstrate a commitment to high standards of probity and integrity including the Nolan principles.	Tayside NHS Board members sign up to the Members Code of Conduct in the NHS Tayside's Code of Corporate Governance.	**BOARD**	Annual	Fully in place The Members' Code of Conduct , Section B of the NHS Tayside Code of Corporate Governance is circulated as part of the annual register of interests update	N/A
NHS Tayside acts in accordance with its values, positively promotes and measures a culture of ethical behaviours and encourages staff to report breaches of its values.	Culture Diagnostics Toolkit	**BOARD**	Annual	Fully in place The Board completed the Board Diagnostic Toolkit during October 2016. A Board Development Session was held on 17 January 2017 to review the feedback.	Further work to be undertaken in respect of Collective Leadership and Culture during the year

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned)
NHS Tayside can demonstrate that continuous improvement is incorporated into its strategy and plans.	The inclusion of trajectories against the HEAT Targets will demonstrate continuous improvement.	**BOARD**	Annual	Partially in place LDP 2015/16 progress report – 26 May 2016	Draft 1 Year Operational Delivery Plan 2017-2018/LDP
Resources required to achieve the strategic plan and operational plans e.g. finance, staff, asset base are identified and additional/changed resource requirements identified.	5 year Strategic transformational plan	**BOARD**	Annual	Partially in place Draft 5 Year Transformation Plan 2016-2021 LDP 2016/17 Draft NHS Tayside Operational Delivery Plan LDP Financial templates Board 26 May 2016 NHS Tayside Elective Waiting Time Investment and Performance 2016-17 Mental Health Service Redesign Programme Shaping Surgical Services Draft 5 year Transformation Plan 2017-2022 presented to the Board 27 March 2017	Further work to be undertaken in respect of regionalisation during 2017/18

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned)
The Board agrees a strategic plan which incorporates the organisation's vision and values and reflects stated priorities.	5 year Strategic transformational plan	**BOARD**	Every five years	Partially in place Draft 5 year Transformation Plan 2017-2022 presented to the Board 27 March 2017	
The strategic plan and operational plans are based on relevant, reliable and sufficient evidence.	Business Unit to feed into development of the 5 year Strategic transformational plan. LDP based on data	**BOARD** **BOARD**	Every five years Annually	Fully in place Draft 5 Year Transformation Plan 2017-2022 Draft 1 Year Operational Delivery Plan 2017-2018/LDP	
The strategic plan is translated into annual operational plans with meaningful, achievable actions and outcomes and clear responsibility for action.	Annual operational plan underlying the 5 year strategic transformational plan.	**BOARD**	Annual	Fully in place Draft 1 Year Operational Delivery Plan 2017-2018/LDP	

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned)
The Board has identified the risks to the achievement of its strategic and operational plans are identified together with mitigating controls.	Each strategic risk has an Assurance Framework which maps the mitigating actions/risks to help achieve the strategic and operational plans. Assurance Framework contains the overarching strategic risks related to the strategic plan.	**BOARD**	Three times per year	Fully in place Board Assurance Framework (BAF) was considered by the Board on 23 June 2016, 27 October 2016 and 23 February 2017.	Board agreed that BAF reporting to the Board could reduce to twice per year. This was in addition to Committee Chairs' assurance reports, minutes and Committee reports from the Audit Committee and the reporting on strategic risks that exceed risk appetite to every Board meeting
The Board has clearly recorded delegation to Committees and management.	The Board has established terms of reference for its Committees and has a Scheme of Delegation.	**BOARD**	Every two years	Partially in place Section A of the NHS Tayside Code of Corporate Governance, How Business is organised includes the terms of reference for the Board's Committees and has been updated in year Section E of the NHS Tayside Code of Corporate Governance, Reservation of Powers and Delegation of Authority required updating in line with the establishment of the health and social care partnerships	Further work to be taken forward during 2017/18 to update Section E of the NHS Tayside Code of Corporate Governance, Reservation of Powers and Delegation of Authority

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned)
The Board of governance has defined its purpose, role and responsibilities and recorded how these will be fulfilled.	Tayside NHS Board's purpose role and responsibilities are clearly set out in NHS Tayside's Code of Corporate Governance.	**BOARD**	Every two years	Fully in place NHS Tayside Code of Corporate Governance – Introduction and Section A, How Business is organised	
The organisation's strategy is communicated effectively to all staff and stakeholders.	A communication and engagement strategy to be developed during 2016/2017.	**BOARD**	Every three years	Partially in place. Draft strategy developed.	New Corporate Communications and Engagement strategy out for consultation with staff and public in first half of 2017/18.

