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 22 June 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

Would **Board Members who are not members of the Audit Committee** please note that they are receiving copies of the agenda and papers for this meeting in order to facilitate the process of adopting the Accounts for the year ended 31 March 2017 at the Board meeting to be held on Thursday 29 June 2017.

Under the terms of the Public Finance & Accountability (Scotland) Act 2000, while the processes can be undertaken in open session, the Board is not permitted either to make the Accounts, nor allow copies or extracts thereof, to be made publicly available prior to the Audited Accounts being formally laid before Parliament. Members must not therefore share the contents of the Accounts with non-Board Members at this stage.

PLEASE NOTE THAT RESERVED BUSINESS WILL BE TAKEN FIRST AT 9:30 AS CERTAIN ASSURANCES NEED TO BE PROVIDED BEFORE THE REVIEW OF THE STATEMENT OF INTERNAL CONTROL AND OPEN BUSINESS TO COMMENCE AT APPROXIMATELY 9:45

Mr Lindsay Bedford
Director of Finance

June 2017

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 - 11 May 2017	S Hay	Attached - for approval
	4.2 Action Points Update.	L Bedford	Attached - to note update
	4.3 Work Plan Update	L Bedford	Attached – to note update
	4.4 Matters Arising	S Hay	
5.	**ENDOWMENT FUNDS**		
	DRAFT ANNUAL ACCOUNTS 2016/17 TAYSIDE NHS BOARD ENDOWMENTS FUND - ***BOARD MEMBERS ONLY***	L Bedford P Crichton	AUDIT42/2017 - attached For consideration/approval
6.	**PATIENTS' FUNDS**		
	PATIENTS' FUNDS - EXTERNAL AUDIT REPORT	L Bedford D Taylor	AUDIT43/2017 - attached For consideration/approval

ITEM NO		LEAD OFFICER	REPORT NO AND ACTION REQUIRED
7.	**EXCHEQUER FUNDS**		
	7.1 Exchequer Process – Verbal Introduction	L Bedford	Verbal update
	7.2 Annual Reports and Assurance Statements by Committees including Best Value Assurances for the year ended 31 March 2017	L Bedford	AUDIT44/2017 - attached For consideration/approval
	7.3 **SHARED SERVICES AUDIT REPORTS** (a) Practitioner Services - Service Audit Report (b) National IT Services Contract – Service Audit Report (c) NHS Ayrshire and Arran National Single Instance Financial Services Ledger - Service Audit Report	L Bedford	AUDIT45/2017 - attached To note for information
	7.4 FTF Annual Internal Audit Annual Report 2016/17	T Gaskin	AUDIT46/2017 - attached For discussion/consideration
	7.5 Review of System of Internal Control - Lead Officer's Statement to Chief Internal auditor – ***BOARD MEMBERS ONLY***	L Bedford	AUDIT47/2017 - attached To note the findings of the Committee re the submission made to the Chief Internal Auditor on internal control
	7.6 Annual Report - Patient Exemption Checking (PECS)	L Bedford	AUDIT48/2017 attached To note for information
	7.7 Annual Report of NHS Tayside Audit Committee 2016/17	L Bedford	AUDIT49/2017 - attached For consideration/approval
	7.8 Report to Tayside NHS Board - Assurance by the Committee	S Hay	AUDIT50/2017 - attached For approval/recommendation to the Board
8.	**DRAFT ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017** ***– BOARD MEMBERS ONLY***	L Bedford	AUDIT51/2017 - attached For consideration
9.	**Audit Scotland - ANNUAL REPORT ON THE 2016/17 AUDIT TO THE BOARD AND THE AUDITOR GENERAL FOR SCOTLAND** - ***BOARD MEMBERS ONLY***	F Mitchell-Knight/ B Crosbie	AUDIT52/2017 - attached For discussion/information
10.	**RECOMMENDATION TO THE BOARD OF ANNUAL ACCOUNTS**	S Hay	Having reviewed the systems of internal control, the Annual Accounts and considered the view of the External Auditor, the Committee is responsible to recommend to the Board the adoption of the Annual Accounts
11.	**NOTIFICATION FROM SPONSORED BODY AUDIT COMMITTEES**	L Bedford	AUDIT53/2017 - attached To note for information

ITEM NO		LEAD OFFICER	REPORT NO AND ACTION REQUIRED
12.	**UPDATES TO THE NHS TAYSIDE CODE OF CORPORATE GOVERNANCE**	M Dunning	AUDIT54/2017 - attached For approval/recommendation to the Board
13.	**UPDATE - BEST VALUE FRAMEWORK ASSURANCE 2016/17 – TAYSIDE NHS BOARD**	M Dunning	AUDIT55/2017 - attached For approval
14.	**AUDIT FOLLOW UP (AFU) – FULL CYCLE REPORT**	L Bedford	AUDIT56/2017 – attached To note for information
15.	**INTERNAL AUDIT ANNUAL PLAN 2017/18**	T Gaskin	AUDIT57/2017 - attached For consideration/approval
16.	**ATTENDANCE RECORD**	S Hay	Attached – for information
17.	**DATE OF NEXT MEETING** **Thursday 24 August 2017** at 9.30 a.m. 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 (FOISA 33)
CODE OF CORPORATE GOVERNANCE

18.	**MINUTE OF THE PREVIOUS MEETING**		
18.1	Minute of the Audit Committee Reserved - 9 March 2017	S Hay	Attached – for approval
18.2	Minute of the Audit Committee Reserved **-** 11 May 2017	S Hay	Attached – for approval
18.3	Action Points Update	L Bedford	Attached - for information
18.4	Matters Arising	S Hay	

FOISA 36(1)
Confidentiality – Legal Proceedings

19.	**LOSSES AND COMPENSATION PAYMENTS/ LITIGATION MONITORING**	L Bedford	AUDIT58/2017 – attached For consideration/approval
20.	**PRIVATE DISCUSSION**		

DISTRIBUTION

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

Minute NHS Tayside

TAYSIDE NHS BOARD
AUDIT COMMITTEE - OPEN BUSINESS

Minute of the meeting of Tayside NHS Board Audit Committee held at 9.30 a.m. on **Thursday 11 May 2017** in the Board Room, Kings Cross Hospital, Dundee

Present:
Ms L Dunion, 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

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
Ms M Dunning, Board Secretary, NHS Tayside
Mrs F Gibson, Head of Financial Services, NHS Tayside
Mrs L Green, Committee Support Officer, NHS Tayside
Miss D Howey, Head of Committee Administration, NHS Tayside
Mrs L Lyall, Capital Finance Manager, NHS Tayside (for Item 10)
Mr R Marshall, Representative of Area Partnership Forum
Mr R MacKinnon, Associate Director of Finance - Financial Services & Governance/FLO, NHS Tayside
Mrs H Walker, Risk Manager, NHS Tayside
Apologies
Mr D Cross, OBE, Non Executive Member, Tayside NHS Board

Mr S Hay in the Chair

ACTION

1. WELCOME

Mr Hay welcomed all to the meeting including Professor Stephen Logan, Chair of NHS Grampian and Member of the Assurance and Advisory Group.

Mr Hay advised the Committee that Glennis Middleton had not been re-elected following the Local Authority Council elections on 4 May 2017. Mr Hay extended his thanks and warm appreciation to Glennis for her valuable input to the Committee.

It was noted there were two vacancies in the Membership of the Committee and confirmation of nominated Local Authority Representatives was awaited.

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 – 9 March 2017

Mr Hussain requested that the first sentence of the last paragraph on page 53 be amended to read "Mr Hussain accepted the recommendations in relation to Staff Governance, noting in relation to the number of deferred items, there had been issues regarding non attendance at meetings".

The Committee agreed to the amendment.

The Audit Committee Minute of the meeting held on 9 March 2017 was approved on the motion of Mr Munwar Hussain and seconded by Mrs Judith Golden.

4.2 Action Points Update

Mr Bedford spoke to the Action Points Update.

Strategic Risk Management Group Minute – 24 November 2016 – The Committee noted that early notification of forthcoming meetings and regular reminders would be put in place to improve attendance at Strategic Risk Management Group (SRMG) meetings. It was noted that Risk Managers would be required to attend to talk to their respective risks if the Risk Owner could not be present and the SRMG Terms of Reference would be updated to incorporate this deputising arrangement.

Mrs Walker advised the Committee that work was ongoing regarding the review of the Terms of Reference and alternative ways of conducting business were being explored.

Internal Audit T08/17 – Interim Evaluation of Internal Control Framework – It was noted this report had been circulated to all Standing Committee Chairs and Committee Support Officers on 19 April 2017.

External Review of all Mental Health Sites – The Committee noted the update provided in Appendix 1 to the Action Points Update. Mr Bedford reminded the Committee that the Finance and Resources Committee had given approval for Phase 1 of the Window Replacement Programme which would focus on Murray Royal Hospital and some areas of the Carseview Centre. It was noted Tayside NHS Board had approved the allocation of £1m for the Mental Health Environmental Programme and a further £2.3m from the Board Contingency had been set aside to allow for emerging environmental issues and expanding the programme to other Mental Health sites.

Mr Gaskin sought clarification that all wardrobe (including cupboard) doors had been removed from all areas within all Mental Health sites. Confirmation was provided that this was the case.

4.3 Work Plan 2017/18

The Committee was asked to note the Work Plan 2017/18.

Mr Bedford advised the Work Plan 2017/18 reflected the current and forthcoming reporting arrangements. The Committee was asked to note the Work Plan 2017/18 and continue to monitor.

The Committee

- **Noted the Work Plan 2017/18**

4.4 Matters Arising

There were no matters arising.

5. AUDIT FOLLOW UP

5.1 Audit Follow Up (AFU) – Mid Cycle Update Report (AUDIT38/2017)

Mr Bedford noted that the Work Plan stated the Full Cycle Update Report would be presented to the Committee however, due to absence within the department the Full Cycle Update Report would be presented to the next Committee meeting.

Mr Bedford advised the report highlights D opinion Internal Audit Reports and previous External Audit Reports. All comments were included in Appendix 1 of the report.

It was noted in relation to T21/14 Medical Equipment and Devices a comprehensive report had been presented to the Committee at its meeting in January 2017 and this action was now complete. An update in relation to T22/17 Follow Up of Financial Planning and Management would be considered separately under Item 6.2 of the Agenda.

Mr Hay sought an update in relation to The Office of the Scottish Charity Regulator (OSCR). It was noted Mr Robert MacKinnon was liaising with OSCR regarding the removal of restrictions. Mr MacKinnon advised the first step was a fund re-organisation scheme. There was a large exercise looking at larger funds and the clinical alignment and a consultation process would be required following that.

The Committee

- **Noted the further progress made during the period from January 2017**

6. INTERNAL AUDIT

6.1 Internal Audit Progress Report (AUDIT40/2017)

Mr Gaskin advised the Committee in relation to Internal Audit Report T01/17 – Audit Risk Assessment and Planning there had been progression following the submission of this report. It was noted that following discussion with the Chief Executive and Directors it had been agreed the report T01/17 – Audit Risk Assessment and Planning would now be submitted to June 2017 Committee meeting.

Mr Gaskin advised the decision to defer submission to the June 2017 meeting would allow additional time for the considerations of both the NHS Tayside and the Integrated Joint Boards (IJBs) and for the focus and consideration of Directors. Mr Gaskin noted he felt a better product would be submitted and was pleased with the level of engagement.

9:43 Ms Margaret Dunning arrived

Mr Gaskin highlighted the requirement to find a balance between governance and the operations arrangements and advised a meeting had been arranged with Mr Bill Nicoll, Director of Strategic Change. It was noted the work would be less focussed on governance and more on operational arrangements.

It was noted Mr Gaskin would meet with Local Authority Internal Audit colleagues to ensure agreement and the inclusion of any key issues in the partner organisations. Mr Gaskin highlighted the importance of the support of the Audit Committees to ensure a cohesive plan was presented.

Prof Connell queried when the Committee would get an update on the D aspect of Health and Social Care Integration (HSCI) in Internal Audit Report T15/17 – Health and Social Care Integration (HSCI). Prof Connell noted concerns regarding this and the need to move this forward.

Mr Gaskin advised there were various submission dates for the delivery of audits within the Integrated Joint Board (IJB) Internal Audit plans and also stated that he was working with both NHS Tayside and the IJBs on developing annual audit plans for 2017/18.

Ms Dunning advised that regarding the governance of HSCI the IJBs had outlined two models in Tayside and there was the requirement to review these models and the consequence for NHS Tayside. It was noted there were difficulties in having two models and a meeting had been scheduled to review the models and consequences to NHS Tayside. It was noted an update would be provided at the June 2017 Committee meeting.

Ms McLay noted her support of the discussions around the Internal Audit Annual Plan 2017/18 and the ongoing work exploring the governance implications of Health and Social Care Integration. It was noted in relation to HSCI, this was also an issue for consideration at national level and there was recognition from Scottish Government (SG) of the challenges, progress made and the variance being described from all Health Boards. Ms McLay noted this was new territory and concluded by noting her appreciation of the helpful work of Internal Audit around the 2017/18 Internal Audit Plan.

Mr Crosbie queried the impact of having two governance arrangements within the Governance Statement (GS). It was noted that there was no clear guidance from NHS Scotland and discussions would continue with Local Authority colleagues and IJB partners to ensure arrangements were suitable for all.

Mr Gaskin highlighted that the Summary of Report Content was included as Appendix 1 of the report.

The Committee

- **Noted the progress on the 2016/17 Internal Audit Plan**
- **Noted that Internal Audit Report T01/17 – Audit Risk Assessment and Planning would be submitted to the June 2017 meeting**
- **Noted that an update regarding the Internal Audit Report T15/17 – Health and Social Care Integration would be submitted to the June 2017 meeting**

6.2 Follow Up of Financial Planning Audit Report No T22/17 (AUDIT39/2017)

Mr Bedford advised the report provided the Committee with an update on the status of the audit recommendations and the management actions which arose from the Follow Up of Financial Planning Internal Audit Report which was presented to Committee at its meeting in March 2017.

Mr Bedford highlighted ref.1 of Appendix 1 in relation to Internal Audit Report T28/14 – Financial Monitoring and advised that following discussions with the Chair of the Finance and Resources Committee, the addition of informal Finance and Resources Committee meetings to “bridge the gap” between reporting had been agreed and would be arranged to alternate with the formal Finance and Resources Committee and Tayside NHS Board meetings.

It was noted the formal meetings scheduled for 2017/18 would remain unchanged however, meetings for 2018/19 would be arranged to be held towards the end of the month to allow for the most up to date financial position being presented to the Finance and Resources Committee in the form of a written report as opposed to a verbal update.

In relation to ref. 5 Mr Bedford advised that following the completion of the annual accounts the Standing Financial Instructions would be updated and where appropriate more detailed operational guidance would be developed. This would be reported to both the Audit and Finance and Resources Committees.

Mr Gaskin advised the Committee a lot of progress had been made however, further work was required due to changes to the risk environment. Mr Gaskin noted that ensuring a robust Finance Team was in place was a fundamental issue.

Mr Hay spoke in relation to ref.6 and noted that it would be reassuring for the Committee to see a detailed Finance Workforce Plan. It was confirmed this would be completed by September 2017.

Mr Hussain noted a number of actions related to Finance and Resources scrutiny and sought assurance that the organisation was committed to the process at an appropriate level and requested an update in relation to working with Information Statistics Division (ISD) Scotland. Mr Bedford advised that all Health Boards were given information from the NSS Discovery tool. It was noted that whilst a number of areas required further review there was a good level of engagement at an operational level.

It was noted the Local Delivery Plan, to be finalised by September 2017, would draw on regional elements and the One Year Operational Plan had identified a number of productive opportunities through the NSS Discovery Tool.

Prof Connell queried how the Finance Workforce Plan, due to be developed by September 2017, would feature within the Corporate Workforce Plan which was required by June 2017. Mr Bedford reflected on the approved Finance structure that was now actively being taken forward and the consideration that would be given to ensuring an effective substructure was in place. This would be more in particular to redefining roles whilst ensuring adequate training and support was in place.

The Committee

- **Noted the current position**

6.3 Internal Audit T12/17 – Integration Joint Board (IJB) Governance Update

Ms Dunning advised this had been discussed under Item 6.1 Internal Audit Progress Report and re-iterated that a meeting had been arranged to discuss plans and an update would be submitted to the June 2017 Committee meeting. **MD**

The Committee

- **Noted the update provided under Item 6.1**
- **Noted an update would be submitted to the June 2017 Committee meeting**

7. EXTERNAL AUDIT

7.1 NHS Tayside External Audit Interim Report 2016/17 (AUDIT37/2017)

Mr Crosbie was in attendance and thanked the Committee for the invitation to present this report.

Mr Crosbie advised the Committee the report provided a summary of the key issues identified during interim audit work on governance arrangements and the key controls within the main financial systems. It was noted that para. 6 of the report highlighted the nature of key controls tested.

Mr Crosbie advised that Audit Scotland would use this work to assess the extent to which the systems could be relied on for the purpose of providing the information for the financial statements and identify where additional work may be required.

Mr Crosbie advised that Audit Scotland had concluded that Tayside NHS Board's systems of internal control were sound however, there were some areas for improvement identified, highlighted in Exhibit 1 of the report. Mr Crosbie also noted that one area was identified where further work would be required and this would be focussed specifically on suppliers' bank details.

It was noted the Annual Audit Report would be submitted to the June 2017 Committee meeting.

Mr Crosbie wished to highlight the reliance placed on the work of Internal Audit to avoid the duplication of efforts.

Mr Bedford noted that significant work had been undertaken by Mrs Frances Gibson and Mr Robert MacKinnon in relation to issues highlighted within the report. Mr Crosbie commended the work undertaken and the timeous response from management.

There was discussion in relation to the appearance of the NHS Tayside website and the need to ensure it was kept up to date. Ms Dunning advised the Committee that there were some complexities in ensuring up to date information due to a fast changing environment however, the website was under continual review, and all efforts were made to ensure accuracy of information. Ms Dunning agreed to explore any areas where improvements can be made.

The Committee

- **Noted the NHS Tayside External Audit Interim Report 2016/17**
- **Noted the Annual Audit Report would be submitted to the June 2017 Committee meeting**

8. RISK MANAGEMENT

8.1 Annual Report of the Strategic Risk Management Group 2016/17 (AUDIT27/2017)

Ms Dunning advised the Committee the Strategic Risk Management Group Annual (SRMG) Report 2016/17 was present to the Committee for information.

Ms Dunning highlighted there had been issues during the year in relation to attendance at meetings and various options had been considered to improve attendance. It was noted that Risk Managers were required to deputise should the Risk Owner be unavailable.

Ms Dunning noted the importance of the group and advised Mrs Hilary Walker, Risk Manager would review the possibility of extending the Membership of the group to Risk Managers.

It was noted the number of strategic risks were also being reviewed.

The Committee

- **Noted the content of the report**

8.2 Risk Management Annual Report (AUDIT28/2017)

Mrs Walker presented the Risk Management Annual Report in relation to Risk Management activities which had been undertaken during 2016/17 to the Committee for approval and advised that it had been endorsed by the .Strategic Risk Management Group (SRMG).

Mrs Walker highlighted the following:

- work was ongoing regarding the review of the Terms of Reference of the SRMG and alternative ways of conducting business were being explored
- an agreement had been reached at the Tayside NHS Board meeting held on 4 May 2017 to only report the Board Assurance Framework/Strategic Risk Profile to the Board twice per year
- the number of risks within the Strategic Risk Profile would reduce during 2017/18
- the NHS Tayside risk appetite statement took effect from 1 April 2017 and reporting of risks above the appetite to Tayside NHS Board first occurred on 4 May 2017
- the survey monkey issued in relation to service level risks had closed and a meeting was scheduled for end May 2017 to consider results and agree an improvement plan
- Draft regulations had been received in respect of the Duty of Candour. These would be issued within the organisation as part of a feedback/consultation exercise and a collective response on behalf of NHS Tayside provided to the Scottish Government

It was noted the Risk Management Mid Year Report had been submitted to the Committee at its meeting on 17 January 2017 and this detailed additional work undertaken and concluded during 2016/17

The Committee

- **Approved the Risk Management Annual Report**

8.3 Risk Management Work Plan 2017/18 (AUDIT29/2017)

Mrs Walker presented the Risk Management Work Plan 2017/18 to the Committee for approval.

It was noted that whilst the production of a Work Plan was not mandatory for Risk Management it was good practice in providing assurances to the Committee and outlined plans for 2017/18.

Mrs Walker advised that the Work Plan for 2017/18 was included as Appendix A to the report and progress and work undertaken during 2016/17 was included within Appendix B to the report.

The Committee noted the information contained within the report was very comprehensive.

The Committee

- **Approved the Risk Management Work Plan 2017/18**
- **Noted the progress and work undertaken during 2016/17**

8.4 Risk Management CIPFA Self Assessment and Audit Checklist (AUDIT30/2017)

Mrs Walker advised the Committee that the report was an element of good practice in providing Members with an assurance of systems and processes in place for risk management.

The Committee was advised that the framework consisted of 12 elements which the organisation was self assessed against. Levels of compliance were contained within the report. Mrs Walker advised that the self assessment score within Projects and Partnerships had been reduced from 100% to 58%. This reflected the changing environment in relation to Health and Social Care Partnerships (HSCPs). It was noted that the report had been shared with Internal Audit and Ms Margaret Dunning, Board Secretary and it was anticipated this score would return to 100% upon conclusion and implementation of governance arrangements with the Integrated Joint Boards (IJBs).

Mrs Walker assured the Committee the self assessment and audit checklist was not just a "box ticking" exercise but was carried out thoroughly and that an audit trail/evidence was available if required.

Mrs Golden wished to thank Mrs Walker for the updated status in relation to staff side representation at meetings of the Strategic Risk Management Group. It was noted that nominations for additional staff side representation at these meetings was being currently being sought.

The Committee noted their appreciation of the work carried out.

The Committee

- **Reviewed progress against the CIPFA Self Assessment and Audit Tool**
- **Noted that a further review against the standard would be undertaken during 2017/18**
- **Recommended that assurance from the HSCPs incorporated an assessment against the requirements of the CIPFA guidance or equivalent to ensure a commonality of approach and as part of the overall governance process between the Health Board and the IJBs**

9. AUDIT COMMITTEE TERMS OF REFERENCE AND WORKPLAN 2017/18 (AUDIT31/2017)

Mr Bedford advised the Committee the Audit Committee Terms of Reference and Work Plan 2017/18 was presented to the Committee for approval.

It was noted all Standing Committees were required to produce annual work plans by the 30 June of each year and the Committee Work Plan was cyclical. The Terms of Reference of the Committee were included within the NHS Tayside Code of Corporate Governance.

Mr Bedford highlighted that in addition to the two vacancies within the Membership of the Committee the position of Vice-Chair was also vacant and would be addressed following confirmation of the nominated Local Authority Representatives.

The Committee

- **Approved the Audit Committee Terms of Reference and Work Plan 2017/18**

10. PROPERTY TRANSACTIONS 2016/17 (AUDIT32/2017)

Mr Bedford advised the Committee that Appendix 2 of the report contained the relevant proformas and certificates however, the Tender Report Forms would not be publically available due to containing commercially sensitive information.

Mrs Lyall was in attendance to present the report.

Mrs Lyall advised the Committee that in line with the Property Transactions Handbook, (the Handbook), the Committee should be advised of all property transactions completed within the year.

Mrs Lyall highlighted the recommendations contained within the report.

It was noted that the Handbook required that the Committee was responsible for monitoring property transactions and that monitoring was carried out on an annual basis.

Mrs Lyall advised the Committee there were six certificated property transactions in 2016/17 noted as being:

- Sale of Dundonnachie House, Aberfeldy
- Sale of the former Sunnyside Royal Hospital, Montrose
- Sale of the former Murray Royal Hospital, Perth
- Sale of surplus land at the former Douglas Clinic, Dundee
- Sale of the former Orleans Day Hospital, Dundee
- Sale of the former Longcroft Clinic, Dundee

The Committee noted that Post Transaction Monitoring was a cyclical process. The cycle normally commenced in May each year when the Committee was provided with the details of the property transactions completed during the previous financial year. A sample of the completed property transactions were measured against the Handbook by Internal Audit. The resultant audit report would be presented to the August 2017 Committee meeting, prior to submission to the Scottish Government Health and Social Care Department (SGHSCD) along with the Property Transaction Monitoring Report by 30 October 2017.

It was noted that Internal Audit had been asked to undertake an inspection of the Sunnyside and Murray Royal transactions and following discussions between Internal Audit and Senior Management it was agreed the Dundonnachie House transaction would also be reviewed.

Mrs Lyall advised that Internal Audit had been consulted on the content of the report prior to submission to the Committee.

It was noted that the Property Asset Management Team had been strengthened in 2016/17with the appointment to a number of posts to ensure compliance with Handbook guidance and timescales were being adhered to.

The Committee noted that all property transactions had been reported to Tayside NHS Board.

The Committee

- **Noted that there were six completed property transactions during 2016/17**
- **Approved a draft return for 2016/17, and noted that the report would be submitted to the SGHSCD by the deadline of 30 October 2017**
- **Noted the copies of relevant proformas and certificates contained within Appendix 2 of the report**

10:32 Mrs Louise Lyall left the meeting.

11. PAYMENT VERIFICATION: FAMILY HEALTH SERVICES (FHS) CONTRACTORS (AUDIT33/2017)

The Committee was asked to note the Payment Verification: Family Health Services (FHS) Contractors report.

The Committee

- **Noted the Payment Verification: Family Health Services (FHS) Contractors report.**

12. TAXATION OF WORKERS PROVIDED THROUGH INTERMEDIARIES (IR35) AND SELF EMPLOYED (AUDIT34/2017)

Mr MacKinnon advised the report provided an update to the Committee around the impact for NHS Tayside of the Finance Act 2017 in respect of taxation of workers provided through intermediaries. The report also provided an update around the taxation by NHS Tayside of self employed workers. The nature of the changes to legislation regarding the taxation of workers provided through intermediaries (IR35) within the Finance Act 2017 placed responsibility on all public sector bodies, including the NHS in Scotland, to determine whether the nature of the work would fall within HRMC's definition of employment for tax purposes. It was noted changes to legislation would take effect as of 6 April 2017.

The Committee noted HMRC/HM Treasury had published policy guidance, draft legislation for the Finance Bill 2017, a Technical Guide and NHS Scotland Management Steering Group (MSG) had also issued guidance to NHS Boards.

Mr MacKinnon advised that where workers were engaged by NHS Tayside the responsibility to apply the intermediaries' or the self employment tax rules was with NHS Tayside, however, in instances where agency staff were recruited through a third party responsibility to apply these rules could be transferred to the third party.

It was noted that NHS Tayside had a duty to apply tax legislation or face liability for employment taxes and penalties.

Mr MacKinnon assured the Committee that due diligence had been applied and section 3.4 of the report set out clear actions in place. There was a significant potential for financial and workforce pressures and based on an initial assessment, the level of expenditure to which the intermediaries or the self employment tax rules could apply was c£10m of annual recurring activity.

Mr MacKinnon highlighted the recommendations within the report and sought the Committee's approval to move forward with the required changes to the NHS Tayside Code of Corporate Governance.

Mr Doherty wished to commend the work of Mr MacKinnon and his team and advised that following a National Human Resources Directors meeting there were significant emerging issues affecting a number of Health Boards, in particular, the sustainability on services within some other Health Boards.

It was noted from an NHS Tayside perspective these changes went beyond clinicians and had implications for other areas such as eHealth however, the impact was greater within other Health Boards.

Ms McLay sought assurance regarding the position of NHS Tayside and risks faced in the event of delays from other Health Boards. Mr Doherty advised all Health Boards had a duty to comply and assured the Committee NHS Tayside had taken steps to reduce risk and sought guidance from Scottish Government (SG).

Mr Hay queried the effect of the new legislation on clinicians and was advised there would be implications for clinicians who provided locum services.

Mr MacKinnon highlighted the importance of working together to apply new legislation and noted the divergence of one Health Board would have implications for NHS Tayside.

The Committee discussed the sourcing of locums through national contracts and noted that SG had taken steps to promote their use by all Health Boards.

The Committee noted that Tayside NHS Board could be deemed the employer of workers provided through intermediaries or the self employed and all cost pressures would be reported to the Finance and Resources Committee.

It was noted all efforts had been made to ensure NHS Tayside was compliant.

Ms McLay noted there may be potential operational risks in relation to areas such as Nursing and Midwifery and Mental Health and this would be monitored.

The Committee

- **Noted the key legislative changes from 6 April 2017**
- **Noted the actions being progressed by management**
- **Agreed in principle to amendments to the Code of Corporate Governance in respect of "off payroll engagements" and taxation of workers which would be brought back to the Committee for approval upon the recommendation to the Board Secretary and Director of Finance through the Governance Review Group**

13. COMPLIANCE WITH SCOTTISH GOVERNMENT WORKFORCE DIRECTORATE CIRCULARS AND NHS TAYSIDE EMPLOYMENT POLICIES (AUDIT35/2017)

Mr Doherty presented this report to the Committee and advised this report was deferred from the previous Committee meeting held on 9 March 2017 as noted within the Action Points Update.

The Committee noted the report provided details as to how NHS Tayside was assured 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.

Mr Doherty advised that the Staff Governance Committee had agreed the following three initial areas for audit:

- Non Grade Protection
- Fixed Term Contracts
- Pay As If At Work (PAAW) – Return to work

It was noted the Staff Governance Committee would receive the outcomes of these audits during this financial year and that the assessment was welcomed from a Staff Side perspective.

The Committee

- **Noted the progress detailed within the report**

14. BEST VALUE FRAMEWORK ASSURANCE 2016/17 – TAYSIDE NHS BOARD (AUDIT41/2017)

Ms Dunning advised the Committee that the purpose of the report was to provide an assurance on the business considered by Tayside NHS Board during 2016/17 against the current Best Value Framework.

The Committee was asked to recommend the approval of the Assessment of Tayside NHS Board's Best Value Characteristics (Framework Assurance) 2016/17, included as Appendix 1 of the report.

The Committee noted that as part of its overall annual governance process, Tayside NHS Board developed a Framework for allocating Best Value characteristics and agreed which were delegated to Tayside NHS Board and its Standing Committees. Ms Dunning advised that Standing Committees were expected to review these characteristics and provide assurance on Best Value through their Annual Reports.

Mrs Dunion raised concerns regarding the value of the report, noting it was difficult to recognise some of the responses to the outcomes/evidence. In particular, Mrs Dunion noted her concerns that Tayside NHS Board had not been sighted on the Communication and Engagement Strategy and in reference to page 19 of the report did not agree that there was involvement in developing indicators. Mrs Dunion noted her unease in relation to some elements of the report and felt further work was required. Mr Hay shared these concerns and noted the need for the report to be reviewed prior to being submitted to Tayside NHS Board.

Ms Dunning advised in relation to the Communication and Engagement Strategy, Mrs Jane Duncan, Head of Corporate Communications was involved in the consultation process with staff and stakeholders. She advised that in option appraisals stakeholders were involved in the development of indicators. She also advised that the requirements and overall characteristics were what was expected to be seen in an effective organisation and this was an assessment of our achievement against these and given our commitments it was understandable not all were achieved in the year.

Mrs Golden noted her agreement with concerns raised and highlighted within the bullet points of section 4 of the report Improvement and Quality Committee should read Clinical and Care Governance Committee.

Mr Gaskin advised the Committee that part of the role of the Committee was to check accuracy, note future work planned and be assured that the report reflected what was happening. Mr Gaskin agreed that more focus on actions may be beneficial to Tayside NHS Board.

It was agreed Ms Dunning would meet with Mrs Dunion and Mr Hay to discuss and review the report and re-submit to the Committee at its meeting in June 2017. **MD**

It was noted the Best Value Framework Assurance was not scrutinised by External Audit or Scottish Government however, was a useful tool for self reflection.

The Committee

- **Noted the content of the report**
- **Noted a review of the report would be undertaken and re-submitted to the June 2017 Committee meeting**

15. PAPERS/MINUTES FOR INFORMATION

15.1 Strategic Risk Management Group Minute – 2 February 2017

The Strategic Risk Management Group Minute of 2 February 2017 was presented to the Committee for information.

The Committee

- **Noted the Strategic Risk Management Group Minute of 2 February 2017**

15.2 Audit Scotland Reports

The Agenda provided links to the following Audit Scotland Reports:

- Technical Bulletin 2017/1

The Committee

- **Noted the Audit Scotland Reports**

15.3 Attendance Record

The Committee

- **Noted the Attendance Record**

Update – Action Points Update

External Review of all Mental Health Sites - Mr Bedford advised, in response to the query raised by Mr Gaskin during discussions, that he had received confirmation that all wardrobe (including cupboard) doors had been removed from all areas.

16. DATE OF NEXT MEETING

The next meeting of the Audit Committee will take place on Thursday 22 June 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 11 May 2017, and approved by the Committee at its meeting held on 22 June 2017.

....

CHAIR **DATE**

NHS Tayside Audit Committee – 22 June 2017 Open Business
Action Points Update

New Actions arising from meeting on 11 May 2017

MEETING	MINUTE REF.	HEADING	ACTION POINT	RESPONSIBILITY	STATUS
11 May 2017	6.3	Internal Audit T12/17 – Integration Joint Board (IJB) Governance Update	An update regarding the Internal Audit T12/17 – Integration Joint Board (IJB) Governance Update would be provided at the June 2017 meeting	M Dunning	Since the Audit Committee on 11 May 2017, there was a further meeting of the working group on 15 May 2017 where there was still a perceived difference of the models in place. The Scottish Government Health and Social Care Directorate has been asked for a view on the integration schemes in Tayside. A further meeting involving the Chairman and Chief Executive has been arranged for 25 July 2017. The Audit Committee will receive an update at its next meeting.
11 May 2017	14	Best Value Framework Assurance 2016/17 – Tayside NHS Board	Ms Dunning to meet with Mrs Dunion and Mr Hay to discuss and review the Best Value Framework Assurance 2016/17 – Tayside NHS Board and re-submit to the Committee at its meeting in June 2017	M Dunning	Agenda Item June 2017 meeting

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

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	Completed

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	Completed
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	Completed

Item Number 4.3

NHS Tayside

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**	**5.1**		**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**	**8.1**						
Risk Management Mid Year Report	**H Walker**	**6 monthly**			**X**				
Risk Management Annual Report	**H Walker**	**Annual**	**8.2**						
Risk Management Workplan	**H Walker**	**Annual**	**8.3**						
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**	**8.4**						
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**	**6.1**		**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**	**7.1**						
Audit Scotland Annual Report on NHS Scotland	L Bedford	**Annual**			**X**				
Audit Scotland Reports (incl Technical Bulletins)	L Bedford	**As & when available**	**15.2**	**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**	**18.1**		**X**	**X**	**X**	**X**	
National Fraud Initiatives (& Bribery Act) Progress Report	R MacKinnon	**Standing item**	**18.1**		**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**	**11**		**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**	**9**					**X**	
Audit Committee Handbook & Checklist	L Bedford	**Annual**					**X**		
Other Reports									
Property Transactions Monitoring	L Lyall	**Annual**	**10**			**X**		**X**	
Litigation Monitoring	R MacKinnon	**Quarterly**		**X**		**X**			**X**
Minutes for Information									
Strategic Risk Management Group	M Dunning	**As & when available**	**15.1**		**X**	**X**	**X**	**X**	**X**
Governance Review Group	M Dunning	**As & when available**			**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 6

AUDIT43/2017
Audit Committee
22 June 2017

PATIENTS' PRIVATE FUNDS – EXTERNAL AUDIT REPORT

1. PURPOSE OF THE REPORT

A copy of the draft Abstract of Receipts and Payments in respect of Patients' Private Funds, and associated documentation for the year ended 31 March, 2017, is attached for consideration by the Audit Committee, prior to submission to Tayside NHS Board. The documentation includes the appointed external auditor, Henderson Loggie's draft audit certificate, and the Audit Findings Report, summarising the results of the audit work undertaken.

2. RECOMMENDATIONS

The Committee is asked to:-

i. review the draft Abstract of Receipts and Payments (page 4);
ii. note the draft audit certificate from Henderson Loggie (page 5);
iii. consider the Audit Findings Report from Henderson Loggie, and
iv. recommend to the meeting of Tayside NHS Board that it formally adopts the Abstract of Receipts and Payments in respect of Patients' Private Funds for the year ended 31 March, 2017, and authorises the Director of Finance and the Chief Executive to sign the Abstract on behalf of Tayside NHS Board, along with the draft letter of representation.

3. EXECUTIVE SUMMARY

Under the terms of relevant Mental Health legislation and Scottish Government Health and Social Care Directorate requirements, Tayside NHS Board has responsibility to provide safe custody for money and personal property handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival. Such funds are managed within a separate bank account from that used for the Board's main Exchequer activities.

The Abstract of Receipts and Payments in respect of Patients' Private Funds for the year ended 31 March, 2017, is attached (page 4), categorised by the headings contained within Scottish Financial Return (SFR) 19.0, as required by the NHS Unified Board Accounts Manual. Also attached is the Audit Findings Report from the appointed external auditors, giving a summary of the results of the audit work undertaken. Management responses have been provided for each current year audit recommendation.

The theme running through many of the audit recommendations arising this year and in previous years relates to reminding staff of the importance of adhering to the procedure.

The Patients' Funds Procedures has been subject to review following its implementation on 1 June, 2014, led by the Finance Governance Accountant with regular meetings with Senior Cashiers. The procedures, supported by an eLearning module, have simplified and clarified processes, whilst maintaining and enhancing key controls.

4. REPORT DETAIL

The report considers Patients' Private Funds – External Audit Report, and the draft Abstract of Receipts and Payments in respect of Patients' Private Funds.

5. CONTRIBUTION TO NHS TAYSIDE'S STRATEGIC AIMS

Not applicable.

6. HEALTH EQUITY

Not applicable.

7. MEASURES FOR IMPROVEMENT

The Audit Findings Report from the appointed external auditor, contains an action plan with five action points (2015/16 - 6 minor action points). Management responses have been provided detailing the action to be taken to mitigate against the weaknesses contained in the action plan, and hence improve the internal controls operating in these areas.

8. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

The external auditor and the Director of Finance has been consulted in the preparation of this report.

9. PATIENT EXPERIENCE

The implementation of the updated procedures and eLearning training modules is expected to release nurse time for direct patient care.

10. RESOURCE IMPLICATIONS

Financial
No resource implications result from the recommendations set out in this paper.

Workforce
Not applicable.

11. RISK ASSESSMENT

An assessment on progress around the actions contained in the action plan will be undertaken in September 2017.

12. LEGAL IMPLICATION

Not applicable.

13. INFORMATION TECHNOLOGY IMPLICATIONS

Not applicable.

14. HEALTH & SAFETY IMPLICATIONS

Not applicable.

15. HEALTHCARE ASSOCIATED INFECTION (HAI)

Not applicable.

16. DELEGATION LEVEL

Not applicable.

17. TIMETABLE FOR IMPLEMENTATION

Subject to the approval of the Audit Committee, Tayside NHS Board will be asked to formally approve the Abstract of Receipts and Payments in respect of Patients' Private Funds for the year ended 31 March, 2017, at its planned meeting on 28 June, 2017.

The Lead Officers are:-

Chief Operating Officer:	Cashier staff and Harlequin system
General Managers:	Overall compliance with Patient Funds procedure by ward level staff
Director of Finance:	Review of Patients' Funds procedure, development of eLearning training modules and bank reconciliation preparation

18. REPORT SIGN OFF

Robert MacKinnon
Associate Director of Finance –
Financial Services & Governance
Lead Officer

Lindsay Bedford
Director of Finance

June 2017

Appendix 1

PATIENTS' PRIVATE FUNDS

NHS TAYSIDE

TO 31 MARCH 2017

TAYSIDE HEALTH BOARD

PATIENTS' PRIVATE FUNDS

ABSTRACT OF RECEIPTS AND PAYMENTS
FOR THE YEAR ENDED 31 MARCH 2017

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Statement of Tayside Health Board Members' Responsibilities	**3**
Draft Abstract of Receipts and Payments (SFR 19.0)	**4**
Draft Independent Auditors' Report to the Scottish Ministers	**5**
Draft Letter of Representation to Henderson Loggie	**6**
Draft Cover letter to Henderson Loggie	**7**
Audit Findings Report 2016/17 from Henderson Loggie	**Report attached**

TAYSIDE HEALTH BOARD

Statement of Tayside Health Board Members' Responsibilities

Patients' Private Funds are managed by Tayside Health Board in fulfilment of the requirements of the Mental Health (Scotland) Act 1984 and the Adults with Incapacity (Scotland) Act 2000. The Scottish Government Health and Social Care Directorates require Tayside Health Board to prepare a consolidated Abstract of Receipts and Payments of Patients' Private Funds.

Tayside Health Board Members are responsible for ensuring proper accounting records are maintained which disclose with reasonable accuracy at any time the financial position of the Patients' Private Funds and enable them to ensure that the accounts comply with the requirements of the Adults with Incapacity Act (Scotland) 2000, and the directions of the Scottish Government Health and Social Care Directorates. They are also responsible for safeguarding the assets held on behalf of the patients, and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As Members of Tayside Health Board, we confirm that the above responsibilities have been discharged during the financial year and in preparing the Abstract of Receipts and Payments.

Lesley McLay
Chief Executive _____

22 June, 2017

Lindsay Bedford
Director of Finance _____

22 June, 2017

DRAFT

		NHS TAYSIDE **PATIENTS PRIVATE FUNDS** **FOR THE YEAR ENDED 31 MARCH 2017**		**SFR 19.0**
2016 **£**			**£**	**TOTAL** **£**
	100	**RECEIPTS**		
	110	Opening Balances:		
571,471	120	Cash in Bank	509,515	
6,025	130	Cash on Hand	6,025	
0	140	Other Funds	0	
577,496	180		----------	515,540
	190			
526,889	200	From or on behalf of Patients		542,444
867	210	Interest on Patient's Fund Account		919
	270			
1,105,252	280	**TOTAL RECEIPTS**		1,058,903
==========	290			==========
	400	**PAYMENTS**		
589,713	410	To or on behalf of Patients		551,121
	420	Extra Comforts		
	500	Closing Balances:		
509,515	510	Cash in Bank	500,931	
6,025	520	Cash on Hand	6,850	
0	530	Other Funds	0	
515,540	550			507,781
	560			
	570			
1,105,253	580	**TOTAL PAYMENTS**		1,058,903
==========	590			==========
	700	Closing Balances accounted for as:		
	710	Patients' Personal Accounts		
514,736	720	Credit Balances	503,395	
0	730	Less: Debit Balances	0	
	740			503,395
804	750	Interest Received but not Credited	4,386	
	760			
	770			
515,540	780	**TOTAL CLOSING BALANCES AS LINE 550**		507,781
==========	790			==========

Draft Independent Auditors' Report to the Scottish Ministers

We have audited the Abstract of Receipts and Payments of Patients' Private Funds administered by Tayside Health Board on page 4.

Our audit work has been undertaken so that we might state to the Scottish Ministers those matters we are required to state to them in an auditors' report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board members as a body, for our audit work, or for this report, or for the opinions we have formed.

Respective responsibilities of Board members and Auditors

As described on page 3, the Board members are responsible for the preparation of the Abstract of Receipts and Payments. Our responsibility is to audit the Abstract in accordance with relevant legal and regulatory requirements and International Standards on Auditing (UK and Ireland).

Basis of opinion

We conducted our audit in accordance with International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the Abstract of Receipts and Payments.

We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the abstract of receipts and payments is free from material misstatement, whether caused by fraud or other irregularity or error. In forming our opinion we also evaluated the overall adequacy of the presentation in the Abstract.

Opinion

We have audited the Abstract of Receipts and Payments of Patients' Private Funds in accordance with approved Auditing Standards. In our opinion the Abstract presents fairly on a receipts and payments basis the state of the funds administered by Tayside Health Board on behalf of its patients, as at 31 March 2017.

Henderson Loggie
Chartered Accountants
Registered Auditors
Dundee
22 June 2017

HENDERSON LOGGIE
Chartered Accountants

NHS Tayside

Patients' Private Funds 2016/17

Audit Findings Report No: 2017/02

Draft issued: 13 June 2017

Final issued: 13 June 2017

Contents

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- Responsibilities of the Board 1
- Responsibilities of the Auditors 1
- Accounting Systems 1
- Restriction on Use 1 - 2
- Scope of Audit 2
- Overall Results 2

Section 2 Action Plan 3

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1. Management Summary

Introduction

This is the fourth year of our current appointment as external auditors of Tayside Health Board Patients' Private Funds accounts.

The responsibilities of both Henderson Loggie and Tayside Health Board are set out in our letter of engagement. The framework is set out within Auditing Standards issued by the Auditing Practice Board.

The purpose of this report is to summarise the results of our audit work during 2016/17. The report aims to describe the ways in which the various requirements of our letter of engagement have been met by both Tayside Health Board and ourselves.

Our testing and results were based on the Patients' Funds and Property Procedures in place during the year ended 31 March 2017. This is the third full year of the new procedures implemented June 2014.

Responsibilities of the Board

Tayside Health Board is responsible for maintaining proper accounting records for the Patients' Private Funds and for preparing the Abstract of Receipts and Payments, safeguarding assets and taking reasonable steps for the prevention and detection of fraud and other irregularities.

Responsibilities of Auditors

Our responsibilities are to give Tayside Health Board assurance that it is discharging in full, its obligations to safeguard and administer patients' monies properly and to certify that the Patients' Private Funds Account presents fairly the funds administered by Tayside Health Board.

Accounting Systems

The objective of our audit was to determine whether adequate accounting systems and internal controls were in place and operating satisfactorily over patients' funds. While we found a number of errors or system weaknesses during our review, in general, audit testing revealed internal controls to be adequate, and generally operating effectively in most cases. Improvements could be made to the internal controls operating in certain areas as detailed in the action plan in section 2 of this report.

Restriction on Use

This report has been prepared in accordance with our responsibilities under International Standards of Auditing for the audit of Tayside Health Board Patients' Private Funds. Our audit does not necessarily disclose every weakness and for this reason the matters referred to in this report may not be the only shortcomings which exist.

We take this opportunity to remind you that:

- This report has been prepared for the sole use of Tayside Health Board and the Audit Committee

Restriction on Use (Continued)

- No responsibility is assumed by us to any other person who may choose to rely on it for his or her own purposes

Scope of Audit

The specific objective of our audit was to determine whether adequate financial systems and associated internal controls were in place and operating satisfactorily over patients' private funds.

In carrying out this role our audit involved reviewing whether:

- Adequate physical security exists over patients' property and valuables
- Property and valuables are properly secured, recorded and accounted for
- All income is properly identified and completely accounted for
- All expenditure from patients' accounts is properly authorised and accounted for
- Management is provided with sufficient information regarding the administration of patients' funds
- The Supervisory Body is carrying out its functions in accordance with the Adults with Incapacity (Scotland) Act 2000 and the directions of the Scottish Government Health & Social Care Directorate.

During the course of the audit, visits were made to the cashiers' offices at Ninewells Hospital, Royal Victoria Hospital, Stracathro Hospital and Perth Royal Infirmary. We also carried out ward level testing at Royal Victoria Hospital, and Stracathro Hospital.

Overall Results

While we found a number of errors or system weaknesses during our review, in general, audit testing revealed internal controls in most cases to be adequate and operating effectively.

Improvements could be made to the internal controls operating in certain areas as detailed in the action plan in section 2 of this report.

Each finding has been allocated a priority rating from A to C. This should assist the Audit Committee and senior management in assessing the significance of the issues raised and prioritising the action required to address them. The rating structure is summarised as follows:

Priority A	high risk, material observations requiring immediate action
Priority B	medium risk, significant observations requiring reasonably urgent action
Priority C	low risk, minor observations which require action to improve the efficiency, effectiveness or economy of operations or which otherwise require to be brought to the attention of the Audit Committee

2. Action plan

Para Ref.	Recommendation	Grade	Management Comments	Agreed	Responsible Officer	Agreed Completion Date
3.1	**R1** Remind nurse managers to ensure that ward control checks are being carried out at least once daily and that the control sheet is being completed.	C	Reminders will be circulated to all nurse managers.	Agreed	D Colley	Sept 2017
3.2	**R2** Ensure individual patient balances at ward level do not exceed £50 for prolonged periods and are being transferred to the cashier.	C	Reminders will be circulated to all nurse managers and ward officers, after consultation with cashiers.	Agreed	D Colley	Sept 2017
3.3	**R3** Cashiers should not be involved with the bank reconciliations. Where possible it should be finance staff outwith the Cashiers that prepare and review the monthly bank reconciliations.	C	Agreed. This will be undertaken within Finance.	Agreed	D Colley	June 2017
3.4	**R4** Remind Nurse Managers of their responsibilities in the completion of spot checks.	C	Reminders will be circulated to all nurse managers.	Agreed	D Colley	Sept 2017
3.5	**R5** Undertake a programme of ward visits to review spot checks and undertake a programme of training and review to ensure adherence to good practice.	C	The current programme of spot checks and ward visits and training will continue. A rolling programme to visit as many locations as possible, after consultation with cashiers, will be completed.	Agreed	D Colley	Sept 2017

3. Main Report

Issues and Recommendations

3.1 Ward Control Checks

Observation
The ward control sheets were not being completed daily by staff in Stracathro's Willow ward.

Risk
Patients balances may not agree to the cash held in the safe and will be more difficult to rectify any issues.

Recommendation
R1 Remind nurse managers to ensure that ward control checks are being carried out at least once daily and that the control sheet is being completed.

3.2 Individual Patient Balances

Observation
Ward 6 at Royal Victoria and wards Rowan and Willow at Stracathro all had patients who had at some point had an individual balance of over £50 for prolonged periods. Understandably there is limited access to the cashier at Stracathro due to only being available 3 days a week, so efforts should be made to transfer funds at the earliest opportunity.

Risk
There is a greater risk of cash going missing when it is held on the ward.

Recommendation
R2 Ensure individual patient balances at ward level do not exceed £50 for prolonged periods and are being transferred to the cashier.

3.3 Cashier Involved in Bank Reconciliation

Observation
The bank reconciliations from January 2017 to March 2017 have been prepared by the Cashier at Ninewells Hospital. This has occurred due to the long term absence of the Finance Governance Accountant. However, the reconciliations were reviewed during this period by the Director of Finance.

Risk
As the Ninewells Cashier is involved in both the Cashier functions and preparing the bank reconciliations there is no independent preparation of the reconciliations taking place.

Recommendations
R3 A member of the finance team out with the Cashiers department should be preparing the bank reconciliations.

Issues and Recommendations

3.4 Spot Checks of Ward

Observation
There was no evidence of the appropriate nurse manager spot checks having been completed for Ward 3 at Royal Victoria.

A minimum of 4 spot checks per ward should have been carried out in the 12 month period.

The failure to carry out spot checks was also an issue in Report 2015/01, Issued May 2015 and Report 2016/01, Issued June 2016. The same recommendations have been carried forward.

Risk
The spot checks required by the procedures are not being carried out leading to a greater risk of inaccuracies in the record of cash held for patients.

Recommendations
R4 Remind Nurse Managers of their responsibilities in the completion of spot checks.

R5 Undertake a programme of ward visits to review spot checks and undertake a programme of training and review to ensure adherence to good practice.

Management Comments 2015/16

R4 Further reminders will be circulated to all ward staff. We will also ensure this topic is included in the ongoing programme of ward inspections and training sessions.

R5 The current programme of spot checks, inspections and ward training will continue. A rolling programme to visit as many locations as possible, after consultation with cashier staff will be completed.

Appendix 3

Tayside NHS Board

Lead Officer's Office
Maryfield House
30 Mains Loan
Dundee
DD4 7AA

Telephone 01382 424449
Fax 01382 424451
www.nhstayside.scot.nhs.uk

Henderson Loggie
Chartered Accountants
The Vision Building
20 Greenmarket
DD1 4QB

Date	29 June, 2017
Your Ref	
Our Ref	RMcK/AI/HL letrep
Enquiries to	Mr Robert G MacKinnon
Extension	70449
Direct Line	01382 424449
Email	robert.mackinnon@nhs.net

Dear Sirs

NHS TAYSIDE PATIENTS' PRIVATE FUNDS – LETTER OF REPRESENTATION

We confirm to the best of our knowledge and belief, and having made appropriate enquiries of other Board members and officials, the following representations given to you in connection with your audit of the abstract of the receipts and payments of the Patients' Private Funds for the year ended 31 March, 2017.

1. We acknowledge as Board Members our responsibilities for preparation of the Abstract of Receipts and Payments that presents fairly the state of the Patients' Private Funds as at 31 March, 2017, and for making accurate representations to you. All the accounting records have been made available to you for the purpose of your audit and all the transactions undertaken by the Patients' Private Funds have been properly reflected and recorded in the accounting records. All other records and related information, including internal audit reports, have been made available to you.

2. We have discussed the Board's compliance with Law and Regulations. Having made enquiries, we are not aware of any actual or potential non-compliance with laws and regulations that could have a material effect on the ability of the Board to conduct its business and therefore on the results to be disclosed in the Abstract for the year ended 31 March, 2017.

3. There have been no events since the balance sheet date which necessitate revision of the figures included in the Abstract. Should further material events occur, which may necessitate revision of the figures included in the Abstract, we will advise you accordingly.

Yours faithfully

Signed on behalf of the Members of Tayside NHS Board.

Lesley McLay

Chief Executive

Appendix 4

Tayside NHS Board

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Dundee
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Henderson Loggie
Chartered Accountants
The Vision Building
20 Greenmarket
DD1 4QB

Date	28 June, 2017
Your Ref	
Our Ref	RMcK/AI/HL letconfirm
Enquiries to	Mr Robert G MacKinnon
Extension	70449
Direct Line	01382 424449
Email	robert.mackinnon@nhs.net

Dear Sirs

NHS TAYSIDE PATIENTS' PRIVATE FUNDS

In relation to the accounts for the year ended 31 March, 2017 we confirm that:-

1. Board Members have read, understood and approved the enclosed, signed, representation letter.

2. Board Members have considered the points raised in the audit findings report.

3. Board Members have considered the ethical issues arising in connection with the audit and are satisfied the safeguards in place are acceptable.