EFFECTIVE PARTNERSHIPS

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

The Board develop relationships and works in partnership wherever this leads to better service delivery. The organisation seeks to explore and promote opportunities for efficiency savings and service improvements through shared service initiatives with partners	NHS Tayside involvement in IJB Strategic Commissioning plans.	**BOARD**	As required	Not demonstrated in year	Work to be progressed as part of NHS Tayside's strategic planning and the work associated with the development of the one year and five year plans

Clear governance arrangements are in place in respect of partnerships and other group-working. Responsibilities and reporting lines in respect of all governance arrangements have been clarified agreed by all parties and reflected in NHS Tayside's Code of Corporate Governance and the structure of assurance	All reports to the Board where appropriate should explicitly detail whether partnership working has been considered. Where partnership arrangements are in place the reports should detail the performance management and governance arrangements. Input into the IJB Strategic Plans and IJB performance arrangements to be agreed with IJBs and the Board.	**BOARD**	As required	Partially in place Partnership engagement demonstrated in : Mental Health Service Redesign Programme Shaping Surgical Services	Work ongoing with a short life working group to scope out the governance arrangements between the relevant organisations.
In joint working with any partners the Board works openly to an agreed vision, objectives and performance management and reporting mechanisms	NHS Tayside involvement in IJB Strategic Commissioning plans.			Not demonstrated in year	Work ongoing with a short life working group to scope out the governance arrangements between the relevant organisations.

GOVERNANCE AND ACCOUNTABILITY

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

REQUIREMENT	**MEASURE/EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year**	**Comment (Future work planned?)**
The Board has identified its stakeholders and understands its relationships with them.	Corporate communications and engagement strategy (to be developed).	**BOARD**		Fully in place Stakeholder engagement plans developed for major service change consultations for Transforming Surgical Services and Transforming Mental Health Services	
The Board understands citizen, patient, staff partner and stakeholder views, perceptions, and expectations.	Board reports should show evidence of the views of its stakeholders.	**BOARD**	As required	Fully in place. Engagement demonstrated in: Mental Health Service Redesign Programme Shaping Surgical Services	

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

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
The performance of the Board is self-assessed and appropriate actions identified and implemented as required.	Board Diagnostic Toolkit and Best Value Framework	**BOARD**	Annual	Fully in place The Board completed the Board Diagnostic Toolkit during October 2016. A Board Development Session was held on 17 January 2017 to review the feedback. Best Value Framework 2016/17 approved by the Board 27 October 2017.	Further work to be undertaken in respect of Collective Leadership and Culture Further work was undertaken with Internal Audit Staff and discussions took place with Standing Committee Chairs and Lead Officers during 2016/17 on the updated Best Value Framework
NHS Tayside regularly conducts rigorous review and option appraisal processes of all areas of activity, develops and develops and monitors action plans for any required improvements.	Transformation Programme	**BOARD**	As required	Partially in place Six workstreams in place and monitoring undertaken by the Transformation Programme Board – reports to Board	Ongoing/ plans in place for work over 5 years transformation programme

USE OF RESOURCES

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

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
NHS Tayside understands and measures and reports on the relationship between cost, quality and outcomes.	Transformation Programme	**BOARD**	As required	Partially in place Transformation Programme Board minutes and assurance reporting to Board	Ongoing/ plans in place for work over 5 years transformation programme
NHS Tayside understands and exploits the value of the data and information it holds.	Business Unit data informs transformation programme. Performance information reported to Board/Committees is validated.	**BOARD**	Annual	Fully in place Performance report to every Board meeting contains validated performance information	

PERFORMANCE MANAGEMENT

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

REQUIREMENT	**MEASURE/EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year**	**Comment (Future work planned?)**
Performance is systematically measured across all key areas of activity.	Board receives regular performance reports.	**BOARD**	Every meeting	Fully in place Performance reports are taken to every regular Board meeting	
The Board and its Committees approve the format and content of the performance reports they receive which should include – Assess its performing against the following criteria: Performance reporting provides an understanding of whether the organisation is on track to achieve its short and long-term strategic, operational and quality objectives	The Board reviews the performance reporting under its remit and agrees the measures.	**BOARD**		Not demonstrated in current year	Work to be undertaken to establish the level of information to be provided

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
Performance reporting allows a reasonable and informed judgement on how the organisation is likely to perform in future.	Board performance report shows trends.	**BOARD**	Every meeting	Fully in place Trends in performance and performance against trajectory is included in the Board performance report. Narrative provides information on corrective actions.	
Public performance reports show performance against: ◊ objectives, targets and service outcomes; ◊ past performance; ◊ improvement plans; ◊ other relevant bodies.				Fully in place Included in Board performance reports- publically available.	
Reports are honest and balanced and subject to proportionate and appropriate scrutiny and challenge from the Board and its Committees.	Board Minutes show scrutiny and challenge when performance is poor as well as good.	**BOARD**	Every meeting	Fully in place Board minutes show scrutiny and challenge as discussed at Board meetings	

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
The Board has received assurance on the accuracy of data used for performance monitoring.	Board performance reporting information uses validated data.	**BOARD**	Every meeting	Fully in place Performance report to every Board meeting contains validated performance information	
NHS Tayside's performance management system is effective in addressing areas of underperformance, identifying the scope for improvement, agreeing remedial action, sharing good practice and monitoring implementation.	Board's regular performance report and regular reporting on Local Delivery Plan.	**BOARD**	Every meeting and quarterly	Partially in place No LDP updates taken in year	Local Delivery Plan 2017/18 combined in One Year Operational Delivery Plan 2017/18
NHS Tayside has evidence that it has the necessary capacity and capability to deploy when performance is slow or weak	Where underperformance has been identified, resources are deployed as required.	**BOARD**	As required	Partially in place Governance and Risk Plan Safe Quality Patient Care – Board 1 December 2016 Mental Health Contingency Plan – 27 October 2017	

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
NHS Tayside prioritises performance improvements likely to have the greatest impact	Transformation Programme	**BOARD**	As required	Partially in place Six workstreams were developed as part of the Transformation Programme.	
NHS Tayside overtly links Performance Management with Risk Management to support prioritisation and decision-making at Executive level, support continuous improvement and provide assurance on internal control and risk.	Board Assurance Framework	**BOARD**	Quarterly	Fully in place. Board Assurance Framework (BAF) was considered by the Board on 23 June 2016, 27 October 2016 and 23 February 2017.	Board agreed that BAF reporting to the Board could reduce to twice per year. This was in addition to Committee Chairs' assurance reports, minutes and Committee reports from the Audit Committee and the reporting on strategic risks that exceed risk appetite to every Board meeting

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
Clients, citizens and other stakeholders are involved in developing indicators and targets and monitoring and managing performance so that information provided is relevant to its audience	Business cases developed in partnership for new or changed services.	**BOARD**		Partially in place During the year the following work was progressed - option appraisals for Mental Health Improvement Programme, Shaping Surgical Services and Interpretation and Translation Services.	

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

NHS Tayside promotes personal well-being, social cohesion and inclusion.		**BOARD**		Partially in place Opening of support centre in Ninewells Concourse	

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

REQUIREMENT	**MEASURE/EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME/EVIDENCE: Fully in place/ Partially in place/ Not demonstrated in year**	**Comment (Future work planned?)**
The Board and senior managers understand the diversity of their customers and stakeholders.	Equality Impact Assessments are reported to the Board and Committees as required and identify the diverse range of stakeholders.	**BOARD**	As required	Partially in place. Decision making report template includes Equality Impact Assessment section. Policies are required to include evidence of Equality Impact Assessment	

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE: Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned?)
NHS Tayside openly engages in a fair and inclusive dialogue to ensure information on services and performance is accessible to all.	Accessible Information document to be developed.	**BOARD**	As required	Partially in place Short life working group established to look at accessibility of NHS Tayside corporate documents NHS Tayside Mainstreaming Report and Equality Outcomes 2013-17	NHS Tayside Mainstreaming Report and Equality Outcomes to come to Board May 2017
NHS Tayside's policies, functions and service planning overtly consider the different current and future needs and access requirements of groups within the community.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments consider the current and future needs and access requirements of the groups within the community.	**BOARD**	As required	Partially in place Decision making report template includes Equality Impact Assessment section. Policies are required to include evidence of Equality Impact Assessment	
Wherever relevant, NHS Tayside collects information and data on the impact of policies, services and functions on different equality groups to help inform future decisions.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments will collect this information to inform future decisions.	**BOARD**	As required	Partially in place Decision making report template includes Equality Impact Assessment section. Policies are required to include evidence of Equality Impact Assessment	

Minute NHS Tayside

STRATEGIC RISK MANAGEMENT GROUP

Minute of the above meeting held at 2:00pm on Monday 2 February 2017 in the Board Room, Ninewells Hospital.