Yours faithfully

Signed on behalf of Members of Tayside NHS Board

Lesley McLay
Chief Executive

disability confident EMPLOYER

PRINTED ON RECYCLED PAPER

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

iItem Number 7.2

AUDIT44/2017
Audit Committee
22 June 2017

ANNUAL REPORTS AND ASSURANCE STATEMENTS BY COMMITTEES INCLUDING BEST VALUE ASSURANCES FOR THE YEAR ENDED 31 MARCH 2017

1. PURPOSE OF THE REPORT

During 2009/10 it was agreed that Standing Committee Annual Reports were not required to be presented to Tayside NHS Board prior to the Annual Accounts Audit Committee meeting. Instead, all Standing Committees were required to approve their Annual Reports prior to 30 May each year. This paper summarises the position to date across the eight Committees (including Board of Trustees) highlighted in the Code of Corporate Governance section "How business is Organised" and the Governance Review Group.

2. RECOMMENDATIONS

The Committee is asked to:-

i. consider the overall conclusion included within each Standing Committee's Annual Report, Board of Trustees and that of the Governance Review Group, and the assurances given therein, in reaching a conclusion on the adequacy and effectiveness of Internal Control in the context of its review of the system of internal control, and

ii. consider and approve the assessment of the Board's Best Value Characteristics.

3. EXECUTIVE SUMMARY

All Standing Committees and the Board of Trustees (Table 1) with the exception of the Audit Committee (Table 2) have approved their Annual Reports.

The Staff Governance Committee formally meets on the afternoon of 22 June, 2017, following the Audit Committee meeting, at which it will consider the approved Annual Report of the Remuneration Committee, the Area Partnership Forum and the Staff Governance Committee itself.

In the interim period from the release of papers on 15 June 2017, approval has been sought and confirmed electronically from the Staff Governance, Universities Strategic Liaison Committees and the Governance Review Group Members of their support to the Annual Report, in order to not inhibit the Audit process.

As agreed in 2007/08, only the "Conclusion" paragraph within each Standing Committee's Annual Report has been extracted and included within Appendix 1 of this paper. A full copy of the Annual Report of all Standing Committees is available to members on request.

The Best Value Framework Assurance 2016/17 report that was presented to and approved by Tayside NHS Board on 27 October, 2016, is attached at Appendix 2. The report details the assessment of the Best Value Characteristics reserved for the Board. The evidence/outcomes were considered by the Audit Committee at the meeting held on 11 May, 2017, with, following a discussion outwith the meeting, an update being received separately at the Audit Committee at its meeting on 22 June, 2017.

The main function of the Audit Committee is to provide assurance to Tayside NHS Board that an appropriate system of internal control is in place. The framework for this assurance is provided within the Governance Statement Guidance which requires the Audit Committee to consider the work of other Standing Committees, particularly Staff and Clinical Governance Committees (i.e. Staff Governance Committee, and Clinical and Care Governance Committee). The Annual Report of the Audit Committee is separately considered under item 7.7 on today's agenda.

In order to comply with the Governance Statement, the Audit Committee will, therefore, be asked to re-affirm the Audit Committee's Annual Report conclusion, at agenda item 7.7 after consideration of the overall conclusions of the Annual Reports of the other Standing Committees, noted in Appendix 1, and after consideration of the other assurances set out in agenda items 7.3 to 7.7.

Table 1

	Standing Committee	**Chair**	**Lead Officer**	**Annual Report considered by Committee on**
1.	East of Scotland Research Ethics Service REC 1	Dr C Macmillan	Ms L Reilly	16 June 2017
2.	Finance and Resources Committee	Mr D Cross	Mr L Bedford	18 May, 2017
3.	Clinical and Care Governance	Mrs A Rogers	Mrs G Costello/ Dr A Russell	11 May 2017
4.	Remuneration Committee	Professor J Connell	Mr G Doherty	14 March 2017
5.	Staff Governance Committee	Mr M Hussain	Mr G Doherty	Approved electronically
6.	Universities Liaison Committee	Dr Cowie	Ms L McLay	Approved electronically
7.	Tayside NHS Board Endowment Fund	Professor J Connell	Mr R MacKinnon	18 May 2017
9.	Governance Review Group	Ms M Dunning		Approved electronically

Table 2

	Standing Committee	**Chair**	**Lead Officer**	**Annual Report considered by Committee on**
8.	Audit Committee (agenda item 7.7)	Mr S Hay	Mr R MacKinnon	22 June 2017

4. REPORT DETAIL

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.

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

The Framework delegates the various aspects of the Best Value characteristics to the Board's Committees.

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 direct implications to health equity arising from this report.

7. MEASURES FOR IMPROVEMENT

A measure for improvement is the consideration of Best Value within each Standing Committee's conclusion, which has been highlighted, where appropriate, in Appendix 1.

8. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

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

9. PATIENT EXPERIENCE

There is no direct patient experience arising from this report.

10. RESOURCE IMPLICATIONS

Financial
There are no direct financial implications arising as a consequence of this report.

Workforce
There are no direct financial implications arising as a consequence of this report.

11. RISK ASSESSMENT

No risks have been identified, which may arise as a direct consequence of this report.

Failure for a Standing Committee of the Board to produce an Annual Report would be a breach of the requirements of the Code of Corporate Governance.

12. LEGAL IMPLICATION

There are no direct legal implications arising from this report.

13. INFORMATION TECHNOLOGY IMPLICATIONS

There are no direct information technology implications arising from this report.

14. HEALTH & SAFETY IMPLICATIONS

There are no implications for health and safety arising as a direct consequence of this report.

15. HEALTHCARE ASSOCIATED INFECTION (HAI)

There is no direct Healthcare Associated Infection (HAI) as a result of this report

16. DELEGATION LEVEL

The Committee's delegated authority is set out in the NHS Tayside Code of Corporate Governance.

17. TIMETABLE FOR IMPLEMENTATION

The report has immediate effect and the Lead Officer is the Director of Finance.

18. REPORT SIGN OFF

Lindsay Bedford
Director of Finance

June 2017

19. SUPPORTING DOCUMENTS

Appendix 1 – Annual Reports and Assurance Statements by Committees including Best Value Assurances for the year ended 31 March 2017
Appendix 2 – Best Value Framework Tayside NHS Board 2016/17

ANNUAL REPORTS AND ASSURANCE STATEMENTS BY COMMITTEES INCLUDING BEST VALUE ASSURANCES FOR THE YEAR ENDED 31 MARCH 2017

1. EAST OF SCOTLAND RESEARCH ETHICS SERVICE (EoSRES) REC 1

As Chair of the East of Scotland Research Ethics Service REC 1 during financial year 2016/17, 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 Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance.

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 Committee, and last, but certainly not least, express my sincere thanks to the East of Scotland Research Ethics Service Administration team for their excellent support of the Committee.

Dr Robert Rea
CHAIRPERSON (2016/2017)
On behalf of the East of Scotland Research Ethics Service REC 1

2. FINANCE AND RESOURCES COMMITTEE

Having considered the breadth and depth of the work undertaken by the Finance and Resources Committee in respect of the financial year ended 31 March. 2017, I wish to advise the Board that in its opinion, the Board had in place, throughout the year, adequate arrangements for securing those Best Value characteristics associated with the work of the Committee, including economy, efficiency and effectiveness in the use of resources, and use of review and options appraisal. The Committee recognises the further enhancements required to improve the Financial Governance, that will be instigated in 2017/18, and are outlined in Section 3 above.

As Chair of the Finance and Resources Committee in 2016/17, 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 Committee has allowed us to fulfil our remit. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements for the Finance and Resources Committee 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 Committee, and to the excellent secretarial and administrative support of the Committee.

MR DOUG CROSS OBE
CHAIRPERSON 2016/17
On behalf of NHS Tayside Finance and Resources Committee

3. CLINICAL AND CARE GOVERNANCE COMMITTEE

As Chair of the Clinical and Care Governance Committee during financial year 2016/17, 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 Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year I can confirm that adequate and effective Clinical Governance 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 Committee, and to express my thanks to Alison Hodge for her support of the Committee.

Mrs Alison Rogers
CHAIRPERSON 2016-17
On behalf of Clinical and Care Governance Committee

4. REMUNERATION COMMITTEE

As Chair of the Remuneration Committee during financial year 2016/17, 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 Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year I can confirm that adequate and effective Remuneration Committee 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 Committee, and last, but certainly not least, express my sincere thanks to Donna Howey for their support of the Committee.

Professor John Connell
CHAIRPERSON 2016/17
On behalf of the Remuneration Committee

5. STAFF GOVERNANCE COMMITTEE

As Chair of the Staff Governance Committee during financial year 2016/17, 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 Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year I can confirm that adequate and effective Workforce Governance 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 Committee, and last, but certainly not least, express my sincere thanks to Mrs Nicki Owen for their support of the Committee.

Munwar Hussain
Chairperson 2016/2017
On behalf of Staff Governance Committee

6. UNIVERSITIES STRATEGIC LIAISON COMMITTEE

The Committee has not met its remit during 2016/17 as it was only able to meet once in this financial year.

Work has been ongoing in year to refresh and reframe the remit and Terms of Reference of the Universities Strategic Liaison Committee to have a wider educational, research and innovation approach.

The membership of the Committee is to be strengthened with representatives from the Academic Health Science Partnership and Dundee and Angus College.

The updated remit will be considered by the Board at its meeting on 29 June 2017. The new arrangements will take effect from the next meeting of the Universities Strategic Liaison Committee on 31 October 2017.

I would like to pay tribute to 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 Committee, and last, but certainly not least, express my sincere thanks to Mrs Nicki Owen for their support of the Committee.

DR ANDREW COWIE CHAIRPERSON *(2016/2017)*
On behalf of Universities Strategic Liaison Committee

7. BOARD OF TRUSTEES

As Chair of Board of Trustees, 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 Board of Trustees has allowed us to fulfil our remit. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements for Board of Trustees were in place throughout the year.

I would again pay tribute to the dedication and commitment of fellow Trustees of Board of Trustees and to all attendees. I would thank Mr Robert MacKinnon, Lead Officer, and his staff who have prepared reports and attended meetings of Board of Trustees, and last, but certainly not least, express my sincere thanks to Mrs Alison Inglis, Committee Support Officer/PA, for her excellent support of Board of Trustees.

Professor John Connell
CHAIRPERSON 2016/17
On behalf of Board of Trustees

8. AUDIT COMMITTEE

As Chair of the Audit Committee during financial year 2016/17, 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 Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year, I can confirm that adequate and effective governance 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 Committee, and last, but certainly not least, express my sincere thanks to Lisa Green for her support of the Committee.

MR STEPHEN HAY
CHAIRPERSON 2016/17
On behalf of NHS Tayside Audit Committee

9. GOVERNANCE REVIEW GROUP

As Chair of the Governance Review Group during 2016/2017 I am satisfied that the breadth of the business undertaken and the range of attendees at meetings have allowed us to fulfil our remit.

Margaret E Dunning
Chairperson
Governance Review Group

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 Implementation of recommendations from the Assurance and Advisory Group

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned)
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	NHS Tayside is undertaking a review of capacity and capability to ensure that it has the staff resource to implement the various elements of the 5 year plan. This is supported by the Scottish Government's Assurance and Advisory Group. Management sub structure review ongoing NHS Tayside Integrated Clinical Services Strategy to be developed during 2017/18 Further work to be undertaken in respect of regionalisation during 2017/18
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	

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned)
The strategic plan and operational plans are based on relevant, reliable and sufficient evidence.	Business Unit to feed into development of the 5 year Strategic transformational plan. LDP based on data	**BOARD** **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	Partially 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 Further work to be done in scoping out risk in relation to IJB and the governance assurance processes between the Board and the IJBs

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned)
The Board has clearly recorded delegation to Committees and management.	The Board has established terms of reference for its Committees and has a Scheme of Delegation.	**BOARD**	Every two years	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 in relation to health and social care integration
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	

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned)
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. Work commenced drafting new Strategy	The Board will have a development event in September/October 2017 to revisit its Vision and Rich Picture. This will allow NHS Tayside to work with its stakeholders on the development of a Corporate Communications and Engagement strategy and allow Board Members to feed into the Vision to be communicated

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 in relation to health and social care integration. However, other partnerships in place with Academic Health Science Partnership (AHSP), regional planning	Work to be progressed with the health and social care partnerships 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 Other partnerships in place with Academic Health Science Partnership (AHSP), regional planning	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 Other partnerships in place with Academic Health Science Partnership (AHSP), regional planning	Development of closer working relationships with the IJBs in developing their strategic commissioning plans

GOVERNANCE AND ACCOUNTABILITY

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

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**		Partially in place Stakeholder engagement plans developed for major service change consultations for Transforming Surgical Services and Transforming Mental Health Services	The Board will have a development event in September/October 2017 to revisit its Vision and Rich Picture. This will allow NHS Tayside to identify work its key stakeholders and work with them on the development of a Corporate Communications and Engagement strategy
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	The implementation of the Duty of Candour legislation may result in changes to how the Board demonstrates feedback from its stakeholders

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	Partially in place Value your NHS Campaign	Taking learning from work done in relation to Realistic Medicine and embedding throughout the organisation
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**		Partially in place In year changes made to the Corporate Finance Report and now include projected outturn and further action	Further work to be undertaken to establish the level of information to be provided including the development of improved performance reports to include the triangulation of data

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	Recognise need in relation to capacity and capability to be further developed to achieve the Board's long terms strategic goals. Future appointment of Director of Planning

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.	Greater emphasis on data and benchmarking and peer reviews with other Boards
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.	More work required with the Communication and Engagement Strategy to ensure involvement from stakeholders

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 Development of strategies and work with public health and partner organisations. Community based work Work progressed through the Community Innovation Fund such as the opening of support centre in Ninewells Concourse	Build on further development of strategies and work with public health and partner organisations e.g. Health Equity, social cohesion , time banking etc

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	Intent to embed Equality Impact Assessment in the organisation
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 develop accessibility guidance for NHS Tayside corporate documents NHS Tayside Mainstreaming Report and Equality Outcomes 2013-17 sets out the context for this	This work will also link to the development of a Communication and Engagement Strategy. NHS Tayside Mainstreaming Report and Equality Outcomes to the Board on 4 May 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'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	Ensure that the process and outcomes from Equality Impact Assessment are embedded in the way the organisation engages. This should allow the identification of appropriate groups for meaningful consultation
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	Requirement to ensure that information and data are used to inform decision making.

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

Item Number 7.3(a)

AUDIT45/2017
Audit Committee
22 June 2017

PRACTITIONER SERVICES - SERVICE AUDIT REPORT

1. PURPOSE OF THE REPORT

The purpose of the report is to bring to the attention of the Audit Committee as part of the annual accounts process, the outcome of the Practitioner, NHS National Services Scotland (NSS) Service Audit undertaken in 2016/17.

2. RECOMMENDATIONS

The Audit Committee is asked to note and take assurance from the following:-

- the audit report from the independent Service Auditors;
- the Introduction by (NSS) Director of Finance and Management Assertion, and
- the management responses to the issues arising set out within the Action Plan.

3. EXECUTIVE SUMMARY

The Service Audit of Practitioner Services of National Services Scotland, has been undertaken in accordance with International Standard on Assurance Engagements 3402 (ISAE 3402), "Assurance Reports on Controls at a Service Organisation", issued by the International Auditing and Assurance Standards Board. ISAE 3402 is in line with adoption of international standards of reporting, e.g. IFRS, and requires management to provide a written assertion regarding the service organisation's responsibilities for systems and controls, with the aim of the Service Audits providing NHS Tayside with assurance on the controls in operation that meet specified control objectives. The service auditor is required to provide an opinion on the suitability of the design of controls related to the control objectives throughout the period.

Appendix 1 includes documents and extracts from the full report, including, Executive Summary, Introduction by (NSS) Director of Finance and Management Assertion, Independent Service Auditors' Report 2016/17, and Action Plan with management responses to the issues arising.

The full reports are available to Members on request.

The Audit Report covers the 12 month period from 1 April, 2016, to 31 March, 2017.

The executive summary in the report states that the service audit "identified no control weaknesses that were considered to be of a significant nature and classified as high risk (Priority 1 or 2)". The Service Audit has identified 8 minor control weaknesses compared to 14 last year.

The report also confirms that actions have been taken to address all of the control weaknesses identified in previous Service Audits.

4. MEASURES FOR IMPROVEMENT

Following on from Service Audits undertaken, recommendations arising are agreed with management and formulated into agreed action plans. Progress against all recommendations is reviewed on a regular basis and reported to the NSS Audit Committee. Outstanding recommendations are reviewed on an annual basis by the Service Auditors. Any issues that remain outstanding would be included in the Service Audit report as exceptions noted by the Service Auditors.

5. RESOURCE IMPLICATIONS

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

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

6. DELEGATION LEVEL

Not applicable.

7. RISK ASSESSMENT

The Service Auditor's report is unqualified. The executive summary indicates action has been taken to address those control weaknesses identified in the previous year Audit report.

8. IMPLICATIONS FOR HEALTH

There are no direct implications for health arising as a consequence of this report.

9. TIMETABLE FOR IMPLEMENTATION AND LEAD OFFICER

Not applicable.

10. IMPACT ASSESSMENT AND INFORMING, ENGAGING AND CONSULTING

Not applicable.

11. PATIENT EXPERIENCE

Not applicable.

Robert MacKinnon
Associate Director of Finance – Financial Services & Governance, FLO

Lindsay Bedford
Director of Finance

June 2017

NHS National Services Scotland

ISAE3402 Service Audit Report – Practitioner Services 2016/17

May 2017

Scott-Moncrieff
business advisers and accountants

NHS National Services Scotland

ISAE 3402 Service Audit Report – Practitioner Services 2016/17

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Executive Summary

Introduction

The executive summary that follows should be read in conjunction with and taking account of all matters raised throughout the detailed sections of this report.

This report describes the control environment of NHS National Services Scotland – Practitioner Services (PS) for the payment of family health service practitioners. This report has been prepared for the use of NHS Boards in Scotland (NHS Boards) and their auditors in accordance with International Standards for Assurance Engagements (ISAE) 3402 "Assurance Reports on Controls at a Service Organisation".

The Board of NHS National Services Scotland (NSS) is responsible for the identification and agreement of control objectives (with the NHS Scotland Directors of Finance) relating to the payment of family health service practitioners. NSS is responsible for the design, implementation and maintenance of controls to ensure with reasonable assurance that the control objectives are achieved.

The Independent Service Auditor's Report, which is contained at Section 2, is unqualified.

Scott-Moncrieff has been engaged to provide assurance to NSS and NHS Boards in the form of a service audit for the PS payment streams. Our service audit work is restricted to the services provided by NSS and does not include those controls in operation within NHS Boards.

Content of the Independent Service Auditor's Report

The Service Audit of the PS payment streams has been performed in accordance with International Standards of Assurance Engagements (ISAE) 3402 "Assurance Reports on Controls at a Service Organisation".

In line with our terms of engagement we have produced a Type 2 ISAE 3402 report. A Type 2 report has distinct requirements as follows:

1. Service Auditor opinion (Section 2)

2. Written assertion by the service organisation that, in all material respects, and based on suitable criteria:

   a. The description fairly presents the service organisation's system as designed and implemented throughout the specified period (Section 1); and

   b. The controls related to the control objectives stated in the service organisation's description of its system were suitably designed and operated effectively throughout the specified period. (Section 1)

3. Details of the testing of the service organisation's controls and the results of that testing. (Sections 4 & 5)

4. Reliance placed on the work of Internal Audit. (detailed in Sections 4 & 5)

5. Other relevant information. (Appendices 3 & 4)

This Service Audit aims to provide user organisations (NHS Boards) and user auditors (Audit Scotland or appointed firms) with assurance on the controls in operation within PS that meet specified control objectives in respect of payments to family health service practitioners.

Specific exclusions

Only the IT controls and control objectives for which PS is solely responsible are included within the scope of this audit. NSS uses a third-party supplier, Atos (comprising Atos, Sopra Group and IBM), for the provision of IT services. The PS systems controls for which Atos is responsible are excluded from this service audit as they are subject to a separate service audit.

The National IT Services Contract Audit Report contains the findings of the service audit of the systems for which Atos is responsible and readers of this report may wish to consider the extent to which any findings within the National IT Services Contract Service Audit Report may impact on the reader's assessment of the PS payment processes.

Overall assessment of control objectives

The output from all of our review work has been consolidated into the overall service audit report on the services provided by NSS PS for the payment of family health services practitioners on behalf of NHS boards.

Control weakness rating

The control weakness rating helps the NSS Audit & Risk Committee, as well as management and auditors of NHS boards, assess the significance of the issues raised and prioritise the action required to address them. The control weakness rating structure is summarised as follows:

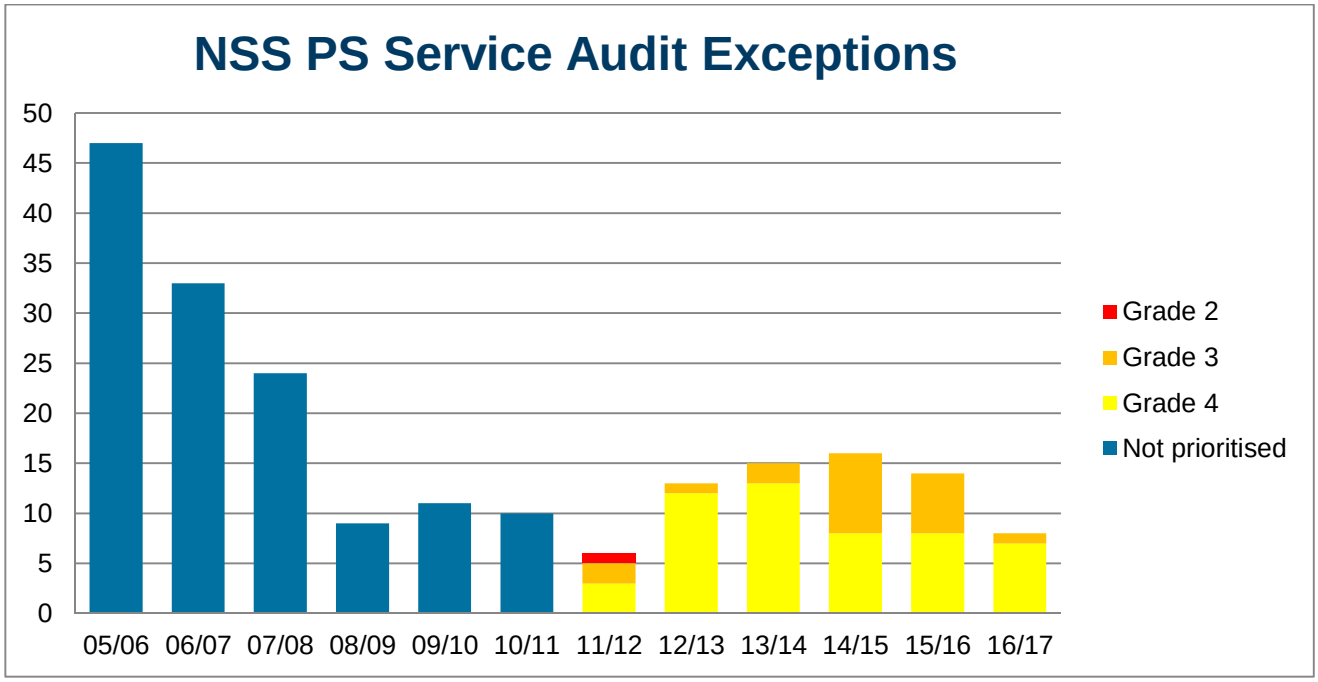
Rating	Definition
1	Very high risk exposure – Major concerns requiring immediate attention.
2	High risk exposure – Absence / failure of significant key controls.
3	Moderate risk exposure – Not all key control procedures are working effectively.
4	Limited risk exposure – Minor control procedures are not in place/working effectively.
5	No significant control weaknesses identified.

The following table provides an overview of our assessment of all of the control objectives reviewed as part of our service audit against the relevant control weakness rating.

Review area	Total controls audited	Control weakness rating				
		1	2	3	4	5
Information Technology General Controls	10	-	-	1	1	8
General Medical Services	29	-	-	-	1	28
General Pharmaceutical Services	29	-	-	-	2	27
General Dental Services	33	-	-	-	2	31
General Ophthalmic Services	31	-	-	-	1	30
Total	**132**	-	-	**1**	**7**	**124**

We have received satisfactory responses from PS management to all of the findings detailed in this report. These are included in the Action Plan at Appendix 1.

Over the last ten years, the number of control exceptions identified by the Service Auditor is shown in the graph below:



Note: Priority ratings have been allocated to service audit exceptions since 2011/12.

Significant control exceptions

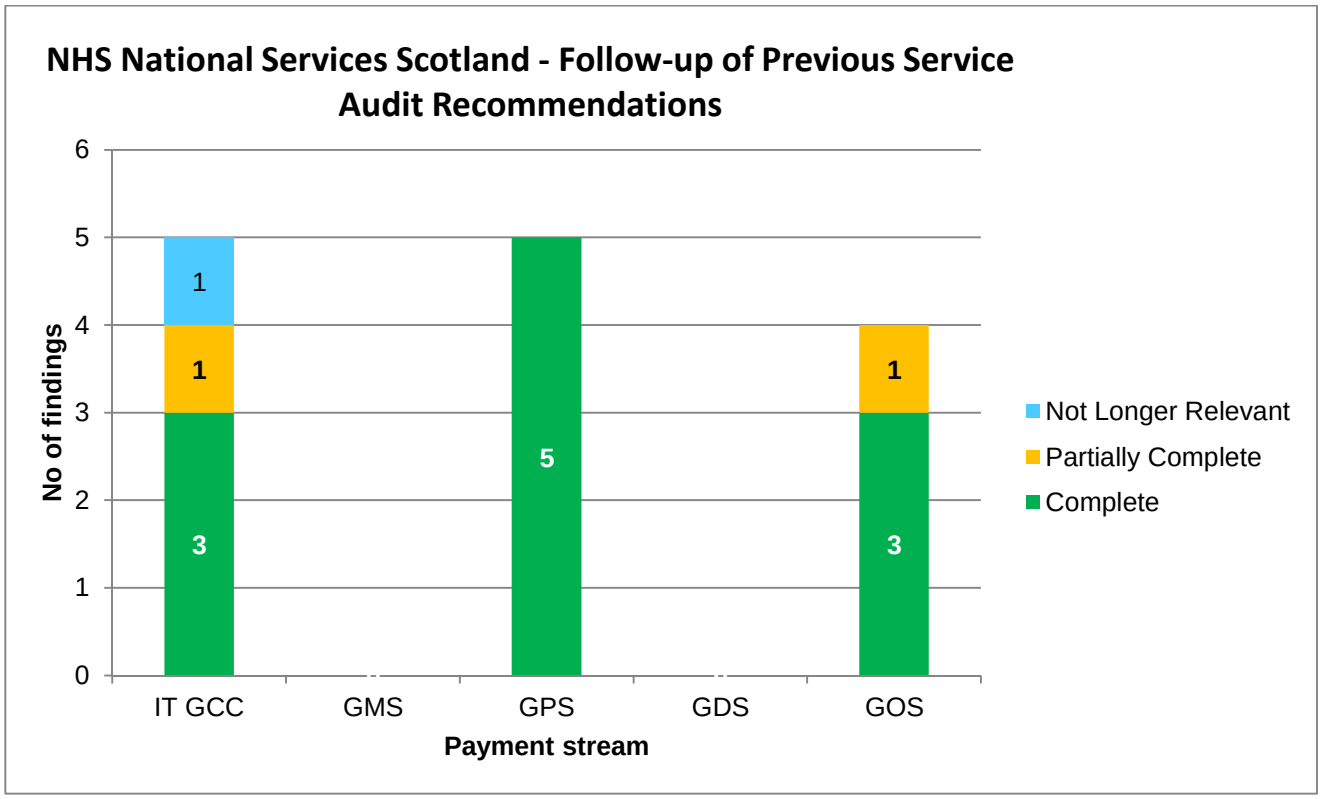
For the sixth year in succession, our service audit identified no control weaknesses that were considered to be of a significant nature and classified as high risk (Priority 1 or 2).

The summary of findings at Appendix 2 gives a quick guide to the results of our testing and indicates, with a control weakness rating structure and colour codes, all areas where any control measure was found to be other than satisfactory.

Follow-up of previous recommendations

As part of our service audit coverage for 2016/17, we have performed testing to confirm progress made in implementing recommendations identified in our previous service audit reports. The NSS Audit & Risk Committee received progress updates throughout the year.

The graph below provides an overview of the number and respective grade of completed actions.



We can confirm that 12 of 14 (85.7%) recommendations have been closed as complete or no longer applicable. Both of the outstanding actions were Grade 4 (limited risk exposure) actions and are partially complete.

1. Introduction by Director of Finance and Management Assertion

This report describes the control environment of NHS National Services Scotland (NSS) Practitioner Services (PS) for the payment of family health services practitioners on behalf of NHS health boards in Scotland (NHS boards). This report has been prepared for the use of NHS boards and their auditors who have a sufficient understanding to consider the description, along with other information including information about controls operated by customers themselves, when assessing the risks of material misstatements of customers' financial statements. In accordance with International Standards for Assurance Engagements 3402 "Assurance Reports on Controls at a Service Organisation", this report includes the Independent Service Auditor's Report on PS arrangements.

An outline of the content of this report is set out in the Executive Summary.

We (NSS Management) are responsible for the identification of control objectives relating to the payment of family health service practitioners in agreement with NHS Scotland Directors of Finance.

We are also responsible for the design, implementation and maintenance of controls to ensure with reasonable assurance and on an ongoing basis that the control objectives are achieved.

We have reviewed the relevant PS control objectives and controls in operation for the period under review (1 April 2016 to 31 March 2017). These controls are continually reviewed and assessed and improvements are made where appropriate, with the agreement of the NHS boards concerned.

We detail in this report the relevant control objectives, as agreed with the NHS boards, the specific controls which were operating as described during 1 April 2016 to 31 March 2017 to meet each of these agreed objectives and detail the results of testing by the appointed independent Service Auditor, Scott-Moncrieff.

Specific exclusions

Only the IT controls and control objectives for which PS is solely responsible are included within the scope of this audit. NSS uses a third-party supplier, Atos (comprising Atos, Sopra Group and IBM), for the provision of IT services. The PS systems controls for which Atos is responsible are excluded from this service audit as they are subject to a separate service audit.

The National IT Services Contract Audit Report contains the findings of the service audit of the systems for which Atos is responsible and readers of this report may wish to consider the extent to which any findings within the National IT Services Contract Service Audit Report may impact on the reader's assessment of the PS payment processes.

Management assertion on controls

NSS PS confirms that:

(a) The accompanying description at Sections 3 and 5 fairly presents the controls in place relating to the PS payment streams for processing customers' transactions throughout the period 1 April 2016 to 31 March 2017. The criteria used in making this assertion were that the accompanying description:

(i) Presents how the system was designed and implemented, including:

• The types of services provided, including, as appropriate, classes of transactions processed.

• The procedures, within both information technology and manual systems, by which those transactions were initiated, recorded, processed, corrected as necessary, and transferred to the reports prepared for customers.

• How the system dealt with significant events and conditions, other than transactions.

• The process used to prepare reports for customers.

• Relevant control objectives and controls designed to achieve those objectives.

• Controls that we assumed, in the design of the system, would be implemented by user entities, and which, if necessary to achieve control objectives stated in the accompanying description, are identified in the description along with the specific control objectives that cannot be achieved by ourselves alone.

• Other aspects of our control environment, risk assessment process, information system (including the related business processes) and communication, control activities and monitoring controls that were relevant to processing and reporting customers' transactions.

(ii) Includes relevant details of changes to the service organisation's system during the period 1 April 2016 to 31 March 2017.

(iii) Does not omit or distort information relevant to the scope of the system being described, while acknowledging that the description is prepared to meet the common needs of a broad range of customers and their auditors and may not, therefore, include every aspect of the system that each individual customer may consider important in its own particular environment.

(b) The controls related to the control objectives stated in the accompanying description were suitably designed and operated effectively throughout the period 1 April 2016 to 31 March 2017. The criteria used in making this assertion were that:

(i) The risks that threatened achievement of the control objectives stated in the description were identified;

(ii) The identified controls would, if operated as described, provide reasonable assurance that those risks did not prevent the stated control objectives from being achieved; and

(iii) The controls were consistently applied as designed, including that manual controls were applied by individuals who have the appropriate competence and authority, throughout the period 1 April 2016 to 31 March 2017.

Carolyn Low

Director of Finance and Business Services
On behalf of NHS National Services Scotland
17 May 2017

2. Independent Service Auditor's Report, including opinion

To the Members of NHS National Services Scotland Board:

Use of report

This report is made solely for the use of the Board members, as a body, of NHS National Services Scotland, and solely for the purpose of reporting on the internal controls of NHS National Services Scotland, in accordance with the terms of our engagement.

Our work has been undertaken so that we might report to the Board members those matters that we have agreed to state to them in this report and for no other purpose. Our report must not be recited or referred to in whole or in part in any other document nor made available, copied or recited to any other party, in any circumstances, without our express prior written permission.

We permit the disclosure of this report, in full only, by the Board members at their discretion to customers of NHS National Services Scotland using NHS National Services Scotland's practitioner services ('Customer NHS Boards') and to the auditors of such Customer NHS Boards, to enable Customer NHS Boards and their auditors to verify that a report by reporting accountants has been commissioned by the Board members of NHS National Services Scotland and issued in connection with the internal controls of NHS National Services Scotland, and without assuming or accepting any responsibility or liability to Customer NHS Boards or their auditors on our part.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board members as a body and NHS National Services Scotland for our work, for this report or for the conclusions we have formed.

Scope

We have been engaged to report on NHS National Services Scotland's description at Sections 3 and 5 of this report of its controls in respect of the Practitioner Services' system for processing payments to family health service practitioners throughout the period 1 April 2016 to 31 March 2017 (the description), and on the design and operation of controls related to the control objectives stated in the description.

The description indicates that certain control objectives specified in the description can be achieved only if complementary customer controls contemplated in the design of NHS National Services Scotland's controls are suitably designed and operating effectively, along with related controls at the customer organisation. We have not evaluated the suitability of the design or operating effectiveness of such complementary customer controls.

NHS National Services Scotland's responsibilities

NHS National Services Scotland is responsible for: preparing the description and accompanying assertion at pages 6 and 7, including the completeness, accuracy and method of presentation of the description and assertion; providing the services covered by the description; stating the control objectives; and designing, implementing and effectively operating controls to achieve the stated control objectives.

Service Auditor's responsibilities

Our responsibility is to express an opinion on NHS National Services Scotland's description and on the design and operation of controls related to the control objectives stated in that description based on our procedures. We conducted our engagement in accordance with International Standards for Assurance Engagements 3402,

“Assurance Reports on Controls at a Service Organisation”, issued by the International Auditing and Assurance Standards Board. That standard requires that we comply with ethical requirements and plan and perform our procedures to obtain reasonable assurance about whether, in all material respects, the description is fairly presented and the controls are suitably designed and operating effectively.

An assurance engagement to report on the description, design and operating effectiveness of controls at a service organisation involves performing procedures to obtain evidence about the disclosures in the service organisation’s description of its system, and the design and operating effectiveness of controls. The procedures selected depend on the service auditor’s judgment, including the assessment of the risks that the description is not fairly presented, and that controls are not suitably designed or operating effectively. Our procedures included testing the operating effectiveness of those controls that we consider necessary to provide reasonable assurance that the control objectives stated in the description were achieved. An assurance engagement of this type also includes evaluating the overall presentation of the description, the suitability of the objectives stated therein, and the suitability of the criteria specified by the service organisation as described at pages 6 and 7. We believe that the evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Limitations of controls at a service organisation

NHS National Services Scotland’s description is prepared to meet the common needs of a broad range of customers and their auditors and may not, therefore, include every aspect of the system that each individual customer may consider important in its own particular environment. Also, because of their nature, controls at a service organisation may not prevent or detect all errors or omissions in processing or reporting transactions. The projection of any evaluation of effectiveness to future periods is subject to the risk that controls at a service organisation may become inadequate or fail.

Opinion

Our opinion has been formed on the basis of the matters outlined in this report. The criteria we used in forming our opinion are those described on pages 6 and 7. In our opinion, in all material respects:

(a) The description fairly presents the Practitioner Services’ payment of family health services practitioners system as designed and implemented throughout the period from 1 April 2016 to 31 March 2017;

(b) The controls related to the control objectives stated in the description were suitably designed throughout the period from 1 April 2016 to 31 March 2017; and

(c) The controls tested, which together with the complementary customer controls referred to in the scope paragraph of this report, if operating effectively were those necessary to provide reasonable assurance that the control objectives stated in the description were achieved, operated effectively throughout the period from 1 April 2016 to 31 March 2017.

Description of tests of controls

The specific controls tested and the nature, timing and results of those tests are listed in Section 5.

Scott-Moncrieff
17 May 2017
Exchange Place 3
Semple Street
Edinburgh

3. Management's description of the system

NHS National Services Scotland

NHS National Services Scotland (NSS) is at the very heart of the health service, providing national strategic support services and expert advice to NHS Scotland. NSS also plays an active and crucial role in the delivery of effective healthcare to patients and the public. NSS's support role to NHS Scotland means that it works closely with all partner organisations, especially NHS boards, in the delivery of its services. Made up of a number of Strategic Business Units and Corporate Support services, it employs around 3,400 dedicated and specialised staff.

The NSS Board meets regularly during the year to formally progress the business of NSS. The NSS Board is supported by the following committees:

- Audit and Risk;
- Clinical Governance;
- Information Governance
- Performance and Finance;
- Staff Governance; and
- Remuneration and Succession Planning.

In addition to the above, Board members meet formally with the Executive Management Team and other Senior Managers to consider strategic and other business risks facing NSS as these arise.

Practitioner Services

PS supports accurate payments and patient registration for NHS Services to Scotland's GPs, dentists, pharmacists, and optometrists, processing and checking thousands of claims every month.

NSS Central Finance is responsible for ensuring the interface with the banking service through which practitioners are reimbursed.

In addition to the above, PS is also responsible for undertaking payment verification procedures (probity assurance checks) on behalf of NHS boards for all four payment streams.

PS consists of four payment streams:

- GMS – General Medical Services
- GPS – General Pharmaceutical Services
- GDS – General Dental Services
- GOS – General Ophthalmic Services

PS works with the Public Health & Intelligence (PH&I) Strategic Business Unit of NSS in maintaining GMS indices, pricing pharmacy products and in producing reports for NSS and NHS boards.

NSS IT provides operational support to the four payment streams including aspects of the main computer systems (interfacing with the service provider, Atos); the production of data for information requests; and systems analysis to investigate, resolve and develop information technology matters.

PS is responsible for collating financial reports for all four payment streams and providing summarised data to NHS boards and the Scottish Government Health and Social Care Directorate ("SGHSCD") to support budget allocation and financial reporting within NHS Scotland.

PS also works closely with the SGHSCD in the implementation of legislative and regulatory changes, as well as monitoring standards to ensure consistency of patient care.

Each year, payments totalling approximately £2 billion are processed by PS and recorded in the NHS boards' financial statements. The SGHSCD allocates resources for monthly payments, which are processed by PS. PS notifies both SGHSCD and the NHS boards of the payments made and the NHS boards are then charged the appropriate amount by SGHSCD.

As the body that calculates and processes the payments, PS must provide assurance to each NHS board and their external auditors. The assurance provided covers both the design and operation of key controls, as well as whether they are designed to achieve the key control objectives.

Scott-Moncrieff has been engaged to provide assurance to NSS in the form of a service audit for PS. The service audit work is restricted to the services provided by PS and does not include those controls in operation within NHS boards.

Policies and procedures including accreditations

PS has a team of Quality Managers whose role is to ensure that policies and procedures are maintained and adhered to, including checking on a sample basis that the necessary controls are in operation.

The four payment streams are also ISO 9001 accredited. ISO 9001 is an internationally recognised quality standard, relevant to organisations whose actions are designed to ensure that its products and services satisfy its customers' quality requirements and comply with any regulatory requirements in respect of the products and services provided. In order to achieve and maintain this accreditation the key PS processes for each payment stream need to be documented, described and supported by detailed manuals and procedures. Built into the quality manual and procedures are quality checks and audit checks which are undertaken by dedicated PS staff to confirm the key controls continue to be in place and operating as intended. The ISO accreditation is subject to six-monthly external review, with action plans developed for any issues raised.

General Medical Services (GMS)

Payments are made to General Practitioner ("GP") Practices on a monthly basis in accordance with the GMS or 17C Contract, Statement of Financial Entitlements, SGHSCD circulars and Scottish Public Pensions Agency directives. Payment values are based on a number of factors including the location of the GP Practice, the number and type of patients registered at the GP Practice and the different services provided.

Key elements that contribute to a GP Practice's monthly payment are:

- Global Sum Payment – This is set out in the Statement of Financial Entitlements within the Contract and is based on an agreed Scottish Allocation Formula;
- Quality aspiration and achievement payments – GP Practices were awarded "quality points" based on the quality of services provided and this then attracted additional payments based on the number of points achieved. In June 2016, the final Quality and Outcome payment was made, with the financial value now being made as Core Standard Payments;
- Seniority payments – Payments are earned based on the length of qualifying service; and
- Enhanced services and other payments – These payments are for services provided by the GP Practice as directed by the SGHSCD and/or NHS boards.

GMS processes are undertaken within three regional offices – Edinburgh, Glasgow and Aberdeen utilising GMS procedure manuals. Payments are made from NSS Central Finance in Edinburgh.

General Pharmaceutical Services (GPS)

Payments are made on a monthly basis for pharmaceutical services (Community Pharmacists and Dispensing doctors) and for the supply of prescribed appliances.

Key elements that contribute to a Pharmacist's payment are:

- Value of prescriptions dispensed based on costs of drugs or appliances supplied;
- Agreed dispensing or other fee payable; and
- Any additional payments, based on national or locally negotiated services.

Prescription forms dispensed in Scotland and Minor Ailment Service ("MAS") registration forms are scanned in batches to capture the data in DCVP, the system which validates and prices scripts. The majority of scripts are processed with details passing from the GP to the pharmacy electronically. The scanning of the script is the trigger to price the item within DCVP. Forms are then automatically validated by the system with recognised prices being applied. Items which fail at the validation stage or cannot be priced by the system are presented to an operator for the item details to be completed manually. Any historical adjustments or additional fees or items are applied before the final totals for payments are arrived at.

General Dental Services (GDS)

Dentists are paid by PS on a monthly basis, in accordance with a detailed processing timetable.

Key elements that contribute to dental payments are set out below:

- Continuing adult dental care payments in line with Statement of Dental Remuneration;
- Specific dental treatment for eligible payments e.g. orthodontic treatment, fillings etc.;
- Treatment of children calculated based on the number of children registered with the practice; and
- Other payments as set out in the agreed Statement of Dental Remuneration, for example out-of-hours treatment and remote access payments.

Dentists are required to submit to PS a dental claim form which sets out the dental work carried out, exemption status of the patient and details of any charge the patient has already paid. PS subsequently pay the dentist for the value of the work done, less any payment already received by the dentist from the patient.

The main processing system used by GDS is the Management Information and Dental Accounting System ("MIDAS"). MIDAS automatically values the work claimed by Dentists, using electronic claims or the dental claim forms and passes the value for payment.

General Ophthalmic Services (GOS)

Key elements that contribute to ophthalmic providers payments are:

- Ophthalmic treatments received are priced based on agreed fee rates;
- Fee paid for eye tests undertaken; and
- Relevant spectacles and repairs payments.

The processes which are undertaken in respect of making GOS payments are:

- Standard claim forms are submitted to Bain Square for processing. All forms are scanned and captured through iDENT and captured into OPTIX.
- Where a claim form is rejected it is either rescanned or returned to the PS GOS team to be manually verified and entered into OPTIX.
- If a claim form has been completed incorrectly it is sent back to the individual optician for re-submission.
- A number of validation checks are undertaken based on ophthalmic claims received prior to making payment, in particular the claim is checked to ensure that it is signed by the contractor, contains a contractor's location code and payment code.
- Where an optician has been identified as exhibiting unusual treatment patterns, these claims are verified by an ophthalmic advisor prior to being processed.
- Claims are priced automatically by OPTIX based on agreed fee rates, which are reviewed and updated within OPTIX when required.

System developments and improvements identified for the period under review

During the year, the Application Compliance programme was completed for PRS.

PS, working with NHS Boards, implemented electronic transfer of medical payments directly to NHS Board ledgers, rather than through a manual interface, from April 2016. This project was carried out working with NHS Boards and included significant testing and review of posting to validate the revised processes.

The roll-out of electronic submission and processing of ophthalmic claims (e-Ophthalmic) has been taking place with around 15% of ophthalmic claims arriving be electronic claim by March 2017. This new process will allow automation of some of the currently manual validation controls within the payment process.

The final payment under the GMS Quality Outcomes Framework was made in June 2016, and a formula to calculate core standard payments has been agreed and implemented.

We do not consider that these changes have had any effect upon the effectiveness of the control environment.

Follow-Up of Previous Service Audit Recommendations

Following on from each Service Audit undertaken, recommendations arising are agreed and formulated into action plans including the allocation of an appropriate person who is responsible for implementing the recommendation within an agreed timetable. Actions taken on such recommendations are reviewed regularly by NSS Senior Management and on an annual basis by the Service Auditor, Scott-Moncrieff. The results of this follow up work are reported separately to management. Any issues that remain as outstanding would be included in this report by Scott-Moncrieff.

Progress against all recommendations is reviewed by the PS Senior Management Team on a regular basis and reported to the NSS Audit and Risk Committee. On a regular basis the Service Auditor also reports to the NSS Audit and Risk Committee on progress, primarily against the more significant recommendations.

Planned future developments

PS plans a number of changes to the systems supporting the current payment processes, which will be progressed during 2017/18. Details of some of the key changes are set out below:

- The Application Compliance programme is designed to bring applications, including MIDAS, OPTIX, PRS, and PMSPS replacing software components that were at the end of support life onto a consistent platform, in order to provide enhanced supportability. PRS has been completed and was live by the end of 2016/17. The remainder are at various stages of development and targeted to complete development in 2017/18.

- Work to a plan extending the direct interface between PS Payment Systems and NHS Boards' eFinancials ledgers allowing expenditure journals to be posted directly into Boards' ledgers will be considered for Dental, Ophthalmic and Pharmacy payment streams in 2017/18.

- Consultation about Dental fee increases and allocations is expected to result in some changes to payments in 2017/18.

- The roll-out of electronic submission and processing of ophthalmic claims (e-Ophthalmic) will continue in 2017/18, increasing from approximately 15% of ophthalmic claims arriving by electronic claim in March 2017. This new process will allow automation of some of the currently manual validation controls within the payment process. Similarly, it is planned that some payment verification checks within the e-Dental process will be moved to the pre-treatment stage.

We will consult with Scott-Moncrieff to consider the impact these developments may have on the design and description of the controls set out in Section 5 during the planning of the 2017/18 service audit.

4. Summary of control objectives

Set out below is an overview of the PS control objectives that have been set by management and agreed with NHS boards. The detailed controls underpinning the control objectives are set out in Section 5 of this report.

Summary of control objectives 2016/17

The PS controls assurance framework encompasses the overall control objectives of the processes used by PS:

1. Payments are made based on valid, authorised claims;
2. Payments are only made to valid contractors;
3. Payments are accurately calculated;
4. All claims are processed and paid only once;
5. Patients make appropriate contributions towards the cost of care;
6. Reports to NHS boards and SGHSCD are correctly compiled; and
7. Payment verification arrangements are in place and operate in accordance with guidance issued by the Scottish Government.

In addition to the above business controls objectives, three Information Technology General Controls ("ITGC") underpin each of the four payment streams:

1. Appropriate logical access and data confidentiality controls are in place for all payment streams – this is controlled by NSS IT and is the responsibility of PS;
2. Disaster recovery and business continuity arrangements are in place to ensure the recovery of data and PS operations in the event of an incident. Business Continuity plans are managed by PS in conjunction with Atos; and
3. Controls are in place to ensure that systems development and changes cannot be undertaken unless valid, authorised and tested. Changes to systems are proposed by users or by NSS IT analysts, solutions received from Atos are subject to user acceptance testing within PS and PS approve the "go live" of changes to PS systems.

These three ITGC control objectives are underpinned by a set of key controls that are the responsibility of PS.

Outsourcing of IT services

NHS Scotland's strategic IT services are delivered through a national IT contract. As a result of this national IT contract many of the IT services for PS are provided by Atos.

Services provided under this contract have been agreed and a split of responsibility is set out between NSS and Atos. All servers and principal systems are now hosted by Atos or by NSS Information Management Technology and are outside the remit of PS. In addition, all relevant system changes are managed by Atos on behalf of PS and NSS.

Controls which remain the responsibility of PS include:

- Granting access to the NSS Network and access to PS applications;
- Reviewing access to PS systems;
- Requesting an IT change and subjecting the requested change (once developed by Atos) to user acceptance testing; and
- Facilitating the liaison between Atos and core PS (the 4 payment streams).

Only the controls which PS is solely responsible for are reflected in this report. The controls which Atos is responsible for, in relation to PS systems, are excluded and subject to a separate service audit, which is undertaken by Scott-Moncrieff.

5. Testing of control objectives

Overall Assessment of Control Objectives

The output from all of our individual reviews has been consolidated into the overall service audit report on the services provided by NSS PS for the payment of family health services practitioners on behalf of NHS Boards.

Control weakness rating

The control weakness rating helps NSS Audit & Risk Committee as well as management and auditors of NHS Boards assess the significance of the issues raised and prioritise the action required to address them. The control weakness rating structure is summarised as follows:

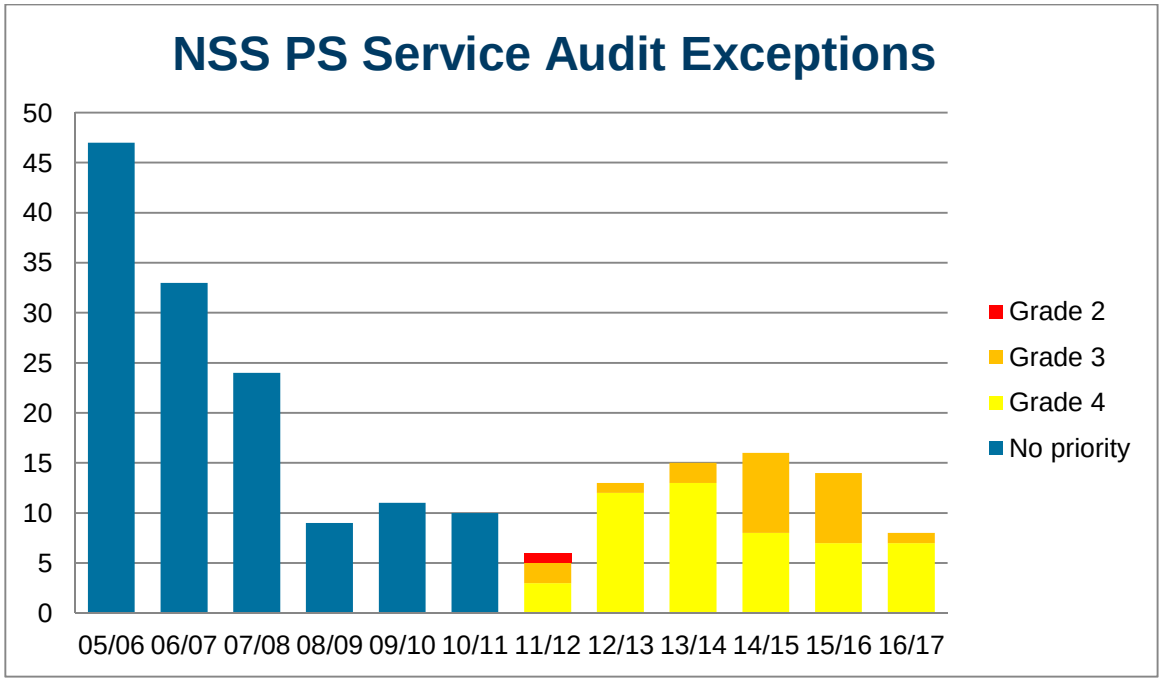
Rating	Definition
1	Very high risk exposure – Major concerns requiring immediate attention.
2	High risk exposure – Absence / failure of significant key controls.
3	Moderate risk exposure – Not all key control procedures are working effectively.
4	Limited risk exposure – Minor control procedures are not in place/working effectively.
5	No significant control weaknesses identified.

The following table provides an overview of our assessment of all of the control objectives reviewed as part of our service audit against the relevant control weakness rating.

Review area	Total controls audited	Control weakness rating				
		1	2	3	4	5
Information Technology General Controls	10	-	-	1	1	8
General Medical Services	29	-	-	-	1	28
General Pharmaceutical Services	29	-	-	-	2	27
General Dental Services	33	-	-	-	2	31
General Ophthalmic Services	31	-	-	-	1	30
Total	**132**	**-**	**-**	**1**	**7**	**124**

We have received satisfactory responses from PS management to all of the findings detailed in this commentary. These are included in the Action Plan at Appendix 1 to this report.

Over the last ten years the number of control exceptions identified by the Service Auditor is shown in the graph below:



Note: Priority ratings have been allocated to service audit exceptions since 2011/12.

Significant Control Exceptions

Our service audit identified no control weaknesses that were considered to be of a significant nature and classified as high risk (Priority 1 or 2).

The summary of findings at Appendix 2 gives a quick guide to the results of our testing and indicates, with a control weakness rating structure and colour codes, all areas where any control measure was found to be other than satisfactory. Our detailed findings under each control objective are given below.

IT General Controls (ITGC)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 1 – Appropriate logical access and data confidentiality controls are in place for all payment streams.			
ITGC 1.1 New users Access to PS Systems is provided by the relevant NSS IT staff based on a suitably authorised request. Note: The term PS Systems is used to refer to the systems used to determine payments to the various Primary Care contractors (Dentists, General Practitioners, Optometry Contractors and Pharmacy Contractors). At the current time those systems are: DCVP (including the associated ePharmacy components), MIDAS, OPTIX, PMSPS, QOF Calculator, SPSAA, CHI, PRS and NHSMail.	We reviewed a sample of five new PS employees (permanent and temporary) since 1 April 2016 to confirm whether all access had been appropriately authorised. No issues were noted.	**Control weakness rating**	**5**

IT General Controls (ITGC)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
ITGC 1.2 Reviews of user access Reviews of user access to PS Systems are performed on a regular basis to ensure access is appropriate.	Our audit testing identified weaknesses in respect of user access during 2016-17. We noted that the Q1 quarterly review was not performed. It was stated that this was due to resourcing challenges. We also noted that when lists of users are issued, there is no control to ensure that all recipients of the email respond to this. From review of the quarterly reviews performed, it was evident that they are not fully effective. This was evidenced by the fact that in some cases, users who had left NSS in 2014 and 2015 were being highlighted as requiring their accounts disabled. We also noted that the information being used for reviews was a roll-forward of previous user lists that had been circulated rather than extracts of live user accounts from systems. Therefore, the lists may not be an accurate reflection of active accounts.	Quarterly user access reviews should be carried out for the all PS systems to confirm that user access is appropriate. User lists circulated to line managers should be based on extracts of current active user accounts from each PS system. Controls should be implemented to ensure that responses are provided by all line managers and action taken to remove/revise access as appropriate. When responses are not received, this should be escalated as appropriate.	
		Control weakness rating	**3**

IT General Controls (ITGC)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
ITGC 1.3 User IDs and passwords Access to PS Systems requires the use of a unique identifiable account for each individual user with an associated password. The passwords in place must be alphanumeric and changed on a regular basis. Note that a number of the individual systems are accessed via a shared Single Sign On Service. This provides a user with a single unique and identifiable account, which provides access to one or more of those systems as determined by the individual user's business role at the time the account is originally set up or subsequently varied.	We confirmed that for SPSAA, DCVP, IDENT (Optix and Dental), MIDAS, OPTIX, PRS, PMSPS, QOF Calculator and CHI, each user has their own unique user ID and password with which to gain access to the system. For SPSSA, DCVP and IDENT (OPTIX and Dental), access is controlled using the user's Active Directory (network) user id and password. MIDAS, OPTIX, PRS and PMSPS are all part of the single sign-on (SSO) group of systems. A specific SSO user id and password provides access to each of these systems. For CHI, we confirmed each user must be set up and be provided with a unique user id and password in order to access each of these systems. With the exception of the known weakness of MIDAS, OPTIX, PMSPS, PRS and CHI not adhering to the NHS Scotland Passwords Policy all passwords were compliant with policy. Although a change note was raised to address this in 2014, after further investigation, the change was not pursued due to it being too challenging at a technical level to implement. It was intended that this would be addressed by the Applications Compliance Technical Refresh project which is scheduled to complete in 2018.	Not applicable.	
		Control weakness rating	**5**

IT General Controls (ITGC)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
ITGC 1.4 Remote access Remote access to PS systems is restricted to authorised members of staff. Other than NHSMail, remote access to PS Systems can only be undertaken if a remote access RAS token is present and remote access needs to be approved and set up by NSS ITSBU.	We confirmed that user remote access has to be subject to approval by line management. We confirmed that remote access requires the use of a PIN and RAS token code. We also confirmed via our walkthrough that, in the event that either or both of these items of information are entered incorrectly, access will be denied. No issues were noted.	Not applicable.	
		Control weakness rating	**5**
ITGC 1.5 Anti-virus software Anti-virus software is in place for all PS Systems to prevent attacks on those systems and potential loss or corruption of data.	We confirmed that Sophos anti-virus software is installed to protect desktops, laptops and servers. All desktops laptops and servers are configured to be scanned and software updated on a nightly basis. Laptops are also configured to look for and obtain an update from Sophos directly. We also confirmed from review of five desktops and five laptops that the latest version of the anti-virus software was installed and running. No issues were noted.	Not applicable.	
		Control weakness rating	**5**

IT General Controls (ITGC)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 2 – Disaster recovery and business continuity arrangements are in place to ensure the recovery of data and PS operations in the event of an incident.			
ITGC 2.1 Business continuity plan PS maintains a Business Continuity Plan (BCP), which considers responses to a range of undesirable events ranging from those that would cause a relatively minor disruption to catastrophic events, which could potentially cause serious disruption to PS business. The business continuity arrangements include a range of measures which are designed to deal with and be proportionate to the potential business impact which may arise and these measures include ensuring that the relevant data is available. The BCP is tested on an annual basis. Atos undertakes regular Disaster Recovery testing on those PS Systems which they support and which have specific Disaster Recovery facilities.	We confirmed that a BCP exists and provides guidance on the way in which PS should respond to an incident as well as detailing specific tasks that should be undertaken by each of the areas within PS. We confirmed that the Business Continuity Group is responsible for maintaining the BCP. A BCP simulation was performed in November 2016.	Not applicable.	
		Control weakness rating	**5**

IT General Controls (ITGC)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 3 – Controls are in place to ensure that systems development and changes cannot be undertaken unless valid, authorised and tested.			
ITGC 3.1 Policy between PS and IT service providers A clear and documented understanding exists between PS and the IT service providers defining who is responsible for each level of change control within each PS system.	We obtained a copy of schedule 5 Service Level Agreement for PS to confirm whether this set out the understanding between PS and IT providers (e.g. Atos). We reviewed a sample of change control meetings for Pharmacy, Medical Payments, Medical Registrations and Dental & Ophthalmic to confirm whether these are held regularly and discuss all changes raised within the month / quarter. No issues were noted.	Not applicable. **Control weakness rating**	**5**
ITGC 3.2 Management of change developments Project teams are currently tasked to manage the review change requests, planned developments and releases to UAT and Production. This is coordinated by the IT Business Partner, PS Informed Customer and Change Manager.	We confirmed that the management of change developments is handled at change control meetings with input from discussions held between the Informed Customer, IT Business Partner and IT Change Manager. Meetings were confirmed as being held monthly at work-stream level. We noted that an IT change management process has been drafted but has yet to be approved.	The IT change management process should be approved by PS management and applied for all future changes. **Control weakness rating**	**4**

IT General Controls (ITGC)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
ITGC 3.3 Authorisation matrix An authorisation matrix exists detailing the individuals within PS who are authorised to approve system changes.	We obtained the latest version of the authorisation matrix and cross checked this with the current organisation charts to confirm that only current employees were listed. From review of the authorisation matrix, we noted that it has been subject to ongoing review through the year, this being noted from the document version control. Our audit testing did not identify any exceptions in relation to the staff listed on the Authorisation Matrix.	Not applicable.	
		Control weakness rating	**5**
ITGC 3.4 Authorisation and testing Changes to PS Systems are first processed in a test environment and then authorisation is provided to the IT service provider confirming that the changes can be released to the live environment.	From a review of a sample of five changes which had taken place since April 2016 all were found to have be subject to appropriate authorisation and testing prior to release to the live environment.	Not applicable.	
		Control weakness rating	**5**

General Medical Services (GMS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 1 – Payments have been made based on valid, authorised claims			
GMS 1.1 Signatory listings An up-to-date listing of all individuals who are authorised to claim payments for practices and NHS Boards is maintained in the three regional offices.	We inspected the signatory lists for a sample of practices and NHS Boards to confirm whether they were up to date and stored electronically. No issues were noted.	**Control weakness rating**	**5**
GMS 1.2 Payments Payments (excluding the Global Sum Correction Factor, Temporary Patient Adjustment, Opt Out adjustments, Training Grants and Sentinel Swabbing payments) are only paid to practices on presentation of a valid claim authorised by an individual from the Practice or NHS Board who is included on the authorisation list.	We observed a member of the payments team processing a payment to confirm whether it was authorised by an individual included on the relevant authorisation list. We inspected a sample of payments made in the period to confirm whether they were appropriately authorised. In one of 24 payments tested (4%) we found that the payments team processed a payment that was authorised by an individual who was not on the authorised signatory list.	Management should remind staff that claims should not be processed for payment if authorised by an individual who is not on the authorisation list.	
		Control weakness rating	**4**

General Medical Services (GMS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GMS 1.3 Training grant payments Payments for training grants are made only on the provision of an amount by NHS Education for Scotland by an authorised delegated officer. Payments are made on a quarterly basis.	We inspected a sample of training grant payments made during the period to confirm whether they were signed by an authorised, delegated officer. No issues were noted	**Control weakness rating**	**5**
GMS 1.4 Sentinel swabbing payments Payments for sentinel swabbing are made only on provision of an agreed amount by Health Protection Scotland by an authorised delegated officer.	We inspected a sample of sentinel swabbing payments made during the period to confirm whether they were signed by an authorised, delegated officer. No issues were noted	**Control weakness rating**	**5**

General Medical Services (GMS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 2 - Payments are made to valid contractors			
GMS 2.1 New practices When a new practice is established, the details supplied by the NHS Board are entered onto PMSPS by one member of the payments team and checked by another.	We inspected a sample of new practice details entered into PMSPS during the period to confirm whether they were signed as reviewed by a second team member. No issues were noted.	**Control weakness rating**	**5**
GMS 2.2 Contractor exception reports The details of all contractors held on PMSPS are auto matched on a quarterly basis with those entered onto CHI by the Registration Team, who is also notified of changes by the NHS Board. Any discrepancies are identified and resolved.	We inspected a sample of exception reports during the period to confirm whether the identified discrepancies were resolved. No issues were noted.	**Control weakness rating**	**5**

General Medical Services (GMS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GMS 2.3 Changes to contractor standing data Practice bank details, and other standing data, are only amended on PMSPS on receipt of an authorised request from the relevant GP Practice. The input of these changes is processed by one team member and reviewed by a second individual. These details are passed automatically to the General Ledger. Bank details for non-PMSPS contractors are updated directly to the general ledger on receipt of an authorised request.	We inspected a sample of changes made to standing data held on the general ledger to confirm whether they were based on an authorised request and the change had been processed by one team member and reviewed by a second individual. No issues were noted.	**Control weakness rating**	**5**
GMS 2.4 Practices ceasing to operate When a practice ceases operation, the details supplied by the NHS Board are recorded as the "practice ceasing" on PMSPS by one member of the Payments Team and checked by another.	We inspected a sample of ceased practices to confirm whether the details were recorded accurately on PMSPS and the change was checked by a second individual. No issues were noted.	**Control weakness rating**	**5**
GMS 2.5 User access to PMSPS and QOF Calculator User access to PMSPS and QOF Calculator is restricted to authorised users.	We confirmed that access to PMSPS and the QOF calculator is restricted to authorised users. We observed, for a sample of users in each region, that a unique user name and password is required to gain access to the systems. No issues were noted.	**Control weakness rating**	**5**

General Medical Services (GMS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 3 - Payments are accurately calculated			
GMS 3.1 Payment rates The SGHSCD provides updated payment rates to PS when required. To ensure accuracy and completeness of information stored within PMSPS, which is used in the calculation of payments, these updates are entered into the PMSPS system and are reviewed. Processing is done by either the Glasgow Regional Financial Services Manager or the Glasgow Deputy Regional Financial Service Manager, and is reviewed by the other.	We inspected the information received from the SGHSCD to confirm whether it related to 2016/17. We inspected the processing of the sheet and confirmed it had been produced and reviewed by the Glasgow Regional Financial Services Manager and the Glasgow Deputy Regional Financial Services Manager. No issues were noted.	**Control weakness rating**	**5**
GMS 3.2 Global sum payment calculation The Global Sum payment is calculated by PMSPS based on the Scottish Allocation Formula. A quarterly check is performed to compare the current values with the previous quarter and any variance over +/- 5% is investigated by the various regional Registration Teams. This check is signed as prepared and reviewed.	We inspected a sample of checks performed during the period to confirm whether any variances of +/- 5% were followed up. We confirmed that the checks were signed as prepared and reviewed. No issues were noted.	**Control weakness rating**	**5**

General Medical Services (GMS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GMS 3.3 Data Quality department checks The Data Quality department performs checks on the accuracy of the CHI data for 10% of practices per year in order to ensure that accurate information is used in the Global Sum Calculation.	We inspected the listing of practices checked in 2016/17 for each region to confirm whether it covered 10% of the total number of practices for that region. We inspected a sample of files relating to these checks and confirmed that they were performed and discrepancies were followed up. No issues were noted.	**Control weakness rating**	**5**
GMS 3.4 Enhanced Services Payments Enhanced Services Payments are agreed on a local, regional or national basis and are paid out to practices at the levels calculated and supplied by the NHS Boards.	We inspected a sample of enhanced services payments made to practices during the period to confirm whether the amounts paid agree to the original notification from the NHS Board. No issues were noted.	**Control weakness rating**	**5**
GMS 3.5 Section 17C Practice Payments Section 17C Practice Payments are agreed on a local, regional or national basis and are paid out to practices at the levels calculated and supplied by the NHS Board.	We inspected a sample of Section 17C payments to confirm whether the amounts paid agreed to the original notification from the relevant NHS Board. No issues were noted.	**Control weakness rating**	**5**
GMS 3.6 Reasonableness check of BACS payments The monthly BACS payments to practices are reviewed for reasonableness by regional office management prior to being processed.	We inspected a sample of BACS payment documentation to confirm whether regional office management had performed a reasonableness review. No issues were noted.	**Control weakness rating**	**5**

General Medical Services (GMS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 4 – All claims are processed and paid only once			
GMS 4.1 Secondary authorisation of payments The original documentation for each claim is signed and dated when processed in PMSPS, and signed and dated when checked by a second individual to ensure accuracy and to prevent duplication of processing.	We observed a member of the Payments Team processing a payment. We inspected a sample of payments made during the period to confirm whether these were appropriately authorised. No issues were noted.	**Control weakness rating**	**5**
GMS 4.2 Month of Payment documents At the end of each month, the Payments Manager responsible for each board performs a reconciliation between the amounts to be paid in the month per the source documentation and the amounts to be paid in the month per PMSPS. The Payments Manager then confirms that all items have been processed accurately and only once, by signing and dating the 'Month of Payment' document.	We inspected a sample of 'Month of Payment' documents to confirm whether they were signed and dated by the relevant payment manager, confirming that the reconciliation was performed. No issues were noted.	**Control weakness rating**	**5**
GMS 4.3 Reasonableness check of BACS payments The monthly BACS payments to practices are reviewed for reasonableness by regional office management prior to being processed.	We inspected a sample of BACS payments documentation to confirm whether management had performed a reasonableness review. No issues were noted.	**Control weakness rating**	**5**

General Medical Services (GMS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GMS 4.4 User access to BACS system Access to the BACS system is restricted to key members of NSS Central Finance.	We inspected the BACS system to confirm whether access to the treasury management screen in the general ledger is restricted to key staff. No issues were noted.	**Control weakness rating**	**5**
GMS 4.5 BACS payment request Prior to processing a BACS payment NSS Central Finance must receive a transmission request from a member of PS Finance Management.	We inspected a sample of BACS runs made during the period to confirm whether they were supported by a transmission request from a member of PS finance management. No issues were noted.	**Control weakness rating**	**5**
GMS 4.6 CHAPS payments Payments made by CHAPS or bank transfer must be authorised by a member of PS Finance Management Team before payment by NSS Central Finance.	We inspected a sample of CHAPS runs and bank transfers made during the period to confirm whether they were supported by a transmission request from a member of PS Finance Management. No issues were noted.	**Control weakness rating**	**5**
GMS 4.7 Monthly BACS reports (OLD – to October 2016) Once the monthly BACS run has been actioned, a copy of the BACS output report is sent to each regional office for verification and retention with the payment documentation.	We inspected a sample of BACS runs to confirm whether, for a sample of NHS Boards, payment documentation was retained, including a copy of the relevant, verified BACS output report. We noted that control changed from October 2016. No other issues were noted.	**Control weakness rating**	**5**

General Medical Services (GMS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GMS 4.7 Monthly BACS reports (NEW – from October 2016) Once the monthly BACS run has been actioned, a copy of the BACS output report is verified and retained centrally with the payment documentation.	We inspected a sample of BACS runs to confirm whether, for a sample of NHS Boards, payment documentation was retained centrally, including a copy of the relevant, verified BACS output report. No issues were noted.	**Control weakness rating**	**5**

General Medical Services (GMS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation
Control Objective 5 – Patients make appropriate contributions towards the cost of care		
This control objective is not applicable to General Medical Services.	This control objective is not applicable to GMS, as patients are not required to make contributions towards the cost of care.	

General Medical Services (GMS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 6 – Reports to NHS Boards and Scottish Government outlining PS payments are complete and accurate			
GMS 6.1 The appendices Monthly NHS Board reports (the "appendices" are compiled from source documentation and other information and signed off by the preparer before being reviewed and signed by a second team member.	We inspected a sample of monthly reports to confirm whether they were signed by the preparer, and reviewed and signed by a second team member. No issues were noted.	**Control weakness rating**	**5**
GMS 6.2 Reconciliation of NHS Board reports A reconciliation is performed to ensure the total on each monthly NHS Board report agrees to the total amount recorded in Cedar. Any reconciling items are identified and explained.	We inspected a sample of monthly reports to confirm whether the reconciliation was performed with any reconciling items being identified and explained. No issues were noted.	**Control weakness rating**	**5**
GMS 6.3 Reconciliation of Form 12 and appendices A reconciliation is performed between the information on the monthly board reports (the "appendices") and the "Form 12" information to be reported to the SGHSCD to ensure accuracy.	We inspected a sample of monthly reconciliations between the monthly board reports and "Form 12s" to confirm the reconciliations were completed. No issues were noted.	**Control weakness rating**	**5**

General Medical Services (GMS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GMS 6.4 Form 12 A "Form12" report summarising the financial information across all four payment streams is supplied to each NHS Board and the SGHSCD on a monthly basis. These are compiled by the PS Finance Department and reviewed by a second individual to ensure the information is correct.	We inspected a sample of "Form 12" reports to confirm whether they were prepared by the PS Finance Department and reviewed by a second individual before submission to the NHS Board. No issues were noted.	**Control weakness rating**	**5**

General Medical Services (GMS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 7 – Payment verification arrangements are in place and operate in accordance with Scottish Government guidance			
GMS 7.1 Payment Verification Team A Payment Verification ("PV") team exists in all three regional offices and provides Payment Verification services as set out in the Scottish Government Chief Executive letter ("CEL") agreed with each of the NHS Boards.	We inspected a copy of the CEL to confirm whether it contained GMS guidance. We also inspected a sample of agreements with individual NHS Boards to confirm if payment verification agreements were in place. No issues were noted.	**Control weakness rating**	**5**
GMS 7.2 Quarterly PV checks The PV department produces quarterly reports for all NHS Boards detailing the level of checking carried out in each NHS Board area and highlighting any specific issues of interest.	We inspected a sample of quarterly reports to confirm whether they were completed and contained the expected information. No issues were noted.	**Control weakness rating**	**5**
GMS 7.3 PV checks of QOF and Enhanced Services The PV department visits 5% of practices for QOF and 3% of practices for Enhanced Services each year to establish the validity of payments made for patient services.	We inspected the payment verification visit register to confirm that 5% of practices were visited for QOF and 3% of practices for Enhanced Services. We also confirmed if a visit report was produced for each of these visits. No issues were noted.	**Control weakness rating**	**5**

General Pharmaceutical Services (GPS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 1 – Payments have been made based on valid, authorised claims			
GPS 1.1 Payment claims Claims for payments relating to prescriptions and stock orders are only made on receipt of a valid claim form which includes the stamp of a registered pharmacist or dispensing doctor.	We inspected a sample of claim forms for prescription or stock-order payments to confirm whether they were valid (i.e. contained the required information) and included the stamp of a registered pharmacist or dispensing doctor. No issues were noted.	**Control weakness rating**	**5**
GPS 1.2 Secondary checks of payment claims Once loaded into the DCVP system all claims relating to prescriptions and stock orders are subject to further verification in line with the inbuilt regulations. Any forms which are identified as foreign forms; urgent forms; unknown items; minimum gross ingredient cost; out of pocket expenses; high value gross ingredient cost; rejected items; unusual fees/quantities; and pay and report items, are included in the 'confirmation reporting' process to ensure validity.	We observed a processing team leader performing second checks on items which had been flagged up by the system as foreign forms; urgent forms; unknown items; minimum gross ingredient cost; out of pocket expenses; high value gross ingredient cost; rejected items; unusual fees/quantities; and pay and report items to confirm whether these were manually approved. No issues were noted.	**Control weakness rating**	**5**

General Pharmaceutical Services (GPS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GPS 1.3 Authorised signatory listing An up to date listing of all individuals who are authorised to claim other GPS payments (e.g. Smoking Cessation, Oxygen therapy) for the NHS Boards is maintained in the three regional offices.	We inspected the signatory lists for a sample of NHS boards to confirm whether they were up to date. No issues were noted.	**Control weakness rating**	**5**
GPS 1.4 Claims for other services Claims for payments relating to other services provided by contractors are only made on receipt of a valid, authorised payment instruction from the relevant NHS board.	We selected a sample of remittance advices throughout the year and inspected the payment instructions received from NHS boards in relation to a sample of contractor payment claims for other services provided to confirm they had been authorised by an authorised signatory. No issues were noted.	**Control weakness rating**	**5**

General Pharmaceutical Services (GPS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 2 - Payments are made to valid contractors			
GPS 2.1 New pharmacy or dispensing doctor When a new pharmacy or dispensing doctor is established, the details supplied by the NHS Board are entered onto eVadis and checked by another team member.	We inspected the details of a sample of new pharmacies or dispensing doctors entered into eVadis to confirm whether they were signed as reviewed by a second individual. We found one item, from a sample of two, had been checked and signed off by the same individual.	Management should remind staff that where a new pharmacy or dispensing doctor starts, details should be added to eVadis by one member of the payment team and checked by a second individual.	
		Control weakness rating	**4**

General Pharmaceutical Services (GPS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation
GPS 2.2 Amendment to contractor standing data Pharmacist and Dispensing doctor bank details, and other standing data, are only amended on the general ledger on receipt of an authorised request from the relevant NHS Board or practice or a request directly from the contractor's bank. The relevant NSS divisional staff complete a NSS Consortium Supplier Setup/Amendment Form, which is signed by two members of divisional staff (Pharmacy Payments) who access FPM (Finance Process Manager) and update the suppliers' details. The update on the FPM is printed out and updated details checked against the Amendment Form for accuracy. A copy of the FPM amendment is attached to the Amendment Form and Bank Mandate Form.	We inspected a sample of changes made to standing data held on Cedar to confirm whether they were based on an authorised request from the health board or contractor, signed by two members of divisional staff, and the change was checked and processed by one NSS PO Team member and reviewed by a second NSS PO Team member. No issues were noted.	**Control weakness rating** **5**

General Pharmaceutical Services (GPS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GPS 2.3 Contractor ceasing operation When a pharmacy or dispensing doctor ceases operation, the details supplied by the NHS Board are removed from eVadis by one member of the payment team and checked by a second individual.	We inspected the details of a sample of ceased contractors that had been removed from eVadis, to confirm whether they had been signed as reviewed by a second individual. We identified one of six (17%) instances where the same individual had processed and reviewed the removal of a contractor.	Management should remind staff that, where a pharmacy or dispensing doctor ceases operation, one member of the payment team should remove the contractor details from eVadis and a second individual should check the changes.	
		Control weakness rating	**4**

General Pharmaceutical Services (GPS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 3 – Payments are accurately calculated			
GPS 3.1 Manual pricing Any dispensed items that are not listed with a price in eVadis must be manually priced by processing staff with reference to the manuals and price lists available to them. The price lists are updated on a monthly basis. The majority of price lists are available electronically on the PS network to ensure processing staff are using the most up-to-date version.	We inspected a sample of distribution lists to confirm whether they were completed by all staff members, with explanations being provided where the form was not signed. No issues were noted.	**Control weakness rating**	**5**
GPS 3.2 Confirmation process All errors identified through the confirmation reporting process are corrected. All processing staff undergo a monthly review to ensure they are aware of any errors they have made and to prevent them from making the same errors the following month.	We inspected the monthly review records for a sample of employees over the period under review to confirm whether reviews had taken place and that prior errors were discussed to prevent repetition. No issues were noted.	**Control weakness rating**	**5**

General Pharmaceutical Services (GPS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GPS 3.3 Random sampling of contractors On a monthly basis a number of contractors are selected for 'random sampling' as part of the confirmation reporting process. A sample of claims (based on ISO sample size guidance) is tested for each selected contractor with any processing errors found being corrected. If the number of errors found requires the sample to be rejected, the full batch is tested and all errors amended. Since March 2016, this process only considers manually keyed in batches and does not include electronic automated batches. This results in the accuracy level being lower than previous years.	We inspected a sample of monthly 'random sampling' DCVP system prints to confirm whether samples were selected based on the number of items submitted by a contractor and that where a sample was rejected; a full 100% check was performed. No issues were noted.	**Control weakness rating**	**5**
GPS 3.4 Fee/allowance changes Government and the NHS Boards provide updated fee and allowance rates to GPS during the year. To ensure accuracy of all fee and allowance amendments, updates are entered into the eVadis system and checked by a second person before it is updated.	We inspected a sample of fee / allowance changes made in eVadis to confirm whether they were processed by one team member and reviewed by a second individual. No issues were noted.	**Control weakness rating**	**5**

General Pharmaceutical Services (GPS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GPS 3.5 Pricing information Item pricing information held on eVadis is updated on a daily basis on receipt of an authorised request and in advance of the monthly upload to DCVP. All changes required are processed by one team member and reviewed by a second individual to ensure accuracy. A Monthly Process Control Form is completed by the two team members, confirming that changes have been processed for each price list.	We inspected a sample of item pricing changes made in eVadis to confirm whether they were processed by one team member and reviewed by a second individual. We also inspected the Monthly Process Control Form for each of these months to confirm if they were appropriately completed and reviewed. No issues were noted.	**Control weakness rating**	**5**
GPS 3.6 High value payments Staff review all individual item payments in excess of £500 for accuracy on a monthly basis by checking the individual scripts from contractors and where necessary notifying the payments team of any adjustments to be made. The print out of payments over £500 is signed as reviewed and checked by a second individual.	We inspected a sample of system generated reports listing payments over £500 to confirm whether management had signed the payments as reviewed and checked by a second individual. No issues were noted.	**Control weakness rating**	**5**

General Pharmaceutical Services (GPS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GPS 3.7 Monthly review of contractor listing To ensure that each contractor is valid, and only paid once, on a monthly basis, before the DCVP payment is processed management review the listing of contractors to be paid in each NHS Board and confirm these agree to expectations. Any discrepancies are resolved.	We inspected a sample of monthly listings of contractors to be paid to confirm whether they were reviewed by management. No issues were noted.	**Control weakness rating**	**5**
GPS 3.8 Reasonableness check of payments Management reviews the DCVP payments to each contractor for reasonableness on a monthly basis by comparing the current month's payment to the prior month's payment and investigating any significant variances.	We inspected a sample of monthly DCVP payment runs to confirm whether the reasonableness check was performed and the payment runs were signed as reviewed. No issues were noted.	**Control weakness rating**	**5**
GPS 3.9 Minor Ailment Scheme payments Before Minor Ailment Scheme (MAS) payments are made, checks are performed to ensure the payment schedule has been updated for new and closed contractors, patient numbers are correct for a sample of contractors across each NHS Board and all contractors have been uploaded onto the DCVP system for payment.	We inspected a sample of payment schedules to confirm whether there was evidence that sample checks had been performed. No issues were noted.	**Control weakness rating**	**5**

General Pharmaceutical Services (GPS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 4 – All claims are processed and paid only once			
GPS 4.1 Checking scanned number of prescriptions The NSS Document Processing Department checks that each contractor's prescriptions are scanned in once for payment on a monthly basis by checking that the number of contractors for whom prescriptions were received for each NHS Board agrees to the number of contractors for whom items have been scanned onto the DCVP system. Any discrepancies are investigated and corrected where necessary.	We inspected a sample of Batch Headers to confirm whether the Document Processing Department had checked that the number of contractors scanned into the DCVP system agreed to the number of original batch headers received. No issues were noted.	**Control weakness rating**	**5**
GPS 4.2 BACS system access Access to the BACS system is restricted to key members of NSS Central Finance.	We confirmed that access to the BACS system was restricted to key members of the payment team. No issues were noted.	**Control weakness rating**	**5**
GPS 4.3 BACS payment request Prior to processing a BACS payment NSS Central Finance must receive a transmission request from a member of PS Finance Management. All processing is carried out in Edinburgh.	We inspected a sample of the 'BACS runs' to confirm whether they were supported by transmission requests from a member of PS Finance Management. No issues were noted.	**Control weakness rating**	**5**

General Pharmaceutical Services (GPS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 4 – All claims are processed and paid only once			
GPS 4.4 BACS report Once the monthly BACS run has been actioned, a copy of the BACS output report is sent to each regional office for verification and retention with the payment documentation.	We inspected the payment documentation retained for a sample of months to confirm whether it contains a copy of the relevant BACS output document. No issues were noted.	**Control weakness rating**	**5**
GPS 4.5 CHAPS payments Payments made by CHAPS and bank transfers must be authorised by a member of the PS Finance Management Team before payment by NSS Central Finance. All processing is undertaken in Edinburgh.	We inspected a sample of monthly 'CHAPS runs' to confirm whether they were supported by transmission requests from a member of PS Finance Management. No issues were noted.	**Control weakness rating**	**5**

General Pharmaceutical Services (GPS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation
Control Objective 5 – Patients make appropriate contributions towards the cost of care		
This control objective is not applicable to Scottish patients using General Pharmaceutical Services in Scotland. A small number of English patients will pay prescription charges to community pharmacists.	This control objective is not applicable to GPS as Scottish patients are not required to make contributions towards the cost of care and the value of prescriptions paid by English patients is immaterial.	

General Pharmaceutical Services (GPS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 6 – Reports to NHS Boards and Scottish Government outlining PS payments are complete and accurate			
GPS 6.1 Appendices Monthly NHS Board reports (the "appendices") are compiled from source documentation and other information and signed off by the preparer before being reviewed and signed by a second team member.	We inspected a sample of monthly NHS Board reports to confirm whether they were signed off by the preparer, and reviewed and signed off by a second team member. No issues were noted.	**Control weakness rating**	**5**
GPS 6.2 Reconciliation of monthly board reports A reconciliation is performed to ensure the total on each of the monthly board reports agree to the total amounts authorised for payment. Any reconciling items are identified and explained.	We inspected a sample of monthly NHS Board reports to confirm whether the reports were reconciled to the total amounts authorised for payment. No issues were noted.	**Control weakness rating**	**5**
GPS 6.3 Reconciliation between Form 12 and appendices A reconciliation is performed between the information on the monthly board reports (the "appendices") and the "Form 12" information to be reported to the SGHSCD to ensure accuracy.	We inspected a sample of reconciliations between the information on the monthly board reports (the "appendices") and the "Form 12" information reported to the SGHSCD to confirm whether they were completed and reviewed by a second individual. No issues were noted.	**Control weakness rating**	**5**

General Pharmaceutical Services (GPS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GPS 6.4 Form 12 report A "Form 12" report summarising the financial information across all four payment streams is supplied to each NHS Board and the SGHSCD on a monthly basis. These are compiled by the PS Finance team and reviewed by a second individual to ensure the information is correct.	We inspected a sample of "Form 12" reports to confirm whether they were prepared by the PS Finance team and reviewed by a second individual. No issues were noted.		
		Control weakness rating	**5**

General Pharmaceutical Services (GPS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 7 – Payment verification arrangements are in place and operate in accordance with Scottish Government guidance			
GPS 7.1 Payment Verification team A Payment Verification team exists that covers all locations and provides PV services as set out in the Scottish Government protocol document.	We inspected a copy of the Scottish Government protocol document to confirm whether it contained GPS guidance. We confirmed the PV team services were in line with the guidance. No issues were noted.	**Control weakness rating**	**5**
GPS 7.2 Quarterly PV checks The PV department produces quarterly reports for all NHS Boards detailing the level of checking carried out in each NHS Board area and highlighting any specific issues.	We inspected a sample of quarterly reports to confirm whether they were produced and contained the expected information. No issues were noted.	**Control weakness rating**	**5**
GPS 7.3 PV check of 1% of contractors The PV team examines dispensing records for 1% of contractors each year to establish the validity of payments made for pharmacy and accuracy of records	We inspected the review register to confirm whether 1% of contractor reports were reviewed during the year under review. We inspected a sample of reports produced following these visits to confirm whether the payments made to pharmacists, and the accuracy of the records, was reviewed. No issues were noted.	**Control weakness rating**	**5**

General Pharmaceutical Services (GPS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 7 – Payment verification arrangements are in place and operate in accordance with Scottish Government guidance			
GPS 7.4 PV referral to Counter Fraud Services Where necessary, following the outcome of payment verification or investigation into unusual prescribing or treatment patterns the payment verification team makes referrals to Counter Fraud Services.	We inquired of management to confirm whether a process is in place for the PV team to make referrals to Counter Fraud Services. We inspected referrals submitted to CFS during the period under review. No issues were noted.	**Control weakness rating**	**5**

General Dental Services (GDS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 1 – Payments have been made based on valid, authorised claims			
GDS 1.1 Payment claims Paper claims for payments relating to dental and orthodontic treatment are only made on receipt of a valid claim form, which includes the registered contractor's payment list number and location code and are signed by the patient and the dentist. Electronic claims can only be submitted by registered contractors, who have purchased the required equipment.	We inspected the claim forms received for a sample of paper based and electronic payments to confirm whether they were valid (i.e. contained the required information), had been signed and included a list number and payment location. No issues were noted.	**Control weakness rating**	**5**
GDS 1.2 Verification of payment claims Once loaded into the MIDAS system all claims relating to dental and orthodontic treatment are subject to further verification in line with the inbuilt regulations from the SGHSCD, to ensure that the claim is valid.	We performed a walkthrough of MIDAS for a sample of regulations in a test environment to confirm whether invalid claims were rejected by the system. No issues were noted.	**Control weakness rating**	**5**
GDS 1.3 Authorised signatory listing An up to date listing of individuals who are authorised to claim payments for each of the NHS Boards is maintained by GDS.	We inspected the authorised signatory lists for a sample of NHS Boards to confirm whether they were up to date. No issues were noted.	**Control weakness rating**	**5**

General Dental Services (GDS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GDS 1.4 Other payments Any other payments are only made on receipt of a valid, authorised claim, signed by an individual included on the NHS Board authorisation listing, or signed by and including the list number and payment location code of a valid contractor.	We inspected a sample of 24 claims of 'other payments' to confirm whether they were signed by an individual included on the NHS Board authorisation listing, or stamped/known contractor. Testing identified three instances (13%) where individuals who had authorised the payment were not on the relevant NHS Board authorisation listing. In one further instance, the signature was not sufficiently clear to allow confirmation against the NHS Board Authorisation Listing.	Management should remind staff that claims should not be approved if signed by an individual who is not on the authorisation list.	
		Control weakness rating	**4**
GDS 1.5 Large/unusual prescribing patterns A list is maintained of all contractors who exhibit large or unusual prescribing/treatment patterns. When a claim is received from a contractor on the list, it is passed to a dental advisor for review and approval prior to being paid through MIDAS.	We inquired of management to confirm whether a list of contractors identified as exhibiting large or unusual prescribing/treatment plans was maintained. We confirmed that claims from these contractors are passed to a dental advisor for review and approval prior to being paid by MIDAS. No issues were noted.		
		Control weakness rating	**5**

General Dental Services (GDS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 2 – Payments are made to valid contractors			
GDS 2.1 New contractors When a new dental contractor is established, the details supplied by the NHS board must be appropriately authorised before they are entered onto MIDAS by a member of the Customer Administration Team. A sample check is performed within 20 working days to ensure that the forms have been processed accurately.	We inspected a sample of new dental contractor details entered onto MIDAS to confirm whether they were authorised by the relevant NHS board. We inspected the sample checks performed for a sample of days during the period to confirm whether they were performed. No issues were noted.	**Control weakness rating**	**5**
GDS 2.2 Changes to contractor standing data Dental contractor bank details are only amended on MIDAS on receipt of a signed request on a bank mandate. Bank details are only updated on the general ledger by NSS Central Finance on receipt of a signed form completed by the PS Finance Department.	We inspected a sample of changes made to bank details in MIDAS and the general ledger to confirm whether they were received from the practice on signed, headed paper and a form was completed and submitted to the Central Finance team by the PS Finance Team. No issues were noted.	**Control weakness rating**	**5**

General Dental Services (GDS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GDS 2.3 Access to MIDAS User access to MIDAS is restricted to only authorised members of staff	We confirmed that access to the MIDAS system was restricted to authorised users. We observed, for a sample of users, that a unique user name and password was required to gain access to the system. No issues were noted.	**Control weakness rating**	**5**
GDS 2.4 Contractor ceasing to operate When a dental contractor ceases to operate, the details supplied by the NHS Board must be appropriately authorised before being entered into MIDAS by a member of the Customer Administration Team. A sample check is performed on a daily basis to ensure that the forms have been processed accurately.	We inspected a sample of ceased dental contractors details removed from MIDAS during the period to confirm whether they were authorised by the relevant NHS Board. We inspected the sample checks performed for a sample of days and confirmed they were performed. No issues were noted.	**Control weakness rating**	**5**

General Dental Services (GDS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 3 – Payments are accurately calculated			
GDS 3.1 Payment rates The SGHSCD provides updated payment rates to PS usually once per year. To ensure accuracy and completeness of information stored within MIDAS, which is used in the calculation of payments, these updates are entered into the MIDAS test environment and authorised before being implemented in the live MIDAS system. Completion of this process is reviewed by the Assistant Director.	We inspected the information received from the SGHSCD to confirm whether it related to 2016/17. We inspected the process sign off sheet to confirm whether it was authorised after being processed in the live MIDAS system. In addition, we confirmed that an authorised individual had signed the document to evidence review of the process. No issues were noted.	**Control weakness rating**	**5**
GDS 3.2 Reasonableness check of payments Claim payments are automatically calculated by MIDAS in line with the regulations and rates which are built into the system. The Test and Support Team perform a high level reasonableness check of the number of claims and values relating to each NHS Board, before the information is transmitted to the NSS Finance Department. This is reviewed by a member of the senior management team.	We inspected evidence for a sample of months to confirm whether the reasonableness check was performed and reviewed by a member of the senior management team. No issues were noted.	**Control weakness rating**	**5**

General Dental Services (GDS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GDS 3.3 Sample of payments to three contractors Before each monthly payment is made, the amounts to be paid in MIDAS for a sample of three contractors are tested by the Dental Payments Team to ensure the payment amounts are valid. Any issues noted are followed up and resolved.	We inspected evidence for a sample of months to confirm whether payments calculated for three contractors were checked for validity and that any issues identified were followed up. No issues were noted.	**Control weakness rating**	**5**
GDS 3.4 Patient refunds The weekly calculation of patient refunds is performed by one team member and then reviewed by a second team member to ensure that the refund is accurately calculated. The refund is authorised by a nominated Senior Officer.	We inspected a sample of weekly refund summary spreadsheets to confirm whether they were prepared by one member of staff, reviewed by a second individual and authorised by a nominated senior officer. No issues were noted.	**Control weakness rating**	**5**
GDS 3.5 Other payments Other Payments notified by the NHS Boards are made in line with the amounts included on that notification. No calculation is performed by PS in relation to these amounts.	We inspected a sample of 'other payments' notified from NHS Boards (additional payment listing) to confirm whether the amount paid was the same as the amount included on the applicable notification (on MIDAS). No issues were noted.	**Control weakness rating**	**5**

General Dental Services (GDS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GDS 3.6 Payments adjustment/non-payment Any adjustment/non-payment/patient detail amendment claims are returned to the contractor with a comment to explain the reason for the non-payment. If the contractor is satisfied with the reason for the action taken then the form is not re-submitted. If the contractor is not in agreement with the action taken the form is re-submitted with additional information to be processed.	We inspect a sample of adjustment/non-payment/patient detail amendment claims to confirm whether they were recorded on the 'adjustment/non-payment/patient detail amendment' spreadsheet, that they were returned to the contractor with a relevant reason and that they were not processed through the system until returned correctly completed. No issues were noted.		
		Control weakness rating	**5**
GDS 3.7 Dental commitment payments Dental commitment payments are automatically calculated by MIDAS in line with the rates which are built into the system based on the number of patients registered to a dental practice. Patient withdrawals/removals requests submitted by NHS Boards must be submitted on a relevant signed form.	We inspected a sample of patient withdrawals to confirm whether they had been submitted on signed, authorised forms and had been "removed" from the relevant dental practice. In three instances from a sample of 24, withdrawal forms that had not been signed as authorised were processed. In one further instance, the processing date was not recorded on a form. We were therefore unable to assess whether this had been processed in a timely manner.	Management should remind staff that withdrawal forms should not be processed without appropriate authorisation. In addition, staff should be reminded to record all required information when processing forms.	
		Control weakness rating	**4**

General Dental Services (GDS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 4 – All claims are processed and paid only once			
GDS 4.1 Reconciliation of dental claim forms A monthly reconciliation is undertaken to ensure that all the dental treatment claim forms received have been processed into MIDAS for payment. Any discrepancies identified as part of this reconciliation are followed up and resolved. This reconciliation is prepared by one member of staff and reviewed by a second staff member.	We inspected a sample of monthly reconciliations to confirm whether they were performed, evidenced as reviewed by a second staff member and that any discrepancies identified were followed up and resolved. No issues were noted.	**Control weakness rating**	**5**
GDS 4.2 Non-payment spreadsheet A spreadsheet is populated for each of the non-payments (on a rolling basis) noting all returned claims and the reason for returning the claims. If a claim is re-submitted this is treated as a completely new claim. The claim form will be returned until the form is fit for processing. The spreadsheet is subject to regular and ongoing review by the Quality Manager.	We inspected the spreadsheet to confirm whether it included evidence of regular and ongoing review by the Quality Manager. No issues were noted.	**Control weakness rating**	**5**

General Dental Services (GDS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GDS 4.3 Duplicate payment claims MIDAS automatically checks all claims relating to dental treatments to ensure that they are not duplicate claims. Any duplicate claims identified are returned to the contractor as unpaid	For a sample of claims which were identified by MIDAS as being duplicates, we observed the procedure for evaluating whether they should be returned to the contractor unpaid, or assessed the reasonableness of the reasons for not returning the claims unpaid. No issues were noted.	**Control weakness rating**	**5**
GDS 4.4 Other payments 'Other' payments notified by the NHS Board are manually keyed into MIDAS by one staff member and reviewed for accuracy by a second member of staff.	We inspected the 'other payments' summary for a sample of months to confirm whether they were processed by one team member and reviewed by a second team member. No issues noted.	**Control weakness rating**	**5**
GDS 4.5 Reasonableness check of claims The Test and Support Team perform a high level reasonableness check of the number of claims and values relating to each NHS Board, before the information is transmitted to the NSS Finance Department for BACS payment. This is reviewed by a member of the management team	We inspected evidence for a sample of months to confirm whether the reasonableness check of the BACS total was performed and reviewed by a member of the management team. No issues were noted.	**Control weakness rating**	**5**

General Dental Services (GDS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GDS 4.6 Access to BACS system Access to the BACS system is restricted to key members of NSS Central Finance	We inspected the system to confirm whether access to the treasury management screen in Cedar was restricted to key staff members. No issues were noted.	**Control weakness rating**	**5**
GDS 4.7 BACS payment request Prior to processing a BACS payment NSS Central Finance must receive a transmission request from a senior member of PS Finance Department.	We inspected a sample of monthly BACS runs to confirm whether a transmission request form was completed and authorised by a senior member of the PS Finance Department. No issues were noted.	**Control weakness rating**	**5**
GDS 4.8 CHAPS payments Payments made by CHAPS, Paymaster General and bank transfers must be authorised by a member of the PS Finance Department before payment is made by NSS Central Finance	We inspected a sample of CHAPS payments for the period to confirm whether they were supported by a transmission request from a member of PS Finance Management. No issues were noted.	**Control weakness rating**	**5**
GDS 4.9 Cheques for patient refunds Prior to raising cheques for patient refunds, NSS Central Finance Department must receive an electronic listing of all refund amounts from an authorised individual in the Dental Payments Team	We inspected a sample of patient refund listings during the period to confirm whether they were notified by an authorised individual in the Dental Payments Team. No issues were noted.	**Control weakness rating**	**5**

General Dental Services (GDS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 5 – Patients make appropriate contributions towards the cost of care			
GDS 5.1 Patient contributions to care Payments made to dental practitioners are net of any contribution received from patients towards the cost of care. MIDAS automatically calculates the amount to be paid given the information received from the dentist on the claim form.	We inspected a claim to confirm whether the payment received by the practitioner was net of the patient contribution towards the cost of care. No issues were noted.	**Control weakness rating**	**5**

General Dental Services (GDS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 6 – Reports to NHS Boards and Scottish Government outlining PS payments are complete and accurate			
GDS 6.1 Monthly board reports Monthly NHS Board reports are compiled from the BACS payment run and other information and are prepared by one team member before being reviewed by a second individual.	We inspected a sample of monthly NHS Board reports to confirm whether they were prepared and signed as reviewed by a second individual. No issues were noted.	**Control weakness rating**	**5**
GDS 6.2 Reconciliation of monthly board reports A reconciliation is undertaken to ensure that the total on each of the monthly NHS Board reports agrees to the total amounts processed in Cedar, the financial ledger. Any reconciling items are identified and explained.	We inspected a sample of monthly NHS Board reports to confirm whether the reconciliation to Cedar was performed and any reconciling items identified were followed up. No issues were noted.	**Control weakness rating**	**5**
GDS 6.3 Form 12 report A "Form 12" report, summarising the financial information across all four payment streams, is supplied to each of the NHS Boards and to the SGHSCD on a monthly basis. These are compiled by the PS Finance Department and reviewed by a second member of staff to ensure the information is correct.	We inspected a sample of "Form 12" reports issued during the period to confirm whether they were prepared by the PS Finance Department and reviewed by a second individual. No issues were noted.	**Control weakness rating**	**5**

General Dental Services (GDS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 7 – Payment verification arrangements are in place and operate in accordance with Scottish Government guidance			
GDS 7.1 Payment Verification team A Payment Verification Team exists (the Dental Monitoring Team) and provides PV services as set out in the Scottish Government protocol document	We inspected a copy of the Scottish Government CEL to confirm whether it contained GDS guidance. No issues were noted.	**Control weakness rating**	**5**
GDS 7.2 Quarterly PV checks The PV department produces quarterly reports for all NHS Boards detailing the results of the checking undertaken in each NHS Board and highlighting any specific issues of interest	We inspected a sample of quarterly reports to confirm whether they were produced and contained the required information. No issues were noted.	**Control weakness rating**	**5**
GDS 7.3 Dental Monitoring Team The Dental Monitoring Team performs a check on a minimum of 1% of contractors each year to test: items of service (risk assessed); patient registration and list size; level of earnings; and cost per claim and throughput. Any issues identified by the team are followed up with more detailed testing.	We inspected the listing of contractors that were tested by the Dental Monitoring Team during the period to confirm whether it represented at least 1% of total contractors. We inspected evidence of testing and confirmed it had been performed and followed up appropriately. No issues were noted.	**Control weakness rating**	**5**

General Dental Services (GDS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GDS 7.4 Referral of patients to SDRS For 11,000 of the total claims received in the year the Dental monitoring team refer patients, on a random and targeted basis, to Scottish Dental Reference Services (SDRS) who perform detailed checks of claim entitlement and clinical nature.	We inspected an extract from the Scottish Dental Reference Services (SDRS) database detailing all patients who were referred to SDRS in the year to confirm whether this equated to 11,000 of the total claims received. No issues were noted.	**Control weakness rating**	**5**

General Ophthalmic Services (GOS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 1 – Payments have been made based on valid, authorised claims			
GOS 1.1 Payment claims Claims for payments relating to sight tests, spectacles, repairs and hospital eye services are only made on receipt of a valid claim form which has been signed and includes the list number and payment location code of a registered contractor	We inspected the claim forms received for a sample of relevant payments to confirm whether they were valid (i.e. contained the required information), signed and included a list number and payment location code. No issues were noted.	**Control weakness rating**	**5**
GOS 1.2 Verification of payment claims Once loaded into the OPTIX system all claims relating to sight tests, spectacles, repairs and hospital eye services are subject to further verification in line with the inbuilt regulations from the SGHSCD, to ensure that the claim is valid.	We performed a walkthrough of all in-built regulations in the OPTIX system in a test environment (system clone) to confirm whether all invalid claims were rejected by the OPTIX system. No issues were noted.	**Control weakness rating**	**5**
GOS 1.3 Authorised signatory listing An up-to-date listing of all individuals who are authorised to claim payments for each of the NHS Boards is maintained	We inspected the signatory lists of NHS Boards to confirm whether they were up to date. No issues were noted.	**Control weakness rating**	**5**

General Ophthalmic Services (GOS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GOS 1.4 Other payments Any other payments are only made on receipt of a valid, authorised claim, signed by an individual included on the NHS Board authorisation listing, or signed by and including the list number and payment location code of a valid contractor.	We inspected the claims for a sample of other payments to determine whether they were signed by an individual included on the NHS Board authorisation listing or stamped by the relevant contractor. We found one instance (4%) in which the Payment Team processed a payment that was authorised by an individual who was not on the relevant NHS Board authorisation listing.	Management should remind staff that claims should not be processed when authorised by an individual who is not on the authorisation list.	
		Control weakness rating	**4**

General Ophthalmic Services (GOS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 2 - Payments are made to valid contractors			
GOS 2.1 New ophthalmic contractor When a new ophthalmic contractor is appointed, the contractor details, supplied by the NHS Board, must be appropriately authorised before being entered into OPTIX by a member of the Customer Administration Team. A sample of changes made to OPTIX, including removal, is audited by a second individual within 20 working days.	We inspected a sample of new practice details entered onto OPTIX during the period to confirm whether they were authorised by the relevant NHS Board and processed by a team member. No Issues were noted.	**Control weakness rating**	**5**
GOS 2.2 Amendment to contractor standing data Ophthalmic contractor bank details are only amended on OPTIX on receipt of a signed request on headed paper. Bank details are only updated in the general ledger by the Central Finance team on receipt of a signed form completed by the PSD finance department.	We inspected a sample of changes made to bank details in OPTIX and Cedar during the period to confirm whether requests were received from the practice on signed headed paper and a form was completed and submitted to the PO Team by the PS Finance Team. No issues were noted.	**Control weakness rating**	**5**
GOS 2.3 OPTIX user access User access to OPTIX is restricted.	We have observed users trying to use the system to confirm that a unique user ID and password are required. No issues were noted.	**Control weakness rating**	**5**

General Ophthalmic Services (GOS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GOS 2.4 Contractor ceasing to operate When an ophthalmic practice ceases operation, the details authorised by the NHS Board are removed from OPTIX by one member of the Customer Administration team. A sample of changes made to OPTIX (including removals) is audited by a second individual within 20 working days.	We inspected a sample of new practice details entered onto OPTIX during the period to confirm whether they were authorised by the relevant NHS Board and processed by a team member. No issues were noted.	**Control weakness rating**	**5**

General Ophthalmic Services (GOS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 3 – Payments are accurately calculated			
GOS 3.1 Payment rates The SGHSCD provides updated payment rates to PS usually once per year. To ensure accuracy and completeness of information stored within OPTIX, which is used in the calculation of payments, these updates are entered into the live OPTIX system. The updates are entered into the system by one person and checked for accuracy by a second individual.	We inspected the information received from the SGHSCD to confirm whether it related to the 2016/17. We inspected the process sign off sheet to confirm whether it was processed in the live OPTIX system. We confirmed that a second individual signed the document to evidence review of the process. No issues were noted.	**Control weakness rating**	**5**
GOS 3.2 Payment claims Claim payments are automatically calculated by OPTIX in line with the regulations and rates which are built into the system. The Test and Support Team performs a high level reasonableness check of the number of claims and values relating to each NHS Board, before the information is transmitted to the NSS Finance Department. This is reviewed by a member of the senior management team.	We inspected the evidence for a sample of months during the period to confirm whether a reasonableness check was performed and reviewed by a member of the senior management team. No issues were noted.	**Control weakness rating**	**5**

General Ophthalmic Services (GOS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GOS 3.3 Sample of payments to three contractors Before each monthly payment is made, the amounts to be paid in OPTIX for a sample of three contractors are tested by the Test and Support Team to ensure the payment amounts are valid. Any issues noted are followed up and resolved.	We inspected a sample of checks performed throughout the period by the Test and Support Team to confirm they were completed. We obtained evidence that any issues were followed up and resolved. No issues were noted.	**Control weakness rating**	**5**
GOS 3.4 Other payments Other Payments notified by the NHS Boards are made in line with the amounts included on that notification. No calculation is performed by PS in relation to these amounts.	We inspected a sample of 'other payments' notified from NHS Boards to confirm whether the amount paid was the same as the amount included on the applicable notification. No issues were noted.	**Control weakness rating**	**5**
GOS 3.5 Patient refunds The weekly calculation of individual patient refunds is performed by one team member, reviewed by a second individual to ensure accuracy of calculation and authorised by a nominated senior officer.	We inspected a sample of weekly refund summary spreadsheets to confirm whether there was evidence of preparation by one team member, review by a second individual and authorisation by a nominated senior officer. No issues were noted.	**Control weakness rating**	**5**

General Ophthalmic Services (GOS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GOS 3.6 Payments adjustments/non-payments Any adjustment/non-payment/patient detail amendment claims are returned to the contractor with a comment to explain the reason for the non-payment. If the contractor is satisfied with the reason for the action taken then the form is not re-submitted. If the contractor is not in agreement with the action taken the form is re-submitted with additional information to be processed. A spreadsheet is populated for each of the non-payments (on a rolling basis) noting all returned claims and the reason for returning the claims. If a claim is re-submitted this is treated as a completely new claim. The claim form will be returned until the form is fit for processing.	We inspected a sample of adjustment / non-payment / patient detail amendment claims to confirm that they were recorded on the 'adjustment / non-payment / patient detail amendment' spreadsheet, that they were returned to the contractor with a relevant reason and that they were not processed through the system until returned correctly completed. No issues were noted.		
		Control weakness rating	**5**

General Ophthalmic Services (GOS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 4 – All claims are processed and paid only once			
GOS 4.1 Monthly reconciliation of claim forms A monthly reconciliation is undertaken to ensure all claim forms received (sight tests, spectacles supply and repairs) have been processed into OPTIX for payment. Any exceptions are followed up and resolved and the reconciliation is reviewed by a second team member.	We inspected a sample of monthly reconciliations to confirm that they were performed, evidenced as reviewed by a second individual and any discrepancies identified were followed up and resolved. No issues were noted.	**Control weakness rating**	**5**
GOS 4.2 Non-payment spreadsheet A spreadsheet is populated for each of the non-payments (on a rolling basis) noting all returned claims and the reason for returning the claims. If a claim is re-submitted this is treated as a completely new claim. The claim form will be returned until the form is fit for processing. The spreadsheet is subject to regular and ongoing review by the Quality Manager.	We inspected the spreadsheet to confirm that it included evidence of regular and ongoing review by the Quality Manager. No issues were noted.	**Control weakness rating**	**5**

General Ophthalmic Services (GOS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GOS 4.3 Duplicate claims OPTIX automatically checks all claims (sight test, spectacles and repairs) to ensure they are not duplicate claims. Any duplicate claims which are identified are returned to the contactor unpaid.	For a sample of claims which were identified by OPTIX as being duplicates, we observed the procedure for evaluating whether they should be returned to the contractor unpaid. Where a claim was not returned unpaid, we confirmed whether a reason for that action was recorded. No issues were noted	**Control weakness rating**	**5**
GOS 4.4 Other payment claims 'Other payments' notified by the NHS Board are manually keyed into OPTIX for payment by one team member and are reviewed for accuracy by a second individual.	We inspected the other payments summary for a sample of months to confirm whether it had been processed by one team member and reviewed by a second individual. No issues were noted.	**Control weakness rating**	**5**
GOS 4.5 Reasonableness check of claims The Test and Support Team performs a high level reasonableness check of the number of claims and values relating to each NHS Board, before the information is transmitted to the NSS Finance Department for BACS payment. This is reviewed by a member of the management team.	We inspected evidence for a sample of months to confirm whether the reasonableness check of the BACS total was performed and reviewed by a member of the senior management team. No issues were noted.	**Control weakness rating**	**5**

General Ophthalmic Services (GOS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GOS 4.6 BACS system access Access to the BACS system is restricted to key members of NSS Central Finance team.	We inspected the system to confirm whether access to the treasury management screen in Cedar was restricted to key staff. No issues were noted.	**Control weakness rating**	**5**
GOS 4.7 BACS payments Prior to processing a BACS payment NSS Central Finance must receive a completed transmission request from a member of the PS Finance Department.	We inspected the BACS runs for a sample of months to confirm whether a transmission request form was completed and authorised by a senior member of the PS Finance Department. No issues were noted.	**Control weakness rating**	**5**
GOS 4.8 CHAPS payments Payments made by CHAPS and bank transfer must be authorised by a member of the PS Finance Department before payment is made.	We inspected the register of CHAPS runs and bank transfers for a sample of months to confirm whether they were supported by a transmission request from a member of PS Finance Management. No issues were noted.	**Control weakness rating**	**5**
GOS 4.9 Cheques for patient refunds Prior to raising cheques for patient refunds, NSS Central Finance must receive an electronic listing of all refund amounts from an authorised individual in the Ophthalmic Payments Team.	We inspected a sample of patient refund listings to confirm whether they were notified by an authorised individual in the Ophthalmic Payments Team. No issues were noted.	**Control weakness rating**	**5**

General Ophthalmic Services (GOS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation
Control Objective 5 – Patients make appropriate contributions towards the cost of care		
This control objective is not applicable to General Ophthalmic Services.	This control objective is not applicable to GOS as patients are not required to make contributions towards the cost of care.	