Present

Members

Mr Lindsay Bedford	Director of Finance, NHS Tayside
Mrs Gillian Costello	Nurse Director, NHS Tayside (to 3:30pm)
Ms Margaret Dunning	Board Secretary, NHS Tayside **(Chair)**
Mrs Hilary Walker	Risk Manager, NHS Tayside

In Attendance

Mr Mark Anderson	Head of Property NHS Tayside deputising for Ms Lorna Wiggin (to 2:30pm)
Ms Alison Hodge	Committee Support Officer, NHS Tayside
Miss Donna Howey	Head of Committee Administration, NHS Tayside
Ms Elisabeth Leslie	Head of Resilience, NHS Tayside
Ms Gail McClure	Quality and Services Manager, Primary Care Services, deputising for Dr Michelle Watts
Ms Jennifer Mudie	Associate Director of HR – Resourcing, deputising for Mr George Doherty
Ms Sue Muir	Service Manager Operations Directorate, deputising for Ms Lorna Wiggin
Ms Arlene Napier	Associate Director, Clinical Governance and Risk, NHS Tayside
Dr Gabby Phillips	Lead Infection Control Doctor, NHS Tayside (to 2:35pm)
Mr Finlay Stewart	Head of eHealth Strategic Delivery, deputising for Ms Jenny Bodie
Ms Audrey Warden	General Manager, Specialist Services Directorate, deputising for Ms Lorna Wiggin
Ms Lesley Wilson	Clinical Governance and Risk Management Administrator, NHS Tayside

Apologies

Ms Karen Anderson	Director of Allied Health Professions (AHPs), NHS Tayside
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 Lesley McLay	Chief Executive, NHS Tayside
Mr Bill Nicoll	Director of Strategic Change, NHS Tayside
Ms Frances Rooney	Director of Pharmacy, NHS Tayside
Professor Andrew Russell	Medical Director, 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

Ms Margaret Dunning in the Chair

1 Welcome and Introduction **ACTION**

Ms Dunning welcomed everyone to the meeting. She advised that the meeting was not quorate and there group would make recommendations only.

Ms Dunning welcomed the deputies attending the meeting for Ms Wiggin, Mr Doherty, Ms Bodie and Dr Watts. The group introduced themselves for the benefit of the attendees.

2 Apologies

Apologies were noted as above.

3 Minute of the last meeting

3.1 Minute of the Strategic Risk Management Group 24 November 2016

The group noted the minute and the risk update reports. There were no comments relating to the minute or the risk update reports of the meeting held on 24 November 2016.

The SRMG:

- Agreed the Minute of the Strategic Risk Management Group 7 April 2016 was an accurate record of the meeting and recommended approval

3.2 Action Points Update Strategic Risk Management Group 2 February 2017

3. Strategic Risks

Ms Dunning advised that the risk assurance template, guidance, the committee chairs templates and guidance had been updated. A follow-up meeting is planned to discuss supporting and up skilling risk managers.

4. Strategic Risks; Infection Control

Mrs Costello advised that there are ongoing discussions regarding the new management arrangements for infection control monitoring. There will be a report to the Directors meeting outlining the proposal for an Infection Control Committee.

The short life working group has been disbanded in the expectation that approval is given for the Infection Control Committee.

6. Update on HSCP Governance Assurance arrangements

Ms Dunning advised that there was a meeting on 12 January 2017 attended by the Chief Executive, Chief Operating Officer, the three IJB Chief Officers and the Chief Finance Officer.

The group noted that at this meeting there was a round table discussion regarding governance arrangements and a beneficial short summary from the IJB Chef Officers on the development of their governance arrangements.

This information is important for NHS Tayside year end and the presentation of the annual accounts

A further meeting will take place at the end of February 2017 with Ms Dunning, Internal Audit and the IJB Chief Officers to describe how the governance arrangements will flow.

The SRMG:

- Noted the action points update

3.3 Matters Arising

There were no matters arising.

4 RISK MANAGEMENT

4.1 Risk Appetite Statement

Mrs Walker spoke to this paper which provided the group with a timeline relating to the development of a risk appetite statement for NHS Tayside. The SRMG are requested to review and agree with the risk appetite statement prior to going to the Audit Committee on 9 March 2017.

The group noted that as part of the development process Ms Walker had contacted other NHS Boards and a short life working group (SLWG) had been established to input into the development of a risk appetite statement for NHS Tayside.

Ms Walker outlined the main points in the risk appetite statement:

A score of 22 or above would require to be reported.

- Strategic Risks will still report to the Board Standing Committees four times per year.
- The strategic risk profile will be reported to the Tayside NHS Board twice per year.
- Risks outwith the risk appetite will be reported to every meeting of Tayside NHS Board until they fall back within acceptable boundaries

Ms Dunning advised that there were 22 risks in the strategic risk profile and most were in the High section.

There was a short discussion on the scoring of risks into high and very high categories. The group provided feedback on the risk appetite matrix and the risk appetite assessment.

Ms Walker thanked the group for the feedback and agreed to update the statement in accordance with this prior to presentation to the Audit Committee. **HW**

Ms Dunning advised that future SRMG meetings would involve a peer review and challenge around risk scoring.

Ms Napier commended the work to develop and agree the definition of risk appetite and that the group involved had been tenacious taking this forward.

The SRMG:

- Recommended approval of the risk appetite statement prior to the Audit Committee on 9 March 2017
- Noted that a review of the Risk appetite Statement would take place annually

4.2 Internal Audit Report T12/16 Assurance Framework Recommendation 6

Mrs Dunning appraised the group that Internal Audit Report T12/16 – Assurance Framework had identified a deficiency where a strategic risk had not been identified and managed through the Board Assurance Framework or Risk Management systems as early as possible. To address this Horizon Scanning has since been added as a Standing Agenda Item to the Strategic Risk Management Group but should a similar situation arise in the future, the group are now committed to carrying out a post-event review.

5 STRATEGIC RISKS

The Chair requested that 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 Phillips was in attendance and provided a verbal update. The group noted that a paper would be considered at a forthcoming Directors meeting regarding a proposal to establish an Infection Control Committee. It was agreed that establishment of this Committee would have a positive impact on infection control issues.

The group recommended no change to the scoring of this risk.

26 Waiting Times and RTT Targets

Owner – L Wiggin
Manager – S Lowry

Ms Audrey Warden was in attendance and provided a verbal update on behalf of Ms Lorna Wiggin.

She advised that the risk remained the same as previously reported. There continued to be breaches of the Treatment Time Guarantee (TTG) in orthopaedics, breast cancer, general surgery and urology.

The group noted:

- Patients are advised by letter of the reasons for the delay and these letters were reviewed and adjusted accordingly.
- Patients have the right to complain and there has been increase in complaints related the longer waiting times

Ms Warden reported that services were identifying what service improvements to ensure the best use of resources to meet the demand.

There is additional in house activity and outsourcing of general surgery and gynaecology activity.

There are currently regular meetings to measure performance against projected targets.

The group recommended no change to the scoring of this risk.

201 Health Equity

Owner – D Walker
Manager – H Scott
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 to be attached to the minute of this meeting. **DW**

312 NHS Tayside Estates Infrastructure Condition

Owner – L Wiggin
Manager – M Anderson

Mr Mark Anderson was in attendance and provided a verbal update on behalf of Ms Lorna Wiggin.

He advised that a revised draft Initial Agreement has been updated to reflect the ongoing discussion with the NHS Tayside Technical Officers and Health Facilities Scotland (HFS) Principle Engineer.

The revised draft Initial Agreement will be sent to HFS in January 2017 to allow consultations with HFS on the preferred technical design option.

Mr Anderson reported that work on the Masterplan will continue to ensure NHS Tayside can meet the Scottish Governments expectations. This will involve working closely with HFS, Scottish Futures Trust (SFT) and Scottish Government over the coming months to ensure a strategic Masterplan can be developed for Ninewells Hospital.

Once a date has been scheduled for the Masterplan development group and NHS Tayside receives feedback from HFS on the draft Initial Agreement and preferred technical design option, a further update could be provided to outline next steps.

Mr Anderson gave a brief outline of the zones within the hospital. It was acknowledged that during zone 1 work (polyclinic) would be carried adjacent to both neonatal and radiology with the requirement for minimal impact.

Dr Philips advised that the team were aware that this work was a high risk for infection control.

The group recommended no change to the scoring of this risk.

Mr Anderson left the meeting at 2:30pm

313 Capacity and Flow (Winter Plan)

Owner – L McLay
Manager – L Wiggin

Ms Audrey Warden was in attendance and provided a verbal update on behalf of Ms Lorna Wiggin.

She advised that the risk remains at the current scoring and reported that there has been significant work across the system.

Regarding escalation work was ongoing to progress how we activate actions from service to a whole systems approach. Early testing is taking place on area action cards and scoring. Work also continues through daily huddles.

The group noted that there had been no change however there was robust management of challenges.

The group recommended no change to the scoring of this risk.