General Ophthalmic Services (GOS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 6 – Reports to NHS Boards and Scottish Government outlining PS payments are complete and accurate			
GOS 6.1 Appendices Monthly NHS Board reports (the "appendices") are compiled from the BACS payment run and other information and are prepared by one team member before being reviewed by a second individual.	We inspected a sample of monthly NHS Board reports to confirm whether they were prepared by one individual and signed as reviewed by a second individual. No issues were noted.	**Control weakness rating**	**5**
GOS 6.2 Reconciliation between board reports and general ledger A reconciliation is performed to ensure the total on each of the monthly NHS Board reports agrees to the total amounts processed on the general ledger. Any reconciling items are identified and explained.	We inspected a sample of monthly NHS Board reports to confirm whether reconciliations to the general ledger were performed and that any reconciling items identified were followed up. No issues were noted.	**Control weakness rating**	**5**
GOS 6.3 Form 12 report A "Form 12" report summarising the financial information across all four payment streams is supplied to each of the NHS Boards and to the SGHSCD on a monthly basis. These are compiled by the PS Finance Department and reviewed by a second individual to ensure the information is correct.	We inspected a sample of monthly "Form 12" reports to confirm whether they were prepared by the PS Finance Department and reviewed by a second individual. No issues were noted.	**Control weakness rating**	**5**

General Ophthalmic Services (GOS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
Control Objective 7 – Payment verification arrangements are in place and operate in accordance with Scottish Government guidance			
GOS 7.1 Payment Verification Team A Payment Verification Team exists and provides PV services which are set out in the Scottish Government protocol document.	We inspected a copy of the Scottish Government CEL to confirm whether it contained GOS guidance. We confirmed the services provided by the PV Team were in line with the guidance. No issues were noted.	**Control weakness rating**	**5**
GOS 7.2 Quarterly PV checks The PV Department produces quarterly reports for all NHS Boards detailing the results of the checking undertaken within each of the NHS Board areas and highlighting any specific issues.	We inspected a sample of PV reports for the period to confirm whether they were produced and contain the required information. No issues were noted.	**Control weakness rating**	**5**
GOS 7.3 High/unusual prescribing patterns Practices with high or unusual patterns are investigated further or it may be decided to refer the matter on to Counter Fraud Services.	We inspected a sample of quarterly reports and other documentation to confirm whether further investigation was evidenced for practices identified as having high or unusual prescribing patterns. No issues were noted.	**Control weakness rating**	**5**

General Ophthalmic Services (GOS)

Management's control description	Scott-Moncrieff testing & observation	Scott-Moncrieff recommendation	
GOS 7.4 Annual sampling of patient records On an annual basis a statistically significant random sample of patient records are to be inspected, primarily through the implementation of practice visits. Any issues identified through practice visits are referred to the relevant NHS Board and resolved.	We inspected the list of random validity checks performed in the period to confirm whether it was statistically significant. We inspected a sample of items included on the list to confirm whether testing was performed. No issues were noted.	**Control weakness rating**	**5**
GOS 7.5 PV Team referral to CFS Where necessary, following the outcome of payment verification or investigation into unusual prescribing or treatment patterns, the Payment Verification Team makes referrals to Counter Fraud Services ("CFS").	We enquired of management to confirm whether a process is in place for the PV team to make referrals to Counter Fraud Services. No issues were noted.	**Control weakness rating**	**5**

Appendix 1 – Action Plan

Reference	Finding	Recommendation	Control weakness rating	Management response
ITGC 1.2 Reviews of user access	Our audit testing identified weaknesses in respect of user access during 2016-17. We noted that the Q1 quarterly review was not performed. It was stated that this was due to resourcing challenges. We also noted that when lists of users are issued, there is no control to ensure that all recipients of the email respond to this. From review of the quarterly reviews performed, it was evident that they are not fully effective. This was evidenced by the fact that in some cases, users who had left NSS in 2014 and 2015 were being highlighted as requiring their accounts disabled. We also noted that the information being used for reviews was a roll-forward of previous user lists that had been circulated rather than extracts of live user accounts from systems. Therefore, the lists may not be an accurate reflection of active accounts.	Quarterly user access reviews should be carried out for the all PS systems to confirm that user access is appropriate. User lists circulated to line managers should be based on extracts of current active user accounts from each PS system. Controls should be implemented to ensure that responses are provided by all line managers and action taken to remove/revise access as appropriate. When responses are not received, this should be escalated as appropriate.	**3**	Current user lists have been getting circulated, responses are being acted upon or noted as non-response. Escalation has not been enacted yet for non-response. We have recently identified and agreed the escalation individual to senior level within P&CFS. The IT Dept manager has discussed this with the Test and Support managers to ensure this is implemented into the general process for the next quarterly check. **Action owner:** Senior IT Service Manager **Due Date:** Aug 2017

Reference	Finding	Recommendation	Control weakness rating	Management response
ITGC 3.2– Management of change developments	We confirmed that the management of change developments is handled at change control meetings with input from discussions held between the Informed Customer, IT Business Partner and IT Change Manager. Meetings were confirmed as being held monthly at work-stream level. We noted that an IT change management process has been drafted but has yet to be approved.	The IT change management process should be approved by PS management and applied for all future changes.	**4**	There had been unexpected delay with completing the Change Management document due to operational pressures, however this is going through its final stage and aiming to get it completed by end of July (accounting for holidays etc) with a view to having initial feedback/approval from P&CFS senior team in August. To note and for re-assurance, this is the official documented process. The basic change process itself is understood and managed by the Change Manager on a regular basis to control IT change via CCMs (change control meetings), with Problem statements used for unplanned change and emergency change being managed via incident/service management engaging with appropriate business leads for approval & downtime using the change matrix. **Action owner:** Senior IT Service Manager **Due Date:** Oct 2017

Reference	Finding	Recommendation	Control weakness rating	Management response
GMS 1.2 – Payments to practices	We observed a member of the payments team processing a payment to confirm whether it was authorised by an individual included on the relevant authorisation list. We inspected a sample of payments made in the period to confirm whether they were appropriately authorised. In one of 24 payments tested (4%) we found that the payments team processed a payment that was authorised by an individual who was not on the authorised signatory list.	Management should remind staff that claims should not be processed for payment if authorised by an individual who is not on the authorisation list.	**4**	All staff will be reminded of the process and we will highlight the consequences of accepting instructions from contractors and NHS Board personnel, where no formal authority has been given by the Directors of Finance to act on their behalf with regards to contractor amendments, payments for services, the registration of patients and any other instructions contained in the partnership agreement with each NHS Board. Staff will also be reminded of the process to retain all documentation applicable to each instruction they action. **Action Owner:** Quality Assurance Manager **Due Date:** 31st May 2017

Reference	Finding	Recommendation	Control weakness rating	Management response
GPS 2.1 New pharmacy or dispensing doctor	We inspected the details of a sample of new pharmacies or dispensing doctors entered into eVadis to confirm whether they were signed as reviewed by a second individual. We found one item, from a sample of two, had been checked and signed off by the same individual.	Management should remind staff that where a new pharmacy or dispensing doctor starts, details should be added to eVadis by one member of the payment team and checked by a second individual.	**4**	All staff will be reminded of the process and we will highlight the consequences of not performing the independent check to transactions made in Evadis. Staff will also be reminded of the importance of segregation of duties with the input and verification of Evadis transactions. **Action Owner:** Pharmacy Payments Manager **Due Date:** 31st May 2017

Reference	Finding	Recommendation	Control weakness rating	Management response
GPS 2.3 – Contractor removal	We inspected the details of a sample of ceased contractors that had been removed from eVadis, to confirm whether they had been signed as reviewed by a second individual. We identified one of six (17%) instances where the same individual had processed and reviewed the removal of a contractor.	Management should remind staff that, where a pharmacy or dispensing doctor ceases operation, one member of the payment team should remove the contractor details from eVadis and a second individual should check the changes.	**4**	All staff will be reminded of the process and we will highlight the consequences of not performing the independent check to transactions made in Evadis. Staff will also be reminded of the importance of segregation of duties with the input and verification of Evadis transactions. **Action Owner:** Pharmacy Payments Manager **Due Date:** 31st May 2017

Reference	Finding	Recommendation	Control weakness rating	Management response
GDS 1.4 – Other payments	We inspected a sample of 24 claims of 'other payments' to confirm whether they were signed by an individual included on the NHS Board authorisation listing, or stamped/known contractor. Testing identified three instances (13%) where individuals who had authorised the payment were not on the relevant NHS Board authorisation listing. In one further instance, the signature was not sufficiently clear to allow confirmation against the NHS Board Authorisation Listing.	Management should remind staff that claims should not be approved if signed by an individual who is not on the authorisation list.	**4**	All staff will be reminded of the process and we will highlight the consequences of accepting instructions from contractors and NHS Board personnel, where no formal authority has been given by the Directors of Finance to act on their behalf with regards to contractor amendments, payments for services, the registration of patients and any other instructions contained in the partnership agreement with each NHS Board. Staff will also be reminded of the process to retain all documentation applicable to each instruction they action. **Action Owner:** Quality Assurance Manager **Due Date:** 31st May 2017

Reference	Finding	Recommendation	Control weakness rating	Management response
GDS 3.7 – Dental commitment payments	We inspected a sample of patient withdrawals to confirm whether they had been submitted on signed, authorised forms and had been "removed" from the relevant dental practice. In three instances from a sample of 24, withdrawal forms that had not been signed as authorised were processed. In one further instance, the processing date was not recorded on a form. We were therefore unable to assess whether this had been processed in a timely manner.	Management should remind staff that withdrawal forms should not be processed without appropriate authorisation. In addition, staff should be reminded to record all required information when processing forms.	**4**	Staff will be reminded that withdrawal forms should not be processed without appropriate authorisation and that all required information must be recorded when processing forms'. **Action Owner**: Operations Manager **Due Date**: 31st May 2017

Reference	Finding	Recommendation	Control weakness rating	Management response
GOS 1.4 – Other payments	We inspected the claims for a sample of other payments to determine whether they were signed by an individual included on the NHS Board authorisation listing or stamped by the relevant contractor. We found one instance (4%) in which the Payment Team processed a payment that was authorised by an individual who was not on the relevant NHS Board authorisation listing.	Management should remind staff that claims should not be processed when authorised by an individual who is not on the authorisation list.	**4**	All staff will be reminded of the process and we will highlight the consequences of accepting instructions from contractors and NHS Board personnel, where no formal authority has been given by the Directors of Finance to act on their behalf with regards to contractor amendments, payments for services, the registration of patients and any other instructions contained in the partnership agreement with each NHS Board. Staff will also be reminded of the process to retain all documentation applicable to each instruction they action. **Action Owner:** Quality Assurance Manager **Due Date:** 31st May 2017

Appendix 2 – Summary of Findings

Summary of Findings

Control weakness rating

The control weakness rating helps the NSS Audit & Risk Committee as well as management and auditors of NHS Boards assess the significance of the issues raised and prioritise the action required to address them. The control weakness rating structure is summarised as follows:

Rating	Definition
1	Very high risk exposure – Major concerns requiring immediate attention.
2	High risk exposure – Absence / failure of significant key controls.
3	Moderate risk exposure – Not all key control procedures are working effectively.
4	Limited risk exposure – Minor control procedures are not in place/working effectively.
5	No significant control weaknesses identified.

The following table indicates our assessment of the application of controls for each control objective by PS management for the payment of family health services practitioners and ranking of any findings resulting from our review.

Control Objective	Control weakness rating				
	1	2	3	4	5
Information Technology General Controls					
Appropriate logical access and data confidentiality controls are in place for all payment streams	-	-	1	-	4
Disaster recovery and business continuity arrangements are in place to ensure the recovery of data and PS operations in the event of an incident	-	-	-	-	1
Controls are in place to ensure that systems development and change control cannot be undertaken unless valid, authorised and tested	-	-	-	1	3

Control Objective	Control weakness rating				
	1	2	3	4	5
General Medical Services					
Payments have been made based on valid, authorised claims	-	-	-	1	3
Payments are made to valid contractors	-	-	-	-	5
Payments are accurately calculated	-	-	-	-	6
All claims are processed and paid only once	-	-	-	-	7
Patients make appropriate contributions towards the cost of care	Not Applicable to GMS				
Reports to NHS Boards and Scottish Government outlining PS payments are complete and accurate	-	-	-	-	4
Payment verification arrangements are in place and operate in accordance with Scottish Government guidance	-	-	-	-	3

Control Objective	Control weakness rating				
	1	2	3	4	5
General Pharmaceutical Services					
Payments have been made based on valid, authorised claims	-	-	-	-	4
Payments are made to valid contractors	-	-	-	2	1
Payments are accurately calculated	-	-	-	-	9
All claims are processed and paid only once	-	-	-	-	5
Patients make appropriate contributions towards the cost of care	Not Applicable to GPS				
Reports to NHS Boards and Scottish Government outlining PS payments are complete and accurate	-	-	-	-	4
Payment verification arrangements are in place and operate in accordance with Scottish Government guidance	-	-	-	-	4

Control Objective	Control weakness rating				
	1	2	3	4	5
General Dental Services					
Payments have been made based on valid, authorised claims	-	-	-	1	4
Payments are made to valid contractors	-	-	-	-	4
Payments are accurately calculated	-	-	-	1	6
All claims are processed and paid only once	-	-	-	-	9
Patients make appropriate contributions towards the cost of care	-	-	-	-	1
Reports to NHS Boards and Scottish Government outlining PS payments are complete and accurate	-	-	-	-	3
Payment verification arrangements are in place and operate in accordance with Scottish Government guidance	-	-	-	-	4

Control Objective	Control weakness rating				
	1	2	3	4	5
General Ophthalmic Services					
Payments have been made based on valid, authorised claims	-	-	-	1	3
Payments are made to valid contractors	-	-	-	-	4
Payments are accurately calculated	-	-	-	-	6
All claims are processed and paid only once	-	-	-	1	8
Patients make appropriate contributions towards the cost of care	Not Applicable to GOS				
Reports to NHS Boards and Scottish Government outlining PS payments are complete and accurate	-	-	-	-	3
Payment verification arrangements are in place and operate in accordance with Scottish Government guidance	-	-	-	-	5

Appendix 3 – Other information provided by the Independent Service Auditor

Introduction

This report is intended to provide interested parties with information sufficient to gain a broad understanding of the processes and controls operated by NSS in respect of PS payments to family health service practitioners on behalf of the Scottish NHS health boards. It is each interested party's responsibility to evaluate this information in relation to the internal controls in place at their organisation. If effective internal controls are not in place at an NHS Board level, the controls applied by NSS PS may not compensate for such weaknesses.

The objective of a coordinated system of controls is to provide reasonable, but not absolute, assurance regarding the level of control over assets and related transactions. The concept of reasonable assurance recognises that the cost of a system of internal control should not exceed the benefits derived and also recognises that the evaluation of these factors necessarily requires estimates and judgements to be made by management.

As part of the examination of NSS PS controls, a variety of tests were performed by Scott-Moncrieff of the controls documented within this report. The remainder of this section describes this testing.

Tests of Controls

Our tests of the operating effectiveness of NSS PS included such tests as we considered necessary in the circumstances to evaluate whether those control procedures, and the extent of compliance with them, were sufficient to provide reasonable, but not absolute, assurance that the specified control objectives were achieved during the period from 1 April 2016 to 31 March 2017.

Our tests were designed to cover a representative number of transactions and procedures throughout the period. In selecting particular tests of the operating effectiveness of the controls, we considered:

- The nature of the controls being tested;
- The nature of the control objectives to be achieved;
- The assessed level of control risk;
- The expected efficiency and effectiveness of the test; and
- The testing of controls relevant to the stated control objective.

The types of testing performed are described briefly below.

Enquiry

Enquiries seeking relevant information or representation from PS personnel were performed to obtain, among other things, knowledge and additional information regarding the controls; and corroborating evidence of the

control. As enquiries were performed for substantially all NSS PS controls, this test was not listed for every individual control in Section 5.

Observation

The operation of specific, described controls was observed. As observations were performed for substantially all NSS PS controls, this test was not listed for every individual control in Section 5.

Inspection

Documents and records indicating performance of the controls were inspected. This included, among other things:

- Inspection of reconciliations and management reports that age or quantify reconciling items to assess whether balances and reconciling items are properly monitored, controlled and resolved;
- Examination of source documentation and authorisations to verify propriety of transactions processed;
- Examination of documents or records for evidence of performance such as the existence of initials or signatures; and
- Inspections of systems documentation, such as operations manuals, flow charts and job descriptions.

Re-performance

Controls or processing applications were re-performed to test the accuracy of their operation.

The sample sizes that have been applied in testing controls, depending on the frequency the control is applied and the assessed level of control risk, are set out in the table below.

Frequency of control (population)	Number of items tested for non-IT controls	Number of items tested for IT controls
Annually	1	1
Quarterly	2	2
Monthly	3	3
Weekly	7	5
Daily	15	25
Multiple times per day	24	30

Our testing methodology has been designed to take account of the inherent and residual risks relating to these controls, along with our previous experience of testing such controls and the nature of the control exceptions identified therein.

Appendix 4 – Other information provided by NSS

This part of the Service Auditor's report is for other information provided by the service organisation. It includes a glossary of terms and other relevant information related to the area reviewed.

Abbreviations used throughout this report:

Reference	Definition/Purpose
CFS	Counter Fraud Services
CHI	Community Health Index
DCVP	Data Capture, Validation and Pricing program, the main computer system within the pharmaceutical process
EDI	Electronic Data Interchange
EVADIS	"Drug dictionary" that contains details of current drugs and prices and details of contractors
GDS	General Dental Services
GMS	General Medical Services
GOS	General Ophthalmic Services
GP	General Practitioner
GPS	General Pharmaceutical Services
HES	Hospital Eye Service
iDENT	The GOS/GDS system used to perform initial validation on forms once they have been scanned i.e. checking of list numbers etc.
IM&T	Information Management and Technology department of NSS
ISD	Information Services Division of NSS
List Number	A unique number assigned to each dentist
MIDAS	Management Information and Dental Accounting System, the main computer system within the dental process
NSS	National Services Scotland
NSS IT	IT Strategic Business Unit which provides technical support and system administration services
OPTIX	Claim processing system for ophthalmic payments
PCDoc	An application used to store optical images of claims that have been processed for payment
PMS	Personal Medical Services
PMSPS	Primary Medical Services Payment System for GMS payments
PPC	Pre-Payment Certificates
PRS	Patient Registration System used in e-pharmacy
PS	Practitioner Services of NSS
PV	Payment Verification

Reference	Definition/Purpose
QA	Quality Assurance
QOF	Quality Outcomes Framework used by GMS for practice aspiration data and handling practice achievement data
SAF	Scottish Allocation Formula
Script	Form used by a GP detailing drugs to be dispensed
SDR	Statement of Dental Remuneration
SGHSCD	Scottish Government Health and Social Care Directorates
SFE	Statement of Financial Entitlements
SLA	Service Level Agreement
SPSaA	Supplementary Payment System and Adjustment

Key information technology systems and applications:

Reference	Definition/Purpose
Cedar	NSS finance system and general ledger (also known as e-financials).
General Medical Services	
Community Health Index ("CHI")	Patients' index which maintains and informs the number of patients registered at each GP Practice.
Quality Management and Analysis System ("QMAS")	This system is used to administer and calculate quality points to be awarded to each GP Practice and the resultant payments are downloaded into PMSPS.
QOF Calculator	This system replaced QMAS for payments being made from 2011/12.
Primary Medical Services Payment System ("PMSPS")	This calculates the monthly payments to GP Practices.
General Pharmaceutical Services	
Scanning equipment	IT Scanning equipment which scans claim forms received.
Data Capture, Validation and Pricing System ("DCVP")	This system validates and values scripts submitted by dispensing contractors once or twice per month.
Patient Registration System ("PRS")	Pharmacy patient registration process for the Minor Ailment Service.
eVadis	Pharmacy drug dictionary and contractors database. Information from eVadis is uplifted into DCVP monthly.
Supplementary Payment System and Adjustment ("SPSaA")	This system is used to process any required adjustments to payments and feeds directly into DCVP.
Pre-Payment Certificates ("PPC")	Used to issue prepayment certificates.
General Dental Services	
Scanning equipment	IT Scanning equipment which scans claim forms received.
iDENT	Scanning and data capture application, feeds directly into MIDAS

Reference	Definition/Purpose
Management Information and Dental Accounting System (“MIDAS”)	Primary system for dental payments.
PCDoc	Database for long term storage of paper claim images (scanned through iDENT). This database is accessed via MIDAS.
Electronic Data Interchange (“EDI”)	System, where dental contractors with the required equipment can enter claims directly.
General Ophthalmic Services	
Scanning equipment	IT Scanning equipment which scans claim forms received.
iDENT	Initial point of contact and used to scan applications received and capture data before being uploaded into OPTIX.
OPTIX	The main system used by GOS to calculate payments to contractors.
PCDoc	Database for long term storage of paper claim images (scanned through iDENT). This database is accessed via OPTIX.

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

Item Number 7.3(b)

AUDIT45/2017
Audit Committee
22 June 2017

NATIONAL IT SERVICES CONTRACT - SERVICE AUDIT REPORTS

1. PURPOSE OF THE REPORT

The purpose of the report is to bring to the attention of the Audit Committee as part of the annual accounts process, the outcome of the NHS National Services Scotland (NSS) Service Audit undertaken in 2016/17, on the National IT Services Contract.

2. RECOMMENDATIONS

The Audit Committee is asked to note and take assurance from the following:-

- the executive summary of the report of the Service Auditors;
- the audit report from the independent Service Auditors, and
- the management responses to the issues arising.

3. EXECUTIVE SUMMARY

The Service Audit of the National IT Services Contract has been undertaken in accordance with International Standard on Assurance Engagements 3402 (ISAE 3402), "Assurance Reports on Controls at a Service Organisation", issued by the International Auditing and Assurance Standards Board. ISAE 3402 is in line with adoption of international standards of reporting, e.g. IFRS, and requires management to provide a written assertion regarding the service organisation's responsibilities for systems and controls, with the aim of the Service Audits providing NHS Tayside with assurance on the controls in operation within Atos Origin Alliance (AOA) that meet specified control objectives. The service auditor is required to provide an opinion on the suitability of the design of controls related to the control objectives throughout the period.

National IT Services

Appendix 1 includes documents and extracts from the full report, including Executive Summary, Independent Service Auditors' Report 2016/17, and Action Plan with management responses to the issues arising.

The full reports are available to members on request.

The Audit Reports cover the 12 month period from 1 April, 2016, to 31 March, 2017.

The executive summary in the National IT Service report states that "the 2016/17 service audit testing did not identify any control weaknesses that were considered to be of a significant nature and classified as high risk (Priority 1 or 2) and identified 16 minor points, and also confirms that all minor actions from the previous year service audit have been fully resolved.

4. MEASURES FOR IMPROVEMENT

Following on from the Service Audit undertaken, recommendations arising are agreed with management and formulated into an agreed action plan. Progress against all recommendations is reviewed on a regular basis and reported to the NSS Audit Committee. Outstanding recommendations are reviewed on an annual basis by the Service Auditors. Any issues that remain outstanding would be included in the Service Audit report as exceptions noted by the Service Auditors.

5. RESOURCE IMPLICATIONS

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

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

6. DELEGATION LEVEL

Not applicable.

7. RISK ASSESSMENT

The Service Auditor's report is unqualified. The executive summary indicates action has been taken to address all of the control weaknesses identified in the previous Audit report. None of the recommendations this year or in last year were considered significant.

8. IMPLICATIONS FOR HEALTH

There are no direct implications for health arising as a consequence of this report.

9. TIMETABLE FOR IMPLEMENTATION AND LEAD OFFICER

Not applicable.

10. IMPACT ASSESSMENT AND INFORMING, ENGAGING AND CONSULTING

Not applicable.

11. PATIENT EXPERIENCE

Not applicable.

Robert MacKinnon
Associate Director of Finance –
Financial Services & Governance,
FLO

Lindsay Bedford
Director of Finance

June 2017

NHS National Services Scotland

ISAE3402 Service Audit Executive Commentary – National IT Services Contract

May 2017

Scott-Moncrieff
business advisers and accountants

NHS National Services Scotland

ISAE3402 Service Audit Executive Commentary – National IT Services Contract

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Executive Summary

Introduction

The executive summary which follows should be read in conjunction with and taking account of all matters raised throughout the detailed sections of this report.

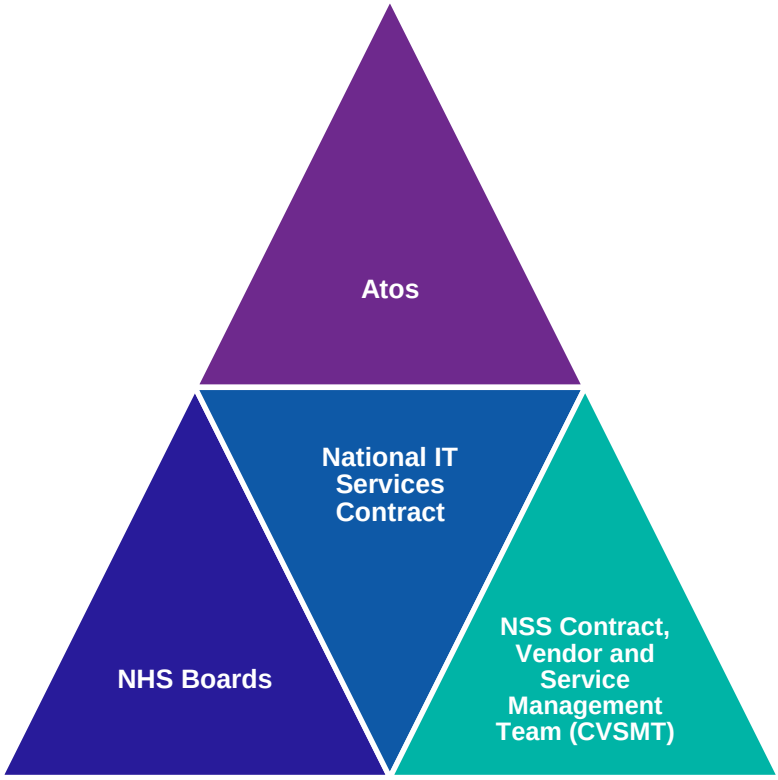
This report describes the control environment in operation within Atos and its alliance partners, IBM and Sopra Group (herein referred to as “Atos”) relating to the delivery of the NHSScotland National Information Technology Services Contract (herein referred to as “National IT Services Contract”). This report has been prepared for the use of NHS Boards in Scotland and their auditors in accordance with International Standard on Assurance Engagements (ISAE) 3402 “Assurance Reports on Controls at a Service Organisation”.

The control areas to be subject to audit, and therefore, the control objectives to be reviewed are agreed annually with NHS National Services Scotland (NSS) management with input from NHSScotland Directors of Finance. Atos management is responsible for the identification and agreement of control objectives that relate to delivery of the National IT Services Contract. Atos management is also responsible for the design, implementation and maintenance of controls to ensure with reasonable assurance that the control objectives are achieved.

The Independent Service Auditor’s Report, which is contained at Section 2, is unqualified.

Atos is responsible for a wide range of IT service provision ranging from a fully managed technical service through to hosting of hardware.

The Contract, with Atos being the prime contractor, took effect from 1 April 2007 and the extended service agreement attached to the contract is now in operation and being used by NHS Boards. On a day-to-day basis, the contract is managed by the NSS Contract, Vendor and Service Management Team (CVSMT) who are responsible for liaison between NHS Boards and Atos.



Contractual payments comprise a fixed annual fee, paid in equal monthly instalments, as well as ad-hoc payments for specific change requests. These are invoiced to agreed deliverables.

Scott-Moncrieff has been engaged to provide assurance to NSS and NHS Boards in the form of a service audit for the National IT Services Contract. Our service audit work is restricted to the services provided under the contract by Atos and does not include those controls in operation within NHS Boards.

Content of the Independent Service Auditor's Report

The Service Audit of the National IT Services Contract has been performed in accordance with International Standard on Assurance Engagements (ISAE) 3402 "Assurance Reports on Controls at a Service Organisation".

In line with our terms of engagement we have produced a Type 2 ISAE 3402 report. A Type 2 report has distinct requirements as follows:

1. Service Auditor opinion (Section 2)
2. Written assertion by the service organisation that, in all material respects, and based on suitable criteria:
   a. The description fairly presents the service organisation's system as designed and implemented throughout the specified period (Section 1); and
   b. The controls related to the control objectives stated in the service organisation's description of its system were suitably designed and operated effectively throughout the specified period. (Section 1)
3. Details of the testing of the service organisation's controls and the results of that testing. (Sections 4 & 5)
4. Reliance placed on the work of Internal Audit. (Sections 4 and 5)
5. Other relevant information. (Appendices 3 & 4)

This Service Audit aims to provide user organisations (NHS Boards) and user auditors (Audit Scotland or appointed firms) with assurance on the controls in operation within Atos that meet specified control objectives in respect of the National IT Services Contract.

Specific exclusions

Only the IT controls and control objectives for which Atos is solely responsible are included within the scope of this audit. The controls which operate within NHS Boards to support the delivery of IT services are excluded from this service audit. Responsibility for assurance for NHS Board-operated controls rests with the NHS Board and their respective internal and external auditors.

Overall Assessment of Control Objectives

The output from all of our review work has been consolidated into the overall service audit report on the services provided by Atos as part of the delivery of the National IT Services Contract.

Control weakness rating

The control weakness rating helps the NSS Audit & Risk Committee as well as management and auditors of NHS Boards assess the significance of the issues raised and prioritise the action required to address them. The control weakness rating structure is summarised as follows:

Rating Definition

1	Very high risk exposure – Major concerns requiring immediate attention.
2	High risk exposure – Absence / failure of significant key controls.
3	Moderate risk exposure – Not all key control procedures are working effectively.
4	Limited risk exposure – Minor control procedures are not in place/working effectively.
5	No significant control weaknesses identified.

The following table provides an overview of our assessment of all of the control objectives reviewed as part of our service audit against the relevant control weakness rating.

Review area	Total controls objectives audited	Control weakness rating				
		1	2	3	4	5
IT System Development	21				2	19
Change Management	5					5
Continuity of Resources	2					2
Security Management	10			2		8
Infrastructure Maintenance	4				2	2
Application, Storage and Media Management	14			3		11
Disaster Recovery & Business Continuity Planning	10				3	7
Third Party Services	5				1	4
Project & Programme Management	14					14
Service Desk – Incident and Problem Management	9					9
Performance Management	5					5
Configuration Management	3			3		-
Capacity and Performance Management	5					5
Cost Control and Charging Arrangements	4					4
Atos Internal Audit	9					9
Total	120			8	8	104

We have received satisfactory responses from Atos and CVSMT management to all of the findings detailed in this report. These are included in the Action Plan at Appendix 1 to this report.

Applications subject to review

Our service audit coverage of the National IT Services Contract has resulted in review of the controls Atos has in place over a wide range of NHSScotland applications and contracted service provision. These were selected following input from the NHSScotland Directors of Finance Group as well as discussion with the NSS CVSMT and Atos and using our knowledge of the NHS in Scotland, to provide a representative sample of the business applications supported by Atos. We have detailed below a list of those applications and contracts included as part of a review and the COBIT Audit Process Area it relates to.

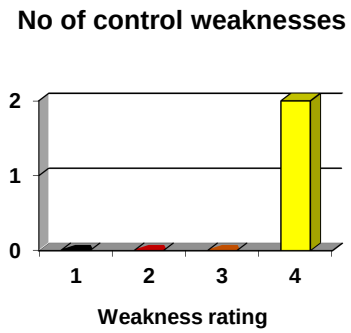
Audit Process Area	Specific areas of coverage
IT System Development, Change Management and Continuity of Resources	SSTS, BoSS
Security Management	SSTS (Wintel) and NSI eFinancials (UNIX)
Infrastructure Maintenance	Standard review
Application, Storage and Media Management	BoSS and SSTS (Wintel) and NSI eFinancials (UNIX)
Disaster Recovery and Business Continuity Planning	Standard review
Third Party Services	SopraSteria
Project & Programme Management	BoSS and SSTS (Applications Compliance) and ServiceNow
Incident and Problem Management	Standard review
Performance Management	Standard review
Configuration Management	Standard review
Capacity and Performance Management	SCI-Gateway
Cost Control and Charging Arrangements	Standard review
Atos Internal Audit	Standard review

It is important to note that we have not conducted full business cycle audits of these applications. Rather we have examined the controls Atos has in place over their services which support these business applications.

Individual Review Findings

To facilitate the reporting process, the significant findings from each of the Audit Process Areas reviewed are summarised in the sections below. We have also included a graph illustrating the number of control weaknesses found in each area, based on the ratings identified above:

IT System Development, Manage Change and Continuity of Resources



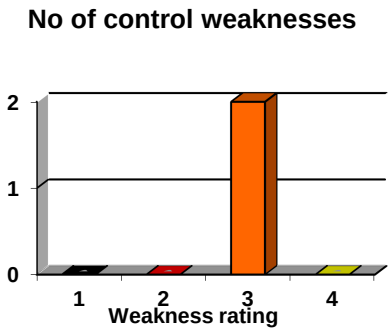
The IT system development life cycle is a process which involves many stages, from establishing the feasibility of the system to live operation and ongoing maintenance of the system. Essentially, it is used to convert a management requirement into an application which is custom developed, purchased or a combination of both.

Many of the systems managed by Atos is critical systems to NHSScotland. As technology evolves and business processes change, there will be a need for applications to similarly evolve to meet the requirements of management and users. Applications can often be in a continual development cycle. It is essential for the successful operation of systems that all developments to IT systems follow a robust system development life cycle which ensures there is detailed analysis and understanding of requirements, development controls, system and user testing, followed by controlled release and maintenance of the systems.

We have concluded that there were no control weaknesses resulting from our service audit of change management and continuity of resource arrangements.

Our review of IT System Development has concluded that there were **two control weaknesses rated as limited risk** resulting from our service audit of system developments. The two weaknesses relate to **one issue.** We found that not all results of testing were fully and accurately completed in testing schedules.

Security Management



Security management is a fundamental part of ensuring the confidentiality, integrity and availability of information technology services.

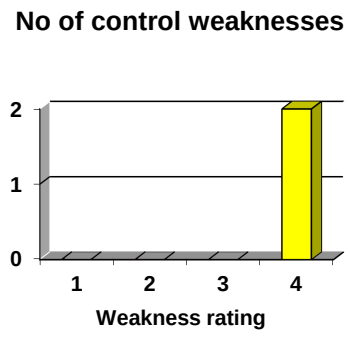
With the increased reliance on technology for all areas of service delivery throughout NHSScotland it is essential that access to technology is subject to robust logical and physical security measures that are clearly understood and applied consistently across all hardware, operating systems and applications.

Our review of this area has concluded that there were **two control weaknesses rated as moderate risk** resulting from our service audit of security management. The two moderate risk weaknesses relate to **one issue** which is as follows:

- An access control master list is maintained by Atos of those users who have privileged access to the server environment. This list is a key element of the monitoring and audit process for access to production servers. This allows listed (approved) users to be matched against the log files generated from the Splunk

monitoring tool to provide assurance that only authorised personnel have gained access to the production servers. Our testing identified that the access control master list was not updated to reflect a new member of the Wintel team who joined Atos in February 2016. We also noted from review of the access control master list that 25 users were listed where there was no confirmation of the date on which they signed an NHSScotland Confidentiality agreement. We subsequently confirmed that all 25 users had signed confidentiality agreements.

Infrastructure Maintenance

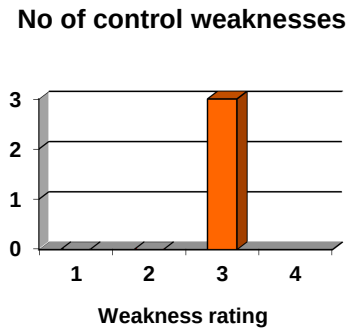


Atos provides a managed technical service for a large number of NHSScotland applications. As part of the service delivered, Atos has responsibility for ensuring that these systems are managed in a manner which ensures their confidentiality, integrity and availability.

The purpose and rationale of an "Enterprise Architecture Platform" (EAP) was outlined as part of the Atos re-bid solution overview. The platform is designed to provide a flexible and scalable architecture, with the capability to meet a wide range of requirements; rapid provisioning to meet new requirements at short notice and granularity through virtualisation technologies for optimum efficiency.

Our review of this area has concluded that there were **two control weaknesses rated as limited risk** resulting from our service audit of infrastructure maintenance. The two weaknesses relate to **one issue** which is to ensure that the Lead Architecture Engagement Framework (LAEF) document is reviewed and updated in line with defined review timescales.

Application, Storage and Media Management and Compliance with External Requirements



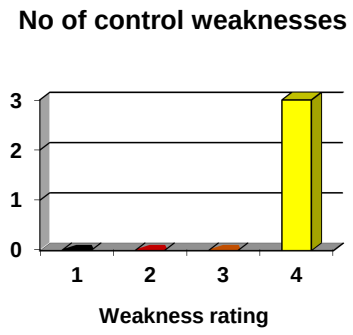
Atos provides a managed technical service for a large number of NHSScotland applications. As part of the service delivered, Atos has responsibility for ensuring that these systems are managed in a manner which ensures their confidentiality, integrity and availability. Although, NHS Boards largely have responsibility for user account management, Atos has to ensure that the applications and hardware on which they reside are available to meet user requirements.

In addition, Atos must also ensure that the applications are logically and physically secure, backup tapes are held securely and adequate arrangements are in place for the recovery of NHSScotland applications. It is also essential that there are effective procedures in place for production of printed outputs that are generated by Canon on behalf of Atos.

Our review of this area has concluded that there were **three control weaknesses rated as moderate risk** resulting from our service audit of application, storage and media management. The three control weaknesses were related to **two issues** as follows:

- In cases of backup failures, Atos will raise an Incident ticket. From our sample of backup failures, we identified that, for seven failures in our sample, an Incident ticket was either not raised, or not raised within 24 hours of the confirmed failure.
- The most recent annual audit of backup media held with a third party indicated a number of discrepancies. This indicates that the monthly audits performed by the Proximity Operations team during the year are not sufficiently robust.

Disaster Recovery & Business Continuity Planning

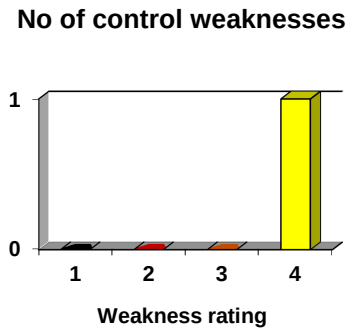


Disaster recovery and business continuity planning arrangements are key features of all major contracts and are a fundamental part of the National IT Services Contract. Effective disaster recovery and business continuity planning arrangements provide management with assurance that in the event of a disaster there will be minimal, if any, interruption to service provision.

Our review of this area has concluded that there were **three control weaknesses rated as limited risk** resulting from our service audit of business continuity and disaster recovery planning. These three control weaknesses were related to **two issues** which are as follows:

- The grab bag for one of the sites relevant to the Contract did not contain the updated version of the site business continuity plan.
- A high level plan has been developed for testing of Business Continuity Plans. The plan, however, was found to be of a basic nature and contained limited information on the timing and types of tests to be performed.

Third Party Services



A number of third parties are used by Atos for the provision of NHSScotland services, including Sopra Steria who provide application development and support services primarily for Practitioner Services.

Our review of this area has concluded that there was **one control weakness rated as limited risk** resulting from our service audit of third party services. We noted that there was no control in place to ensure that sub-contractor records in the Atos SAP system were reconciled on a regular basis with the Register of Sub-Contractors.

Project & Programme Management

No significant control weaknesses identified ✓

Project and programme management is a key feature of all major contracts. It provides management with assurance that services are being delivered to the expected quality and on time. Effective project and programme management should also ensure that risks are identified and mitigated, where possible, and that issues and changes that could affect the project are communicated and managed efficiently.

The workstreams that were considered as part of our audit were the ServiceNow and Applications Compliance (BoSS and SSTS) programmes.

We have concluded that there were no control weaknesses resulting from our service audit of project and programme management arrangements.

Service Desk Provision – Problem Management and Incident Management

No significant control weaknesses identified ✓

The Service Desk operated by Atos is the first point of contact for NHSScotland users who are experiencing issues with those services managed by Atos. The successful operation of a Service Desk requires that all user issues are logged and managed to a satisfactory resolution within specified timeframes, according to the relative priority of the issue being experienced. These timeframes will typically be identified in a service level agreement.

In addition, it is essential that the Service Desk works towards building a knowledgebase in order that they can quickly diagnose and resolve issues effectively and efficiently. The Service Desk also requires a link to the problem management system in order that issues are fully resolved to prevent their recurrence rather than provide temporary resolutions.

We have concluded that there were no control weaknesses resulting from our service audit of Service Desk Provision – Problem Management and Incident Management.

Performance Management

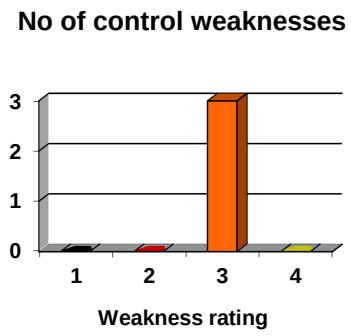
No significant control weaknesses identified ✓

Performance management is a key feature of all major contracts. It provides management with assurance that services are being delivered to the expected quality and on time. It also provides management with the opportunity to identify those areas where performance has not met expected standards and seek resolutions to ensure performance improvement.

We have concluded that there were no control weaknesses resulting from our service audit of performance management arrangements for the National IT Services Contract.

Configuration Management

An effective configuration management process provides the master record of configuration items against which changes are implemented. It provides reference baselines for the change management service and will assist in identifying the services and systems changes will impact on. It is also an information point for the hardware and software estates.



Our review of this area has concluded that there were **three control weaknesses rated as moderate risk** resulting from our service audit of configuration management. The three control weaknesses were related to **two issues** as follows:

- The Configuration Management Local Work Instruction Day Book was no longer representative of the current processes in operation.
- The configuration management spreadsheet for software had not been periodically and independently verified to confirm that it is an accurate reflection of the NHSScotland software asset estate.

Capacity and Performance Management

No significant control weaknesses identified ✓

Effective and consistent provision of IT services relies on robust capacity and performance management of network services. These processes ensure that there is proactive monitoring of both the capacity and performance of communications, storage and network devices confirm what is needed so that long and short term requirements can be met without a decline in the quality of service and/or the availability of critical IT services.

We have concluded that there were no control weaknesses resulting from our service audit of capacity and performance management procedures.

Cost Control and Charging Arrangements

No significant control weaknesses identified ✓

It is essential for any service contract that the costing and charging bases are agreed in advance in order that all parties are aware of what it will cost to access/use services. The National IT Services contract defines the basis of charging to NHSScotland which is essentially the operational cost model (the core costs) and the additional costs incurred through change control notes (CCNs). It is essential that there are procedures in place which ensure that charges are levied at agreed rates and that all costs are agreed to in advance.

We have concluded that there were no control weaknesses resulting from our service audit of cost control and charging procedures.

Atos Internal Audits

No significant control weaknesses identified ✓

Atos is subject to internal audit through their quality and security directorates. They are also subject to accreditation visits from external bodies to confirm that they remain compliant with external standards such as ISO27001, ISO20000 and ISO9001.

It was agreed during the planning of the 2016/17 Service Audits for the National IT Services contract that we would aim, wherever possible, to place reliance on the work of the in-house internal audit teams as well as the external audits commissioned by Atos to minimise duplication of effort.

We have concluded that we are able to place reliance on Atos internal audit work performed by their Quality and Security Directorates and the external auditing work commissioned by Atos. These independent audit functions were carried out in compliance with good practice and, in general, satisfied the control requirement to provide independent audit and review of the Atos control environment.

Significant control weaknesses

The summary of findings at Appendix 2 gives a quick guide to the results of our testing and indicates, with a control weakness rating structure and colour codes, all areas where any control measure was found to be other than satisfactory.

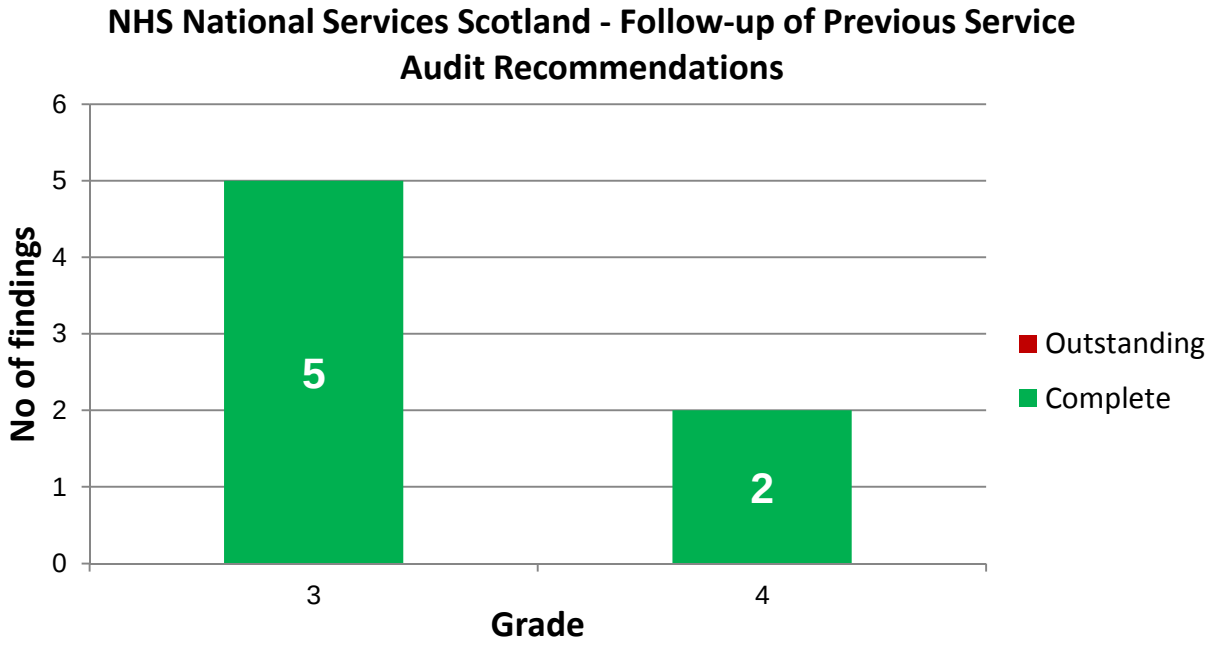
For the fourth year in succession, our service audit testing did not identify any control weaknesses that were considered to be of a significant nature and classified as high risk (Priority 1 or 2).

Follow-up of Previous Recommendations

As part of our service audit coverage for 2016/17, we have performed testing to confirm progress made in implementing recommendations identified in our previous service audit reports. The NSS Audit & Risk Committee has received progress updates throughout the year.

As was reported to NSS Audit & Risk Committees during 2016/17, all of the recommendations arising from the 2015/16 Service Audit were confirmed to have been fully resolved by Atos.

The graph below provides an overview of the number and respective grade of completed actions.



Independent Service Auditor's Report, including Opinion

(Extract from full Service Audit Report)

To the Members of NHS National Services Scotland Board:

Use of report

This report is made solely for the use of the Board members, as a body, of NHS National Services Scotland, and solely for the purpose of reporting on the internal controls of Atos as part of their delivery of the NHS Scotland National IT Services Contract, in accordance with the terms of our engagement.

Our work has been undertaken so that we might report to the Board members those matters that we have agreed to state to them in this report and for no other purpose. Our report must not be recited or referred to in whole or in part in any other document nor made available, copied or recited to any other party, in any circumstances, without our express prior written permission.

We permit the disclosure of this report, in full only, by the Board members at their discretion to customers of NHS National Services Scotland using the NHS Scotland National IT Services Contract ('Customer NHS Boards') and to the auditors of such Customer NHS Boards, to enable Customer NHS Boards and their auditors to verify that a report by reporting accountants has been commissioned by the Board members of NHS National Services Scotland and issued in connection with the internal controls of Atos as part of their delivery of the NHS Scotland National IT Services Contract, and without assuming or accepting any responsibility or liability to Customer NHS Boards or their auditors on our part.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board members as a body and NHS National Services Scotland for our work, for this report or for the conclusions we have formed.

Scope

We have been engaged to report on Atos' description at Sections 3 and 5 of this report of its controls in respect of the delivery of the NHS Scotland National IT Services Contract to NHS Boards throughout the period 1 April 2016 to 31 March 2017 (the description), and on the design and operation of controls related to the control objectives stated in the description.

The description indicates that certain control objectives specified in the description can be achieved only if complementary customer controls contemplated in the design of Atos' controls are suitably designed and operating effectively, along with related controls at the customer organisation. We have not evaluated the suitability of the design or operating effectiveness of such complementary customer controls.

Atos' responsibilities

Atos is responsible for: preparing the description and accompanying assertion at pages 11-12, including the completeness, accuracy and method of presentation of the description and assertion; providing the services covered by the description; stating the control objectives; and designing, implementing and effectively operating controls to achieve the stated control objectives.

Service Auditor's responsibilities

Our responsibility is to express an opinion on Atos' description and on the design and operation of controls related to the control objectives stated in that description based on our procedures. We conducted our engagement in accordance with International Standards for Assurance Engagements 3402, "Assurance

Reports on Controls at a Service Organisation", issued by the International Auditing and Assurance Standards Board. That standard requires that we comply with ethical requirements and plan and perform our procedures to obtain reasonable assurance about whether, in all material respects, the description is fairly presented and the controls are suitably designed and operating effectively.

An assurance engagement to report on the description, design and operating effectiveness of controls at a service organisation involves performing procedures to obtain evidence about the disclosures in the service organisation's description of its system, and the design and operating effectiveness of controls. The procedures selected depend on the service auditor's judgment, including the assessment of the risks that the description is not fairly presented, and that controls are not suitably designed or operating effectively. Our procedures included testing the operating effectiveness of those controls that we consider necessary to provide reasonable assurance that the control objectives stated in the description were achieved. An assurance engagement of this type also includes evaluating the overall presentation of the description, the suitability of the objectives stated therein, and the suitability of the criteria specified by the service organisation as described at pages 11-12. We believe that the evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Limitations of controls at a service organisation

Atos' description is prepared to meet the common needs of a broad range of customers and their auditors and may not, therefore, include every aspect of the system that each individual customer may consider important in its own particular environment. Also, because of their nature, controls at a service organisation may not prevent or detect all errors or omissions in processing or reporting transactions. The projection of any evaluation of effectiveness to future periods is subject to the risk that controls at a service organisation may become inadequate or fail.