353 Sustainable Primary Care Services

Owner – V Irons
Manager – J Galloway

Ms Gail McClure was in attendance and provided a verbal update on behalf of Dr Michelle Watts.

She highlighted that at November 2016, there were six practices with closed lists and three have opened. There were no further items to be highlighted to the group.

The group recommended no change to the scoring of this risk.

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 advised that both risks were reported to the Finance and Resources Committee on 19 January 2017. The risk assurance reports also included an update on all operational risks that support the strategic risks. Mrs Walker advised that there were two new operational risks to be added to the profile associated with the Property Asset Management Strategy (PAMS).

The group recommended no change to the scoring of this risk.

38 Information Governance Risk

Owner – M Dunning
Manager – A Dailly

Ms Dunning advised that this risk was reported to the Finance and resources Committee and that a Gap analysis had been undertaken leading to the development of an improvement plan, which will be monitored, by the Information Governance Committee and updates provided through the assurance report to the Finance and Resources Committee.
The group recommended no change to the scoring of this risk.

415 Implementation of TrakCare

Owner – J Bodie
Manager – A Graham

Mr Finlay Stewart, Head of eHealth Strategic Delivery was in attendance and gave a verbal update on behalf of Ms Jenny Bodie. He advised that this risk was reported for the first time at the Finance and Resources Committee on 19 January 2017.

Mr Finlay advised that the TrakCare go live date had been delayed and a new date would be advised once a revised plan had been confirmed. During testing issues were identified which have resulted in the decision to delay the implementation.

Mr Stewart confirmed that there would be a communication to all staff regarding training sessions.

The group recommended no change to the scoring of this risk.

Strategic Risks aligned with the Staff Governance Committee

58 Workforce Optimisation

Owner – G Doherty
Manager – J Mudie

Mrs Jennifer Mudie was in attendance and gave a verbal update on behalf of Mr Doherty.

Ms Mudie commented that the Staff Governance Committee was establishing stronger links with the Finance & Resources Committee and the Clinical & Care Governance Committee.

Ms Mudie highlighted to the group that there would be challenges ahead in relation to the eKSF system as from January 2018 funding would cease.

To anticipate this Ms Mudie advised that all eKSF records should be up to date so that information can be migrated to a new system. Options for a new system are being explored and Ms Mudie and Ms Bodie have met with a national lead to progress this.

The group recommended no change to the scoring of this risk.

95 Medical Workforce

Owner – G Doherty
Manager – J Mudie

Ms Mudie advised that this risk had been updated to reflect GPs and salaried GPs.

The group recommended no change to the scoring of this risk.

280 Nursing and Midwifery Workforce

Owner – G Costello
Manager – E McKenna

Mrs Costello advised that a review of this risk had taken place and the Associate Nurse Director portfolios have been reconfigured due to workforce changes at the end of March 2017.

The group recommended no change to the scoring of this risk.

28 Health and Safety

Owner – L Wiggin
Manager – S Muir (interim)

Ms Walker advised that an owner and manager had been identified for this risk. The risk is not in the Datix system yet but would be aligned to the Staff Governance Committee. Information on this risk would be reported to the Staff Governance Committee on 14 March 2017.

Strategic Risks aligned with the Clinical and Care Governance Committee

15 Delivering Care for Older People

Owner – G Costello, A Russell
Manager – C Rodriguez

Mrs Costello advised that Dr Cesar Rodriguez had provided an update at the last Clinical and Care Governance Committee. Ms Sarah Dickie, Associate Nurse Diretcor was now aligned to this risk and would support the Older People Clinical Board. The risk is updated after each meeting of the Older People Clinical Board.

The group recommended no change to the scoring of this risk.

16 Clinical Governance

Owner – G Costello, A Russell
Manager – A Napier

The group recommended no change to the scoring of this risk.

22 Health Protection of Children and Young People

Owner – G Costello
Manager – K Fowlie, (J Wilson)

Ms Costello advised that more work was being progressed and in partnership with the three Community Health Partnerships.

The group recommended no change to the scoring of this risk.

121 Person Centredness

Owner – G Costello, A Russell
Manager – E McKenna

Noted that there was new work in relation to this risk. There would be a change in the manager for this risk and this would be reported at the next meeting.

The group recommended no change to the scoring of this risk.

144 Maternity Services

Owner – G Costello, A Russell
Manager – C Goodman, J Craig

Mrs Costello advised that the risk was discussed in reserved business at the last CCGC and that it was anticipated that further work will be undertaken and the risk updated.

The group recommended no change to the scoring of this risk.