Opinion

Our opinion has been formed on the basis of the matters outlined in this report. The criteria we used in forming our opinion are those described on pages 11-12. In our opinion, in all material respects:

(a) The description fairly presents Atos' delivery of the National IT Services Contract as designed and implemented throughout the period from 1 April 2016 to 31 March 2017;

(b) The controls related to the control objectives stated in the description were suitably designed throughout the period from 1 April 2016 to 31 March 2017; and

(c) The controls tested, which together with the complementary customer controls referred to in the scope paragraph of this report, if operating effectively were those necessary to provide reasonable assurance that the control objectives stated in the description were achieved, operated effectively throughout the period from 1 April 2016 to 31 March 2017.

Description of tests of controls

The specific controls tested and the nature, timing and results of those tests are listed in Section 5.

Scott-Moncrieff
17 May 2017

Exchange Place 3
Semple Street
Edinburgh

Appendix 1 – Action Plan

Reference (page = full report page no.)	Recommendation	Control weakness rating	Joint Management response
5.1.8 Software Quality Assurance **(Page 61)** **5.1.14 Test Plan** **(Page 76)**	We recommend that the results of all tests are completed in the relevant testing schedules to ensure that there is an accurate record of the outcome of tests performed.	**4**	

Actions to address the recommendations	Evidence that will be provided	Target Date
Introduce 'self-checklist' to ensure test plans are updated fully.	AI2 I7 GDP_E3_CHK_Test_Case_Review	28/4/17

Reference (page = full report page no.)	Recommendation	Control weakness rating	Joint Management response
5.2.3 Identity Management **(Page 115)** **5.2.4 User Account Management** **(Page 119)**	We recommend that management seek to ensure that the user access master list is updated to reflect changes to personnel to ensure an accurate record is maintained. We further recommend that this list is periodically reviewed to ensure that it remains accurate and only contains current Atos and third party personnel. We recommend that management take steps to ensure that the access control list is fully complete and that all fields within it are accurately completed. We recommend that management confirm that confidentiality agreements are in place for all users listed on the Master Access Control list. If any exceptions are identified, management should ensure that confidentiality agreements are signed as soon as possible.	3	Atos has investigated the issue where one member of staff was identified as not having been updated within the list of authorised staff. Our investigations confirm that the staff member's account creation went through the correct approvals process and that can be evidenced through change UK:C5629910 (August 2016) when the member of staff started on the NHS Scotland service. The account is listed on the master list of authorized users as it should be but was not updated on the SPLUNK access control list. As per ATOS-POL-0038, accounts are only appended to the SPLUNK ACL when a new event is triggered and at this point a series of actions are initiated to confirm that the user is authorized to access the Production DB environment. Follow up action is therefore required to investigate at a technical level why this event did not trigger in this case.

Actions to address the recommendations	Evidence that will be provided	Target Date
The SPLUNK tooling team have been engaged to investigate in detail, and resolve, the technical issue that meant the "trigger event" did not occur for the particular staff member in this case where other steps of the process had been completed as per the ATOS-POL-0038 policy	Report provided by technical team to identify the root cause of this issue, actions taken to address the issue and to confirm that it has been resolved.	31/5/2017

Reference (page = full report page no.)	Recommendation	Control weakness rating	Joint Management response
5.3.1 Technology Infrastructure Acquisition Plan **(Page 137)** **5.3.2 Infrastructure Resource Protection & Availability** **(Page 140)**	We recommend that the Lead Architect Engagement Framework (UKD-MMB-6000) documentation is reviewed in accordance with defined review schedules. Processes should be established to ensure that documents are reviewed on a regular basis.	**4**	

Actions to address the recommendations	Evidence that will be provided	Target Date
"Provide correct version of Atos LAEF applicable for NHSS.	Evidence that LAEF doc (UKD-MMB-6000 Lead Architect Engagement Framework) has been reviewed	Provided 2/3/17
Provide evidence that there is a process to ensure BMS controlled docs are reviewed on a regular basis"	Evidence of the process that ensures BMS controlled docs are reviewed on a regular basis (UKP-MMB-5302MS UK&I BMS CHANGE MANAGEMENT AND RELEASE PROCESS)	Provided 2/3/17

<table>
<tr><th>Reference
(page = full report page no.)</th><th>Recommendation</th><th>Control weakness rating</th><th>Joint Management response</th></tr>
<tr><td>5.4.2 Storage & Retention Requirements

(Page 149)</td><td>Where backups have been confirmed as failed, management should ensure that an incident is raised promptly in order to identify the root cause of the failure and instigate corrective action. By minimising the window between a backup failure occurring and normal processing resuming, the risk of unacceptable data loss, and recovery point objectives (RPO) not being met, is minimised.</td><td>3</td><td><table>
<tr><th>Actions to address the recommendations</th><th>Evidence that will be provided</th><th>Target Date</th></tr>
<tr><td>To ensure failures are reviewed within 24 hours then we will review current process and amend to raise incident on first backup failure.</td><td>Revised UKW-MMK-251R UK CS Backup Failure Incident Management Quick Guide.docx</td><td>15/5/17</td></tr>
</table></td></tr>
<tr><td>5.4.3 Media Library Management System

(Page 153)</td><td>We recommend that management ensure that the vault inventory report is updated to confirm that it documents an accurate list of media tapes held. Once this has been conducted we recommend that a further physical verification audit be undertaken to ensure that all records which are maintained are accurate.

We also recommend management review the monthly audit process for tapes held within DRS to gain assurance that all tapes held can be appropriately accounted for.</td><td>3</td><td><table>
<tr><th>Actions to address the recommendations</th><th>Evidence that will be provided</th><th>Target Date</th></tr>
<tr><td>Review Prox Ops monthly checklists backed up by physical audit to ensure lists are accurate.</td><td>Provide the monthly audit checklist, a sample monthly DRS audit report, a sample inventory audit from DRS and findings of tapes not at DRS.</td><td>15/5/17</td></tr>
</table></td></tr>
</table>

Reference (page = full report page no.)	Recommendation	Control weakness rating	Joint Management response
5.4.5 Backup & Restoration **(Page 158)**	We recommend that management ensure that the vault inventory report is updated to confirm that it documents an accurate list of media tapes held. Once this has been conducted we recommend that a further physical verification audit be undertaken to ensure that all records which are maintained are accurate. We also recommend management review the monthly audit process for tapes held within DRS to gain assurance that all tapes held can be appropriately accounted for. Where backups have been confirmed as failed, management should ensure that an incident is raised promptly in order to identify the root cause of the failure and instigate corrective action. By minimising the window between a backup failure occurring and normal processing resuming, the risk of unacceptable data loss, and recovery point objectives (RPO) not being met, is minimised.	3	

Actions to address the recommendations	Evidence that will be provided	Target Date
Satisfactory completion of 5.4.2 and 5.4.3 will close this action.	See 5.4.2 and 5.4.3	15/5/17

Reference (page = full report page no.)	Recommendation	Control weakness rating	Joint Management response
5.5.1 Ensure Continuous Service **(Page 172)** **5.5.2 IT Continuity Plans** **(Page 175)**	We recommend that management ensure that, whenever Business Continuity Plans are updated, those copies held in grab bags are replaced with the updated version.	**4**	

Actions to address the recommendations	Evidence that will be provided	Target Date
As described above, the BCP for the Livingston Data Centre had been reviewed as planned in October 2016. However, at the time of the audit in November 2016 the hard copy version in the site grab bag version had not replaced with the new version. An additional step will be added to the review process to include a tick box to confirm that the new version has been printed off and inserted into the site grab bag.	Confirmation email following visual check that the grab bag version is now correct. Confirmation email that the extra check (tick box) will be added to the process to ensure that when the version is reviewed the updated copy is printed and added to the site grab bag.	17/5/17
Evidence of commitment to annual review	Internal email from Site Security Advisor.	Provided 28/4/17
Atos will produce a BCP review schedule for each of the key sites supporting the NHSS contract.	BCP review schedule	30/6/2017

<table>
<tr><th>Reference
(page = full report page no.)</th><th>Recommendation</th><th>Control weakness rating</th><th>Joint Management response</th></tr>
<tr><td>5.5.5 Testing of IT Continuity Plans
(Page 180)</td><td>We recommend that a detailed BCP test plan be developed to ensure that there is clarity with regards to the timing, location and scenarios for which the tests will be carried out.</td><td>4</td><td>
<table>
<tr><th>Actions to address the recommendations</th><th>Evidence that will be provided</th><th>Target Date</th></tr>
<tr><td>BCP test plan covering BCP tests for sites supporting the NHSS contract</td><td>BCP test plan</td><td>30/6/17</td></tr>
</table>
</td></tr>
<tr><td>5.6.1 Identification of all Supplier Relationships
(Page 190)</td><td>We recommend that regular reconciliations are carried out between the Register of Sub-Contractors and the SAP system to ensure the accuracy of sub-contractor information.</td><td>4</td><td>
<table>
<tr><th>Actions to address the recommendations</th><th>Evidence that will be provided</th><th>Target Date</th></tr>
<tr><td>Atos accepts the recommendation and will set up a schedule of reviews for the Register of Sub-Contractors and SAP system.</td><td>Schedule of Reviews
Output of first Review</td><td>30/6/2017</td></tr>
</table>
</td></tr>
</table>

Reference (page = full report page no.)	Recommendation	Control weakness rating	Joint Management response
5.10.1 Configuration Repository & Baseline **(Page 272)**	We recommend that management ensure that a comprehensive review of the Configuration Management Local Work Instruction Day Book is undertaken to ensure that the document is fully representative of the current processes in operation. We also recommend that the NHSS-REG-0413 software asset spreadsheet is periodically and independently verified against a trusted source to ensure that it contains an accurate record of the NHSS software asset estate.	3	

Actions to address the recommendations	Evidence that will be provided	Target Date
The Configuration Management Local Work Instruction will be reviewed and out-dated procedures removed.	The Updated Configuration Management Local Work Instruction Day Book.	30/6/17
The NHSS-REG-0413 software asset spreadsheet will be verified and updated to ensure that it is an accurate record of the software asset estate.	Updated NHSS-REG-0413 software asset spreadsheet will be made available.	30/6/17
A regular review calendar will be implemented to ensure that the periodic verification of the NHSS-REG-0413 is carried out.	NHSS-REG-0413 Review Calendar will be shared	30/6/17

Reference (page = full report page no.)	Recommendation	Control weakness rating	Joint Management response
5.10.2 Identification & Maintenance of Configuration Items (Page 275) **5.10.3 Configuration Integrity Review (Page 278)**	We recommend that the NHSS-REG-0413 software asset spread sheet is periodically and independently verified against a trusted source to ensure that it contains an accurate record of the NHSS software asset estate. Once the process has been migrated to the team in located in Poland the relevant policy and procedures, such as the Local Work Instruction process should be update to reflect the new processes.	3	

Actions to address the recommendations	Evidence that will be provided	Target Date
The NHSS-REG-0413 software asset spreadsheet will be verified and updated to ensure that it is an accurate record of the software asset estate.	Updated NHSS-REG-0413 software asset spreadsheet will be made available.	30/6/17
A regular review calendar will be implemented to ensure that the periodic verification of the NHSS-REG-0413 is carried out.	NHSS-REG-0413 Review Calendar will be shared	30/6/17

Appendix 2 – Summary of Findings

Summary of findings

Control weakness rating

The control weakness rating helps the NSS Audit & Risk Committee as well as management and auditors of NHS Boards assess the significance of the issues raised and prioritise the action required to address them. The control weakness rating structure is summarised as follows:

Rating	Definition
1	Very high risk exposure – Major concerns requiring immediate attention.
2	High risk exposure - Absence / failure of significant key controls.
3	Moderate risk exposure - Not all key control procedures are working effectively.
4	Limited risk exposure – Minor control procedures are not in place / not working effectively.
5	No significant control weaknesses identified.

The following table indicates our assessment of the application of each control by Atos management as it relates to the arrangements in place for those applications and infrastructure managed within Atos and ranking of any findings resulting from our review.

Control objective	Testing result	1	2	3	4	5
IT System Development, Manage Change and Continuity of Resources						
IT System Development						
Translate business requirements into a high-level design specification for software acquisition, taking into account the organisation's technological direction and information architecture. Have the design specifications approved by management to ensure that the high-level design responds to the requirements. Reassess when significant technical or logical discrepancies occur during development or maintenance.	Satisfactory					✓
Prepare detailed design and technical software application requirements. Define the criteria for acceptance of the requirements. Have the requirements approved to ensure that they correspond to the high-level design. Perform reassessment when significant technical or logical discrepancies occur during development or maintenance.	Satisfactory					✓
Implement business controls, where appropriate, into automated application controls such that processing is accurate, complete, timely, authorised and auditable.	Satisfactory					✓
Address application security and availability requirements in response to identified risks and in line with the organisation's data classification, information architecture, information security architecture and risk tolerance.	Satisfactory					✓
Configure and implement acquired application software to meet business objectives.	Satisfactory					✓
In the event of major changes to existing systems that result in significant change in current designs and/or functionality, follow a similar development process as that used for the development of new systems.	Satisfactory					✓
Ensure that automated functionality is developed in accordance with design specifications, development and documentation standards, QA requirements, and approval standards. Ensure that all legal and contractual aspects are identified and addressed for application software developed by third parties.	Satisfactory					✓
Develop resource and execute a software QA plan to obtain the quality specified in the requirements definition and the organization's quality policies and procedures.	Control weakness				✗	
Track the status of individual requirements (including all rejected requirements) during the design, development and implementation, and approve changes to requirements through an established change management process.	Satisfactory					✓
Develop a strategy and plan for the maintenance of software applications.	Satisfactory					✓
Transfer knowledge and skills to allow end users to effectively and efficiently use the system in support of business processes.	Satisfactory					✓

Control objective	Testing result	1	2	3	4	5
Transfer knowledge and skills to enable operations and technical support staff to effectively and efficiently deliver, support and maintain the system and associated infrastructure.	Satisfactory					✓
Train the staff members of the affected user departments and the operations group of the IT function in accordance with the defined training and implementation plan and associated materials, as part of every information systems development, implementation or modification project.	Satisfactory					✓
Establish a test plan based on organisation wide standards that defines roles, responsibilities, and entry and exit criteria. Ensure that the plan is approved by relevant parties.	Control Weakness				×	
Establish an implementation and fallback/backout plan. Obtain approval from relevant parties.	Satisfactory					✓
Define and establish a secure test environment representative of the planned operations environment relative to security, internal controls, operational practices, data quality and privacy requirements, and workloads.	Satisfactory					✓
Plan data conversion and infrastructure migration as part of the organisation's development methods, including audit trails, rollbacks and fallbacks.	Satisfactory					✓
Test changes independently in accordance with the defined test plan prior to migration to the operational environment. Ensure that the plan considers security and performance.	Satisfactory					✓
Ensure that business process owners and IT stakeholders evaluate the outcome of the testing process as determined by the test plan. Remediate significant errors identified in the testing process, having completed the suite of tests identified in the test plan and any necessary regression tests. Following evaluation, approve promotion to production.	Satisfactory					✓
Following testing, control the handover of the changed system to operations, keeping it in line with the implementation plan. Obtain approval of the key stakeholders, such as users, system owner and operational management. Where appropriate, run the system in parallel with the old system for a while, and compare behaviour and results.	Satisfactory					✓
Establish procedures in line with the organisational change management standards to require a post-implementation review as set out in the implementation plan.	Satisfactory					✓
Continuity of resources						
Evaluate staffing requirements on a regular basis or upon major changes to the business, operational or IT environments to ensure that the IT function has sufficient resources to adequately and appropriately support the business goals and objectives.	Satisfactory					✓

Control objective	Testing result	1	2	3	4	5
Define and identify key IT personnel (e.g., replacements/backup personnel), and minimise reliance on a single individual performing a critical job function.	Satisfactory					✓
Manage Change						
Set up formal change management procedures to handle in a standardised manner all requests (including maintenance and patches) for changes to applications, procedures, processes, system and service parameters, and the underlying platforms.	Satisfactory					✓
Assess all requests for change in a structured way to determine the impact on the operational system and its functionality. Ensure that changes are categorised, prioritised and authorised.	Satisfactory					✓
Establish a process for defining, raising, testing, documenting, assessing and authorising emergency changes that do not follow the established change process.	Satisfactory					✓
Establish a tracking and reporting system to document rejected changes, communicate the status of approved and in-process changes, and complete changes. Make certain that approved changes are implemented as planned.	Satisfactory					✓
Whenever changes are implemented, update the associated system and user documentation and procedures accordingly.	Satisfactory					✓
Security Management						
Manage IT security at the highest appropriate organisational level, so the management of security actions is in line with business requirements.	Satisfactory					✓
Translate business, risk and compliance requirements into an overall IT security plan, taking into consideration the IT infrastructure and the security culture. Ensure that the plan is implemented in security policies and procedures together with appropriate investments in services, personnel, software and hardware. Communicate security policies and procedures to stakeholders and users.	Satisfactory					✓
Ensure that all users (internal, external and temporary) and their activity on IT systems (business application, IT environment, system operations, development and maintenance) are uniquely identifiable. Enable user identities via authentication mechanisms. Confirm that user access rights to systems and data are in line with defined and documented business needs and that job requirements are attached to user identities. Ensure that user access rights are requested by user management, approved by system owners and implemented by the security-responsible person.	Control weakness			✗		

Control objective	Testing result	1	2	3	4	5
Controls provide reasonable assurance that reporting systems are appropriately secured to prevent unauthorized use, disclosure, modification, damage or loss of data. Address requesting, establishing, issuing, suspending, modifying and closing user accounts and related user privileges with a set of user account management procedures. Include an approval procedure outlining the data or system owner granting the access privileges.	Control weakness			×		
Test and monitor the IT security implementation in a proactive way. IT security should be reaccredited in a timely manner to ensure that the approved enterprise's information security baseline is maintained. A logging and monitoring function will enable the early prevention and/or detection and subsequent timely reporting of unusual and/or abnormal activities that may need to be addressed.	Satisfactory					✓
Clearly define and communicate the characteristics of potential security incidents so they can be properly classified and treated by the incident and problem management process.	Satisfactory					✓
Determine that policies and procedures are in place to organise the generation, change, revocation, destruction, distribution, certification, storage, entry, use and archiving of cryptographic keys to ensure the protection of keys against modification and unauthorised disclosure.	Satisfactory					✓
Put preventive, detective and corrective measures in place (especially up-to-date security patches and virus control) across the organisation to protect information systems and technology from malware (e.g., viruses, worms, spyware, spam).	Satisfactory					✓
Use security techniques and related management procedures (e.g., firewalls, security appliances, network segmentation, intrusion detection) to authorise access and control information flows from and to networks.	Satisfactory					✓
Exchange sensitive transaction data only over a trusted path or medium with controls to provide authenticity of content, proof of submission, proof of receipt and non-repudiation of origin.	Satisfactory					✓
Infrastructure Maintenance						
Produce a plan for the acquisition, implementation and maintenance of the technological infrastructure that meets established business functional and technical requirements and is in accord with the organisation's technology direction.	Control weakness				×	
Implement internal control, security and auditability measures during configuration, integration and maintenance of hardware and infrastructural software to protect resources and ensure availability and integrity. Responsibilities for using sensitive infrastructure components should be clearly defined and understood by those who develop and integrate infrastructure components. Their use should be monitored and evaluated.	Control weakness				×	

Control objective	Testing result	1	2	3	4	5
Develop a strategy and plan for infrastructure maintenance, and ensure that changes are controlled in line with the organisation's change management procedure. Include periodic reviews against business needs, patch management, upgrade strategies, risks, vulnerabilities assessment and security requirements.	Satisfactory					✓
Establish development and test environments to support effective and efficient feasibility and integration testing of infrastructure components	Satisfactory					✓
Application, Storage and Media Management						
Verify that all data expected for processing are received and processed completely, accurately and in a timely manner, and all output is delivered in accordance with business requirements. Support restart and reprocessing needs.	Satisfactory					✓
Define and implement procedures for effective and efficient data storage, retention and archiving to meet business objectives, the organisation's security policy and regulatory requirements.	Control weakness			×		
Define and implement procedures to maintain an inventory of stored and archived media to ensure their usability and integrity.	Control weakness			×		
Define and implement procedures to ensure that business requirements for protection of sensitive data and software are met when data and hardware are disposed or transferred.	Satisfactory					✓
Define and implement procedures for backup and restoration of systems, applications, data, and documentation in line with business requirements and the continuity plan. Controls provide reasonable assurance that data is regularly backed-up and adhere to the decided retention period to avoid loss of data. Restore tests are performed when contractually agreed. The requirements and procedures for restoration scenarios are defined, implemented, and monitored in accordance with either the contractual agreements or the defined Atos defaults. Atos handles restore tests as changes as per request of the customer and reports the restore results.	Control weakness			×		
Define and implement policies and procedures to identify and apply security requirements applicable to the receipt, processing, storage and output of data to meet business objectives, the organisation's security policy and regulatory requirements.	Satisfactory					✓
Organise the scheduling of jobs, processes and tasks into the most efficient sequence, maximising throughput and utilisation to meet business requirements.	Satisfactory					✓
Establish appropriate physical safeguards, accounting practices and inventory management over sensitive IT assets, such as special forms, negotiable instruments, special purpose printers or security tokens.	Satisfactory					✓

Control objective	Testing result	1	2	3	4	5
Define and implement procedures to ensure timely maintenance of infrastructure to reduce the frequency and impact of failures or performance degradation.	Satisfactory					✓
Identify, on a continuous basis, local and international laws, regulations, and other external requirements that must be complied with for incorporation into the organisation's IT policies, standards, procedures and methodologies.	Satisfactory					✓
Review and adjust IT policies, standards, procedures and methodologies to ensure that legal, regulatory and contractual requirements are addressed and communicated.	Satisfactory					✓
Establish procedures and associated responsibilities to ensure that output is handled in an authorised manner, delivered to the appropriate recipient, and protected during transmission; that verification, detection and correction of the accuracy of output occurs; and that information provided in the output is used.	Satisfactory					✓
Before passing transaction data between internal applications and business/operational functions (in or outside the enterprise), check it for proper addressing, authenticity of origin and integrity of content. Maintain authenticity and integrity during transmission or transport.	Satisfactory					✓
Establish a classification scheme that applies throughout the enterprise, based on the criticality and sensitivity (e.g., public, confidential, top secret) of enterprise data. This scheme should include details about data ownership; definition of appropriate security levels and protection controls; and a brief description of data retention and destruction requirements, criticality and sensitivity. It should be used as the basis for applying controls such as access controls, archiving or encryption.	Satisfactory					✓
Business Continuity & Disaster Recovery Planning						
Develop a framework for IT continuity to support enterprise wide business continuity management using a consistent process. The objective of the framework should be to assist in determining the required resilience of the infrastructure and to drive the development of disaster recovery and IT contingency plans. The framework should address the organisational structure for continuity management, covering the roles, tasks and responsibilities of internal and external service providers, their management and their customers, and the planning processes that create the rules and structures to document, test and execute the disaster recovery and IT contingency plans. The plan should also address items such as the identification of critical resources, noting key dependencies, the monitoring and reporting of the availability of critical resources, alternative processing, and the principles of backup and recovery.	Control weakness				✗	
Develop IT continuity plans based on the framework and designed to reduce the impact of a major disruption on key business functions and processes. The plans should be based on risk understanding of potential business impacts and address requirements for resilience, alternative processing and recovery capability of all critical IT services. They should also cover usage guidelines, roles and responsibilities, procedures, communication processes, and the testing approach.	Control weakness				✗	

Control objective	Testing result	1	2	3	4	5
Focus attention on items specified as most critical in the IT continuity plan to build in resilience and establish priorities in recovery situations. Avoid the distraction of recovering less-critical items and ensure response and recovery in line with prioritised business needs, while ensuring that costs are kept at an acceptable level and complying with regulatory and contractual requirements. Consider resilience, response and recovery requirements for different tiers, e.g., one to four hours, four to 24 hours, more than 24 hours and critical business operational periods.	Satisfactory					✓
IT management to define and execute change control procedures to ensure that the IT continuity plan is kept up to date and continually reflects actual business requirements. Communicate changes in procedures and responsibilities clearly and in a timely manner.	Satisfactory					✓
Test the IT continuity plan on a regular basis to ensure that IT systems can be effectively recovered, shortcomings are addressed and the plan remains relevant. This requires careful preparation, documentation, reporting of test results and, according to the results, implementation of an action plan. Consider the extent of testing recovery of single applications to integrated testing scenarios to end-to-end testing and integrated vendor testing.	Control weakness				×	
Provide all concerned parties with regular training sessions regarding the procedures and their roles and responsibilities in case of an incident or disaster. Verify and enhance training according to the results of the contingency tests.	Satisfactory					✓
Determine that a defined and managed distribution strategy exists to ensure that plans are properly and securely distributed and available to appropriately authorised interested parties when and where needed. Attention should be paid to making the plans accessible under all disaster scenarios.	Satisfactory					✓
Plan the actions to be taken for the period when IT is recovering and resuming services. This may include activation of backup sites, initiation of alternative processing, customer and stakeholder communication, and resumption procedures. Ensure that the business understands IT recovery times and the necessary technology investments to support business recovery and resumption needs.	Satisfactory					✓
Store offsite all critical backup media, documentation and other IT resources necessary for IT recovery and business continuity plans. Determine the content of backup storage in collaboration between business process owners and IT personnel. Management of the offsite storage facility should respond to the data classification policy and the enterprise's media storage practices. IT management should ensure that offsite arrangements are periodically assessed, at least annually, for content, environmental protection and security. Ensure compatibility of hardware and software to restore archived data, and periodically test and refresh archived data.	Satisfactory					✓
Determine whether IT management has established procedures for assessing the adequacy of the plan in regard to the successful resumption of the IT function after a disaster, and update the plan accordingly.	Satisfactory					✓

Control objective	Testing result	1	2	3	4	5
Third Party Services						
Identify all supplier services, and categorise them according to supplier type, significance and criticality. Maintain formal documentation of technical and organisational relationships covering the roles and responsibilities, goals, expected deliverables, and credentials of representatives of these suppliers.	Control weakness				✗	
Formalise the supplier relationship management process for each supplier. The relationship owners should liaise on customer and supplier issues and ensure the quality of the relationship based on trust and transparency (e.g., through SLAs).	Satisfactory					✓
Identify and mitigate risks relating to suppliers' ability to continue effective service delivery in a secure and efficient manner on a continual basis. Ensure that contracts conform to universal business standards in accordance with legal and regulatory requirements. Risk management should further consider non-disclosure agreements (NDAs), escrow contracts, continued supplier viability, conformance with security requirements, alternative suppliers, penalties and rewards, etc.	Satisfactory					✓
Establish a process to monitor service delivery to ensure that the supplier is meeting current business requirements and continuing to adhere to the contract agreements and SLAs, and that performance is competitive with alternative suppliers and market conditions.	Satisfactory					✓
Set up a procedure for establishing, modifying and terminating contracts for all suppliers. The procedure should cover, at a minimum, legal, financial, organisational, documentary, performance, security, intellectual property, and termination responsibilities and liabilities (including penalty clauses). All contracts and contract changes should be reviewed by legal advisors.	Satisfactory					✓
Project and Programme Management						
Maintain the programme of projects, related to the portfolio of IT-enabled investment programmes, by identifying, defining, evaluating, prioritising, selecting, initiating, managing and controlling projects. Ensure that the projects support the programme's objectives. Co-ordinate the activities and interdependencies of multiple projects, manage the contribution of all the projects within the programme to expected outcomes, and resolve resource requirements and conflicts.	Satisfactory					✓
Establish and maintain a project management framework that defines the scope and boundaries of managing projects, as well as the method to be adopted and applied to each project undertaken. The framework and supporting method should be integrated with the programme management processes.	Satisfactory					✓

Control objective	Testing result	1	2	3	4	5
Establish a project management approach commensurate with the size, complexity, and regulatory requirements of each project. The project governance structure can include the roles, responsibilities and accountabilities of the programme sponsor, project sponsors, steering committee, project office and project manager, and the mechanisms through which they can meet those responsibilities (such as reporting and stage reviews). Make sure all IT projects have sponsors with sufficient authority to own the execution of the project within the overall strategic programme.	Satisfactory					✓
Obtain commitment and participation from the affected stakeholders in the definition and execution of the project within the context of the overall IT-enabled investment programme.	Satisfactory					✓
Define and document the nature and scope of the project to confirm and develop amongst stakeholders a common understanding of project scope and how it relates to other projects within the overall IT-enabled investment programme. The definition should be formally approved by the programme and project sponsors before project initiation.	Satisfactory					✓
Approve the initiation of each major project phase and communicate it to all stakeholders. Base the approval of the initial phase on programme governance decisions. Approval of subsequent phases should be based on review and acceptance of the deliverables of the previous phase, and approval of an updated business case at the next major review of the programme. In the event of overlapping project phases, an approval point should be established by programme and project sponsors to authorise project progression.	Satisfactory					✓
Establish a formal, approved integrated project plan (covering business and information systems resources) to guide project execution and control throughout the life of the project. The activities and interdependencies of multiple projects within a programme should be understood and documented. The project plan should be maintained throughout the life of the project. The project plan, and changes to it, should be approved in line with the programme and project governance framework.	Satisfactory					✓
Define the responsibilities, relationships, authorities and performance criteria of project team members, and specify the basis for acquiring and assigning competent staff members and/or contractors to the project. The procurement of products and services required for each project should be planned and managed to achieve project objectives using the organisation's procurement practices.	Satisfactory					✓
Eliminate or minimise specific risks associated with individual projects through a systematic process of planning, identifying, analysing, responding to, monitoring, and controlling the areas or events that have the potential to cause unwanted change. Risks faced by the project management process and the project deliverable should be established and centrally recorded.	Satisfactory					✓
Prepare a quality management plan that describes the project quality system and how it will be implemented. The plan should be formally reviewed and agreed to by all parties concerned and then incorporated into the integrated project plan.	Satisfactory					✓

Control objective	Testing result	1	2	3	4	5
Establish a change control system for each project, so all changes to the project baseline (e.g., cost, schedule, scope, quality) are appropriately reviewed, approved and incorporated into the integrated project plan in line with the programme and project governance framework.	Satisfactory					✓
Identify assurance tasks required to support the accreditation of new or modified systems during project planning, and include them in the integrated project plan. The tasks should provide assurance that internal controls and security features meet the defined requirements.	Satisfactory					✓
Measure project performance against key project performance scope, schedule, quality, cost and risk criteria. Identify any deviations from the plan. Assess the impact of deviations on the project and overall programme, and report results to key stakeholders. Recommend, implement, and monitor remedial action, when required, in line with the programme and project governance framework.	Satisfactory					✓
Require that, at the end of each project, the project stakeholders ascertain whether the project delivered the planned results and benefits. Identify and communicate any outstanding activities required to achieve the planned results of the project and the benefits of the programme, and identify and document lessons learned for use on future projects and programmes.	Satisfactory					✓
Service Desk – Incident and Problem Management						
Incident Management						
Establish a service desk function, which is the user interface with IT, to register, communicate, dispatch and analyse all calls, reported incidents, service requests and information demands. There should be monitoring and escalation procedures based on agreed-upon service levels relative to the appropriate SLA that allow classification and prioritisation of any reported issue as an incident, service request or information request. Measure end users' satisfaction with the quality of the service desk and IT services.	Satisfactory					✓
Establish a function and system to allow logging and tracking of calls, incidents, service requests and information needs. It should work closely with such processes as incident management, problem management, change management, capacity management and availability management. Incidents should be classified according to a business and service priority and routed to the appropriate problem management team, where necessary. Customers should be kept informed of the status of their queries.	Satisfactory					✓
Establish service desk procedures, so incidents that cannot be resolved immediately are appropriately escalated according to limits defined in the SLA and, if appropriate, workarounds are provided. Ensure that incident ownership and life cycle monitoring remain with the service desk for user-based incidents, regardless which IT group is working on resolution activities.	Satisfactory					✓

Control objective	Testing result	1	2	3	4	5
Establish procedures for the timely monitoring of clearance of customer queries. When the incident has been resolved, ensure that the service desk records the resolution steps, and confirm that the action taken has been agreed to by the customer. Also record and report unresolved incidents (known errors and workarounds) to provide information for proper problem management.	Satisfactory					✓
Produce reports of service desk activity to enable management to measure service performance and service response times and to identify trends or recurring problems, so service can be continually improved.	Satisfactory					✓
Problem Management						
Implement processes to report and classify problems that have been identified as part of incident management. The steps involved in problem classification are similar to the steps in classifying incidents; they are to determine category, impact, urgency and priority. Categorise problems as appropriate into related groups or domains (e.g., hardware, software, support software). These groups may match the organisational responsibilities of the user and customer base, and should be the basis for allocating problems to support staff.	Satisfactory					✓
Ensure that the problem management system provides for adequate audit trail facilities that allow tracking, analysing and determining the root cause of all reported problems considering: • All associated configuration items • Outstanding problems and incidents • Known and suspected errors • Tracking of problem trends Identify and initiate sustainable solutions addressing the root cause, raising change requests via the established change management process. Throughout the resolution process, problem management should obtain regular reports from change management on progress in resolving problems and errors. Problem management should monitor the continuing impact of problems and known errors on user services. In the event that this impact becomes severe, problem management should escalate the problem, perhaps referring it to an appropriate board to increase the priority of the (RFC or to implement an urgent change as appropriate. Monitor the progress of problem resolution against SLAs.	Satisfactory					✓
Put in place a procedure to close Problem Records either after confirmation of successful elimination of the known error or after agreement with the business on how to alternatively handle the problem.	Satisfactory					✓
Integrate the related processes of configuration, incident and problem management to ensure effective management of problems and enable improvements.	Satisfactory					✓

Control objective	Testing result	1	2	3	4	5
Performance Management						
For the information technology and internal control processes, management should ensure relevant performance indicators (e.g., benchmarks) from both internal and external sources are being defined, and that data is being collected for the creation of management information reports and exception reports regarding these indicators.	Satisfactory					✓
Services to be delivered by the information services function should be measured (key performance indicators and/or critical success factors) by management and be compared with target levels. Assessments should be performed of the information services function on a continuous basis.	Satisfactory					✓
At regular intervals management should measure customer satisfaction regarding the services delivered by the information services function to identify shortfalls in service levels and establish improvement objectives.	Satisfactory					✓
Management reports should be provided for senior management's review of the organisation's progress toward identified goals. Upon review, appropriate management action should be initiated and controlled.	Satisfactory					✓
Identify and initiate remedial actions based on performance monitoring, assessment and reporting. This includes follow-up of all monitoring, reporting and assessments through: • Review, negotiation and establishment of management responses • Assignment of responsibility for remediation • Tracking of the results of actions committed	Satisfactory					✓
Configuration Management						
Establish a supporting tool and a central repository to contain all relevant information on configuration items. Monitor and record all assets and changes to assets. Maintain a baseline of configuration items for every system and service as a checkpoint to which to return after changes.	Control weakness			✗		
Establish configuration procedures to support management and logging of all changes to the configuration repository. Integrate these procedures with change management, incident management and problem management procedure.	Control weakness			✗		
Periodically review the configuration data to verify and confirm the integrity of the current and historical configuration. Periodically review installed software against the policy for software usage to identify personal or unlicensed software or any software instances in excess of current license agreements. Report, act on and correct errors and deviations.	Control weakness			✗		

Control objective	Testing result	1	2	3	4	5
Capacity and Performance Management						
Establish a planning process for the review of performance and capacity of IT resources to ensure that cost-justifiable capacity and performance are available to process the agreed-upon workloads as determined by the SLAs. Capacity and performance plans should leverage appropriate modelling techniques to produce a model of the current and forecasted performance, capacity and throughput of the IT resources.	Satisfactory					✓
Assess current performance and capacity of IT resources to determine if sufficient capacity and performance exist to deliver against agreed-upon service levels.	Satisfactory					✓
Conduct performance and capacity forecasting of IT resources at regular intervals to minimise the risk of service disruptions due to insufficient capacity or performance degradation, and identify excess capacity for possible redeployment. Identify workload trends and determine forecasts to be input to performance and capacity plans.	Satisfactory					✓
Provide the required capacity and performance, taking into account aspects such as normal workloads, contingencies, storage requirements and IT resource life cycles. Provisions such as prioritising tasks, fault-tolerance mechanisms and resource allocation practices should be made. Management should ensure that contingency plans properly address availability, capacity and performance of individual IT resources.	Satisfactory					✓
Continuously monitor the performance and capacity of IT resources. Data gathered should serve two purposes: To maintain and tune current performance within IT and address such issues as resilience, contingency, current and projected workloads, storage plans, and resource acquisition. To report delivered service availability to the business, as required by the SLAs Accompany all exception reports with recommendations for corrective action.	Satisfactory					✓
Cost Control and Charging Arrangements						
Identify all IT costs, and map them to IT services to support a transparent cost model. IT services should be linked to business processes such that the business can identify associated service billing levels.	Satisfactory					✓
Capture and allocate actual costs according to the enterprise cost model. Variances between forecasts and actual costs should be analysed and reported on, in compliance with the enterprise's financial measurement systems.	Satisfactory					✓
Establish and use an IT costing model based on the service definitions that support the calculation of chargeback rates per service. The IT cost model should ensure that charging for services is identifiable, measurable and predictable by users to encourage proper use of resources.	Satisfactory					✓

Control objective	Testing result	1	2	3	4	5
Regularly review and benchmark the appropriateness of the cost/recharge model to maintain its relevance and appropriateness to the evolving business and IT activities.	Satisfactory					✓
Atos Internal Audit						
To confirm the reliance that could be placed on Atos commissioned reviews in respect of assessing the effective operation of the Atos defined control objectives relevant to ensuring security management.	Satisfactory					✓
To confirm the reliance that could be placed on Atos commissioned reviews in respect of assessing the effective operation of the Atos defined control objectives relevant to infrastructure maintenance.	Satisfactory					✓
To confirm the reliance that could be placed on Atos commissioned reviews in respect of assessing the effective operation of the Atos defined control objectives relevant to third party management.	Satisfactory					✓
To confirm the reliance that could be placed on Atos commissioned reviews in respect of assessing the effective operation of the Atos defined control objectives relevant to ensuring project and programme management.	Satisfactory					✓
To confirm the reliance that could be placed on Atos commissioned reviews in respect of assessing the effective operation of the Atos defined control objectives relevant to ensuring service desk operations.	Satisfactory					✓
To confirm the reliance that could be placed on Atos commissioned reviews in respect of assessing the effective operation of the Atos defined control objectives relevant to ensuring application, storage and media management operations.	Satisfactory					✓
To confirm the reliance that could be placed on Atos commissioned reviews in respect of assessing the effective operation of the Atos defined control objectives relevant to ensuring manage change operations.	Satisfactory					✓
To confirm the reliance that could be placed on Atos commissioned reviews in respect of assessing the effective operation of the Atos defined control objectives relevant to ensuring configuration management operations.	Satisfactory					✓
To confirm the reliance that could be placed on Atos commissioned reviews in respect of assessing the effective operation of the Atos defined control objectives relevant to ensuring service level management operations.	Satisfactory					✓

Appendix 3 - Other information provided by Atos

Introduction

This part of the Service Auditor's report is for other information provided by the service organisation. It includes a glossary of terms and other relevant information related to the area reviewed.

Glossary

Abbreviations used throughout this Report

Reference	Definition/Purpose
1LS	The requestor's (caller's) first contact with Atos who will perform FTFs and referrals to 2nd Level Support, 3rd Level Support and 3rd parties.
2LS	The requestor's (caller's) 2nd contact with Atos who perform FTFs and refer to 3rd Level Support.
AIRA	Audit & Improvement Repository Application. This is used by Atos to record and track corrective actions resulting from audits.
Atos D&S	Atos Delivery & Support team
AOPN	Atos Private Network. This is a secure network maintained by Atos.
ATAB	Atos Account Technical Assurance Board
BAU	Business as Usual.
BCP	Business Continuity Planning
BMS	Business Management System.
BRS	Business Requirements Specification.
CAB	Change Advisory Board.
CCN	Change Control Note. This is a legal document identifying changes to the original contract between NSS and Atos.
CDC	Client Delivery Centre.
CDP	Committed Development Pool.
CI	Configuration Item.
CIP	Contracts In Progress.
CMDB	Configuration Management Database.
CPC	Community Preventative Care.
CPMG	Clinical Portfolio Management Group.

Reference	Definition/Purpose
CPNI	Centre for Protecting National Infrastructure.
CVSMT	Contract, Vendor and Service Management Team within NSS.
DBA	Database Administrator.
DBMS	Database Management System.
DFD	Detailed Functional Designs.
DR	Disaster Recovery.
DTD	Detailed Technical Design
EAP	Enterprise Architecture Platform.
EMC	Atos Enterprise Monitoring Centre.
EPOC	ePharmacy Point of Contact
ERT	Emergency Response Test.
FDS	Functional Design Solution.
FSC	Forward Schedule of Change.
FTF	First Time Fix – Incident resolutions that are provided to the caller within a defined time frame, without the user having to chase the ticket.
FTP	File Transfer Protocol.
ICAP	Infrastructure Construction Architecture Practice.
IMAC	Installations, Moves, Additions and Changes.
ISACA	Information Security Audit and Control Association.
ISMS	Information Security Management System.
ISO20000	International IT service management standard.
ISO27001	International information security management system standard.
ISO27002	International information security management system – Code of Practice
ISO9000	International quality management standard relating to business processes.
ITF	Integrated Test Facility.
ITIL	IT Infrastructure Library – IT service management best practice library published by the OGC.
KIS	Key Information Services.
KPI	Key Performance Indicator(s) - financial and non-financial metrics used to help an organisation define and measure progress toward organisational goals.
LAEF	Atos Lead Architect Engagement Framework.

Reference	Definition/Purpose
LAN	Local Area Network.
Livelink	Atos corporate document repository.
MIR	Major Incident Review – a review carried out to find the root cause of a major incident.
MIRP	Major Incident Response Plan
MS	Atos Managed Services team
MTS	Managed Technical Service.
N&SS	Network & System Security.
NDA	Non Disclosure Agreement. This is a confidential relationship between the parties to protect any type of confidential and proprietary information or a trade secret.
NHS GG&C	NHS Greater Glasgow & Clyde.
NHSS	NHSScotland
NISG	National Information Systems Group.
NSS	NHS National Services Scotland.
OFM	Operational Financial Model.
OS	Operating System.
OSM	Operational Security Manager.
PI	Performance Indicator.
P&I	Managed Operations Planning and Installation.
PID	Project Initiation Document.
PKI	Public Key Infrastructure.
PMO	Atos Programme Management Office.
PRINCE2	This is generally accepted as the de facto standard for project management methodology.
P&CFS	NSS Practitioner & Counter Fraud Services (formerly known as PSD)
Pulsant	The disaster recovery site for Atos supported services in the event of failure of the Livingston Data Centre.
PVCS	Version Management Software.
RADIUS	An access control server used for supporting remote access.
RAG	Red, Amber, Green (status).
RAID	Risk and Issues Document.

Reference	Definition/Purpose
RFC	Request for Change.
SAM	Software Asset Management.
SAN	Storage Area Network.
SEF	Scottish Enhanced Functionality.
SG	Sopra Group.
SI	Atos Systems Integration team.
SI CDC	Systems Integration Client Delivery Centre.
SIP	Service Improvement Plan.
SIWD	Small Items of Work Definition.
SLA	Service Level Agreement between the Customer and Atos.
SMC	Service Management Centre – consists of the Atos Service Desk and ITIL Process Management Teams.
SOP	Security Operating Procedures. This is used to specify the rules necessary to comply with the Statement of Systems Security Policy (SSP) for an IT system. For example, the SSP might specify the computer needs to be kept in a room that is locked during silent hours and the SOP will state who will be responsible for locking and opening the room, where the key is to be held and the times the room is open. SOPs serve to state who is to do what, when and in what manner.
SSL	Secure Sockets Layer (SSL), are cryptographic protocols that provide security and data integrity for communications over TCP/IP networks such as the Internet. Several versions of the protocols are in wide-spread use in applications like web browsing, electronic mail, Internet faxing, instant messaging and voice-over-IP (VoIP). TLS and SSL encrypt the datagrams of the Transport Layer protocols in use for an end-to-end connection across the network.
SSP	System Security Policy. This is used to spell out the level of security for a particular identified and defined computer system with the aim of ensuring that the system is adequately protected in the light of the perceived risks to that system.
SUDO	A program for UNIX operating systems that allows users to run programs with the security privileges of another user.
TACACS	Terminal Access Controller Access Control System. Allows a remote access server to communicate with an authentication server in order to determine if the user has access to the network.
TAEF	Atos Technical Architecture Engagement Framework.
TAR	NHSS Technical Architecture Repository
UAT	User Acceptance Testing.
USD6	Service Desk system.
XML	Extensible Markup Language. This is a markup language that defines a set of rules for encoding documents in a format that is both human-readable and machine-readable

Reference	Definition/Purpose
VPN	Virtual Private Network – a secure means through which remote access can be gained to a network.

Key information technology systems and applications

Reference	Definition/Purpose
.NET	A software framework that runs primarily on Microsoft Windows.
AAA	Abdominal Aortic Aneurysm screening system.
BoSS	Bowel Screening System. This is the system which holds data on screening test results.
DCVP	Data Capture, Validation and Pricing System. This system validates and values scripts submitted by dispensing contractors once or twice per month.
DDMA	HP Discovery and Dependency Mapping Advanced.
ECS	Emergency Care Summary
eESS	The new single national HR system.
eFinancials	The national NHSS finance system
eLinks	A multi-purpose communications tool which can be used in most Windows environments. It manages the safe and accurate transmission of electronic patient data across NHSScotland.
ePay	A PSD system which checks the electronic Pharmacy claim and identifies the priceable item from the contents of the electronic claim message.
ePayroll	The new NHSScotland Payroll system.
ePharmacy	A P&CFS system which controls the encrypted messages between GP systems, community pharmacy systems and NSS.
GPASS	General Practice Administration System for Scotland. This was the primary clinical record and administration system for GP practices. The system is being retired.
MIDAS	Management Information and Dental Accounting System.
MOM	Microsoft Operations Manager. A tool used for monitoring network server availability and performance.
N3	The NHS national broadband network linking hospitals, medical centres and GPs in England and Scotland
Nagios	The industry standard for open source infrastructure monitoring.
NaSH	National Sexual Health systems.
NCCIAS	National Colposcopy Clinical Information and Audit System.

Reference	Definition/Purpose
NHSCR	NHS Central Register.
Oracle	A database management system.
PCR	Pharmacy Care Record
PMSPS	Primary Medical Services Payment System
QOF Calculator	Quality Outcomes Framework used by GMS for practice aspiration data and handling practice achievement data.
SBSP	Scottish Breast Screening Programme (Digital Mammography)
SCCRS	Scottish Cervical Call-Recall System.
SCI Gateway	A national system that integrates primary and secondary care systems.
SHIS-R	Scottish Health Information Service for Research.
Software Organiser	A software utility used to support software licence management.
SQL	Structured Query Language. This is a programming language designed for managing data in relational database management systems
SSPS	Scottish Standard Payroll System.
SSTS	Scottish Standard Timesheet System.
TFS	Team Foundation Server.
Unix	An open source computer operating system.
Wintel	A means through which to define a Windows and Intel based network environment.

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

AUDIT45/2017
Audit Committee
22 June 2017

NHS AYRSHIRE & ARRAN NATIONAL SINGLE INSTANCE FINANCIAL LEDGER SERVICES – SERVICE AUDIT REPORT

1. PURPOSE OF THE REPORT

The purpose of the report is to bring to the attention of the Audit Committee as part of the annual accounts process, the outcome of the Service Audit Report for the National Single Instance finance system and related services (NSI). The report was prepared by PricewaterhouseCoopers, and reviewed and approved by the host Board's (NHS Aryshire & Arran), Audit Committee at their meeting on 3rd May 2017.

2. RECOMMENDATIONS

The Audit Committee is asked to note and take assurance from the following:

- The cover letter from the Director of Finance, NHS Aryshire & Arran;
- The Service Audit Report from the NSI independent Service Auditors, BDO UK LLP.

3. EXECUTIVE SUMMARY

3.1 The Service Audits of Practitioner Services Division, National IT Services Contract and National Single Instance have been undertaken in accordance with International Standard on Assurance Engagements 3402 (ISAE 3402), "Assurance Reports on Controls at a Service Organisation", issued by the International Auditing and Assurance Standards Board. ISAE 3402 is in line with adoption of international standards of reporting e.g. IFRS, and requires management to provide a written assertion regarding the service organisation's responsibilities for systems and controls, with the aim of the Service Audits providing NHS Tayside with assurance on the controls in operation that meet specified control objectives. The service auditor is required to provide an opinion on the suitability of the design of controls related to the control objectives throughout the period.

3.2 NHS Ayrshire & Arran management are responsible for the design, implementation and maintenance of controls to ensure, with reasonable assurance, the control objectives as set out are achieved. These controls are reviewed and assessed with the agreement of the NHS Boards concerned.

3.3 NHS Ayrshire & Arran hosted the NSI eFinancials service on behalf of all Scottish NHS Boards for the year ended 31 March 2017. NHS Ayrshire & Arran's management confirm that key controls over the service were in accordance with the Service Level Agreement in place with customer NHS Boards.

3.4 The following documents are attached:

- **Appendix 1**: Letter from the NHS Ayrshire & Arran Director of Finance on NSI;
- **Appendix 2**: Statement by Director of Finance, NHS Ayrshire & Arran (Management's Statement), Independent Service Auditors' Assurance Report 2016/17, Management's Description of System, Summary of Agreed Control Objectives, Testing of Controls, Other information provided by the Independent Service Auditor and Other Information Provided by Management, including management responses.

The Audit Report covers the twelve month period from 1 April 2016 to 31 March 2017.

3.5 BDO UK LLP's audit opinion states that, in all material respects:

a) The description in sections 3 to 5 fairly presents the Service Organisation's financial ledger services as designed and implemented throughout the period from 1 April 2016 to 31 March 2017;

b) The controls related to the control objectives stated in the description were suitably designed to provide reasonable assurance that the specified control objectives would be achieved if the described controls operated effectively throughout the period from 1 April 2016 to 31 March 2017 and customers applied the complementary user entity controls referred to in the scope paragraph of the assurance report; and

c) The controls tested which, together with the complementary user entity controls referred to in the scope paragraph of the assurance report, if operating effectively, were those necessary to provide reasonable assurance that the control objectives stated in the description were achieved, operated effectively throughout the period from 1 April 2016 to 31 March 2017.

3.6 The service auditor reported no critical or significant risk findings.

3.7 There was one exception identified relating to the biannual check on user access levels, whereby the lack of response from some Boards was not followed up on has been taken.

4. MEASURES FOR IMPROVEMENT

Following on from the Service Audit undertaken, recommendations arising are agreed with management and formulated into agreed action plans. Progress against all recommendations is reviewed on a regular basis and reported to the NHS Ayrshire & Arran Audit Committee. Outstanding recommendations are reviewed on an annual basis by the Service Auditors. Any issues that remain outstanding would be included in the Service Audit report as exceptions noted by the Service Auditors.

5. RESOURCE IMPLICATIONS

Financial

There are no direct financial implications arising from this report.

Workforce

There are no direct workforce implications arising from this report.

6. DELEGATION LEVEL

Not applicable.

7. RISK ASSESSMENT

The Service Auditor's report is unqualified. Two control exceptions were identified, which were not considered to be significant.

8. IMPLICATIONS FOR HEALTH

There are no direct implications for health arising as a consequence of this report.

9. TIMETABLE FOR IMPLEMENTATION AND LEAD OFFICER

Not applicable.

10. IMPACT ASSESSMENT AND INFORMING, ENGAGING AND CONSULTING

Not applicable.

11. PATIENT EXPERIENCE

Not applicable.

Robert MacKinnon
Associate Director of Finance
- Financial Services & Governance, FLO

Lindsay Bedford
Director of Finance

June 2017

Finance Division
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NHS Scotland Directors of Finance – see distribution

Via Email Only

Date	3 May 2017
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Dear Sir/madam

National Single Instance – Service Audit Report 2016/2017

I attach the service audit report for the National Single Instance (NSI) for your review and presentation to your Audit Committee as part of the annual accounts process. The report was approved by NHS Ayrshire and Arran Audit Committee at their meeting on 3 May 2017.

Sections 1-3 of the report contains summary information, should you wish to limit the level of detail provided to your Audit Committee members, whilst the remainder of the report provides the full detail, which will be reviewed by your auditors.

The attached service audit report describes the system and control objectives relating to access to e-financials and business objects reports, standing data changes, upgrades, helpdesk function and financial ledger closedown procedures operated on your behalf by NHS Ayrshire and Arran. BDO UK LLP carried out the service audit under International Standard on Assurance Engagements 3402 and gave a clean audit report. Only one exception was identified which related to the biannual check on user access levels, whereby the lack of response from some Boards was not followed up.

Please contact me, Bob Brown - email bob.brown2@aapct.scot.nhs.uk, or Colin White - email colin.white@aapct.scot.nhs.uk if you require more information.

Yours faithfully

Derek Lindsay

Derek Lindsay
Director of Finance

Distribution: NHS Scotland Directors of Finance

NHS Ayrshire and Arran
NHS Borders
NHS Dumfries and Galloway
NHS Education for Scotland
NHS Fife
NHS Forth Valley
NHS Grampian
NHS Greater Glasgow and Clyde
NHS Highland
NHS Lanarkshire
NHS Lothian
NHS Orkney
NHS Shetland
NHS Tayside
NHS Western Isles
National Waiting Times
NHS 24
NHS Education for Scotland
NHS Health Scotland
NHS National Services Scotland
Healthcare Improvement Scotland
Scottish Ambulance Service
The State Hospitals Board for Scotland

NHS
Ayrshire
& Arran

NHS Ayrshire & Arran

National Single Instance Financial Ledger Services for the year ended 31 March 2017

Our purpose

Working together to achieve the healthiest life possible for everyone in Ayrshire and Arran

NHS Ayrshire & Arran

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NHS Ayrshire & Arran

Introduction

NHS Ayrshire & Arran ("NHS A&A") operated the National Single Instance ("NSI") financial ledger services on behalf of all Customer NHS Boards for the financial year ended 31 March 2017. This report sets out the overarching control objectives in place for the service, as set out in the Service Level Agreement, along with the individual controls we have designed and operated for the year 1 April 2016 to 31 March 2017 to achieve the stated control objectives.

NHS A&A management detail in this report:

- The relevant control objectives, as agreed with the Customer NHS Boards;
- The specific controls which were operating as described during the year 1 April 2016 to 31 March 2017 to meet each of these agreed objectives; and
- The results of testing by the appointed Independent Service Auditor, BDO UK LLP.

NHS Ayrshire & Arran

Section 1: Management's Statement

Description

NHS Ayrshire & Arran ("NHS A&A") management is responsible for the design, implementation and maintenance of controls to ensure, with reasonable assurance, and on an ongoing basis, that the control objectives as set out are achieved. NHS A&A's management has reviewed the relevant National Single Instance ("NSI") financial ledger services control objectives and the relevant controls in operation for the year under review (1 April 2016 to 31 March 2017). These controls are reviewed and assessed with the agreement of the Customer NHS Boards concerned.

In carrying out those responsibilities we have regard not only to the interests of Customer NHS Boards but also to those of NHS A&A and the general effectiveness and efficiency of the relevant operations

The accompanying description of the service has been prepared for Customer NHS Boards who have used the NSI financial ledger services and their auditors who have sufficient understanding to consider the description, along with other information including information about controls operated by Customer NHS Boards themselves, when assessing the risks of material misstatements within the Customer NHS Boards' financial statements.

We have evaluated the fairness of the description and the suitability and effectiveness of NHS A&A's controls having regard to the International Standard on Assurance Engagements 3402 ("ISAE 3402"), issued by the International Auditing and Assurance Standards Board.

We confirm that:

a) The accompanying description at Sections 3-5 fairly presents the NSI financial ledger services throughout the period 1 April 2016 to 31 March 2017. The criteria used in making this assertion were that the accompanying description:

   i) Presents how the services were designed and implemented, including: the types of services provided, and as appropriate, the nature of transactions processed; the procedures, both automated and manual, by which Customer NHS Board transactions were initiated, recorded and processed; the accounting records and related data, that was maintained and corrected as necessary; the system which captured and addressed significant events and conditions, other than Customer NHS Board transactions; the components of the information systems supporting the relevant transactions that protected the confidentiality and integrity of data; relevant control objectives and controls designed to achieve those objectives; controls that we assumed, in the design of the system, would be implemented by user entities, and which, if necessary to achieve control objectives stated in the accompanying description, are identified in the description along with the specific control objectives that cannot be achieved by ourselves alone; and other aspects of our control environment, risk assessment process, monitoring and information and communication systems that were relevant to our control activities;

   ii) Includes relevant details of changes to NHS A&A's systems during the period; and

   iii) Does not omit or distort information relevant to the scope of the services being described, while acknowledging that the description is prepared to meet the common needs of the Customer NHS Boards and their auditors and may not, therefore, include every aspect of the services that the Customer NHS Boards may consider important in its own particular environment.

b) The controls related to the control objectives stated in the accompanying description were suitably designed and operated effectively throughout the period 1 April 2016 to 31 March 2017. The criteria used in making this assertion were that:

   i) The risks that threatened achievement of the control objectives stated in the description were identified;

NHS Ayrshire & Arran

ii) The identified controls would, if operated as described, provide reasonable assurance that those risks did not prevent the stated control objectives from being achieved; and

iii) The controls were consistently applied as designed, including that manual controls were applied by individuals who have the appropriate competence and authority, throughout the period.

Derek Lindsay

Mr Derek Lindsay
Director of Finance
Signed on behalf of NHS Ayrshire & Arran

25 April 2017

Section 2: Independent Service Auditor's Assurance Report

Independent service auditor's assurance report on National Single Instance Financial Ledger Services controls at NHS Ayrshire & Arran (the "Service Organisation")

To the Directors of NHS Ayrshire & Arran

Scope

We have been engaged to report on NHS Ayrshire & Arran's description of its National Single Instance ("NSI") Financial Ledger Service controls throughout the period 1 April 2016 to 31 March 2017 (the "description"), and on the suitability of the design and operating effectiveness of controls to achieve the related control objectives.

The Service Organisation uses a variety of sub-service organisations as described in Section 3. The description includes only the controls and related control objectives of the Service Organisation and excludes the control objectives and related controls of the sub-service organisations. Our examination did not extend to controls of the sub-service organisations.

The description indicates that certain control objectives specified in the description can be achieved only if complementary user entity controls contemplated in the design of the Service Organisation's controls are suitably designed and operating effectively, along with related controls at the Service Organisation. We have not evaluated the suitability of the design or operating effectiveness of such complementary user entity controls.

While the controls and related control objectives may be informed by the Service Organisation's need to satisfy legal or regulatory requirements, our scope of work and our conclusions do not constitute assurance over compliance with those laws and regulations.

Service Organisation's Responsibilities

The Service Organisation is responsible for: preparing the description in sections 3 to 5 and the accompanying management statement set out in section 1, including the completeness, accuracy and method of presentation of the description and the management statement; providing the NSI financial ledger services covered by the description; specifying the criteria and stating them in the description; identifying the risks that threaten the achievement of the control objectives; and designing, implementing and effectively operating controls to achieve the stated control objectives.

The control objectives stated in the description in section 4 are those specified by the Service Organisation.

Service Auditor's Responsibilities

Our responsibility is to express an opinion on the fairness of the presentation of the description and on the suitability of the design and operating effectiveness of the controls to achieve the related control objectives stated in that description based on our procedures. We conducted our engagement in accordance with International Standards on Assurance Engagements 3402. That standard requires that we comply with ethical requirements and plan and perform our procedures to obtain reasonable assurance about whether, in all material respects, the description is fairly presented and the controls were suitably designed and operating effectively to achieve the related control objectives stated in the description.

An assurance engagement to report on the description, design and operating effectiveness of controls at a service organisation involves performing procedures to obtain evidence about the presentation of the description and the suitability of design and operating effectiveness of the controls. Our procedures included assessing the risks that the description is not fairly presented and that the controls were not suitably designed or operating effectively to achieve

the related control objectives stated in the description. Our procedures also included testing the operating effectiveness of those controls that we consider necessary to provide reasonable assurance that the related control objectives stated in the description were achieved. An assurance engagement of this type also includes evaluating the overall presentation of the description, the suitability of the control objectives stated therein, and the suitability of the criteria specified by the Service Organisation and described in section 1.

We believe that the evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Limitations of Controls at a Service Organisation

The Service Organisation's description is prepared to meet the common needs of a broad range of Customer NHS Boards and their auditors and may not, therefore, include every aspect of the Service Organisation's activities that each individual Customer NHS Board may consider important in its own particular environment. Also, because of their nature, controls at a service organisation may not prevent or detect all errors or omissions in processing or reporting transactions. Also, the projection of any evaluation of effectiveness to future periods is subject to the risk that controls at a service organisation may become inadequate or fail.

Opinion

Our opinion has been formed on the basis of the matters outlined in this report. The criteria we used in forming our opinion are those described in the management assertion in Section 1.

In our opinion, in all material respects:

a) The description in sections 3 to 5 fairly presents the Service Organisation's financial ledger services as designed and implemented throughout the period from 1 April 2016 to 31 March 2017;

b) The controls related to the control objectives stated in the description were suitably designed to provide reasonable assurance that the specified control objectives would be achieved if the described controls operated effectively throughout the period from 1 April 2016 to 31 March 2017 and customers applied the complementary user entity controls referred to in the scope paragraph of this assurance report; and

c) The controls tested which, together with the complementary user entity controls referred to in the scope paragraph of this assurance report, if operating effectively, were those necessary to provide reasonable assurance that the control objectives stated in the description were achieved, operated effectively throughout the period from 1 April 2016 to 31 March 2017.

Description of Test of Controls

The specific controls tested and the nature, timing and results of those tests are detailed in Section 5.

Other information

The information included in Section 7 describing the Service Organisation's responses to exceptions noted is presented by the Service Organisation to provide additional information and is not part of the Service Organisation's description of controls that may be relevant to customers' internal control as it relates to an audit of financial statements. Such information has not been subjected to the procedures applied in the examination of the description of the Service Organisation, related to the NSI financial ledger services, and accordingly, we express no opinion on it.

Intended Users and Purpose

This report and the description of tests of controls and results thereof in section 5 are intended solely for the use of the Service Organisation and solely for the purpose of reporting on the controls of the Service Organisation, in accordance with the terms of our engagement letter dated 30 March 2017 (the "agreement").

Our report must not be recited or referred to in whole or in part in any other document nor made available, copied or recited to any other party, in any circumstances, without our express prior written permission. We permit the disclosure of this report, in full only, including the description of tests of controls and results thereof by the Service Organisation at its discretion to Customer NHS Boards using its NSI financial ledger services and to the auditors of such Customer NHS Boards, to enable Customer NHS Boards and their auditors to verify that a service auditor's report has been commissioned by the Service Organisation and issued in connection with the controls of the Service

Organisation, and without assuming or accepting any responsibility or liability to Customer NHS Boards or their auditors on our part.

We are prepared to extend our assumption of responsibility to those Customer NHS Boards of the Service Organisation who first accept in writing the relevant terms of the agreement entered previously with the Service Organisation as if the Customer NHS Board had signed the agreement when originally issued, and including the provisions limiting liability contained in the agreement ("Contracted Customers"). This extension will not apply to a Customer NHS Board where we inform that Customer NHS Board, whether before or after the Customer NHS Board accepts the relevant terms of the agreement, that they do not meet our acceptance criteria.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Service Organisation and Contracted Customers for our work, for this report or for the opinions we have formed.

Signature:

BDO LLP.

BDO LLP - Chartered Accountants

Date of Assurance Report: 25 April 2017

NHS Ayrshire & Arran

Section 3: Management's description of system

Introduction

NHS Ayrshire & Arran ("NHS A&A") hosted the National Single Instance ("NSI") financial ledger services on behalf of all Customer NHS Boards in Scotland for the financial year ended 31 March 2017. These 22 Customer NHS Boards all used the NSI financial ledger services during 2016/17 for core financial transactions. The finance system used is Advanced Business Solutions ("ABS") Limited's eFinancials 4.0.4 Business Suite ("eFinancials"). The business suite also includes the third party product, Real Asset Management ("RAM")'s Asset 4000 ("RAM"), for Fixed Asset Accounting and the V1 document management suite of products. Use is also made of Business Objects Xi ("Business Objects" or "BOXi") for reporting against the eFinancials database. These services are provided through a national contract managed on behalf of NHS Scotland by NHS A&A.

Overview of Third Party Service Providers

NHS Ayrshire & Arran uses various outsourced third-party service providers perform certain aspects of its operations. This is primarily to improve efficiency the specialist nature of the tasks requires specific expertise. Relevant to this are the following third-party service providers:

- Atos provides national IT services to the NHS in Scotland and hosts the servers upon which the NSI financial ledger sits.
- Advanced Business Solutions ("ABS") maintains the eFinancials application therefore is responsible for the provision of software upgrades, control improvements and eFinancials system developments and changes.
- NSS Business Intelligence Team maintains the Business Intelligence environment and process any user/universe changes as instructed by the NSI Team.

Main Finance Systems accessed at Boards

- eFinancials - Financial Ledgers;
- Asset 4000 Real Asset Management (RAM) - Fixed Assets;
- Finance Process Manager (FPM) – Customer/Supplier Standing;
- Business Intelligence 4 (BI4) – Reporting and Analysis;
- DbCapture (V1 Product Suite) – OCR Document Management; and
- DbBACS (V1 Product Suite) – BACS File Transmissions.

Summary of Services Offered

The following 22 Customer NHS Boards utilise the NHS Ayrshire & Arran hosted NSI financial ledger services:

- NHS 24;
- NHS Ayrshire & Arran;
- NHS Borders;
- NHS Dumfries & Galloway;
- NHS Education for Scotland;
- NHS Fife;
- NHS Forth Valley;
- NHS Grampian;

- NHS Greater Glasgow & Clyde;
- NHS Health Scotland;
- NHS Healthcare Improvement Scotland;
- NHS Highland;
- NHS Lanarkshire;
- NHS Lothian;
- NHS National Services Scotland;
- NHS National Waiting Times Centre;
- NHS Orkney;
- NHS Scottish Ambulance Service;
- NHS Shetland;
- NHS State Hospital;
- NHS Tayside; and
- NHS Western Isles.

The National Finance Systems Team (the "NSI Team") provide a helpdesk service (Zendesk) where standing data and support tickets are raised via a web portal or through an email. The range of services provided by the NSI Team is listed below:

- Agreeing system modifications and developments with the relevant NHS Scotland Boards and the software owners;
- Ensuring software developments are consistent and functionality is maintained/enhanced;
- Liaising with ATOS to ensure timeous resolution of all logged faults in line with SLAs;
- Liaising with the ABS Help Desk to ensure timeous resolution of all logged faults in line with SLA;
- Login and password administration for each of the Finance Systems managed under the SLA;
- First line and second line application support;
- Control of secure access to for each of the Finance Systems managed under the SLA via allocation of roles;
- Administration of User Accounts for each of the Finance Systems managed under the SLA;
- User Support/Training/Advice;
- Standing Data maintenance; and
- BOXi Universe Maintenance.

Responsibilities of NHS Ayrshire & Arran and Individual Customer NHS Boards

NHS A&A has established a Service Level Agreement ("SLA") with each of the Customer NHS Boards which is reviewed on an annual basis by NHS A&A and the governance group National Finance Systems Management Group (on behalf of the Customer NHS Boards). The SLA sets out the responsibilities of NHS A&A to provide the NSI financial ledger services and the responsibilities of the individual Customer NHS Boards. NHS A&A has defined the control objectives and key controls in place for the financial ledger arrangements operated by the NSI financial ledger services and these have been agreed with each NHS Board and are re-confirmed annually by the National Finance Systems Management Group.

Financial Ledger Arrangements – Processes

NSI financial ledger services provides certain financial ledger services for the Customer NHS Boards that receive this service. This service is provided through a geographically dispersed and remotely managed delivery model managed by the National Finance Systems Manager, who is responsible for the National Finance System Support Team ("NSI Team"). The NSI Team has team members based in NHS A&A,

NHS Greater Glasgow & Clyde, NHS Lanarkshire, NHS Lothian, NHS National Services Scotland and NHS Tayside Health Boards. A number of these staff were previously employed by the Health Boards where they are currently based. These staff became NHS A&A employees through a TUPE process which came into effect on the 1 April 2014. As part of the TUPE process agreements are in place with local Boards to continue to host these remotely located members of the NSI Team.

Authorised users

When a new or a change of user access request, for any of the Finance Systems managed under the SLA, is received from a Customer Health Board, the NSI Team will check that the request is authorised by an appropriate named individual within that Customer Health Board before the request is processed by an appropriate member of the NSI Team.

Access to any of the Finance Systems managed under the SLA agreement restricted to authorised personnel as approved by the Customer Health Boards.

Business Objects

Access to Business Objects is managed by the NSI Team to ensure that only individuals authorised by the Customer Health Boards have access to their own and only their own Health Board data. Note that a third party, National Services Scotland Business Intelligence Team, process requests logged with them by the NSI Team on behalf of the Boards.

Changes to eFinancials and RAM standing data

eFinancials standing data is maintained on behalf of the Customer Health Boards by the NSI Team. Boards maintain their own RAM standing data with the NSI Team maintaining system-wide settings and user access levels.

Customer and supplier standing data (as well as other standing data elements) is created or amended by the NSI Team on receipt of a request form from an authorised approver from a Customer Health Board. The set-up of the data is performed by restricted personnel within the NSI Team.

System upgrades and developments

The NSI Team agree system modifications and developments with the relevant Scottish NHS Boards and the software owners.

The NSI Team ensures software developments are consistent and functionality is maintained / enhanced.

The NSI Team liaises with support teams from ATOS, Advanced (ABS) and the NSS BI team to ensure timeous resolution of all logged faults in line with the SLA.

System queries

The NSI Team provides/arranges system support, training and advice for each of the Finance Systems managed under the SLA.

The NSI Team assists with login and password administration queries for each of the Finance Systems managed under the SLA.

Period-end general ledger close

The NSI Team performs the month-end financial ledger close processes for the General Ledger and each of the Board's sub-ledgers. Where exceptions are identified by the NSI Team these are reported to the relevant Customer NHS Boards.

The NSI Team performs the year-end financial ledger close process for the General Ledger and each of the Board's sub-ledgers. Where exceptions are identified by the NSI Team these are reported to the relevant Customer NHS Boards.

NHS Ayrshire & Arran

Monitoring and governance

Service delivery is governed by an extensive SLA with all the Customer NHS Boards. The National Finance Systems Management Group (includes customer representation) provides the direct monitoring and governance for the service. Monthly KPIs are produced on performance against the SLA targets.

Financial Ledger Arrangements (In Scope)

The aspects of the NSI Financial Ledger Services which are within the scope of this report are:

- Managing user access to each of the Finance Systems managed under the SLA, processing documentation for standing data requests including the creation of new supplier/customer accounts and Chart of Accounts requests as well as standing data amendments and the deletion/marking codes inactive of standing data elements;
- Managing software upgrades on behalf of the Customer NHS Boards and liaising with the third party supplier over any necessary changes to the core software; and
- Logging system queries from the Customer NHS Boards which relate to the service provision and taking these forward internally or with third parties as required.

Financial ledger Arrangements (Excluded from Scope)

Excluded from the scope of this report are the following services and related controls:

- Any transactional processing services provided by any Board to another Board, for example accounts payable services, on behalf of Customer NHS Boards;
- Atos provides national IT services to the NHS in Scotland and hosts the servers upon which the financial ledger sits. Therefore, IT general controls, controls over the server, backup of financial ledger data and disaster recovery arrangements are outside the scope of this report;
- The National Services Scotland Business Intelligence Team provides Business Intelligence services to the NHS in Scotland and hosts the servers that the Business Intelligence reporting tools sit on. Therefore, IT general controls, controls over the server, backup of Business Intelligence reporting solutions are outside the scope of this report; and
- Advanced Business Solutions ("ABS") maintains eFinancials and therefore is responsible for the provision of software upgrades, control improvements and eFinancials system developments and changes. These activities are outside the scope of this report.

Complementary Controls

The following controls are expected to be in operation at the Customer NHS Boards to complement the NSI service:

- Reviewing and approving the authorisation matrices used to approve requests in eFinancials/FPM (for standing data and user access requests) and RAM/DbCapture (for user access requests);
- Communicating changes to the local authorisation matrices to NSI on a timely basis;
- Individual Customer NHS Boards perform user access reviews twice per calendar year and as a result of this review Boards will inform the NSI Team of any required changes to user access levels that should be undertaken;
- Any change/update to standing data records (including requests for new records) have been reviewed/validated by appropriate authorised individuals in the Customer NHS Boards before the request is submitted for input by the NSI Team; and
- Individual Customer NHS Boards undertake housekeeping and ensure that they process transactions in-line with agreed timetables as well as reviewing and resolving any issues with their ledgers that are identified and notified to them by the NSI Team.

NHS Ayrshire & Arran

Section 4: Summary of agreed control objectives

Set out below are the control objectives over the financial ledger services provided by the NSI Team to the Customer NHS Boards, as set out in the Service Agreement between NHS A&A and each individual Customer NHS Board, as relevant to this report.

Ref	Financial Systems Services Control Objective	Consideration of key risks
1	Only authorised users (as determined by Customer NHS Boards) can access the Finance Systems used under this SLA.	• Access to the Finance Systems is granted to an individual without the necessary approval of the Customer NHS Board; • Amendment to access rights requests is not appropriately authorised by the Customer NHS Board but still processed by NSI Team; and • Access to each of the Finance Systems is not adequately restricted.
2	Business Objects reporting data is restricted to authorised users.	• Data for a specific Board(s) is visible to any other NHS Board's Business Objects users; • Changes to the eFinancials and RAM universes are made by unauthorised users.
3	Changes to eFinancials and RAM standing data will only be undertaken when appropriately authorised by the Customer NHS Board.	• Changes to standing data are made by the NSI Team without appropriate authorisation from the individual Customer NHS Board, resulting in risk of supplier payment and customer invoice submission errors.
4	Ensure that Third Party Performance is managed and monitored in line with contractual service level agreements.	• Third Party service provider's performance does not meet the contractual standards that are required to allow the NSI Team to provide a professional and resilient service to the Boards using the National Finance Systems Teams services.
5	Ensure any system bugs and/or any required system enhancements are logged on the third party support desk and these are managed/ coordinated and monitored by the NSI Team and any fixes/developments received are only applied to the LIVE system after successful User Acceptance Testing.	• Logging of incidents/changes are not adequate, resulting in a fix/enhancement not being delivered for a system deficiency; and • User acceptance testing is not completed by the NSI Team before a system change is made to the live by the supplier.

Ref	Financial Systems Services Control Objective	Consideration of key risks
6	Finance System queries received by the NSI Team are accurately recorded and managed through to closure using the NSI helpdesk system.	• Not all queries are logged resulting in action not being taken by the NSI Team or the supplier to address the issues reported; • Queries are resolved in an "ad hoc" manner not following procedures; • A full record of all queries is not available for analysis; and • Incidents, standing data requests and queries are not formally logged and monitored in line with the agreed SLA resulting in poor and untimely support provision and a loss of control of the issues that are arising with the system.
7	eFinancials and RAM monthly ledger closedowns are closed accurately and on a timely basis as set out in the timetable agreed with the Customer NHS Boards.	• Common period closedowns are not coordinated and agreed with Customer NHS Boards resulting in closedown failures. Outstanding transactions may not be processed in advance of the scheduled closedown routines and therefore delay the rollover to the next accounting period.
8	Responsibilities set out in the Customer NHS Board Service Level Agreement are completed and reported as agreed.	• Performance reporting may not identify areas for improvement internally and may not provide necessary assurances to Customer NHS Boards.

NHS Ayrshire & Arran

Section 5: Testing of Controls

CONTROL OBJECTIVE 1: Only authorised users (as determined by Customer NHS Boards) can access the Finance Systems used under this SLA.			
Ref	**NSI Team description of controls**	**Service Auditor's testing**	**Exceptions Noted**
1.1	User access rights to each of the Finance Systems managed under the SLA (eFinancials/RAM/FPM/BOXi/DbCapture) are granted/amended on receipt of an authorised request from individual Customer Boards. o An up-to-date list of individuals allowed to authorise changes is maintained by Boards and shared with the NSI Team. o A review of user access is carried out on a 6 monthly basis by requesting information from Health Boards that user access remains appropriate.	**Inspection** For a sample of user access right requests relating to systems eFinancials, RAM, FPM, BOXi and DbCapture, inspected service desk tickets against Board authoriser listings to confirm that requests were appropriately authorised prior to implementation. **Inspection** For a biannual sample, and for a sample of NHS Boards, inspected evidence to confirm that the NSI team circulated user access listings to NHS Boards to allow them to review and confirm the validity of system access. Also, inspected evidence to confirm that the feedback (i.e. user access changes) received from the NHS Boards was suitably actioned by the NSI service desk.	Exception noted. We noted that for a biannual check of user access levels, one of the Boards in our sample did not respond to NSI's request to confirm the validity of their current user access settings and that this lack of response was not followed up by the NSI Team.

Ref	NSI Team description of controls	Service Auditor's testing	Exceptions Noted
1.2	Logical access to eFinancials is controlled through an appropriate authentication method as defined in 'NHS Scotland eFinancials Business Suite National Single Instance Finance System - System Operating Procedures' (v4.0): o Authentication by unique user ID and complex password. o Minimum password length is 8 characters. o System enforced user password changes at regular intervals (30 days). o Automatic lockout of the user ID after a predetermined number of incorrect log-in attempts (3 failures). o Access to data/sub-ledgers is managed through the assignment of roles to users. o The number of users with full administrator access is restricted to members of the NSI Team.	**Inspection** Inspected the eFinancials system security settings to confirm that: • Board user authentication is by unique user ID and complex password; • Minimum password length is set to be 8 characters; • System enforced user password change is set to occur every 30 days; • Automatic lockout of user accounts will occur after 3 incorrect log-in attempts; • Access to data/sub-ledgers is managed through the assignment of roles to users; and • The number of users with full administrator access is restricted to members of the NSI Team.	No exceptions noted.

NHS Ayrshire & Arran

CONTROL OBJECTIVE 2: Business Objects reporting data is restricted to authorised users.			
Ref	**NSI Team description of controls**	**Service Auditor's testing**	**Exceptions Noted**
2.1	User access rights to Business Objects are granted/amended on receipt of an authorised request from individual Customer Boards	**Inspection** For a sample of user access right requests relating to the BOXi system, inspected service desk tickets against Board authoriser listings to confirm that the requests were appropriately authorised prior to implementation.	No exceptions noted.
2.2	Users can only access specific Board data through the use of security views	**Inspection** Inspected system settings to confirm that security views have been implemented, through SQL based queries against BOXi universe tables/objects, in order to prevent Boards from viewing data other than their own.	No exceptions noted.
2.3	Only the NSI Team can perform Business Objects Universe Maintenance. Requests for changes to the Universe are made through the helpdesk by users	**Inspection** Inspected membership of the relevant Active Directory LDAP security group which allows administration and maintenance level access to BOXi to confirm that access is restricted to members of the NSI team. **Enquiry** Confirmed through enquiry that the standard service desk change management process (see control objective 3) is followed to control any changes or amendments to the BOXi universe required by the Boards.	No exceptions noted.

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CONTROL OBJECTIVE 3: Changes to eFinancials and RAM standing data will only be undertaken when appropriately authorised by the Customer NHS Board.			
Ref	**NSI Team description of controls**	**Service Auditor's testing**	**Exceptions Noted**
3.1	Customer standing data within eFinancials is amended on receipt of an authorised request from the relevant Customer Board.	**Inspection** For a sample of changes to customer standing data within eFinancials, inspected evidence to confirm that these were amended following receipt of an authorised request from the relevant NHS Board.	No exceptions noted.
3.2	Supplier standing data within eFinancials is amended on receipt of an authorised request from the relevant Customer Board.	**Inspection** For a sample of supplier standing data changes within eFinancials, inspected evidence to confirm that these were amended following receipt of an authorised request from the relevant NHS Board.	No exceptions noted.
3.3	Amendments to the Chart of Accounts, Cost Centres, Job Codes and Internal Delivery Addresses ("IDAs") are only made on receipt of an authorised request from Customer NHS Board.	**Inspection** For a sample of amendments to the Chart of Accounts, Cost Centres, Job Codes and Internal Delivery Addresses (IDAs) within eFinancials, inspected evidence to confirm that these were implemented following receipt of an authorised request from the relevant NHS Board.	No exceptions noted.
3.4	Ad-hoc Board specific standing data requests are created/amended on receipt of an authorised request from the relevant Customer Board.	**Inspection** For a sample of ad-hoc Board specific standing data requests within eFinancials, inspected evidence to confirm that these were created/amended following receipt of an authorised request from the relevant NHS Board.	No exceptions noted.
3.5	Ad-hoc shared standing data areas are only created/amended on receipt of an authorised request through the appropriate governance channels.	**Inspection** For a sample of ad-hoc shared standing data area requests within eFinancials, inspected evidence to confirm that these were only created/amended following receipt of an authorised request through an appropriate NHS governance channel.	No exceptions noted.

NHS Ayrshire & Arran

CONTROL OBJECTIVE 4: Ensure that Third Party Performance is managed and monitored in line with contractual service level agreements.			
Ref	**NSI Team description of controls**	**Service Auditor's testing**	**Exceptions Noted**
4.1	Appropriate and current support contracts with third-party suppliers (Atos, Advanced and the NSS BI Team) are in place and performance is monitored through agreed KPIs which are reviewed by the NSI Team Manager on a monthly (Atos and Advanced) and quarterly (NSS BI Team) basis with follow-up actions taken to address any exceptions.	**Inspection** Inspected evidence to confirm that support contracts with defined KPIs are in place for all three third parties currently supporting NSI service provision. **Inspection** For a sample of months and quarters, inspected evidence to confirm that NSI Management reviewed monthly (for Atos and Advanced) and quarterly (for NSS BI Team) KPIs and followed-up on actions to address any exceptions.	No exceptions noted.
4.2	Atos and Advanced provide monthly service performance reports to NSI Management.	**Inspection** For a sample of months, inspected evidence to confirm that service performance reports were produced by Atos and Advanced and that these were reviewed by NSI Management.	No exceptions noted.
4.3	Monthly service review meetings are held with Atos attended by NSI Management and Atos Service Management.	**Inspection** For a sample of months, inspected evidence to confirm that monthly service review meetings were held between NSI Team and Atos and that these meetings were attended by relevant individuals from both parties.	No exceptions noted.
4.4	4 Monthly service review meetings are held with Advanced to review performance attended by an Advanced Support Manager and NSI Management.	**Inspection** For a sample of 4-monthly service review meetings, inspected evidence to confirm that service review meetings were held between NSI Team and Advanced to review service performance and that these meetings were attended by relevant individuals from both parties.	No exceptions noted.

Ref	NSI Team description of controls	Service Auditor's testing	Exceptions Noted
4.5	Fortnightly service calls are held with Advanced to discuss and review current performance issues with participation by an Advanced Support Manager and NSI Service Management.	**Inspection** For a sample of fortnightly calls, inspected evidence to confirm that calls were held between the NSI Team and Advanced to discuss service performance issues and that there was participation on calls by relevant individuals from both parties.	No exceptions noted.

NHS Ayrshire & Arran

CONTROL OBJECTIVE 5: Ensure that system bugs and/or any required system enhancements are logged on the third party helpdesk or development forum and these are managed/ coordinated and monitored by the NSI Team and any fixes/developments received are only applied to the LIVE system after successful User Acceptance Testing.			
Ref	**NSI Team description of controls**	**Service Auditor's testing**	**Exceptions Noted**
5.1	All system functionality issues are logged on the third party helpdesk/support desk.	**Enquiry & Observation** Confirmed through enquiry and observation the process for logging system functionality issues on the third party (Advanced) helpdesk and (NSI) support desk. Note: As part of our testing for controls 5.2 and 5.3 we confirmed through inspection that these processes are being followed by the NSI Team.	No exceptions noted.
5.2	All application fixes/changes received are logged on the NSI Fix Log to monitor progress throughout the change lifecycle. This includes the relevant NSI Helpdesk (Zendesk) ticket reference and third party helpdesk reference.	**Inspection** For a sample of implemented fixes/changes logged on the FSI Fix Log, inspected evidence to confirm that the log was used to record progress throughout the lifecycle of the change. Also, confirmed that the log included details of the relevant NSI and third party (Advanced) service desk reference.	No exceptions noted.
5.3	All changes/developments are subject to User Acceptance Testing ("UAT") and NSI Management approval prior to being deployed to the live environment.	**Inspection** For a sample of fixes/changes, inspected evidence to confirm that these were subject to NSI user acceptance testing and management approval prior to being deployed in the live environment.	No exceptions noted.

Ref	NSI Team description of controls	Service Auditor's testing	Exceptions Noted
5.4	A service desk ticket must be raised with Atos in order to apply a fix/change to any system environment (development, test and live).	**Enquiry** Confirmed through enquiry that only Atos has system access rights that would allow the application of changes to the various environments supporting the eFinancials and RAM systems. **Inspection** For a sample of fixes/changes, inspected evidence to confirm that these were applied to the live environment by third party Atos through a request logged with their service desk.	No exceptions noted.
5.5	Third Party application developers do not have direct access to the live environment and can only gain access in a controlled manner.	**Enquiry** Confirmed through enquiry that third party application developers (i.e. Advanced) have not been setup with direct access to the live environment. By default, their system access is locked down and can only be enabled through the NSI Team raising a call with the Atos service desk. Also, confirmed that Atos provide metrics on the number of instances of third party access in their monthly service performance report. Data for these reports is collated from the Atos service desk.	No exceptions noted.

CONTROL OBJECTIVE 6: Finance System queries received by the NSI Team are accurately recorded and managed through to closure using the helpdesk system.			
Ref	**NSI Team description of controls**	**Service Auditor's testing**	**Exceptions Noted**
6.1	All queries, standing data requests and issues are logged and recorded as tickets on the NSI Helpdesk and, where appropriate, with the Advanced (ABS-eFinancials and Atos Helpdesks). o A minimum dataset is defined for all tickets; severity levels are agreed and actioned accordingly. o All requests are assigned a severity level by the NSI Team based on the policy defined in the Service Level Agreement in order to prioritise the requests and manage the timely resolution of queries. o All tickets have a current status and target resolution date logged on the system.	**Enquiry & Observation** Confirmed through enquiry and observation that a minimum dataset is enforced for all tickets raised on the NSI service desk (Zendesk). **Inspection** Also, inspected a sample of service desk tickets to confirm that a minimum dataset, including severity levels, incident status and target resolution date, was recorded for each ticket logged on Zendesk.	No exceptions noted.

NHS Ayrshire & Arran

CONTROL OBJECTIVE 7: eFinancials and RAM monthly ledger closedowns are closed accurately and on a timely basis as set out in the timetable agreed with the Customer NHS Boards.			
Ref	**NSI Team description of controls**	**Service Auditor's testing**	**Exceptions Noted**
7.1	Month-end financial ledger close procedures are undertaken in accordance with the agreed timetable with the individual Customer NHS Boards. The process to close the General Ledger and each of the Boards sub-ledgers is run as per the agreed timetable and any issues identified on the exception reports will be taken forward by the NSI Team to ensure each of the Ledgers are successfully closed.	**Inspection** For a sample of months, and for a sample of Boards, inspected evidence to confirm that the process to close the General, Purchase and Sales ledgers for each Board was run as per the agreed timetable. Also, confirmed that where necessary, issues identified during the close process were investigated and escalated by the NSI team to ensure close timelines were met.	No exceptions noted.

NHS Ayrshire & Arran

CONTROL OBJECTIVE 8: Responsibilities set out in the Customer NHS Board Service Level Agreement are completed and reported as agreed.			
Ref	**NSI Team description of controls**	**Service Auditor's testing**	**Exceptions Noted**
8.1	Monthly performance reports against agreed KPIs (as defined in the Service Level Agreement) are produced and provided to the Customer NHS Board in line with the Service Level Agreement.	**Inspection** For a sample of months, inspected evidence to confirm that performance reports with agreed KPI metrics were produced and submitted to NHS Boards.	No exceptions noted.
8.2	The National Financial Systems Management Group ("NFSMG") meets on a quarterly basis in order to monitor the NSI service provision. The members of the group receive performance reports on a quarterly basis in advance of the NFSMG meetings. This includes a performance summary overview from the monthly NSI KPI reports, monthly Atos service reports and Advanced incident reports to identify those areas which require follow-up and action.	**Inspection** For a sample of quarters, inspected evidence to confirm that the NFSMG met formally to monitor and review NSI service provision. Also, inspected evidence to confirm that NFSMG received third party service performance information in advance of meetings and that this highlighted areas where service improvement was required.	No exceptions noted.
8.3	The 'NHS Scotland eFinancials Business Suite National Single Instance Finance System - System Operating Procedures' document is reviewed by an appropriate individual in the NSI Team. These are reviewed for completeness on an annual basis and updates are subject to authorisation by the NFSMG.	**Inspection** Inspected evidence to confirm that the SOP 'eFinancials Business Suite National Single Instance Finance System - System Operating Procedures' was subject to annual review by NSI Management and that any updates made were formally authorised by NFSMG.	No exceptions noted.
8.4	System Disaster Recovery (DR) arrangements for the eFinancials system are tested annually by Atos to ensure systems can be run from the secondary hosting site in an emergency.	**Inspection** Inspected the Atos 'NHSS eFinancials DR' report to confirm that a disaster recovery test was performed for the eFinancials system and that the result of the test was documented. Also, confirmed that the report details lessons learned and post-test improvement actions/requirements.	No exceptions noted.

Section 6: Other information provided by the Independent Service Auditor

Introduction

This report is intended to provide interested parties with information sufficient to understand the processes and controls operated by NHS A&A in respect of the Financial Ledger Services provided to Customer NHS Boards.

It is each individual Customer NHS Board's responsibility to evaluate this information in relation to the internal controls in place at their organisation. If effective internal controls are not in place at the individual Customer Board, the controls applied by the NHS A&A Financial Ledger services may not compensate for such weaknesses.

The objective of a coordinated system of controls is to provide reasonable, but not absolute, assurance regarding the level of control over Customer NHS Boards' financial ledger, as operated by NHS A&A's NSI Team. The concept of reasonable assurance recognises that the cost of a system of internal control should not exceed the benefits derived and also recognises that the evaluation of these factors necessarily requires estimates and judgements by management.

Tests of Controls

Testing of control procedures by BDO was restricted to the control objectives and related control procedures outlined by management of NHS A&A as set out in Section 5 of this report, which management believes are the relevant control procedures for the stated objectives. Testing was not extended to control procedures in place at Customer NHS Boards.

The tests, which are described in Section 5 included such tests as were considered necessary in the circumstances to evaluate whether those control procedures, and the extent of compliance with them, were sufficient to provide reasonable, but not absolute, assurance that the specified control objectives were achieved during the period from 1 April 2016 to 31 March 2017. Our tests were designed to cover a representative number of transactions and procedures throughout the period.

In selecting particular tests of the operating effectiveness of the controls, we considered:

- The nature of the controls being tested
- The types and competence of available evidential matter
- The nature of the control objectives to be achieved
- The assessed level of control risk
- The expected efficiency and effectiveness of the test
- The testing of controls relevant to the stated control objective.

The types of testing performed are described briefly below.

Enquiry

Enquiries seeking relevant information or representation from NHS A&A personnel were performed to obtain, among other things:

- Knowledge and additional information regarding the controls
- Corroborating evidence of the control.

Observation

Observed the application or existence of the specific controls, as represented.

Inspection

Inspected documents and records indicating performance of the controls. This included, amongst other things:

- Inspection of applicable management reports
- Examination of source documentation and authorisations
- Examination of documents or records for evidence of performance such as the existence of initials or signatures.

The sample sizes that have been applied in testing controls, depending on the frequency the control is applied and the assessed level of control risk, are set out in the table below:

Frequency of control	Number of items tested
Annual	1
Biannual	1
Quarterly	2
Monthly	4
Weekly	8
Daily	25
Multiple Times per Day	45

NHS Ayrshire & Arran

Section 7: Other information provided by management

Further information on reported exceptions

In relation to the exceptions noted within the Service Auditors procedures, set out in section 5, we provide the following explanations/disclosures.

Ref	Exception	Response
1.1	We noted that for a biannual check of user access levels, one of the Boards in our sample did not respond to NSI's request to confirm the validity of their current user access settings and that this lack of response was not followed up by the NSI Team.	Reminder emails were sent out in February 2017 reminding Boards of their responsibility to conduct a 6 monthly user access review and notify the NFST of any updates. However some Boards did not respond to this request and due to an oversight the lack of a response from some Boards was not followed up in a timely manner. A further reminder of the Boards responsibility to undertake this user access review has now been sent to those Boards who did not respond and any lack of response to this further reminder will be reported to the relevant governance group. In future a central log will be kept to show the status of each Board's response and a further reminder will be sent out to those Boards if they haven't responded by the deadline set.

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

Item Number 7.4

AUDIT46/2017
Audit Committee
22 June 2017

FTF ANNUAL INTERNAL AUDIT REPORT 2016/17

1. PURPOSE OF THE REPORT

The purpose of this report is to present the Annual Internal Audit Report for the year 2016/17 to NHS Tayside's Audit Committee.

2. RECOMMENDATIONS

The Audit Committee is asked to consider this report as part of the portfolio of evidence provided in support of its evaluation of the internal control environment and the Governance Statement.

3. EXECUTIVE SUMMARY

Opinion

Based on work undertaken throughout the year and building on audit evidence obtained over a five-year audit cycle by Internal Audit, I have concluded that subject to the matters highlighted in the report narrative and in the appendices to the report:-

- The Board has adequate and effective internal controls in place, and
- The 2016/17 internal audit plan has been delivered in line with Public Sector Internal Audit Standards.

In addition, I have not advised management of any concerns around the following:-

- consistency of the Governance Statement (GS) with information that we are aware of from our work;
- the processes adopted in reviewing the adequacy and effectiveness of the system of internal control and how these are reflected;
- the format and content of the GS in relation to the relevant guidance, and
- the disclosure of all relevant issues. The Board has disclosures on the Treatment Time Guarantee, Enhancements during Leave and the Financial Position.

2016/17 Mid Year Review

The Internal Audit Interim Report 2016/17, issued on 7 March, 2017, stated that "o*verall, we would conclude that whilst progress has been made in establishing the intended structures, and appointments to key posts are planned to populate these, assurance on the essential question of whether NHS Tayside has the capacity and capability to deliver its operational and strategic objectives will need to be provided to Board through the Chief Executive's paper in April 2017".*

The report also highlighted the need for a clear, consistent and coherent understanding of precise responsibilities and accountabilities of the Health Board, Council and the Integrated Joint Boards (IJBs) in relation to operational activities.

Update since 2016/17 Mid Year Review

Following the issue of the 2016/17 Interim Report, internal audit report T12/16 – Assurance Framework highlighted the need for a clear, consistent and coherent understanding of Health and Social Care Inrtegrations accountabilities. In response, a short life working group with representation from NHS Tayside and the IJBs met on 12 January, 8 February and 15 May, 2017. While significant progress has been made, not all key principles were agreed by year-end, particularly in relation to the model of governance to be applied in Perth and Kinross IJB. As IJBs continue to evolve it is important that there is clarity around these issues particularly in relation to the provision of assurances and risk management as well clear understanding around the tripartite roles of IJB Chief Officers.

Of the 11 individual recommendations included in the 2016/17 Mid Year Review, three are not yet due, five have been completed in line with the agreed responses, three actions are partially completed, and no actions remain outstanding.

The Internal Audit Plan 2016/17 was approved by Audit Committee in May 2016, with changes approved by Audit Committee in March and May 2017. The revisions reflected known changes to NHS Tayside's risk profile.

Summary Control Environment Assessment 2016/17

A summary of the grades provided in 2016/17 and comparison with 2015/16 and 2014/15 is included in the following table (total grades vary due to areas removed since 2013/14):-

Grade	2016/17	2015/16	2014/15
A	6	7	19
B	17	19	12
C	9	8	3
D	1	1	0

Grade ‘A’ – Best Practice
Grade ‘B’ – No major weaknesses in the control environment but scope for improvement
Grade ‘C’ – Compliance with minimum control standards
Grade ‘D’ – Increased risk that objectives may not be achieved

We wish to acknowledge the enormous efforts made by officers to remediate NHS Tayside’s ongoing performance issues. Our report has identified robust controls in a number of areas.

The grades over the last three years need to be considered within the context of a much more challenging environment.

4. MEASURES FOR IMPROVEMENT

Progress on implementation of agreed actions from the 2016/17 Internal Audit Annual Report will be monitored at the interim review in 2017/18 and routinely as part of the NHS Tayside Audit Follow System and through regular reporting to the Audit Committee to ensure continuous improvement in 2017/18.

5. RESOURCE IMPLICATIONS

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

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

6. DELEGATION LEVEL

The Audit Committee is delegated with responsibility for detailed review of the Governance Statement and assessing the adequacy and effectiveness of internal controls before the Annual Accounts are approved by the Board.

7. RISK ASSESSMENT

The report provides assurance that sufficient audit work has been undertaken to allow me to provide my opinion on the adequacy and effectiveness of internal controls required for the 2016/17 Governance Statement.

The assurance contained in the report is one of the assurance sources available to the Chief Executive and the Audit Committee in undertaking their annual review of the effectiveness of internal controls. The report forms part of the consideration of the Audit Committee and the Board prior to finalising the Governance Statement included and published in the Board's Accounts.

8. IMPLICATIONS FOR HEALTH

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

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

The Chief Executive, Directors and Director of Finance were consulted on the content of the Annual Report prior to it being considered by the Audit Committee.

10. EQUALITY& DIVERSITY IMPACT ASSESSMENT

There are no direct implications for equality and diversity arising from this report.

11. TIMETABLE FOR IMPLEMENTATION AND LEAD OFFICER

Following the presentation of this report and the other key components of the portfolio of evidence, the Audit Committee concludes on whether it will recommend the signing of the Annual Accounts (which include the Governance Statement) to the Board. If so recommended, the Board will receive the Accounts at its meeting following the Audit Committee on 22 June to be signed by the Accountable Officer.

Anthony Gaskin BSc ACA
Chief Internal Auditor

Lindsay Bedford
Director of Finance

June 2017

FINAL REPORT

NHS TAYSIDE
INTERNAL AUDIT SERVICE

ANNUAL INTERNAL AUDIT REPORT

2016/2017

Issued To: L McLay, Chief Executive
A Russell, Deputy Chief Executive

L Wiggin, Chief Operating Officer
L Bedford, Director of Finance

IJB Chief Officers

M Dunning, Board Secretary
NHS Tayside Directors
H Scott, General Manager – Public Health

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

Audit Committee
External Audit

Date: 12 June 2017

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ANNUAL INTERNAL AUDIT REPORT 2016/17

INTRODUCTION AND CONCLUSION

1. This annual report to the Audit Committee provides details on the outcomes of the 2016/17 internal audit and my opinion on the Board's internal control framework for the financial year 2016/17.

Based on work undertaken throughout the year we have concluded that:

- **The Board has adequate and effective internal controls in place;**
- **The 2016/17 internal audit plan has been delivered in line with Public Sector Internal Audit Standards.**

In addition, we have not advised management of any concerns around the following:

- **Consistency of the Governance Statement with information that we are aware of from our work.**
- **The description of the processes adopted in reviewing the effectiveness of the system of internal control and how these are reflected.**
- **The format and content of the Governance Statement in relation to the relevant guidance.**
- **The disclosure of all relevant issues.**

ACTION

2. The Audit Committee is asked to **note** this report in evaluating the internal control environment and **report** accordingly to the Board.

AUDIT SCOPE & OBJECTIVES

3. The strategic and annual audit plans for 2016/17 incorporate the requirements of the NHSScotland Governance Statement, and were based on joint risk assessment by Internal Audit and the Director of Finance. The resultant audits range from transaction processing systems and organisational controls through to the control environment and corporate review and reporting mechanisms.

4. The authority, role and objectives for Internal Audit are set out in section 20 of the Board's 2016/17 Standing Financial Instructions and are consistent with Public Sector Internal Audit Standards.

5. Internal Audit is also required to provide the Audit Committee with an annual assurance statement on the adequacy and effectiveness of internal controls. The Audit Committee Handbook states:

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

INTERNAL CONTROL

6. The Chief Executive was appointed Accountable Officer for the Board on 16 December 2013. The Accountable Officer carries statutory duties and personal responsibility for propriety, regularity and value for money in the Board's use of public funds.

7. As part of this year's annual accounts, the Chief Executive, as Accountable Officer, is required to sign a statement on his or her responsibilities as Accountable Officer. The Chairman and Director of Finance will sign the statement on NHS Board Members' responsibilities.

8. HDL(2002)11 was first issued on 1 March 2002 and was updated annually until 2014. The most recent Dear Colleague letter of 18 December 2014, which is still extant, defined the Governance Statement guidance and requires Chief Executives for each NHS Board, in their capacity as Accountable Officers, to report on the internal control and risk management processes in place covering:

    - Corporate Governance
        - Clinical Governance
        - Staff Governance
        - Financial Governance
        - Information Governance

9. The guidance sets out the essential elements and format of a Governance Statement and indicates the following sources of assurance for the Accountable Officer, which may also be provided to the Audit Committee:

    - Reports from all standing governance committees of the Board confirming whether they have fulfilled their remits and, based on assurances received, that there are adequate and effective governance arrangements in place;
    - Formal assurance from executive directors and senior managers that adequate and effective internal controls and risk management have been in place across their areas of responsibility and that any breaches of Standing Orders or Standing Financial Instructions and all significant failures of internal control have been reported to the Chief Executive;
    - Report from the Chief Internal Auditor or equivalent;
    - Advice from Internal and External Audit on whether there are any exceptions around the format, content and consistency of the Governance Statement and the description of the processes adopted in reviewing the systems of internal control and the disclosure of all relevant issues.

10. In addition, the Dear Colleague letter identifies other information which the Audit Committee may wish to receive in addition to that provided to the Accountable Officer. At its meeting on 9 March 2017, the NHS Tayside Audit Committee reaffirmed the decision to receive assurance on the reports from Governance Committees and, as in previous years, to have access to the other information listed in Annex A. The types of information included in Annex A are as follows:

    - Details from the Chief Executive on the governance framework that provides assurance that the Chief Executive has discharged his or her responsibilities as Accountable Officer as set out in the Accountable Officer Memorandum;
    - Summaries of any relevant significant reports by Healthcare Improvement Scotland or other external review bodies.

11. Our evaluation of the Chief Executive's compliance with Accountable Officer requirements and of the Board's Governance Statement draws on:

- Results of individual audits conducted during the year and in prior periods;
- Cumulative audit knowledge of the control environment at the Board derived from previous Annual Internal Audit Reports;
- Assurances from Board officers;
- Official Board documentation;
- Reviews by external agencies including External Audit.

12. Our evaluation of the Board's 'Governance Framework' is summarised in Appendix 1 and shows that the minimum control standards are in place. An assessment at level C equates to compliance with minimum control standards while level A represents best practice. A description of all audit opinion categories and recommendation priorities is given in the final section of this report.

13. A summary opinion for each of the five control environments noted in paragraph 8 is shown in Appendix 2, together with narrative highlighting areas of best practice, where assessments have changed and any areas where improvement is required to meet the necessary control standards.

14. The Board has produced a Governance Statement with the following disclosures for 2016/17:

    - Treatment Time Guarantee
    - Enhancements During Leave
    - Financial Position

15. Our audit has provided evidence of compliance with the requirements of the Accountable Officer Memorandum and this combined with a sound corporate governance framework in place in the Board throughout 2016/17, provides assurance for the Chief Executive as Accountable Officer.

16. Therefore, **it is my opinion** that:

    - The Board has adequate and effective internal controls in place;
    - The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role.

AUDIT PRODUCTS AND OPINIONS

17. During 2016/17 we delivered 24 audit products, which reviewed the systems of financial and management control operating within the Board. Work is ongoing to finalise the remaining 5 reports contained within the 2016/17 audit plan. Our reviews assisted the Board by:

- In addition to the lead auditor role for the three Tayside IJBs and working in partnership on the delivery of their Internal Audit plans , Internal Audit have made a significant contribution to HSCI governance within NHS Tayside through:
    - the identification of key governance issues for resolution
    - attendance at the HSCI short-life working group
    - the delivery of papers, presentations and reports on HSCI and;
    - ongoing discussion with officers and executive and non-executives Directors.
- Reviewing processes for notification and recording of gifts and hospitality;

- Follow up review of previous internal and external audit recommendations around Financial Planning and opinion provided on progress achieved;
- Evaluation and review of Property Management arrangements within NHS Tayside through recommendations on:
    - mitigation of risks and achievement of savings targets
    - disposal strategy and generation of receipts from sales to repay brokerage
    - alignment with the Clinical Strategy
    - data quality and accuracy of data
    - governance and accountability arrangements
    - Community Empowerment (Scotland) Act 2015
- Evaluation of the work undertaken by NHST to improve and sustain performance in the Children and Adolescent Mental Health Service, to address the specific concerns raised by the Board in relation to demand forecasting and to evaluate any wider lessons for NHS Tayside as a whole;
- Review undertaken of the governance arrangements of the workstreams and evaluation of any wider lessons for NHS Tayside as a whole.

ADDED VALUE

18. The Internal Audit Service has been responsive to the needs of the Board and has added value by:

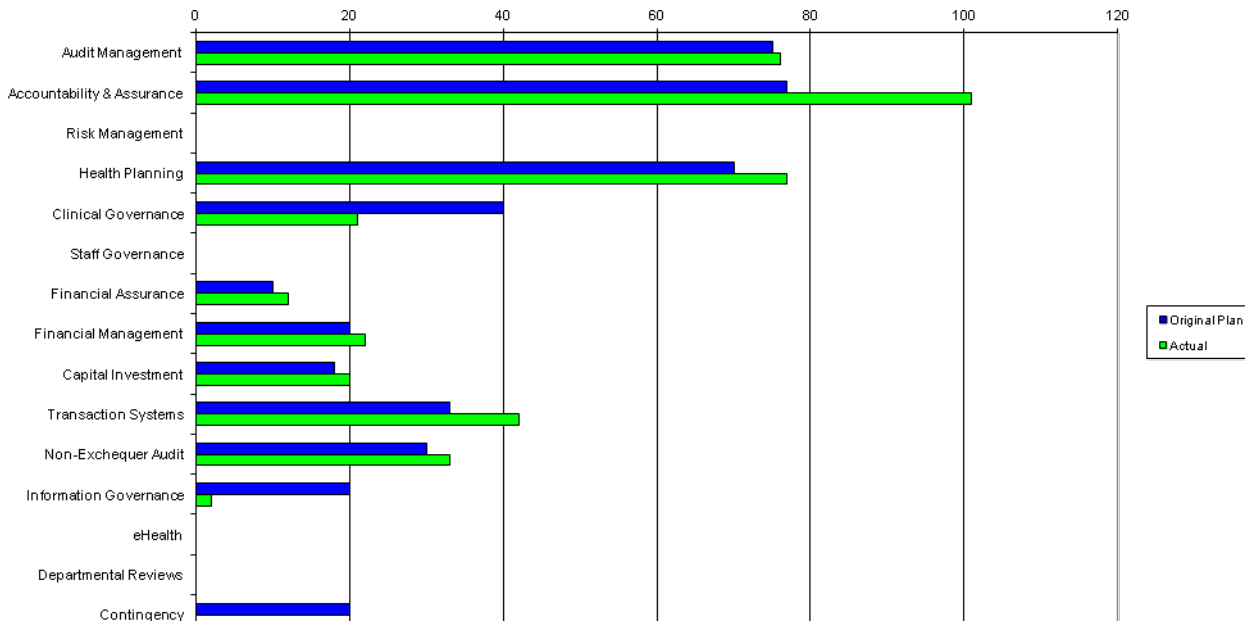
- Providing opinion on and evidence in support of the Governance Statement at year-end and conducting an interim review which permitted remedial action to be taken in-year;
- Assisting and working jointly with Board staff to further strengthen Best Value within the committee structure and reporting arrangements;
- Continued attendance to Governance Review Group around contributing to the update process for the Code of Corporate Governance;
- Provision of information, advice and opinion by the Chief Internal Auditor to the Board, Chairman and Officers;
- Regular liaison meetings with the Director of Finance;
- Regular meetings with Clinical Governance and Risk colleagues around the Board Assurance Framework, strategic risk reporting, adverse event management and risk management arrangements for Health and Social Care Integration. Internal Audit also advised on the governance aspects of NHS Tayside risk management;
- Participated in Short Life Working Group to develop Risk Appetite and Risk Management key performance indicators (KPIs);
- Providing advice and recommendations to strengthen accountability and reporting arrangements for Patient Safety;
- Provided advice to risk owners and managers on the content of individual Board Assurance Frameworks (BAF) as well as the BAF template;
- Provision of deputy support to the Fraud Liaison Officer throughout the year, including assistance in internal investigations where required;

19. Our 2016/17 audits of the various financial and business systems provided opinions on the adequacy of controls in these areas. These showed that the Board continues to improve its control environment with positive assurance (grade C or better) being provided on all reviews, Summarised findings or full report for each review are presented to the Audit Committee during the year.