302 PRI/Patient Flow

Owner – A Cook
Manager – K Wilson

There were no items to highlight to the group.

The group recommended no change to the scoring of this risk.

395 Mental Health Services – Sustainability of Safe and Effective Services

Owner – A Russell
Manager – R Packham

The group noted that the Continuity Plan for Mental Health Services was invoked on 1 February 2017. Weekly meetings were being held at the Carseview Centre to monitor activity. There was a smooth transition of patients. Mrs walker advised that the risk score had increased since the last SRMG.

The group recommended no change to the scoring of this risk.

414 Managed/ 2C Practices

Owner – A Russell
Manager – M Watts

Ms Gail McClure was in attendance and provided a verbal update on behalf of Dr Michelle Watts.

She reported that all three of the 2c practices have open lists and a degree of stability had been achieved. Regarding recruitment of GPs, there are a number of initiatives/ programmes that were being taken forward.

There was a short discussion on this risk and if it could be removed from the risk register. It was noted that a decision would be made after the mapping of governance arrangements had been completed.

Mrs Walker reported that this risk had been downgraded by the risk owner.

The group recommended no change to the scoring of this risk.

The SRMG:

- Noted the updates
- Acknowledged that there had been limited discussion due to the absence of risk owners

5.2 Risk Horizon Scanning and Emerging Risks

Ms Dunning discussed that internal audit which highlighted the requirement for horizon scanning at the SRMG where there would be an opportunity to pick up on emerging risks within the organisation. It was agreed that early identification of issues beneficial.

Ms Dunning advised that Internal Audit had highlighted that in respect of risk 144, Managed / 2C Practices there had been a delay in the escalation of the issues to Board level.

Mrs Napier advised that emerging risks was an item that was discussed at the end of after every performance review meeting. Groups and individuals are given the opportunity to highlight emerging risks.

Ms Mudie highlighted again the eKSF system and that the current eKSF product would no longer be in use from January 2018 onwards. This issue has been discussed at the Staff Governance Committee where concern has been raised that not all staff have not had a performance review meeting.

She added that it is now extremely important that all staff participate in the performance review process and that this information is up to date and maintained in the current eKSF system so that information can be migrated when a replacement product has been confirmed.

As there were national groups progressing a replacement the group recommended no escalation to strategic risk at present.

Mrs Costello left the meeting at 3:30pm

6 HEALTH AND SAFETY

6.1 NHS Tayside Health and Safety Support

Ms Sue Muir was in attendance for this report and provided an update on behalf of Ms Loran Wiggin.

The group noted the report and the work that was progressing in the following areas:

- Sharps Management
- Skin Health
- Domestic Gloves Risk assessment
- Murray Royal Hospital environmental improvement programme
- Local Exhaust Ventilation (LEV) assessment

Ms Muir advised:

- That the Health and Safety Compliance Officer (Property Department) had been appointed to ensure Health and Safety Governance within the estates department.
- Recruitment to the Health and Safety manager was ongoing.
- A review of Health and Safety training and mandatory courses has mapped training opportunities across the organisation and this framework is working to ensure that staff are signposted to the appropriate internal/external training programmes
- The Health and Safety GAP analysis has been completed underpinned by a health and safety workplan

The SRMG:

- Noted the content of the report and actions being taken to mitigate the effects of gaps in the Health and Safety Team
- Noted the progress on recruitment of a Health and Safety Manager and Health and Safety Compliance Manager (property department)
- Noted the process for interim arrangements
- Noted that the Health and Safety Executive (HSE) are aware of the current position within NHS Tayside

7 RESILIENCE PLANNING

7.1 Resilience Planning Quarterly Update

Ms Leslie spoke to the report which provided and update on the progress on Resilience Planning functions since the last meeting on 24 November 2016.

The group noted that the HMIMMS training had been cancelled.

The SRMG:

- Noted the report

7.2 Core Competencies for Major Incidents and Emergencies

Ms Leslie advised that the NHSScotland Standards for Organisational Resilience issued in May 2016 sets out minimum standards expected of health boards in relation to resilience.

Ms Leslie highlighted standard 11.3 which requires
"A clear remit/role specification for the on-call staff /Duty Director, backed up by a training and development programme, to ensure that the individuals meet the competencies for the role they are required to perform, and have the required knowledge and skills".

Ms Leslie requested feedback on core competencies that were included with the report. She acknowledged that information had been gathered and used from NHS Grampian and NHS Greater Glasgow and Clyde.

There was a short discussion and the following points were noted:

- Staff appointed were not always aware of their responsibilities in respect of major incidents and emergencies
- NHS Tayside training for major Incidents and Emergencies is not overt

Ms Dunning advised that regretfully a scheduled Major Incident Medical Management and Support (HMIMMS) training session has had to be cancelled due to a lack of facilitators and has been rearranged for 29/30 May 2017.

Ms Dunning advised that there were plans and action cards available and a tabletop exercise arranged.

Following discussion it was agreed that the posts which would be categorised as a senior manager for the purposes of this training would be defined. Ms Leslie agreed to progress this. **EL**

The SRMG:

- Agreed that this was a welcomed document
- Agreed that this should be circulated to members for their comments

8 POLICY MANAGEMENT

8.1 Policy Management Quarterly Report

Miss Donna Howey was in attendance. The group discussed the policies which included an update in appendix 1.

Ms Mudie described the process with the development of PIN guidelines and policies. There was short discussion on the possibility of dates being extended automatically however it was agreed that this would not be appropriate and that an audit trail would be required. Ms Mudie to ensure that a formal request is made regarding extensions which will include confirmation that the policies are applicable and remain as a policy. **JM**

The SRMG:

- Noted the report and the updates
- Noted that to ensure correct governance written communication for extensions is required for all policies

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 Datix Implementation Group 13 December 2016

The SRMG:

- Noted the Datix Implementation Group 13 December 2016

10.2 Sharps Management Committee 26 August 2016

The SRMG:

- Noted the Sharps Management Committee 26 August 2016

10.3 Sharps Management Committee 26 October 2016

The SRMG:

- Noted the Sharps Management Committee 26 October 2016

10.4 Strategic Risk Management Meeting Dates 2017/18

The SRMG:

- Recommended approval of the Strategic Risk Management Meeting Dates 2017/18

10.5 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 27 April 2017, 2:00pm – 3:30pm in the Board Room Ninewells Hospital.

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	Present
Cllr D Doogan	Non Executive Member (Vice Chair)	NHS Tayside	Apologies	Apologies	Present	Apologies	Present
Mrs L Dunion	Non Executive Member	NHS Tayside	Present	Apologies	Present	Present	Apologies
Mrs J Golden	Non Executive Member & Employee Director	NHS Tayside	Apologies	Present	Present	Apologies	Present
Mr S Hay	Non Executive Member (Chair)	NHS Tayside	Present	Present	Present	Present	Present
Mr M Hussain	Non Executive Member	NHS Tayside	Present	Present	Present	Apologies	Present
Cllr Middleton	Non Executive Member	NHS Tayside	Apologies	Present	Present	Present	Present
In Attendance							
Mr L Bedford	Director of Finance	NHS Tayside	Present	Present	Present	Present	Present
Ms M Dunning	Board Secretary	NHS Tayside	Present	Present	Present	Present	Present
Mr T Gaskin	Chief Internal Auditor	FTF Audit & Management Services	Present	Present	Apologies	Present	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	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	Present
Mr B Hudson	Regional Audit Manager	FTF Audit & Management Services	-	-	Present	Apologies	Apologies

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Mrs J Lyall	Principal Auditor	FTF Audit & Management Services	Present	Present	Present	Present	Present
Mr R MacKinnon	Associate Director of Finance, Financial Svs & Governance/FLO	NHS Tayside	Present	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	Present
Mr K Wilson	Partner	PricewaterhouseCoopers	-	Present	-	-	-
Mr R Marshall	Representative Area Partnership Forum	NHS Tayside	-	-	-	Present	Present
For Information							
Prof J Connell FMedSci FRSE	Chair, Tayside NHS Board	NHS Tayside	Present	Present	Present	Apologies	Present
Mrs G Costello	Nurse Director	NHS Tayside	-	-	-	-	-
Mrs L Green	Committee Support Officer	NHS Tayside	Present	Present	Present	Present	Present
Miss D Howey	Head of Committee Administration	NHS Tayside	Present	Present	Present	Present	Present
Ms L McLay	Chief Executive	NHS Tayside	Apologies	Present	Apologies	Apologies	Present
Mr H Robertson	Non Executive Member	NHS Tayside	-	-	-	-	-
Mrs A Rogers	Non Executive Member	NHS Tayside	-	-	-	-	-
Mr A Russell	Medical Director	NHS Tayside	-	-	-	-	-
Prof M Smith	Non Executive Member	NHS Tayside	-	-	-	-	-
Mrs S Tunstall-James	Non Executive Member	NHS Tayside	-	-	-	-	-
Dr D Walker	Director of Public Health	NHS Tayside	-	-	-	-	-