20. Board management continue to respond positively to our findings and action plans have been agreed to improve the systems of control. Board staff have maintained a system for the follow-up of internal audit recommendations and reporting of results to the Audit Committee and our cyclical review of this follow up system during 2016/17 confirmed that the arrangements are robust.

INTERNAL AUDIT COVER

Figure 1: Internal Audit Cover 2016/17



21. Figure 1 summarises the 2016/17 outturn position against the planned internal audit cover. The Internal Audit plan was approved by the Audit Committee at its meeting on 9 March 2016, with further agreed changes presented to the March and May 2017 Audit Committee meetings. We delivered 406 days against the original planned 413 days. Fieldwork on the outstanding assignments is ongoing.

22. Plans are in place to ensure that outstanding work on the 2016/17 Audit Plan will be completed without impacting on the delivery of the 2017/18 plan. A summary of 2016/17 performance is shown in Appendix 3.

PERFORMANCE AGAINST THE SERVICE SPECIFICATION AND PUBLIC SECTOR INTERNAL AUDIT STANDARDS (PSIAS)

23. In 2016/17 the Board's Internal Audit was provided as part of a shared service arrangement with 4 other statutory NHS organisations. We deliver the audit according to a specification which sets challenging requirements for:

    - Risk Assessment and Planning
    - Audit Management and Reporting

- Quality Control and Performance Measurement

24. The role of Internal Audit is incorporated within an Audit Charter, approved by the Audit Committee on 24 March 2011. We have designed protocols for the proper conduct of the audit work at the Board to ensure compliance with the specification and Audit Charter and the Public Sector Internal Audit Standards (PSIAS).

25. Internal Audit is compliant with PSIAS, and has organisational independence as defined by PSIAS. There are no impairments to independence or objectivity.

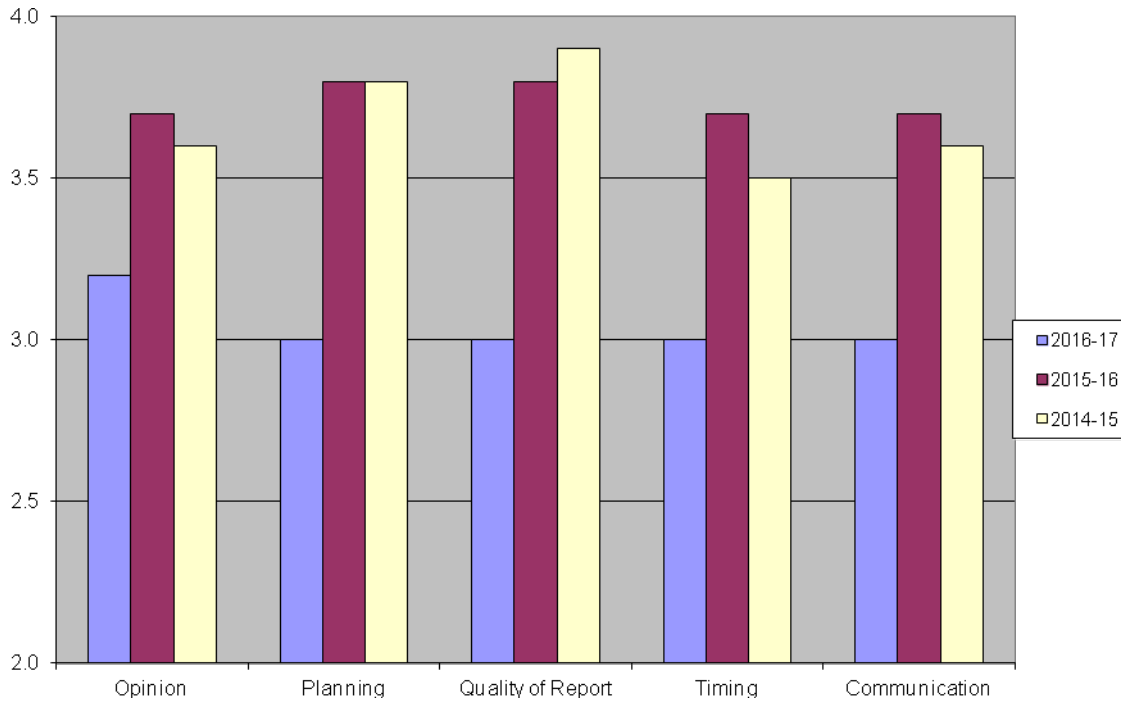
26. Internal and External Audit liaise closely to ensure that the audit work undertaken in the Board fulfils both regulatory and legislative requirements. Both sets of auditors are committed to avoiding duplication and securing the maximum value from the Board's investment in audit.

27. Auditing standards require internal and external auditors to work closely together to make optimal use of available audit resources. External Audit seek to rely on the work of Internal Audit wherever possible and, as part of the external audit planning process an early assessment is carried out of the internal audit function. The adequacy of Internal Audit was reviewed by the External Auditors of NHS Fife, on behalf of the External Auditors of all FTF clients. The review concluded that the service provided by FTF Audit and Management Services operates in accordance with the required Internal Audit Standards and has sound documentation standards and reporting procedures in place.

28. A key measure of the quality and effectiveness of the audits is the Board's responses to our client satisfaction surveys, which are sent to line managers following the issue of each audit report. Fig 2 shows that, overall, our audits have been perceived as good or very good by the report recipients.

Figure 2: Summary of Client Satisfaction Surveys

Scoring: 1 = poor, 2 = fair, 3= good, 4 = very good.



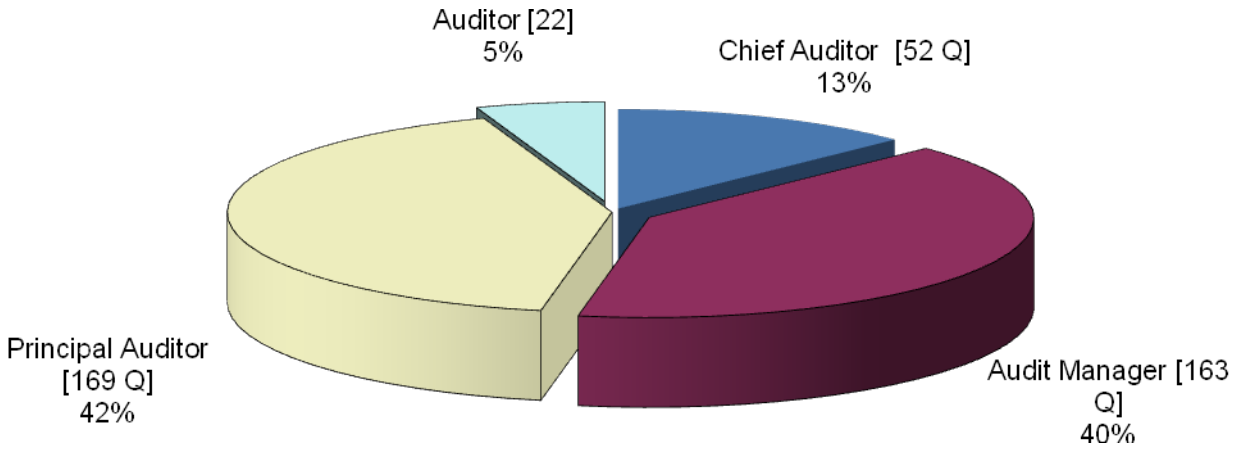
29. Other detailed performance statistics are shown in Appendix 3.

STAFFING AND SKILL MIX

30. Figure 3 below provides an analysis, by staff grade and qualification, of our productive time. In 2016/17 the audit was delivered with a skill mix of 95%, which exceeds the service specification requirement of 50%.

Figure 3: Audit Staff Skill Mix 2016/17

Audit Staff Inputs in 2016/17 [days] Q= qualified input.



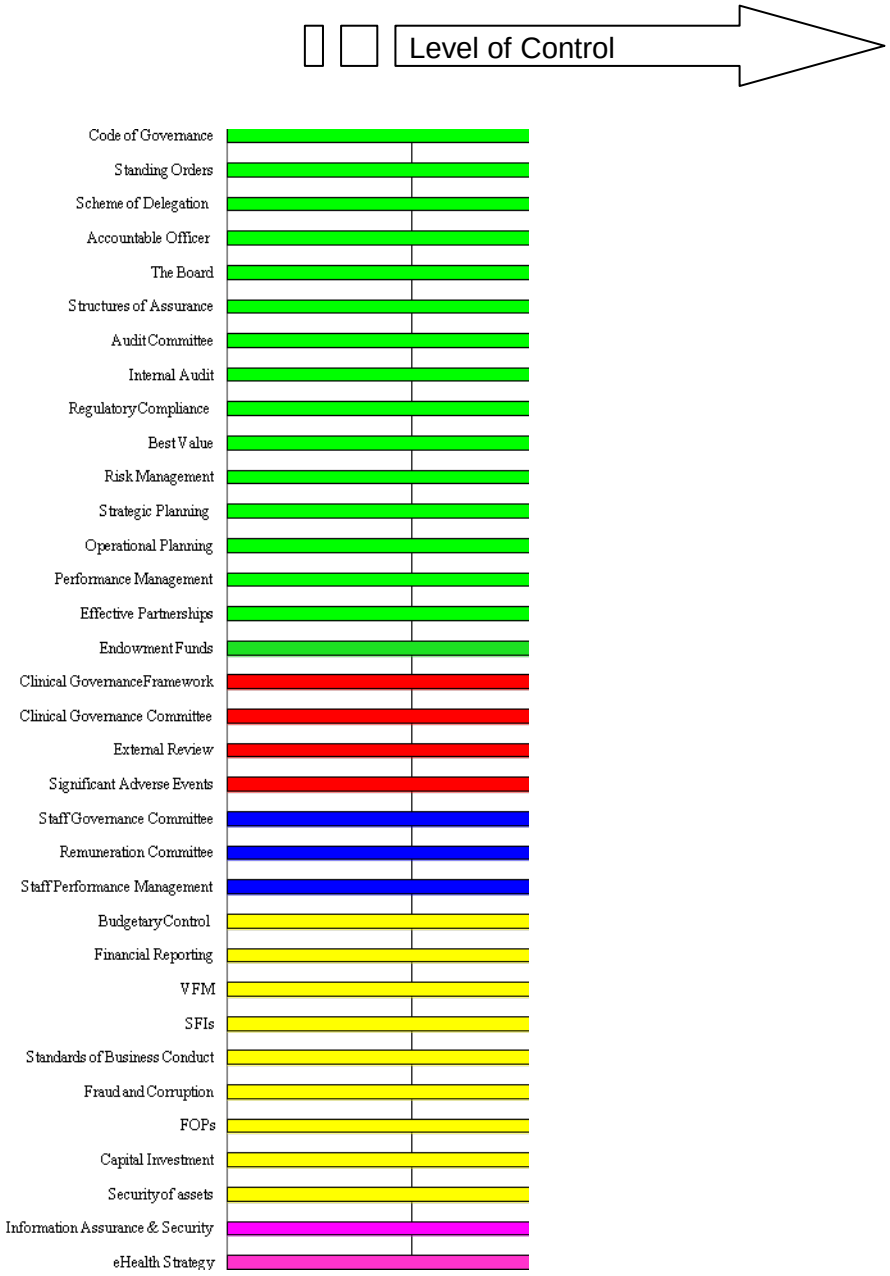
ACKNOWLEDGEMENT

31. On behalf of the Internal Audit Service I would like to take this opportunity to thank all members of staff within the Board for the help and co-operation extended to Internal Audit throughout this challenging year. My team and I have greatly appreciated the positive support of the Director of Finance and the Audit Committee.

A Gaskin, BSc. ACA
Chief Internal Auditor

Appendix 1

2016/17 Summary Evaluation of Internal Control Framework



Audit Rating **F** **E** **D** **C** **B** **A**

- Corporate Governance
- Clinical Governance
- Staff Governance
- Financial Governance
- Information Governance

Corporate Governance	Components	16/17	15/16	Action Plan Ref.
Revisions to the Code of Corporate Governance including updates relating to the Bribery Act 2010 were approved by Tayside NHS Board on 23 February 2017, following approval by Audit Committee in January 2017. The Governance Review Group annual work plan includes the substantial further update of Standing Orders and the Scheme of Reservation and Delegation to reflect both revised management structures and the impact of HSCI. The risk assessment section of the Board and Standing Committee 'Paper for Decision Making' is currently under review by the Governance Review Group.	Code of Corporate Governance	**A**	**A**	
	Standing Orders	**B**	**B**	
	Scheme of Reservation & Delegation	**C**	**C**	
	Accountable Officer Responsibilities	**B**	**B**	
	The Board	**B**	**B**	
	Structures of Assurance	**B**	**B**	**1,2**
	Audit Committee	**B**	**B**	
The University Strategic Liaison Committee (USLC) met once during 2016/17 and therefore did not fulfil its remit which requires it to meet twice. While the Committee's annual report did not conclude on adequacy and effectiveness of arrangements during the year we note that the remit of the USLC has been under review by the Governance Review Group and a revised version will be presented to the June 2017 Board for approval.	Internal Audit Function	**B**	**B**	
	Compliance with Laws & Regulations	**B**	**B**	
	Best Value Arrangements	**B**	**B**	
	Risk Management Strategy	**B**	**B**	**3**
	Strategic Planning	**C**	**B**	
	Operational Planning	**B**	**B**	
The Auditor General issued a second Section 22 report in October 2016, setting out the scale of the challenge NHS Tayside faces in meeting its financial targets. The report was considered in detail by the Public Audit and Post Legislative Scrutiny Committee (PAPLSC) of the Scottish Parliament, following which, the SGHSCD agreed with NHS Tayside the establishment of an Assurance and Advisory Group (AAG) to work with NHS Tayside to provide challenge, advice and assurance to the Five Year Transformation Programme. The AAG reviewed financial plans, service change plans and governance arrangements during May 2017 and will report back to the Scottish Government after three months.	Performance Management	**C**	**C**	
	Effective Partnerships	**C**	**B**	
	Endowment Funds	**A**	**A**	
A revised senior leadership structure was approved by the Remuneration Committee on 12 April 2016, following which, the 14 March 2017 Board paper 'Development of Senior Management Sub-Structure for NHS Tayside' provided an update on progress. At the 4 May 2017 Board meeting the Chief Executive gave a short update presentation to the Board on the Senior Management Substructure, highlighting key principles. The commitment to grow talent, skill and leadership capability was noted.				
During the year 2016/17 NHS Tayside has been proactive in obtaining advice via				

external Human Resources support, and input from National Shared Services colleagues, including in the area of Productive Opportunities. Arrangements have also been strengthened though the appointment of the Medical Director as Deputy Chief Executive and through the role of the Director of Performance. In March 2017 the Scottish Government published the revised 'On Board - A Guide for Members of Statutory Bodies'. The guidance was noted at the May 2017 Governance Review Group. The 2015/16 Interim and Annual Internal Audit Reports, the 2016/17 Interim Report and internal audit report T12/16 – Assurance Framework all highlighted the need for a clear, consistent and coherent understanding of HSCI accountabilities. In response, a short life working group with representation from NHS Tayside and the IJBs met on 12 January, 8 February and 15 May 2017. While significant progress has been made, not all key principles were agreed by year-end, particularly in relation to the model of governance to be applied in Perth and Kinross IJB. As IJBs continue to evolve it is important that there is clarity around these issues particularly in relation to the provision of assurances and risk management as well clear understanding around the tripartite roles of IJB Chief Officers. Assurances have been received from all Executive Directors and Senior Managers that adequate and effective internal controls and risk management have been in place across their areas of responsibility and that any breaches of Standing Orders or Standing Financial Instructions and all significant failures of internal control have been reported to the Chief Executive. Although the December 2016 and February 2017 Audit Committee meetings were rescheduled to allow for preparation and attendance at the Public Audit and Post-Legislative Scrutiny Committee, the Audit Committee was still able to meet five times in 2016/17, thereby exceeding the criteria for all Standing Committees to meet at least four times per annum. During 2016/17 the Audit Committee received three Audit Follow Up (AFU) reports. Mid cycle reports were presented in May 2016 and January 2017 and a full cycle report was produced in September 2016. On 9 March 2017 the Audit Committee concluded positively on their Audit Committee self assessment.				

Following detailed discussions and approval by the Audit Committee, the Internal Audit Plan was amended to focus on areas of high priority, risk and urgency. In discussion with management, Internal Audit identified areas where the Board's planning and monitoring arrangements could be clarified and will work with management in 2017/18 to ensure that systems are in place to deliver and provide assurance on the Board's strategic objectives. The Audit Scotland Annual Audit Plan 2016/17 report, presented to the 17 January 2017 Audit Committee, stated that '*formal review of internal audit has been undertaken from which we have concluded that FTF generally operates in accordance with the Public Sector Internal Audit Standards (PSIAS) and has appropriate documentation standards and reporting procedures in place'.* As reported to the Strategic Risk Management group (SRMG) on 24 April 2017, 86% (an improvement on 80% in May 2016) of policies were within their review date. Where policies had breached their review dates, reasons for extending the review dates were provided. Following Board approval of the updated Best Value Framework 2016/17 in October 2016, the Head of Committee Administration and the Principal Auditor met with Standing Committee Chairs, Lead Officers and Support Officers to help ensure that Committees fulfilled their Best Value obligations in 2016/17. The first draft of the Best Value Framework Assurance 2016/17 was presented to the 11 May 2017 Audit Committee where members agreed the report should be reviewed and on 8 June 2017 Internal Audit contributed to a meeting with Non Executive Members and the Board Secretary to agree amendments to the Framework Assurance, ahead of presentation to Tayside NHS Board. The revised Best Value Framework Assurance 2016/17 will be presented to Audit Committee. The Board Assurance Framework (BAF) was presented to Tayside NHS Board in June, October and February 2017. Risk management systems and processes have been further embedded during 2016/17, including the introduction of horizon scanning as a standing agenda item at the SRMG and the further development of risk appetite. The full BAF will now be presented to Board twice a year with all strategic risks that exceed risk appetite reported to every Board meeting. The Board also receives assurance from the Committee Chairs Assurance Reports and from Audit Committee reports. The Risk Manager and Internal Audit have worked collaboratively to improve				

the content of Datix reports reported to Board. The Board Assurance Framework reported to the Board in February 2017 included 21 strategic risks (20 in February 2016). The strategic risks were rated: • Very High 8 (8 in 2015/16) • High 11 (11 in 2015/16) • Medium 1 (1 in 2015/16) The Risk Appetite Short Life Working Group (SLWG) originally considered a risk appetite of 'High'. This would however have resulted in 91% of strategic risks falling above the risk appetite and a more realistic risk appetite of 'Very High' was ultimately agreed, meaning that 36% of strategic risks are above risk appetite. Tayside NHS Board has requested a Board Development Event on risk. Standing Committees continue to consider reports on individual strategic risks a minimum of four times per annum and a new risk assurance report is in use. The Risk Management Annual Report, the Strategic Risk Management Group (SRMG) Annual Report, the 2017/18 Risk Management workplan and the CIPFA self assessment tool were presented to 11 May 2017 Audit Committee. The CIPFA framework measures risk management compliance against 12 elements. For 2016/17, 11 of the 12 elements were assessed at 100% and the score for 'project and partnerships' was reduced from 100% in 2015/16 to 58% in 2016/17 to reflect the changing HSCI landscape and the recommendations from Internal Audit report T12/16. The Risk Management Strategy was approved on 29 October 2015 and was updated in June and November 2016, at which times minimal changes were made. We recommend the Risk Management Strategy is reviewed and updated to ensure it aligns with those of the IJBs. Internal Audit Report T13B/16 recommended further articulation of risk appetite. A SLWG with membership including a Non Executive Board Member and Internal Audit representatives developed the revised draft risk appetite statement for NHS Tayside which was approved by the SRMG in February 2017 and by Audit Committee in March 2017. Draft risk management KPIs have been developed and have been distributed for initial				

consultation to the members of the risk appetite SLWG. Whilst the Board Secretary is the Executive Lead for Risk Management the Head of Clinical Governance manages the risk management function. There may be benefit in reviewing this arrangement to ensure that the Risk Management function is aligned with executive responsibility and that management of the overall portfolio of risks is not compromised by the demands of clinical governance activities. The Board has recognised the high level of apologies at the SMRG and is currently reviewing and streamlining its Terms of Reference, agenda and workload. NHS Tayside has decided that the Transformation Board will have a greater focus on Strategic Plans and has recognised the need to address strategic planning capacity. The draft 2016/17 Local Delivery Plan (LDP) was approved by the Board on 26 May 2016, prior to submission to the Scottish Government. The LDP identified a potential year end shortfall of £11.65m. The Board did not receive an LDP progress report during 2016/17 but in response to a recommendation in our Interim Report 2016/17, management have agreed that a formal 2017/18 LDP mid-year report will be presented by end October 2017. The draft Transformation Programme 2016 – 2021 and the supporting Operational Delivery Plan 2016/17 were endorsed at the June 2016 Board meeting. The Transformation Programme was refreshed in year and the revised Five Year Transformation Plan 2017 – 2022 and the draft One Year Operational Delivery Plan 2017 – 2018 were noted by the Board at their March 2017 meeting. The Internal Audit Interim Report 2016/17 and Internal Audit T17A/16 – Transformation Programme Board (TPB) Governance Arrangements, reported that whilst the governance of the TPB was good, there were continuing challenges to the timely delivery of outputs, particularly in relation to the culture change required and ongoing issues around capacity to drive forward the work streams. As reported to the December 2016 Board the TPB is now fully staffed. Minutes of the TPB are provided to Tayside NHS Board accompanied by comprehensive Chairman's Committee Assurance reports. The Transformation Programme Annual Report, including a section on the TPB, will be presented to the August 2017 Tayside NHS Board. NHS Tayside performance to end of February 2017 was reported in the Key Metrics				

report to Board on 4 May 2017: • We were pleased to note that the Child and Adolescent Mental Health Service (CAMHS) 18 week performance standard was met in February 2017 with 93.5% being attained. Performance against A&E targets remains above standard; • Performance against waiting times has deteriorated across all Scottish mainland Boards and whilst NHS Tayside improved its ranking, it did not meet any of the TTG targets; • NHS Tayside met four of the seven 18 weeks RTT targets and was ranked 6th in Scotland for percentage of patients seen within 18 weeks – combined performance; • Psychological Therapy 18 weeks RTT: Performance 74.9% , target 90%; • 31 day cancer waiting times: Performance 93.7% Target 95%; • 62 day cancer waiting times: Performance 87.3% Target 95%. The Chief Operating Officer spoke to the Waiting Times and RTT risk at the February 2017 Board meeting and advised that the risk score remained high despite an improvement in performance against the rest of the NHS Boards in Scotland. Internal Audit T36A/16 – CAMHS was presented in full to the 9 March 2017 Audit Committee and confirmed that whilst considerable work had been undertaken to improve the effectiveness of the service, there was scope for further enhancement. Community Planning was the subject of a September 2016 Board Development Event and the Executive team has recently considered a report on Community Planning and Joint Working, formal output has been delayed by the need to take account of guidance on Community Planning, Part 2 of the Community Empowerment Act (2015), which has significant impact on the roles and responsibilities of the Board. Internal Audit T26/17 – NHS Tayside Health Fund (Endowments) concluded positively on the five risk areas audited and was presented to the Endowment Advisory Group on 7 June 2017.				

Clinical Governance	**Components**	**16/17**	**15/16**	**Action Plan Ref.**
The review of the Clinical Governance Strategy is ongoing and has been included in the 2017/18 workplans for both the Clinical Quality Forum (CQF) and the Clinical and Care Governance Committee (CCGC). Clinical governance arrangements for integrated services are still developing. Whilst regional R2 groups have been meeting and reporting through their minutes to the CQF, the Tayside wide R1 group, which was a central feature of the Clinical Care & Professional Governance Framework, has not yet been established. The gap has been acknowledged in the Clinical Governance Strategic risk and the risk score has been raised. Work is ongoing by the Medical Director, Nurse Director and IJB Chief Officers to refine clinical and care governance reporting to achieve a consistency of reporting to the CQF and a critical appraisal of minutes of the R2 Governance Groups is ongoing. Although the CCGC places reliance on assurance provided by the CQF in relation to detailed review of clinical risks as well as clinical and care governance through the performance review reporting process, the CCGC approved its annual report without the formal assurance of the CQF annual report, which was not approved until a CQF meeting 4 days later. The Internal Audit 2016/17 Interim Review recommended a review of the scheduling of CQF and CCGC meetings to allow CQF minutes and assurance reports to be reported to CCGC in a more timely manner. Our review of meetings in 2016/17 and the scheduling of meetings in the workplans for 2017-18 do not demonstrate best assurance flow from CQF to CCGC. However, the CCGC and CQF Chairs and the Executive Leads are reviewing the timetable to address this known issue. As previously reported in our 2016/17 Interim Review, the membership and remit of the CQF has been updated and the forum now has an increased focus on learning and sharing of good practice, as well as further emphasis on the review of strategic clinical risks to provide assurance to the CCGC. The NHS Tayside Clinical Governance Strategy is supported by a framework of Performance Reviews which was refreshed on 22 February 2017. A Public Health Performance Management Framework is now in place. Whilst the first Public Health performance reviews for the period 1 April to 30 September 2016 were directly	Clinical Governance Framework	**B**	**A**	**4,5,6**
	Clinical & Care Governance Committee	**B**	**B**	
	External Review	**A**	**A**	
	Significant Adverse Events	**B**	**B**	

reported to CCGC in August and November 2016 respectively, none have been reported for the second half of the year. However, Public Health Performance reviews are included on the CQF workplan for 2017/18. We were pleased to note that, after a long gap, a Mental Health performance review meeting took place in March 2017 and was subsequently reported to CQF in May 2017. However, only one Mental Health Service Governance member and two members of the Review Group were present at the meeting. The Performance Review summary overview report highlighted areas of good practice and emergent issues but did not identify any issues to highlight to the local Clinical Governance Assurance meeting, nor any identified risks. The CCGC also received updates from the Perth & Kinross Health & Social Care Partnership in February and March 2017, including progress on development of mental health services governance arrangements. The February 2017 Board was advised of the continuing challenge of the mental health contingency plan and that the Mental Health Service Redesign Transformation Programme Team was concluding the final stages of work and the completed option appraisal would come forward to the Board in June 2017. Both the CQF and CCGC have appropriately reviewed the eight strategic clinical risks. Between October 2016 and February 2017 the risk rating for four risks went up, two went down and the risk score for two risks remained the same. The format of risk reporting to Standing Committees has been enhanced by a move to summary assurance reports and Datix print outs. Following the August 2016 CCGC, the Mental Health strategic risk was rebranded as an operational risk with a new strategic risk on Mental Health Services – sustainability of safe and effective services being created. The February 2017 Board meeting was informed that the strategic risk for PRI/Patient Flow had been updated and the current risk score increased from Amber to Red. Regular reports on this issue are presented to Board. A Whole System Safety and Flow Framework was endorsed at the February 2017 meeting of the CCGC. However, concerns were raised as to the sustainability of funding to achieve this. The Adverse Event Management (AEM) Policy is under review and a consultation				

exercise has been completed. Further work on the issues raised during consultation is ongoing and it is anticipated that the revised policy will be presented to Audit Committee in early autumn 2017. However, final approval of the updated policy is also dependent on receiving awaited HIS guidance on applicable timescales. Internal Audit T16/17 is ongoing and will conclude on the systems in place to ensure lessons are learned from adverse events and that appropriate, adverse event reviews result in actions and improvements which are monitored, shared and followed up. The review will also assess arrangements for the introduction of Duty of Candour, which has a target implementation date of 1 April 2018. Work has been ongoing in NHS Tayside in preparation and progress updates have been provided to the CQF and CCGC. Updates on the action plan in place in relation to the Health and Safety Executive (HSE) Improvement Notice following the deaths by suicide of two patients in Moredun Ward, Murray Royal Hospital continue to be provided. At the March 2017 CCGC meeting concerns were raised over some of these action points still being outstanding and it was agreed that monthly progress reports would be provided. The Procurator Fiscal has made contact with the Central Legal Office in respect of a likely prosecution against the organisation but there is no further update at this stage. Local and national reports are a CCGC standing agenda item and the CQF considers external visits and external clinical scrutiny reports at every meeting.				

Staff Governance	Components	16/17	15/16	Action Plan Ref.
On 13 December 2016 the SGC agreed revised Terms of Reference, subject to agreed changes, and that membership and quoracy issues would be discussed with the Board Secretary. The Action Points update for the March 2017 meeting noted that the revision of the Terms of Reference was complete. We were pleased to note that the SGC, the Finance & Resources Committee (F&RC) and CCGC will now meet twice a year to review performance and agree priorities for future reporting. The next SGC meeting is scheduled after the June 2017 Audit Committee which considers the annual accounts and year end assurances. Therefore, the draft SGC annual report will be circulated electronically to members for their comment and approval, before being presented to Audit Committee on 22 June 2017. The SGC will also receive electronically the approved Remuneration Committee and the Area Partnership Forum (APF) annual reports. We would also highlight that the most recent minute of the APF presented to the SGC relates to November 2016. We have however been assured that when the SGC draft annual report is circulated, the Remuneration Committee annual report as well as an assurance statement from the Chairs of the APF, setting out whether the APF has fulfilled its remit and any risks to be highlighted to the SGC, will be appended. As the SGC draft annual report is not yet available we cannot comment on whether it provides the appropriate assurances supported by relevant, reliable and sufficient evidence. Following previous audit recommendations regarding how the SGC best demonstrates oversight and ownership of key workforce issues, we commend the development of a Workforce Dashboard to be reported to both the F&RC and the SGC. In addition, following the most recent update to the remit of the SGC, links have been established with the CCGC, in order to ensure staff, clinical and financial aspects of key risks that are being considered by disparate Standing Committees are linked in a meaningful way and duplication is avoided. The first of the dashboard reports was submitted to the SGC in March 2017 and provided data and trends on various areas including Whole Time Equivalents/ hours	Staff Governance Committee	**C**	**B**	**7**
	Remuneration Committee	**B**	**C**	
	Performance Management & Development	**C**	**B**	**8**

paid/ supplementary cost/ total paybill cost/ turnover/ age profile/ skill mix. The paper requested feedback from members and it was noted that a simple dashboard for Patient & Staff Experience would be developed and a report on benchmarking against other Boards would come to the June 2017 meeting. Our interim review reported the planned development that workforce reports would be adapted to demonstrate how they support the achievement of the Board's operational and strategic objectives and agenda items, such as the Promoting Attendance at Work and Recruitment Activity SBAR cover papers, will provide an overt link to the organisation's financial position and the achievement of organisational objectives. Whilst we were unable to see incontrovertible and overt evidence of this in the papers, we do note the development of the workforce dashboard which goes some way towards progressing this. During 2016/17 the SGC considered the three strategic risks for which it has responsibility - Medical Workforce, Workforce Optimisation and Nursing & Midwifery Workforce. The Staff Governance Standard was a Standing Agenda item at each SGC meeting and all five strands of the Standard have been considered during the year. As notified in the 'NHSScotland National Staff Experience Measurement' letter from the Scottish Government Head of Workforce Practice Unit on 13 December 2016, the national annual Staff Survey has been discontinued and in future national staff experience will be measured using the iMatter Continuous Improvement Model. The 'People Matter Strategic Framework 2016 – 2021' was presented to Board in August 2016 and it was agreed that, in order to track progress, each item would have an action plan in addition to using outcomes from iMatter. As reported to the March 2017 SGC meeting, the response rate to the iMatter Staff Experience Continuous Improvement Model in NHS Tayside was 67%, the highest return rate in NHSScotland. A Board Development session on culture was held on 23 February 2017 and was led by an expert on team working and organisational effectiveness in health. A detailed feedback and development session with the full Board took place on 4 May and as an outcome of this, the Board have commissioned a further programme of detailed design work around strategic interventions, with a further planned report back to the				

Board requested for December 2017. Health & Safety is now within the remit of the Chief Operating Officer and the health and safety support structure has been reconfigured. The health and safety risk will need to be included within the 2017/18 SGC work plan. The March 2017 SGC received a briefing on arrangements, including the Terms of Reference for the recently re-established Health and Safety Strategic Management Group which reports to the SRMG. The Health and Safety 2016 Annual Report has not been presented to the SGC. The Remuneration Committee approved their draft 2016/17 annual report on 14 March 2017. The Remuneration Committee self assessment for 2016/17 was approved at the March 2017 meeting and has been provided to Internal Audit who will validate the self-assessment as part of the 2017/18 internal audit plan. The December 2016 Remuneration Committee received a paper on Director Objectives 2016/17 and Redesign of Appraisal System and Fit for Purpose Assurance and noted their approval of the progress made in the quality of submissions. Our 2016/17 interim review reported that the Corporate Workforce Plan for 2016/17 described the strategic direction and it is acknowledged that Local Workforce Plans are still to be developed in partnership and in conjunction with the transformational change decisions. The NHS Tayside Corporate Workforce Plan, and associated workforce projections, will be presented to the Staff Governance Committee for consideration and approval at its meeting on 22 June. Final national guidance in the form of the Integrated Health & Social Care Plan is awaited. Scottish Government have advised that consultation with COSLA remains ongoing, with a likely consequence that, whilst NHS Boards meantime continue to use the existing national planning framework for Health, a further system-wide workforce plan will be required in late 2017 taking in to account Primary Care and Social Care resources. The 2017/18 Corporate Workforce Plan will be presented to the APF on 15 June before presentation to the SGC on 22 June 2017.				

The medical vacancy rate has increased from 1.3% at end of 2015/16 to 2.94% at the end of 2016/17. In particular, we noted the higher vacancy rates within Mental Health (5.88%) and Dundee IJB (10.20%) in the third quarter of the year. An Agenda for Change Improvement Plan was produced during 2016/17 with an agreed stretch goal that "80% of staff will have an up to date Personal Development Review (PDR)/Plan in place by the end of the year". As at the end of January 2017 compliance was 39%, with no improvement from the end of November 2016. The Chairs Assurance report from the March 2017 meeting noted that this is an area in need of significant improvement and evidence of Senior Management commitment. The Committee was informed that the Knowledge & Skills Framework (KSF) would not be available for staff from 2018 and agreed to use alternative processes to evidence appraisal and development through revalidation processes and the iMatter toolkit. An evaluation of a pilot is due to be presented to the SGC in September 2017. An update on the Scheme for Medical Appraisal and Revalidation was presented to the 13 December 2016 SGC, having been carried forward from June to September then to December. The paper provided figures for the year 2015/16 which highlighted a fall in compliance at that point. HIS noted the fall in compliance for 2015/16 and an action plan was agreed. No figures for 2016/17 were available to Internal Audit and we have been informed that there are concerns in relation to the quality of the data on which reporting is currently based. This data quality issue was highlighted in the December 2016 paper to SGC which stated that *'There is uncertainty regarding the denominator figure of 611, and the 71 unassigned doctors. These are inaccurate and the denominator figure is likely to be a significant overestimation while the unassigned doctors are slightly underestimated. The Appraisal Coordinator is cross checking SOAR against appropriate HR records to obtain more accurate figures'.* All GP appraisals due by the end of the appraisal year 31 March 2017 have been carried out, although 6% (27) have still to be signed off by the appraisee. The Chair of the SGC provided an update on performance to the December 2016 Board. He advised the Board that amongst its peer boards, NHS Tayside was currently the best performing peer Board in relation to staff absence, whilst highlighting three areas where performance could still improve, The rate of sickness absence for NHS Tayside for the third quarter period 2016/17 was 4.81%, against the standard of 4% (0.5% tolerance), down 0.24% from the same period last year.				

Financial Governance	**Components**	**16/17**	**15/16**	**Action Plan Ref.**
Internal Audit T22/17 – Follow up of Financial Planning and Reporting was presented in full to the 9 March 2017 Audit Committee and the Director of Finance provided the 11 May 2017 Audit Committee with an update on the status of management actions. The report highlighted a range of findings in relation to Governance, Budgeting, Efficiencies, Benchmarking and Financial Planning as well as following up a number of previous Internal and External Audit recommendations relating to these areas. The report concluded that whilst considerable work has been undertaken and many improvements made, further improvements are still required and the pace of change will need to accelerate if targets are to be achieved. The 2015/16 Annual Internal Audit Report and Internal Audit Interim Review 2016/17 highlighted the importance of ensuring that a robust Finance Team was in place. The Director of Finance has confirmed that a detailed Finance Workforce Plan will be completed by September 2017 and the March 2017 Remuneration Committee was informed that the new structure for senior finance posts reporting directly to the Director of Finance continues to be progressed. The finance structure will provide financial assurance and governance to both the NHS Tayside Board and to the three Integrated Health and Social Care Partnership Boards. The Finance & Resources Committee (F&RC) Terms of Reference were reviewed in detail and approved by the F&RC in November 2016. The F&RC Annual Report 2016/17 noted that the Internal Audit Interim Report 2016/17 identified a range of recommendations that sought to improve the overall financial governance, recognising the particular financial challenges faced by NHS Tayside, and that these aspects will once again be considered in 2017/18. As reported in T22/17, until recently the budgetary control approach adopted in NHS Tayside used an incremental approach to budget setting where existing budgets were rolled forward year on year, although we acknowledge that more recently the Board's budgets have specifically addressed legacy issues to provide more meaningful and achievable targets. The incremental approach continued to be used in circumstances where operational budgets have overspent for a number of years and a further consequence of rolling	Budgetary Control System	**D**	**D**	
	Financial Reporting	**C**	**C**	
	Arrangements to ensure Resources are Used Effectively, Efficiently & Economically	**C**	**C**	
	Standing Financial Instructions	**A**	**A**	
	Standards of Business Conduct	**A**	**A**	
	Anti Fraud, Theft & Corruption Policy & Response Plan	**B**	**B**	
	Financial Operating Procedures	**A**	**A**	
	Capital Investment Control & Project Management	**C**	**C**	
	Acquisition, Use, Safeguarding & Disposal of Assets	**C**	**C**	

forward budgets without a formal methodology for challenging the expenditure base is that of potentially perpetuating inefficiencies in existing budgets. Management have agreed that, following completion of the Annual Accounts process, the SFIs will be updated and where appropriate more detailed operational guidance will be developed and continuously reviewed. In order to improve the budget setting process, a revised approach has been incorporated within the 2017/18 – 2021/122 Financial Framework, approved at the 27 March 2017 Tayside NHS Board subject to the finalisation of the IJB budgets and subject to assurance that the Framework and budget setting would be driven by health service redesign and clinical requirements, not the financial requirements and priorities. A revised business planning and budgeting process for NHS Tayside was considered at an F&RC development session and a process to engage and involve service teams in the build of business planning and budgeting and progressively restore ownership, responsibility and accountability at clinical and operational level was agreed. As noted in the F&RC Annual Report 2016/17, a truncated approach will be in place for 2017/18, laying the foundations for full implementation of the process in 2018/19. At the March 2017 Board meeting there was detailed discussion around the need for an open and transparent budgeting process; however it was noted that budgetary control was not solely in the gift of the Board to deliver and there were a number of external influencing factors such as the ability to recruit staff the requirement for non contract agency staff and the impact of delayed discharges. It was noted that the budget was dynamic and had come later to the Board than was preferred, the overhaul of the budgeting process would assist with this next year as would the depth of budgetary planning throughout the organisation. T22/17 recommended that the format and style of Corporate Financial Reports should be further revisited to ensure that they 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. The Director of Finance has assured the Audit Committee that reports will be subject to continuous review. The Local Delivery Plan approved by the Board on 26 May 2016, prior to submission to Scottish Government, identified a potential deficit of £11.65 million in 2016/17,				

recognising both unidentified savings and an element of high risk savings proposals. The draft Corporate Financial Report to 31 March 2017 was presented to the F&RC on 18 May 2017 and reported an underspend of £0.231 million for year ended 31 March 2017, with the year end position reflecting three key components:- • the unbalanced LDP figure of £11.65 million; • a further in-year exposure/efficiency savings shortfall of £1.3 million; • the receipt of £13.2 million financial brokerage from SGHSCD, which offsets the underlying overspend position above. The subsequent identification of a March adjustment, which classified £1.2 million expenditure as non-core rather than core, presented a risk to the draft position due to the associated funding implications. This risk is mitigated through identification of further adjustments which maintain financial balance. Efficiency savings of £45.56 million were delivered during 2016/17 (£23.4m in 2015/16). Whilst a considerable achievement, this was £1.29 million short of the figure of £46.75 million required to meet the unbalanced LDP. 51% of these savings were recurrent (35% in 2015/16). The Chairman advised the March 2017 Board meeting that the F&RC had requested that the Board authorise the Chief Executive and the Director of Finance to request additional brokerage from the SGHSCD for 2016/17. The Risk Sharing Agreement in place with IJBs has resulted in the Board picking up overspends within IJB health related budgets. The value of these overspends is £8.4 million, with the most significant element being FHS Prescribing at £7 million which has been a long standing issue in NHS Tayside. We had previously reported on a number of occasions on the risks associated with deferred expenditure. In response to detailed recommendations in T22/17, the Board has taken positive steps to increase reporting and oversight of this area and the 5 year plan presented to the March 2017 Board contained detailed proposals to reduce the level of deferred expenditure over the 5 year cycle. The F&RC has four strategic risks aligned to it and these were considered at every				

meeting. These risks are for Information Governance and Implementation of the replacement Patient Administration System, as well as two 'very high' financial risks: • Delivery of the Strategic Financial Plan and the impact on delivery of national and local plans, and the potential to breach the statutory financial obligations of the Board. – Very high • Reduction in capital resources experienced by the Board, and the impact this has on our ability to deliver the Clinical Strategy and the Property Asset Management Strategy – Very high. T32/17 – Standards of Business Conduct (SoBC) concluded that NHS Tayside guidance 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. The Associate Director of Finance is the NHS Tayside Fraud Liaison Officer (FLO) and also delivers National Fraud Initiative (NFI) work. The Audit Committee was provided with Counter Fraud updates at each meeting. Internal Audit T24/17 – Financial Process Compliance covered high level compliance testing on controls within the central payroll, travel expenses, accounts receivable, accounts payable and banking systems and concluded that controls were operating well. All Financial Operating Procedures were considered fit for purpose and the majority have been recently reviewed, with work ongoing to review the others. Internal Audit report T28A/17 – Property Management was presented to the 17 January 2017 Audit Committee. In response to this report, two new service risks on the organisation's ability to deliver the Property & Asset Management Strategy (PAMS) and the accuracy of the PAMS have been developed and governance and reporting lines have been strengthened and clarified.				

Information Governance	**Components**	**16/17**	**15/16**	**Action Plan Ref.**
The F&RC continues to receive Information Security Improvement and Action Plan reports, including progress on DL (2015) 17 – Information Governance and Security Measures 2015 – 2017. The most recent report to the May 2017 F&RC *'reflects that the majority of this work has been completed, with the remaining areas sitting with eHealth and Information Governance.'* Progress on implementation of the DL is monitored by the Information Governance Committee (IGC) which considered an updated version of the Information Security Improvement and Action Plan at their April 2017 meeting. The Information Governance (IG) Annual Report, which had been considered by the IGC, was presented to the F&RC on May 2017 and provided appropriate IG assurance. However the format and style of the report requires to be refreshed, mostly around presentation and style of reporting, and this is recognised by the IG Manager as a future action. On 21 February 2017, the NHSScotland Chief Operating Officer wrote to all Senior Information Risk Owners (SIROs) requesting assurance around IT back up in response to cyber attacks experienced in the NHS in England. NHS Tayside provided a robust and clear response that the IT back up procedures within the organsiation were fit for purpose. The IG Policy was approved in February 2016 and the Information Security Policy was approved and published in July 2016. The IG strategic risk is monitored by the IGC and F&RC. As reported to the May 2017 F&RC, the current risk score of "high" reflects the ongoing work to comply with DL (2015)17 Information Governance and Security Improvement Measures 2015-2017, including the new NHSS Information Security Policy Framework. In addition, a further risk has been identified in relation to the Information Commissioners Office (ICO) Power for Compulsory Audit for NHS Bodies. These audits will review how the NHS handles personal information, including data security, data sharing, records management and staff training.	Information Assurance and Security	**B**	**B/C**	**10**
	eHealth Strategy	**B**	**B**	**9**

NHS Tayside has continued to progress development of the Information Asset Register (IAR) which will identify key assets and identify their owners. The top 21 systems within NHS Tayside have been identified and information to populate the IAR has been received for approximately 50% of the 21 critical systems. This will continue to be monitored by the IGC through the Information Security Improvement and Action Plan. As reported in both the mid year and year end IGC reports for 2016/17, the draft Data Quality Strategy was reported to the September 2015 meeting of the IG Committee where it was agreed that to fully develop the document, it would need to be presented to and discussed with key individuals and relevant groups, and progress with development of this Strategy would be reported to the IGC for monitoring and input. Once complete and agreed by the IGC, the Strategy will be widely circulated for consultation and the proposed final version will be presented to the F&RC for final approval. As reported in both the mid year and year end IGC reports for 2016/17, the FairWarning process remains dependent on manual extraction of system data and manual incorporation of personnel data from different sources and there is currently no pro-active way of identifying incidents (inappropriate access/breach of confidentiality) within NHS Tayside. Investigations surrounding the practicality of FairWarning working with Trakcare are ongoing and the Information Governance Team and eHealth colleagues are liaising with the FairWarning Support Specialist. The Area Business IM&T Group is required to meet four times each year. In 2016/17 the Group only met 3 times and already the first meeting of 2017/18 has been cancelled. The Group will need to put appropriate arrangements in place to ensure it meets its remit during 2017/18. The update on the eHealth Strategy presented to the F&RC in February 2017 highlighted progress against key issues and identified current risks to the overall programme, particularly around eEES, eRostering and the risk to other programme delivery due to delays experienced in implementing Trakcare. The Trakcare Programme Board met on 8 March 2017 and a revised timetable for implementation has been put in place. The Go Live date is now 24 – 26 June 2017.				

The Senior eHealth Team met with the Scottish Government eHealth representatives on 28 April 2016 and 13 March 2017 to review the eHealth delivery plan to ensure progress towards meeting the requirements of the national eHealth Strategy and appropriate management of the strategic funds allocated to Tayside. The Scottish Government eHealth representatives indicated that they were satisfied with progress made in NHS Tayside with the Local eHealth Delivery Plan and confirmed their work in attempting to secure continued support for Strategic Fund monies from Scottish Government for 2017/18 and 2018/19. HSCI is a recurring theme within the eHealth Delivery Plan, which is considered at each Area Business IM&T Group meeting. Specific projects from the eHealth Delivery Plan include for example the Tayside Health and Social Care IT Approach.				

Appendix 3: Performance against service specification

	Planning	Target	2016/17	2015/16
1	Strategic/Annual Plan presented to Audit Committee by April 30th	Yes	Yes – 24 March 2016	No – 7 May 2015
2	Annual Internal Audit Report presented to Audit Committee by June	Yes	Yes	Yes
3	Audit assignment plans for planned audits issued to the responsible Director at least 2 weeks before commencement of audit	75%	86%	75%
4	Draft reports issued by target date	75%	46%	77%
5	Responses received from client within timescale defined in reporting protocol	75%	82%	90%
6	Final reports presented to target Audit Committee	75%	83%	86%
7	Number of days delivered against plan	100% at year-end	98%	94%
8	Number of audits delivered to planned number of days (within 10%)	75%	75%	76%
9	Skill mix	50%	95%	88%
10	Staff provision by category	As per SSA/Spec	Pie chart	
	Effectiveness			
11	Client satisfaction surveys	Average score of 3	Bar chart	

Ref.	Finding	Audit Recommendation	Priority	Management Response/ Action	Action by/Date
1.	NHS Tayside needs to complete an extremely challenging transformation programme in the context of severe financial pressure and a rapidly rising risk profile. Whilst progress has been made, we have concluded that the pace of change needs to accelerate. Board members do receive a wide range of detailed reports at Board, Committee and IJB reports throughout the year, but do not necessarily have the opportunity to reflect on them and share information that allows a holistic view to be formed.	The Board should consider a mid-year Board Development Event where Board members can have an off-line discussion, away from the formality of a Board meeting to take stock of progress to date, draw together the disparate stands of performance and risk and take a holistic view of whether NHS Tayside is on track to achieve its objectives.	**2**	Agreed. The Board Secretary will work with the Chairman and Chief Executive to identify a date in the autumn for this to be incorporated into a Board Development Event programme.	Board Secretary 31 October 2017
2.	The revised senior leadership structure has been updated in 2016/17 and a paper on 'Development of Senior Management Sub-Structure for NHS Tayside' was presented to the Remuneration Committee on 14 March 2017. At the 4 May 2017 Board meeting the Chief Executive gave a short update presentation to the Board on the Senior Management Substructure, highlighting key principles. The	The revised senior leadership structure, in totality, should be presented to Board with the previously recommended assurance on capability. This should include Business As Usual, Strategy production with targets for delivery, delivery of strategies and working with and supporting the IJBs.	**2**	Agreed.	Chief Executive 31 December 2017

Ref.	Finding	Audit Recommendation	Priority	Management Response/ Action	Action by/Date
	commitment to grow talent, skill and leadership capability was noted.				
3.	Whilst the Board Secretary is the Executive Lead for Risk Management, the Head of Clinical Governance manages the risk management function.	There may be benefit in reviewing this arrangement to ensure that the Risk Management function is aligned with executive responsibility and that strategic management of the overall portfolio of risks is not compromised by quotidian clinical governance activities. We are aware that such a review was undertaken elsewhere with the conclusion that the Risk Management function was better placed within the Chief Executive's department, under the auspices of the Board Secretary.	**2**	Agreed.	Chief Executive 31 December 2017

Ref.	Finding	Audit Recommendation	Priority	Management Response/ Action	Action by/Date
4.	As Clinical & Care Governance arrangements for IJBs continue to evolve, the Medical Director, Nurse Director and IJB Chief Officers continue to refine clinical and care governance reporting to achieve consistency. However, neither the CCGC nor the CQF have received any updates on the implementation of the Clinical Care & Professional Care Governance Framework. When the December 2016 CGC considered the Delivering Care for Older People risk members raised the issue of awareness of this risk within the IJBs and the group discussed the necessity of establishing links. It was acknowledged that within the IJBs that there was currently no performance review system in place and no external scrutiny. It was agreed that the Medical Director would write to the three Chief Officers to obtain an update on progress in relation to governance arrangements.	NHS Tayside should ensure that the CCGC and CQF are fully aware of progress in this key governance and assurance area. A mechanism for ensuring that learning is shared across Tayside should be an important feature of any new arrangement. The key priority however, is the provision of regular and robust assurance on clinical and care governance to NHS Tayside, the three IJBs and their Local Authority partners.	**2**	Agreed. The CCGC and the CQF will be provided with regular and robust assurances on the implementation of the Clinical Care & Professional Care Governance Framework. As previously agreed, the Medical Director will write to the three Chief Officers to obtain an update on progress in relation to governance arrangements.	Medical Director & Nurse Director 30 September 2017

Ref.	Finding	Audit Recommendation	Priority	Management Response/ Action	Action by/Date
5.	The first Public Health performance reviews for the period 1 April to 30 September 2016 were reported to CCGC in August and November 2016 respectively but none have been reported for the second half of the year. However, Public Health Performance reviews have been included on the CQF workplan for 2017/18.	Public Health performance reviews should take place every three months in line with the standard timetable and should be reported to the CCGC Committee timeously.	**3**	Agreed. Public Health performance reviews will take place every three months in line with the standard timetable and will be reported to the CCGC Committee timeously.	General Manager, Public Health 30 September 2017
6.	Only one Mental Health Service Governance member and two members of the Review Group were present at the Mental Health performance review meeting which took place in March 2017.	As previously reported in T08/17, management should ensure that there is sufficient capacity and administration to support performance review meetings across all departments and particularly for Mental Health.	**3**	Agreed. Management will ensure that there is sufficient capacity and administration to support performance review meetings across all departments, and particularly for Mental Health.	Chief Officer Perth and Kinross HSCP – Mental Health 30 September 2017
	The summary overview report highlighted areas of good practice and emergent issues, but did not identify any issues to highlight to the Clinical Governance Assurance meeting, nor any identified risks.	The CQF should review the quality of the summary overview reports presented to them and identify any areas which are not adequately documented or explained in line with the organisation's risk profile.	**3**	Agreed. The CQF will review the quality of the summary overview reports presented to them and identify any areas which are not adequately documented or explained in line with the organisation's risk profile.	Medical Director & Nurse Director 30 September 2017

Ref.	Finding	Audit Recommendation	Priority	Management Response/ Action	Action by/Date
7.	A Health & Safety Annual Report was not presented to the SGC in 2016/17 and the SGC did not consider the health & safety risk The March 2017 SGC received a briefing on arrangements in March 2017, including the Terms of Reference for the recently re-established Health and Safety Strategic Management Group which reports to the SRMG. The Health and Safety 2016/17 Annual Report has not been presented to the SGC.	Health & Safety Governance responsibilities should be included within the 2017/18 SGC work plan and a Health and Safety Annual Report has should be presented to the SGC.	**2**	Agreed. The Health & Safety Annual Report will be presented to the 22 June 2017 SGC. Health & Safety will be included in the SGC workplan for 2017/18 and an annual report will again be presented at year end.	Director of HR and OD 31 March 2018
8.	Secondary Care Doctors' Appraisal figures for 2015/16 highlighted a fall in compliance at that point. No figures for Medical appraisal in 2016/17 were available to Internal Audit and we have been informed that there are concerns in relation to the quality of the data on which reporting is currently based. This data quality issue was highlighted in the December 2016 paper to SGC which reported that the Appraisal Coordinator was cross checking SOAR against appropriate HR records to obtain more accurate figures.	The availability and accuracy of Secondary Care Doctors' Appraisal should be addressed as a priority and appropriate assurances on compliance provided to the SGC. These assurances should include the current position on the action plan to address HIS concerns around compliance in 2015/16.	**2**	Agreed.	Medical Director / Director of HR & OD 31 March 2018

Ref.	Finding	Audit Recommendation	Priority	Management Response/ Action	Action by/Date
10.	The Area Business IM&T Group met 3 times during 2016/17 with one other meeting cancelled. Already for 2017/18 the first scheduled meeting has been cancelled.	The Area Business IM&T Group will need to put appropriate arrangements in place to ensure it meets its remit during 2017/18.	**2**	Agreed. The Area Business IM&T Group will review its remit and scheduling of its meetings.	Director of HR & OD 31 March 2018
11.	The development of a Data Quality Strategy was reported to the IGC in September 2015, but no further updates have been provided	An update on the development of the Data Quality Strategy should be reported to the IGC to the next available meeting.	**2**	Agreed. An update on the development of the Data Quality Strategy will be reported to the next IGC meeting.	Board Secretary 31 August 2017

APPENDIX 5: DEFINITION OF ASSURANCE CATEGORIES AND RECOMMENDATION PRIORITIES

Categories of Assurance:

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

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

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

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

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

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

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

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

Item Number 7.6

AUDIT48/2017
Audit Committee
22 June 2017

ANNUAL REPORT - PATIENT EXEMPTION CHECKING (PECS)

1. SITUATION AND BACKGROUND

The purpose of this report is to advise the Committee on the work of Counter Fraud Services (CFS) during 2016/17 in checking the propriety of exemptions claimed by patients for charges for ophthalmic and dental work. The report also identifies the amounts recovered and those written off.

2. ASSESSMENT

CFS has issued its annual report on PECS for 2016/17 (see Appendix 1).

The report sets out the recoveries and write offs by service for NHS Tayside and NHS Scotland.

The amount recovered by CFS on behalf of NHS Tayside for 2016/17 was £20,143 (2015/16 - £16,602). This represented 5.7% (2015/16 – 5.6%) of the Scotland total.

The value of the write offs increased from £12,169 last year to £12,889 this year, which represented 4.8% (2015/16 – 6.3%) of the Scotland total.

3. RECOMMENDATIONS

The Committee is asked to note the following:-

i. the 2016/17 Annual Reporting Package from Counter Fraud Services;
ii. the level of recoveries made during 2016/17, and
iii. the reported level of write offs across the Contractor Groups, which are recorded in the losses form (SFR18) in the 2016/17 Annual Accounts.

Robert MacKinnon
Associate Director of Finance – Financial Services & Governance

Lindsay Bedford
Director of Finance

June 2017

NHS SCOTLAND COUNTER FRAUD SERVICES

NHS TAYSIDE

SUMMARY OF PATIENT RECOVERIES AND WRITE OFFS - 1 APRIL 2016 TO 31 MARCH 2017

The tables in this section provide a summary of the number and value of recoveries by service (Table 1) and the number and the value of proposed write offs (Table 2) resulting from patient exemption checking.

Table 1 - Amount of patient recoveries in respect of period 1 April 2016 to 31 March 2017

	NHS TAYSIDE		SCOTLAND	
Service	**Number of Cases**	**Value**	**Number of Cases**	**Value**
Dental	201	£12,937.75	3,776	£255,377.27
Ophthalmic	108	£7,495.10	1,549	£105,032.83
Total	**309**	**£20,432.85**	**5,325**	**£360,410.10**
Less Debt recovery costs*	N/A	£289.60	N/A	£5,108.14
Total value of monies to be transferred to Health Board	N/A	**£20,143.25**	N/A	**£355,301.96**

* Total debt recovery costs have been split between each Board on a pro-rata basis.

Table 2 - Proposed write-offs in respect of period 1 April 2016 to 31 March 2017

	NHS TAYSIDE		SCOTLAND	
Service	**Number of Cases**	**Value**	**Number of Cases**	**Value**
Dental	162	£8,981.92	3,105	£191,643.31
Ophthalmic	75	£3,907.42	1,353	£74,809.82
Total	**237**	**£12,889.34**	**4,458**	**£266,453.13**

A more detailed breakdown of the write offs, by Exemption Category and Write off Reason, is attached for your information. The report showing the number of GP17(PR) forms which were not submitted is no longer required. The process has been streamlined and there are no incidences of forms not being available when requested.

If you have any queries or need any further information, please telephone Derek Smith (Patient Claims Manager) on 01506 705204.

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

Item Number 7.7

AUDIT49/2017
Audit Committee
22 June 2017

ANNUAL REPORT OF THE NHS TAYSIDE AUDIT COMMITTEE 2016/17

1. PURPOSE OF THE REPORT

The attached draft 2016/17 Annual Report of the Audit Committee is submitted for approval by the Committee. Once approved, the report will be submitted to Tayside NHS Board on 29 June, 2017, in fulfilment of the requirement placed upon the Committee.

2. RECOMMENDATIONS

The Committee is asked to consider, and subject to any amendment, approve its 2016/17 Annual Report for submission to Tayside NHS Board.

3. EXECUTIVE SUMMARY

The draft Annual Report describes the purpose and composition of the Committee, and details:-

- membership of the Committee;
- frequency of meetings;
- schedule of business considered, and
- Outcomes

The final report should be signed on behalf of the Committee by Mr Stephen Hay in his capacity as the Chair of the Audit Committee.

4. REPORT DETAIL

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.

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

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

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 as a result of this report.

7. MEASURES FOR IMPROVEMENT

The Committee considers measures for improvement in agreeing its annual work plan. The Committee's focus is to secure continuous improvement in governance.

8. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

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

9. PATIENT EXPERIENCE

There are no implications to patient experience arising as a direct consequence of this report.

10. RESOURCE IMPLICATIONS

Financial
There are no direct financial implications arising as a consequence of this report.

Workforce
There are no direct workforce implications arising as a consequence of this report.

11. RISK ASSESSMENT

No risks have been identified, which may arise as a direct consequence of this report

Failure of a Standing Committee of the Board to produce an Annual Report would have a detrimental impact on the Governance Statement.

12. LEGAL IMPLICATION

There are no direct legal implications arising as a consequence of this report.

13. INFORMATION TECHNOLOGY IMPLICATIONS

There are no direct information technology implications arising as a consequence of this report.

14. HEALTH & SAFETY IMPLICATIONS

There are no direct health and safety implications arising as a consequence this report.

15. HEALTHCARE ASSOCIATED INFECTION (HAI)

There is no direct Healthcare Associated Infection (HAI) arising from this report.

16. DELEGATION LEVEL

The Committee's delegated authority is set out in NHS Tayside's Code of Corporate Governance.

17. TIMETABLE FOR IMPLEMENTATION

This report will be submitted to a meeting of Tayside NHS Board on 29 June, 2017, and the assurances therein will also be considered by the Audit Committee in undertaking its annual review of internal controls operating within Tayside NHS Board.

18. REPORT SIGN OFF

Lindsay Bedford
Director of Finance

June 2017

19. SUPPORTING DOCUMENTS

Appendix 1 – Audit Committee Annual Report 2016/17
Appendix 2 – Audit Committee Record of Attendance 2016/17
Appendix 3 – Business Items Considered at Audit Committee 2016/17
Appendix 4 – Tayside NHS Board Best Value Framework 2016/17

TAYSIDE NHS BOARD

ANNUAL REPORT OF AUDIT COMMITTEE 2016/17

1. PURPOSE

In order to assist the Board in conducting a regular review of the effectiveness of the systems of internal control, the Code of Corporate Governance requires that this Standing Committee submits an annual report to the Audit Committee. This report is submitted in fulfilment of this requirement.

2. AUDIT COMMITTEE

2.1 Composition

During the financial year ended 31 March, 2017, membership of **the Audit Committee** comprised:

Mr Stephen Hay, Non Executive Member, Tayside NHS Board is Chair of the Committee, and Cllr Dave Doogan, Non Executive Member, Tayside NHS Board is the Vice-Chair.

Mrs P Campbell, Non Executive Member, NHS Tayside (from 29 October, 2015, to 2 June 2016)
Mr D Cross, Non Executive Member, NHS Tayside
Mrs L Dunion, Non Executive Member, Tayside NHS Board
Mrs J Golden, Non Executive Member and Employee Director, NHS Tayside
Mr M Hussain, Non Executive Member, NHS Tayside
Councillor G Middleton, Non Executive Member, Tayside NHS Board

Regular Attendees
Mr L Bedford, Director of Finance (Lead Officer)
Mr D Colley, Finance Governance Accountant, NHS Tayside
Prof J Connell, FMedSci FRSE, Chairman, Tayside NHS Board
Mr G Doherty, Director of Human Resources, NHS Tayside
Ms M Dunning, Board Secretary, 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
Mr R MacKinnon, Associate Director of Financial Services & Governance/FLO
Ms L McLay, Chief Executive
Ms H Walker, Safety, Governance and Risk Co-ordinator
Representative Area Clinical Forum
Representative Area Partnership Forum
Representative Communications Department

Support to the Committee is provided by Mrs Lisa Green.

2.2 Meetings

The Committee has met on five occasions during the period from 1 April, 2016, to 31 March, 2017, on the undernoted dates:-

Thursday 5 May 2016
Tuesday 21 June 2016
Thursday 1 September 2016
Tuesday 17 January 2017
Thursday 9 March 2017

The Audit Committee attendance record is attached as Appendix 2.

2.3 Business

During the year the Committee dealt with some 72 items of business (excluding minutes, etc.). Items of reserved business were considered in accordance with the terms of Standing Orders Section of the Code of Corporate Governance.

The Committee has received and reviewed the Audit Scotland Technical Bulletins as a means of independently keeping abreast of NHS accounting and audit developments. In addition, the Committee has received regular reports on issues relating to potential Primary Care contractor fraud and other issues arising from the extended role of the Counter Fraud Services.

Details of the business items considered are attached at Appendix 3.

Minutes of the meetings of the Committee have been timeously submitted to Tayside NHS Board for its information.

3. OUTCOMES

The Terms of Reference/Work Plan was considered and approved at the Audit Committee on 5 May, 2016, (AUDIT 41/2016). The paper considered the membership, frequency of meetings, remit and Work Plan, and was cross referenced to the scheme of delegation and authority as set out in the Standing Orders of the NHS Tayside Code of Corporate Governance.

Specifically the Committee has considered the following during 2016/17 as laid down in the approved Work Plan:-

- Approved terms of reference;
- Considered and approved its work plan for all Committee meetings in 2016/17;
- Received regular reports from Chief Internal Auditor against the Annual Internal Audit Plan approved on 5 May, 2016;
- Received audit reports and action plans;
- Considered Audit Follow Up progress reports on actions taken by managers;
- Reviewed the appointed External Auditor’s Audit Planning Memorandum, including fees and reporting arrangements for 2016/17;
- Reviewed the 2015/16 Report to Members on the Audit of NHS Tayside;
- Reviewed a number of audit publications relevant to economy, efficiency and effectiveness of services;
- Received and reviewed the Internal Audit’s mid year Statement 2016/17 on Internal Control and will consider the 2016/17 Annual Internal Audit Report from the Chief Internal Auditor in June 2017;
- Received the PricewaterhouseCooper's Annual Report on 2015/16 Audit;
- Received Property Transaction Monitoring Report 2015/16;
- Considered detailed Payment Verification reports and updates on Primary Care Contractors and actions taken by management, under Reserved Business, throughout 2016/17;
- Received Annual Reports from Strategic Risk Management Group, and considered Risk Management work plans and self assessments;
- Received Minutes from the Strategic and Operational Risk Management Groups;
- Received the Action Notes of the Corporate Governance Review Group;
- Reviewed changes to the Code of Corporate Governance Received updates from staff within NSS regarding payment verification, around annual reports, service audit reports and action plans;
- Received update reports on Counter Fraud Service Investigations and considered their potential impact on NHS Tayside;

- Reviewed the Annual Accounts (2015/16) prior to submission to Tayside NHS Board;
- Received a report on NHS Tayside's losses and compensation payments and a mid-year report on the status of clinical negligence claims;
- Submitted Minutes of all meetings to the Tayside NHS Board, and
- All business was conducted in open session/reserved session with 85% being held in open business and 15% in reserved business.

4. BEST VALUE

The Board is required to provide overt assurance on Best Value. An updated Best Value Framework was approved by the Board on 27 October 2016. The Committee has considered the elements relevant to it and this evidence is provided at Appendix 4.

5. RISK REPORTING

The Audit Committee has a duty to:-

- review the organisation's risk management arrangements, systems and processes;
- review biannual reports from corporate risk owners with risks aligned to the Committee;
- review and approve the risk management work plan;
- approve the Terms of Reference and Committee Annual Report of the Strategic Risk Management Group, and
- receive the Minutes and Action Points Update from the Strategic Risk Management Group.

Through the items considered by the Audit Committee as part of its work plan in 2016/17, this remit has been covered.

6. CONCLUSION

As Chair of the Audit Committee during financial year 2016/17, 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 Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year, I can confirm that adequate and effective governance 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 Committee, and last, but certainly not least, express my sincere thanks to Lisa Green for her support of the Committee.

(signed)……..

MR STEPHEN HAY
CHAIRPERSON 2016/17
On behalf of NHS Tayside Audit Committee

Record of Attendance

NHS Tayside

AUDIT COMMITTEE FOR YEAR 1 APRIL 2016TO 31 MARCH 2017
ATTENDANCE RECORD

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
Mrs J Lyall	Principal Auditor	FTF Audit & Management Services	Present	Present	Present	Present	Present

Mr R MacKinnon	Associate Director of Finance, Financial Services & 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	-	-	-	-	-

AUDIT COMMITTEE

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

5 May 2016
Audit Follow Up (AFU) – Mid Cycle Update Report
Progress on Internal Audit Report T21/14 Medical Instrumentation and Devices
Internal Audit Progress Report
Internal Audit Plan 2016/17
External Audit Progress Report as at 25 April 2016
Annual Report of Strategic Risk Management Group 2015/16
Risk Management Annual Report
Risk Management Work Plan 2016/17
Risk Management CIPFA Self Assessment and Audit Checklist
Best Value Framework Assurance 2015/16 – Tayside NHS Board
Audit Committee Terms of Reference and Work Plan 2016/17
Governance Statement Preparation Update
Accounting Policies
Property Transactions 2015/16
Payment Verification Services Reporting
Health and Social Care Integration – Governance - Presentation
NHS Scotland Counter Fraud Services and National Fraud Initiative Update
Bribery Act Progress Update – Verbal Update
Payment Verification

21 June 2016
Draft Annual Accounts 2015/16 Tayside NHS Board Endowments Fund
Patients Funds External Audit Report
Review of System of Internal Control
Annual Reports and Assurances by Committees incl Best Value Assurance
Shared Services Audit Reports
FTF Annual Internal Audit Report 2015/16
Review of System of Internal Control – Lead Officers Statement to Chief Internal Auditor
Annual Report – Patient Exemption Checking (PECS)
Annual Report of NHS Tayside Audit Committee 2015/16
Report to Tayside NHS Board – Assurance to the Committee
Annual Accounts for the year to 31 March 2016 – Board Members Only
PricewaterhouseCoopers – Annual Report on the 2015/16 Audit to the Board and the Auditor General for Scotland
Notification from Sponsored Body Audit Committees
Updates to the NHS Tayside Code of Corporate Governance
Losses and Compensation Payments and Litigation Monitoring

1 September 2016
Audit Follow Up (AFU) – Full Cycle Update Report
Interim Evaluation of Internal Control Framework 2015/16 Audit Report No T08/16
Internal Audit Progress Report
Updates to the NHS Tayside Code of Corporate Governance
Best Value Framework 2016/17
Property Transaction Management
Payment Verification: Family Health Service (FHS) Contractors
Audit Scotland – External Auditors (verbal update)

1 September 2016 cont'd....
NHS Scotland Counter Fraud Services and National Fraud Initiative Update
Banking and Treasury Management
Payment Verification: Family Health Service (FHS) Contractors

17 January 2017
Audit Follow Up (AFU) – Mid Cycle Update Report
Interim Evaluation of Internal Control Framework 2015/16 Audit Report No T08/16 – Update
Medical Equipment and Devices T21/14 – Head of Instrumentation (Verbal Update)
Internal Audit Progress Report
Internal Audit T28A/16 – Property Management
Internal Audit T36A/16 – Child and Adolescent Mental Health Service (CAMHS) Report
External Audit - NHS Tayside Annual Audit Plan 2016/17
Audit Scotland Statutory Fees 2016/17
Risk Management Mid Year Report
Payment Verification: Family Health Service (FHS) Contractors
Updates to the NHS Tayside Code of Corporate Governance
NHS Scotland Counter Fraud Services and National Fraud Initiative Update
External Audit Service for Endowment and for Patients Private Funds
Litigation Monitoring

9 March 2017
Internal Audit T22/17 – Follow Up of Financial Planning and Management
Internal Audit T12/17 – Assurance Framework
Internal Audit Progress Report
Internal Audit T08/17 – Interim Evaluation of Internal Control Framework 2016/17
External Audit Progress Report February 2017
Risk Appetite
Skin Health Surveillance Policy
Payment Verification: Family Health Service (FHS) Contractors
Audit Committee Handbook
Annual Accounts Process Update
Accounting Policies
Compliance with Scottish Government Workforce Directorate Circulars and NHS Tayside Employment Policies
NHS Scotland Counter Fraud Services and National Fraud Initiative Update

Appendix 4

Tayside NHS Board

Best Value Framework 2016/17

GOVERNANCE AND ACCOUNTABILITY

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

OVERVIEW

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

REQUIREMENT	**MEASURE/EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME/EVIDENCE** **Fully in place/ Partially in place/ Not demonstrated in year**
Board and Committee decision-making processes are open and transparent.	Board and Committee meetings are held in open session and minutes are publically available.	**BOARD/** **COMMITTEES**	On going	The Committee monitors the Board's risk management through regular review of the Strategic Risk Management Group minutes and those of its operational sub group. "D" grade Internal Audit reports are presented to Committee and Audit Follow Up reports progress on corrective actions.

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE **Fully in place/ Partially in place/ Not demonstrated in year**
Board and Committee decision-making processes are based on evidence that can show clear links between activities and outcomes	Reports for decision to be considered by Board and Committees should clearly describe the evidence underpinning the proposed decision.	**BOARD/** **COMMITTEES**	As required	Management actions in response to audit recommendations identify clear links to intended outcomes
NHS Tayside has a robust framework of corporate governance to provide assurance to relevant stakeholders that there are effective internal control systems in operation which comply with the SPFM and other relevant guidance.	Explicitly detailed in the Governance Statement.	**AUDIT** **COMMITTEE**	Annual	Annual Governance Statement provides assurance on the effectiveness of Internal Controls

USE OF RESOURCES

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

OVERVIEW

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

REQUIREMENT	**MEASURE/EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME/EVIDENCE** **Fully in place/ Partially in place/ Not demonstrated in year**
NHS Tayside maintains an effective system for financial stewardship and reporting in line with the SPFM.	Annual Accounts process.	**AUDIT COMMITTEE**	Annual	Annual Governance Statement provides assurance

PERFORMANCE MANAGEMENT

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

OVERVIEW

A Best Value organisation will ensure that robust arrangements are in place to monitor the achievement of outcomes (possibly delivered across multiple partnerships) as well as reporting on specific activities and projects. It will use intelligence to make open and transparent decisions within a culture which is

action and improvement oriented and manages risk. The organisation will provide a clear line of sight from individual actions through to the National Outcomes and the National Performance Framework. The measures used to manage and report on performance will also enable the organisation to provide assurances on quality and link this to continuous improvement and the delivery of efficient and effective outcomes.

REQUIREMENT	**MEASURE/EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME/EVIDENCE** **Fully in place/ Partially in place/ Not demonstrated in year**
Performance is systematically measured across all key areas of activity.	The Board delegates to Committees the performance reporting for key areas of activity. Board receives regular performance reports.	**COMMITTEES/ BOARD**	As required Every meeting	Counter Fraud Services reports are brought to each meeting together with Payment Verification reports in respect of Primary Care Services In 2016/17 performance information in respect of negligence and other claims was enhanced. Internal Audit progress reports are considered at each meeting.

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE **Fully in place/ Partially in place/ Not demonstrated in year**
The Board and its Committees approve the format and content of the performance reports they receive which should include – Assess its performing against the following criteria: Performance reporting provides an understanding of whether the organisation is on track to achieve its short and long-term strategic, operational and quality objectives	The Board/Committees reviews the performance reporting under its remit and agrees the measures.	**COMMITTEES/ BOARD**		Reports are continuously reviewed internally to ensure that both the format and content of reports provide information that is relevant and understandable to ensure that both performance measures and actions from audit reports are on track.

CROSS-CUTTING THEME – SUSTAINABILITY

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

OVERVIEW

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

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

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

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

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

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE **Fully in place/ Partially in place/ Not demonstrated in year**
NHS Tayside has self-assessed and reported against the Public Bodies Climate Change Duties Guidance.	Part of Annual Accounts process.	**AUDIT COMMITTEE**		A Statutory Order came into force in November 2015 that made standardised annual climate change reporting mandatory for those public bodies classified by the Scottish Government to be “major players” onwards. This includes NHS Tayside. NHS Tayside’s input is acknowledged by the Cabinet Secretary for Environment, Climate Change and Land Reform A section on Sustainability and Environmental Reporting is incorporated into the Annual Accounts

CROSS-CUTTING THEME – EQUALITY

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

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

OVERVIEW

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

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

REQUIREMENT	**MEASURE/EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME/EVIDENCE:** **Fully in place/ Partially in place/ Not demonstrated in year**
The Board and senior managers understand the diversity of their customers and stakeholders.	Equality Impact Assessments are reported to the Board and Committees as required and identify the diverse range of stakeholders.	**BOARD/** **COMMITTEES**	As required	Reports are subject to impact assessment where deemed appropriate

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

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

Item Number 7.8

AUDIT50/2017
Audit Committee
22 June 2017

REPORT TO TAYSIDE NHS BOARD – ASSURANCE BY AUDIT COMMITTEE

1. PURPOSE OF THE REPORT

The purpose of this report is to advise Tayside NHS Board with regard to the Audit Committee's review of the System of Internal Control within NHS Tayside, and to provide assurance thereon. Tayside NHS Board is required to consider this report, and the assurances therein, prior to agreeing that the Chief Executive, in her capacity as Accountable Officer for NHS Tayside, may sign the Governance Statement that accompanies the Annual Accounts for the year ended 31 March, 2017.

2. RECOMMENDATIONS

The Audit Committee is required to consider and approve this report for submission to Tayside NHS Board, at their meeting on 29 June, 2017.

3. EXECUTIVE SUMMARY

At its meeting held on 22 June, 2017, the Audit Committee undertook a review of the Governance Statement that has operated within NHS Tayside during financial year 2016/17. In undertaking this review, the Committee has considered the following:-

i. the review of the System of Internal Control,

ii. the Annual Reports and assurances by Committees, including Best Value Assurances;

iii. the assurance provided by Scott-Moncrieff as Service Auditor to NHS National Services Scotland on the payment processes operated by the Practitioner Services Division (PSD), Internal and External Audit plans, and reports up to and including 22 June, 2017;

iv. the assurance provided by Scott-Moncrieff, as Service Auditor to NHS National Services Scotland on the services provided by National Information Technology Services provided by the Atos Origin Alliance;

v. the assurance provided by PricewaterhouseCoopers as Service Auditor to NHS Ayrshire & Arran hosting the National Single Instance Financial Ledger Services (eFinancials) on behalf of 22 NHS Boards, including NHS Tayside;

vi. the FTF Internal Audit 2016/17 Annual Report, noting the satisfactory conclusions of the Chief Internal Auditor;

vii. Lead Officer's statement to the Chief Internal Auditor with regard to assurances affecting the Governance Statement;

viii. the Patient Exemption Checking report on progress around Patient Exemption Checking as a direct result of the checks undertaken by Counter Fraud Services, and

ix. the Annual Report for 2016/17 previously submitted to the Audit Committee.

4. REPORT DETAIL

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.

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 direct implications to health equity arising from this report**.**

7. MEASURES FOR IMPROVEMENT

Action plans are developed on the basis of audit recommendations from both Internal and External Audit recommendations, and are monitored through the agreed Follow Up process.

8. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

This report was reviewed in draft form at the meeting of the Audit Committee held on the 22 June, 2017.

9. PATIENT EXPERIENCE

There are no direct implications for patient experience arising from this paper.

10. RESOURCE IMPLICATIONS

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

Workforce
There are no workforce implications arising from this report.

11. RISK ASSESSMENT

The Audit Committee considers that the Board has in place systems of internal control consistent with the management of risk to NHS Tayside.

12. LEGAL IMPLICATION

There are no legal implications arising from this report.

13. INFORMATION TECHNOLOGY IMPLICATIONS

There are no information technology implications arising from this report.

14. HEALTH & SAFETY IMPLICATIONS

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

15. HEALTHCARE ASSOCIATED INFECTION (HAI)

There is no direct Healthcare Associated Infection (HAI) as a result of this report.

16. DELEGATION LEVEL

The Director of Finance is Lead Officer for the Audit Committee.

17. TIMETABLE FOR IMPLEMENTATION

Tayside NHS Board is required to conduct regular reviews of the System of Internal Control, consistent with the processes for adoption of the Annual Accounts. The Chair of the Audit Committee has responsibility for reporting to Tayside NHS Board thereon, and is supported in this role by the Director of Finance. The review in respect of financial year 2016/17 will be submitted to the Board on 29 June, 2017.

18. REPORT SIGN OFF

Stephen Hay
Chair of Audit Committee

Lindsay Bedford
Director of Finance

June 2017

19. SUPPORTING DOCUMENTS

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

Item Number 11

AUDIT53/2017
Audit Committee
22 June 2017

NOTIFICATION FROM SPONSORED BODY AUDIT COMMITTEES

1. PURPOSE OF THE REPORT

The purpose of the report is to advise Members of the content of the attached letter (Appendix 1) from Scottish Government Health & Social Care Directorate (SGHSCD), intimating a requirement to notify the Health and Wellbeing Audit and Risk Committee of any significant issues of frauds which arose during 2016/17 that are considered to be of wider interest, and to seek the Committee's approval to the draft response (Appendix 2).

2. RECOMMENDATIONS

The Committee is asked to:-

i. approve the attached draft nil response to SGHSCD, and
ii. authorise the Chair of the Audit Committee to sign the letter attached at Appendix 2.

Lindsay Bedford
Director of Finance

June 2017

Appendix 1

Health Finance Directorate
Health Finance and Infrastructure Division

Scottish Government
Riaghaltas na h-Alba
gov.scot

T: 0131-244 5054
E: elizabeth.aston@gov.scot

NHS Board Chairs

Copy to:
NHS Board Chief Executives
NHS Board Directors of Finance

Our ref: A17101630

13 April 2017

Dear Chair

SIGNIFICANT ISSUES THAT ARE CONSIDERED TO BE OF WIDER INTEREST

The guidance in the Scottish Public Finance Manual requires Audit Committees of Sponsored Bodies to notify the Scottish Government Portfolio Audit and Risk Committee of any significant issues that are considered to be of wider interest.

http://www.scotland.gov.uk/Topics/Government/Finance/spfm/auditcommittees

The Chair of your Board's Audit Committee should provide details of any significant issues of fraud which arose during 2016-17 which they consider should be brought to the attention of the Health and Social Care Assurance Board, previously the Health and Wellbeing Audit and Risk Committee.

This should be informed by the assurances received to support the Governance Statement in your Board's Annual Accounts. It would be appropriate for the Audit Committee to consider this statement at the same time as the Accounts and the Governance Statement.

Audit committees in bodies sponsored by the Scottish Government have a role in providing the assurance required to underpin the governance statement provided by the Principal Accountable Officer (the Scottish Government Permanent Secretary) as part of the consolidated accounts of the Scottish Government. Your Board's Audit Committee is therefore required, at the earliest opportunity, to notify the Health and Social Care Assurance Board if it considers that it has identified a significant problem which may have wider implications. The Health and Social Care Assurance Board will in turn report relevant issues to the Scottish Government Assurance and Audit Committee.

All statements should be submitted by **30 June 2017** in line with the Annual Accounts timetable to Elizabeth.aston@gov.scot.

Please do not hesitate to contact me if you require further information.

Yours faithfully

Liz Aston
Directorate for Health Finance

y.

Appendix 2

Director of Finance's Office
Tayside NHS Board
Ninewells Hospital & Medical School
Dundee
DD1 9SY
Telephone Number: 01382 660111
www.nhstayside.scot.nhs.uk

Ms E Aston
Directorate for Health Finance
Health Finance and Infrastructure Division
St Andrew's House
Regent Road
Edinburgh EH1 3DG

Date	29 June, 2017
Your Ref	
Our Ref	LB/AS/sigissues16-17
Enquiries to	Miss Alison Stibbles
Extension	32054
Direct Line	01382 632054
Email	alison.stibbles@nhs.net

Dear Ms Aston

NOTIFICATION FROM SPONSORED BODY AUDIT COMMITTEES

I refer to your letter of 13 April, 2017, addressed to the Chair of Tayside NHS Board.

The Audit Committee advises of a nil response. There have been no significant issues arising in 2016/17, beyond those raised in the Governance Statement, although a number of frauds/potential frauds under investigation by the Counter Fraud Service have been considered by the Audit Committee.

A copy of the Audit Committee's Annual Report for 2015/16 is attached.

Yours sincerely

Stephen Hay
Chair of the Audit Committee

Enc.

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

Item Number 12

AUDIT54/2017
Audit Committee
22 June 2017

UPDATES TO THE NHS TAYSIDE CODE OF CORPORATE GOVERNANCE

1. PURPOSE OF THE REPORT

The purpose of the report is to seek the Audit Committee's approval to the amendments and updates to the Code of Corporate Governance for consideration by the Board on 29 June 2017.

2. RECOMMENDATIONS

The Audit Committee is asked to:

- Scrutinise the amendments and updates to the Code of Corporate Governance and recommend approval of these to the Board at its meeting on 29 June 2017. The amendments and updates are detailed in appendix 1

3. EXECUTIVE SUMMARY

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

The Audit Committee's role is to scrutinise the proposed updates and to approve recommendation of these to Tayside NHS Board. The Board retains the responsibility for approving any updates to the Code of Corporate Governance.

4. REPORT DETAIL

A number of updates and amendments are included as Appendix 1 and tracked changes are also attached as requested by Board Members. These cover updates to the Introduction, Section A, How the Business is Organised and Section C, The Standards of Business Conduct for NHS Staff.

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 Code of Corporate Governance allows these to be achieved.

6. HEALTH EQUITY

There are no implications for tackling health inequalities in respect of these updates to the Code of Corporate Governance

7. MEASURES FOR IMPROVEMENT

The Code of Corporate Governance provides the standards to be achieved with regard to Corporate Governance in NHS Tayside.

8. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

A Rapid Impact Assessment was completed for the revised Code in June 2010 and there is no change to this assessment.

9. PATIENT EXPERIENCE

The Code of Corporate Governance provides the overarching governance framework for NHS Tayside and describes the main control systems and processes. It ensures that governance and assurance systems are embedded in NHS Tayside, which will ultimately contribute to the patient experience.

10. RESOURCE IMPLICATIONS

Financial

There are no financial implications.

Workforce

There are no workforce implications.

11. RISK ASSESSMENT

NHS Tayside Code of Corporate Governance is subject to regular review and update which ensures NHS Tayside has a framework in place for its governance arrangements.

The likelihood of the Code of Corporate Governance not being up to date is low as the Governance Review Group was established with the remit to ensure the Code of Corporate Governance is reviewed and updated regularly.

Processes are also in place to review the Code of Corporate Governance against changes in legislation or guidance and therefore the consequence of the Code of Corporate Governance not being up to date is moderate. The control levels around this area are high and with these in place the risk is well mitigated.

12. LEGAL IMPLICATION

There are no legal implications.

13. INFORMATION TECHNOLOGY IMPLICATIONS

The Code is available electronically on Staffnet and the NHS Tayside website.

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 making, alteration and revocation of the Code of Corporate Governance are a matter reserved for Board agreement.

17. TIMETABLE FOR IMPLEMENTATION/ COMMUNICATON PROCESS

Following approval by the Board the following communications process will be put in place:

- A document detailing the changes will be posted on Staffnet and the NHS Tayside wbsite alongside the Code of Corporate Governance;
- The Code of Corporate Governance will be updated and posted on Staffnet and the NHS Tayside website;
- All previous versions of the Code of Corporate Governance will be archived on Staffnet and the NHS Tayside website

The Lead Officer is the Board Secretary who will keep the Code under continuous review to ensure it is updated and reflects changes occurring during the year.

18. REPORT SIGN OFF

Ms M Dunning
Board Secretary

Lindsay Bedford
Director of Finance

June 2017

19. SUPPORTING DOCUMENTS

Appendix 1 - Details of proposed changes to Code of Corporate Governance

Page No.	**Section/ Paragraph**	**Suggested change**
Front page of Code	Front page of Code	Version Control to be updated
4	Introduction	5. Members of Tayside NHS Board Change 4 Executive Members to 5 Executive Members and add the Director of Finance Total to be changed to 20 Members Remove Director of Finance from In Attendance
74	Section A How the Business is Organised	Purpose and Remits, j) Universities Strategic Liaison Committee, update with revised remit as attached at Annex A
127	Section C Standards of Business Conduct for NHS Staff	Annex 2 Registration of Hospitality Form At end of form add in following text: **Line Manager Informed** Print Name of Line Manager Signature and Date

Annex A

NHS and Universities Strategic Liaison Committee

1.1 Purpose & Remit

The Committee provides a platform for all the key stakeholders to discuss strategic matters concerning collaboration in education and training, research, innovation, informatics and service development and improvement across the health and social care system.

This dialogue will support the priorities outlined in the National Clinical Strategy, Realistic Medicine Report, the 2016 Health and Social Care Delivery Plan and the Academic Health Sciences Partnership [ASHP] strategy and work plan. The aim is to strategically discuss means of improving health and wealth in Tayside and Fife.

1.2 Composition

Membership of the NHS Universities Strategic Liaison Committee will be consistent with the purpose of the committee and will be:

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

- Chair, Transformation Programme
- Chair, [one of] Integrated Joint Boards
- Chair, Area Clinical Forum
- 2 Representatives from Dundee University
- 2 representatives from St Andrews University
- 2 Representatives from NHS Fife
- 2 Representatives from Abertay University
- 2 Representatives from Dundee and Angus College
- AHSP Co-Directors
- Post Graduate Dean (or nominated Deputy) NHS Education Scotland

Each representative will have a nominated deputy.
Other representatives will attend if they are presenting a report to the Committee or the Committee requests their attendance.

1.3 Meetings

Meetings of the Committee shall be quorate when five or more Members are present. The Chair/Vice Chair of the committee will set

the agenda for each meeting but ensure it is strategic and consistent with the remit outlined above.
The meetings will be 2 times a year. Dates will be set in advance.

1.4 Reporting Arrangements

The NHS & Universities Strategic Liaison Committee reports to Tayside NHS Board and Fife NHS Board.

Following a meeting of the NHS & Universities Strategic Liaison Committee, minutes of the meeting should be shared with NHST next board meeting and all members should share minutes with its constituent organisations.

The NHS & Universities Strategic Liaison Committee should produce an annual report summarising its activity and any recommendations that will support its core remit. This will be submitted to the NHS Tayside Audit Committee and provide an assurance to the Audit Committee that the Committee has met its remit during the year.

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The Functions of the Board are:

- Strategy development (including regional planning and cross Board working alongside health promotion, health improvement and community planning)
- Resource allocation to address local priorities
- Development and implementation of the Local Delivery Plan
- Performance Management of the local NHS system as a whole.

5. Members of Tayside NHS Board

15 Non Executive Members which include the Chairman and 6 stakeholder members representing the following:

- Angus Council
- Dundee City Council
- Perth & Kinross Council
- University of Dundee
- Area Clinical Forum
- Staff side Employee Director

~~4~~ 5Executive Members

- Chief Executive
- Medical Director
- Nurse Director
- Director of Public Health
- Director of Finance

Total of 20~~19~~ members

In attendance

- Board Secretary
- Head of Committee Administration
- Staff side representative
- Medical Director, Operational Unit
- Director of Human Resources and OD
- ~~Director of Finance~~

~~Universities Strategic Liaison Committee~~

~~1.1 Purpose~~

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

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

~~1.2 Composition~~

~~Membership of the Universities Strategic Liaison Committee will be:~~

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

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

~~Membership will also include:~~

- ~~Chief Executive, NHS Tayside (Lead Officer)~~
- ~~3 representatives from the University of Dundee covering Medicine, Nursing and Dentistry~~

- ~~2 representatives from St Andrews University covering Medicine~~
- ~~2 representatives from Abertay University covering Professions Allied to Medicine~~
- ~~2 representatives from Fife NHS Board~~
- ~~1 representative NHS Education for Scotland~~
- ~~2 representatives from the Academic Health Science Partnership~~
- ~~1 Director of Medical Education, NHS Tayside~~
- ~~1 Director of Medical Education, NHS Fife~~
- ~~Post Graduate Dean (or nominated Deputy) NHS Education Scotland~~

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

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

~~1.3 Meetings~~

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

~~1.4 Remit~~

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

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

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

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

~~Consider teaching and training resources for the next 5 years.~~

~~To provide strategic guidance in developing models of healthcare.~~

~~1.5 Authority~~

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

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

~~1.6 Reporting Arrangements~~

~~The Universities Strategic Liaison Committee reports to Tayside NHS Board.~~

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

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

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

NHS and Universities Strategic Liaison Committee

1.1 Purpose & Remit

The Committee provides a platform for all the key stakeholders to discuss strategic matters concerning collaboration in education and training, research, innovation, informatics and service development and improvement across the health and social care system.

This dialogue will support the priorities outlined in the National Clinical Strategy, Realistic Medicine Report, the 2016 Health and Social Care Delivery Plan and the Academic Health Sciences Partnership [ASHP] strategy and work plan. The aim is to strategically discuss means of improving health and wealth in Tayside and Fife.

1.2 Composition

Membership of the NHS Universities Strategic Liaison Committee will be consistent with the purpose of the committee and will be:

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

- Chair, Transformation Programme
- Chair, [one of] Integrated Joint Boards
- Chair, Area Clinical Forum
- 2 Representatives from Dundee University
- 2 representatives from St Andrews University
- 2 Representatives from NHS Fife
- 2 Representatives from Abertay University
- 2 Representatives from Dundee and Angus College
- AHSP Co-Directors
- Post Graduate Dean (or nominated Deputy) NHS Education Scotland

Each representative will have a nominated deputy.
Other representatives will attend if they are presenting a report to the Committee or the Committee requests their attendance.

1.3 Meetings

Meetings of the Committee shall be quorate when five or more Members are present. The Chair/Vice Chair of the committee will set the agenda for each meeting but ensure it is strategic and consistent with the remit outlined above.
The meetings will be 2 times a year. Dates will be set in advance.

1.4 Reporting Arrangements

The NHS & Universities Strategic Liaison Committee reports to Tayside NHS Board and Fife NHS Board.

Following a meeting of the NHS & Universities Strategic Liaison Committee, minutes of the meeting should be shared with NHST next board meeting and all members should share minutes with its constituent organisations.

The NHS & Universities Strategic Liaison Committee should produce an annual report summarising its activity and any recommendations that will support its core remit. This will be submitted to the NHS Tayside Audit Committee and provide an assurance to the Audit Committee that the Committee has met its remit during the year.

ANNEX 2
Ref

NHS TAYSIDE NHS BOARD
REGISTRATION OF HOSPITALITY

This form must be completed by Members and staff of Tayside NHS Board who receive hospitality of any nature. For further information please see Standards of Business Conduct paragraph 6.2.

YOUR DETAILS

Name	
Designation	
Telephone Number	Email

DETAILS OF HOSPITALITY

Please give as much detail as you can, including approximate value and nature of hospitality

Signature Date

Line Manager Informed

Print Name of Line Manager

Signature Date

Formatted: Font: Bold

FOR OFFICIAL USE

Date Received Recorded in register

Form completed by
Officer who received hospitality ☐
Person notified of the receipt of hospitality ☐

Notified by -: Phone ☐ Letter ☐ Form ☐ Email ☐

Signature Date
Officer of Tayside NHS Board

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

Item Number 13

AUDIT56/2017
Audit Committee
22 June 2017

UPDATE - BEST VALUE FRAMEWORK ASSURANCE 2016/17 – TAYSIDE NHS BOARD

1. SITUATION AND BACKGROUND

The Best Value Framework Assurance is to provide an assurance on the business considered by Tayside NHS Board during 2016/17 against the Best Value requirements reserved to the Board. This is part of the internal control and Annual Accounts processes.

2. ASSESSMENT

The Best Value Framework Assurance 2016/17 for Tayside NHS Board was considered by the Audit Committee on 11 May 2017. Whilst the Audit Committee was generally supportive, it was agreed that a meeting should be held Mr S Hay, Chair, Audit Committee, Mrs L Dunion, Non Executive Member, Ms M Dunning, Board Secretary and Ms J Triebs, Principal Auditor to further consider the Best Value Framework Assurance for 2016/17.

The meeting was held on 8 June 2017 and the Best Value Framework Assurance was discussed in detail. An updated Best Value Framework Assurance for 2016/17 – Tayside NHS Board is attached at Appendix 1 for approval.

3. RECOMMENDATIONS

The Audit Committee is asked to approve the Best Value Framework Assurance 2016/17 – Tayside NHS Board

4. REPORT SIGN OFF

Ms Margaret Dunning
Board Secretary

Mr Lindsay Bedford
Director of Finance

June 2017

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 Implementation of recommendations from the Assurance and Advisory Group

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned)
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	NHS Tayside is undertaking a review of capacity and capability to ensure that it has the staff resource to implement the various elements of the 5 year plan. This is supported by the Scottish Government's Assurance and Advisory Group. Management sub structure review ongoing NHS Tayside Integrated Clinical Services Strategy to be developed during 2017/18 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	Partially 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 Further work to be done in scoping out risk in relation to IJB and the governance assurance processes between the Board and the IJBs

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned)
The Board has clearly recorded delegation to Committees and management.	The Board has established terms of reference for its Committees and has a Scheme of Delegation.	**BOARD**	Every two years	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 in relation to health and social care integration
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	

REQUIREMENT	MEASURE/EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME/EVIDENCE Fully in place/ Partially in place/ Not demonstrated in year	Comment (Future work planned)
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. Work commenced drafting new Strategy	The Board will have a development event in September/October 2017 to revisit its Vision and Rich Picture. This will allow NHS Tayside to work with its stakeholders on the development of a Corporate Communications and Engagement strategy and allow Board Members to feed into the Vision to be communicated

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 in relation to health and social care integration. However, other partnerships in place with Academic Health Science Partnership (AHSP), regional planning	Work to be progressed with the health and social care partnerships 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 Other partnerships in place with Academic Health Science Partnership (AHSP), regional planning	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 Other partnerships in place with Academic Health Science Partnership (AHSP), regional planning	Development of closer working relationships with the IJBs in developing their strategic commissioning plans

GOVERNANCE AND ACCOUNTABILITY

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

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**		Partially in place Stakeholder engagement plans developed for major service change consultations for Transforming Surgical Services and Transforming Mental Health Services	The Board will have a development event in September/October 2017 to revisit its Vision and Rich Picture. This will allow NHS Tayside to identify work its key stakeholders and work with them on the development of a Corporate Communications and Engagement strategy
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	The implementation of the Duty of Candour legislation may result in changes to how the Board demonstrates feedback from its stakeholders

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	Partially in place Value your NHS Campaign	Taking learning from work done in relation to Realistic Medicine and embedding throughout the organisation
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**		Partially in place In year changes made to the Corporate Finance Report and now include projected outturn and further action	Further work to be undertaken to establish the level of information to be provided including the development of improved performance reports to include the triangulation of data

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	Recognise need in relation to capacity and capability to be further developed to achieve the Board's long terms strategic goals. Future appointment of Director of Planning

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.	Greater emphasis on data and benchmarking and peer reviews with other Boards
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.	More work required with the Communication and Engagement Strategy to ensure involvement from stakeholders

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 Development of strategies and work with public health and partner organisations. Community based work Work progressed through the Community Innovation Fund such as the opening of support centre in Ninewells Concourse	Build on further development of strategies and work with public health and partner organisations e.g. Health Equity, social cohesion , time banking etc

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	Intent to embed Equality Impact Assessment in the organisation
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 develop accessibility guidance for NHS Tayside corporate documents NHS Tayside Mainstreaming Report and Equality Outcomes 2013-17 sets out the context for this	This work will also link to the development of a Communication and Engagement Strategy. NHS Tayside Mainstreaming Report and Equality Outcomes to the Board on 4 May 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'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	Ensure that the process and outcomes from Equality Impact Assessment are embedded in the way the organisation engages. This should allow the identification of appropriate groups for meaningful consultation
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	Requirement to ensure that information and data are used to inform decision making.

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

Item Number 14

AUDIT56/2017
AUDIT COMMITTEE
22 JUNE, 2017

AUDIT FOLLOW UP (AFU) – FULL CYCLE UPDATE REPORT

1. SITUATION AND BACKGROUND

The purpose of this report is to present to the Audit Committee a progress update on the action taken to 30 May, 2017, relating to recommendations made in NHS Tayside Internal/External Audit reports.

2. ASSESSMENT

Audit Follow Up status update requests have been sent out to Responsible Officers for all actions with due dates up to the cut off month of May 2017.

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

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

Progress on D Opinion Audits
Appendix 3 provides a progress update of remaining high risk actions included within 'D' opinion audit reports (see Appendix 4). Due dates reflect the original due dates specified in the final issued audit report, and it should be noted that no revised due date requests from Responsible Officers are accepted. However, where notified, target dates for completion of the actions from Responsible Officers, are included for information only.

Noted for this cycle:-

- **T12/16 Assurance Framework** (presented to Audit Committee March 2017). One item is yet to be completed
- **T06/17 Annual Report of Internal Control Framework** (presented to Audit Committee June 2016). All items categorised as D opinion are complete.
- **T36A/16 Child and Adolescent Mental Health Services (CAMHS)** (presented to Audit Committee January 2017). There is one high risk action point this to be completed.
- **T22/17 Follow up of Financial Planning & Management** (presented to Audit Committee March 2017). Three remaining action points are due for completion this autumn.

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

Points Subject to National Initiatives and transfers to Datix
Members are advised that no new action points have been deferred as a result of national initiatives, and, therefore, no new action points were deferred to the Datix system of Organisational Risk resulting from an inability to complete.

Current AFU Protocol
On appointment to the Head of Finance – Governance & Assurance post as part of the restructuring of the Finance function, a review will be undertaken of the Audit Follow Up protocol to ensure that procedures remain effective together with the consideration of contingency arrangements.

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

3. RECOMMENDATIONS

The Audit Committee is asked to note the findings for this full cycle to May 2017.

Derek Colley
Financial Governance Accountant
June 2017

Lindsay Bedford
Director of Finance

NHS TAYSIDE APPENDIX 1

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

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

Internal Audit Report Year of Issue	Report Number	Assignment Description	Report Category	Report Date of Issue	Total Action Points	.....STATUS CLASSIFICATION.....					See Appendix 2	See Appendix 3	Referred to Internal Audit
						A Actioned	F No longer relevant	B Not yet due - Outwith scope for this cycle	E Deferred - Due date revised	C Overdue			
2014/15	T21/15	Clinical Effectiveness Programme of meetings - Surgical Directorate	C	22-Feb-16	2	1			1		✓		
	T25/15	Property management strategy	C	15-Dec-15	2				2		✓		
2015/16	T12/16	Assurance Framework	D	15-Dec-16	7	6			1			✓	
	T13B/16	Follow up of T13B/14 - Risk Maturity	NA	26-Nov-15	3			2	1		✓		
	T18C/16	Health & Social Care Integration - Financial Assurance (Dundee)	NA	16-Jun-16	6	4			2		✓		
	T20/16	Patient Safety	B+	05-Jan-17	2	1		1					
	T28A/16	Property Management	C	09-Jan-17	15	1		12	2		✓		
	T31/16	NHS Tayside Health Fund (Endowments)	B	11-May-16	7	4			3				
	T34/16	Ehealth Strategy, planning and Governance	NA	22-Aug-16	1				1		✓		
	T36A/16	Child & Adolescent Mental Health Services (CAMHS)	C-	09-Jan-17	9	8			1			✓	
	T36C/16	Department Review - Outpatients	C	03-Feb-16	15	14			1		✓		
2016/17	T06/17	Annual Internal Audit Report	A - C	15-Jun-16	4	2			2				
	T22/17	Follow up of Financial Planning & Management	D	05-Mar-17	9	1		3	5			✓	
	T23/17	Post Transaction Monitoring	A	24-Aug-16	1				1				

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

NHS TAYSIDE
AUDIT FOLLOW UP - FULL CYCLE UPDATE REPORT

Appendix 2

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

Report Ref	Report Title	Responsible Officer	Original due date	Likely completion date	Priority	Action Point No	Agreed Management Action to Audit Recommendation	Comment from Responsible Officer for September 2016 Audit Committee
T21/15	Clinical Effectiveness programme of meetings - Surgical Directorate	Head of Clinical Governance & Risk	Dec-16	Dec-17	2	2	The current clinical governance strategy covers 2013-2016 and is being reviewed to produce a revised strategy to cover 2017-2020. As part of the review being led by Head of Clinical Governance & Risk, the recommendations in relation to clinical audit will be addressed for incorporation into the 2017/2020 strategy.	**Comment received 30.1.17:** strategy refresh commenced but requiring further consultaion with large number of clinical colleagues and also outcome of National Qulaity of care review to be incorporated. Expected completion in December.
T25/15	Property Management Strategy	Property & Asset Manager	Aug-16	Mar-17	2	1	Standard wording, covering method of calculation, review periods and procedures for agreeing changes for agreements between NHS Tayside Board and General Practices will be compiled by the Property and Asset Manager in consultation with representatives from the Practice Managers Group.	**Comment received 13.9.17:** Due to the complexities of the audit to be carried out and the capacity required to carry out each area, this has not been progressed. Staff shortages and changes in the Property & Asset management team have also impacted.
	Property Management Strategy	Property & Asset Manager	Aug-16	Mar-17	2	2	An exercise will be completed to update floor plans to include square metres for all areas and to indicate which areas are utilised by NHS Tayside Board and which are utilised by the Practice and other parties. This exercise will be co-ordinated by the Property and Asset Manager involving appropriate representation from Practices Managers Group.	
T13B/16	Follow up of T13B/14 - Risk Maturity	Board Secretary & Risk Manager	Dec-16	Mar-17	2	1a	The Risk appetite statement will be reviewed and updated following liaison with other NHS Boards. When available, the revised risk appetite will be presented to the SRMG for approval and will be incorporated into the Risk Management Strategy.	**Comment recieved 9.6.17:** Report to be submitted to SRMG and thereafter Tayside NHS Board or Audit Committee
T18C/16	Health & Social care Integration - Financial Assurance (Dundee)	Chief Finance Officer	Sep-16	Jun-17	2	2	The March 2016 IJB meeting received information on the amounts to be set aside for Large Hospital Services in scope. At that point, the paper did not yet set out financial risks and risk management principles to be adopted; although this has since been agreed across Tayside. This will be progressed further over the coming months as available staffing resources are confirmed.	**Comment received 19.6.17:** NHS Tayside is working in conjunction with SGHSCD on refining the methodology for teh Large Hospital Set Asise Budget. The Chief Finance Offices and core NHS Tayside finance staff have been working collaboratively on the information available that will inform discussion at a national level. This work is ongoing.
	Health & Social care Integration - Financial Assurance (Dundee)	Chief Finance Officer	Sep-16	Jun-17	2	4	Arrangements should be made to review actual performance against the assumptions made and where applicable adjustments made for future years. Guidance on Financial Planning for Large Hospital Set Aside should also be taken into account. This will be reported to the IJB in line with agreed performance reporting timescales.	
T28A/16	Property Management	Property Asset Manager	Feb-17	Oct-17	2	3a	The Asset Management Group will be re-established with membership from Property, Finance, Transport, IM&T and Medical Equipment Departments. Emphasis will be placed on the reconciliation between EAMS and Cost Book area figures.	**Comments received 19.6.17:** There has been attemptto re=establish the group but was unseuccessful. Recommendations made in draft PAMS to resurrect group with an appropriate Chairperson
	Property Management	Property Asset Manager	Mar-17	Oct-17	2	9	The planned delivery of financial benefits and the resource needs for the full 5 year transformation programme will be formally agreed and incorporated into the Property Sales and Brokerage Plan Strategic Workstream workplan.	**Comments received 19.6.17:** Work is ongoing to determine outputs from Phase 3 of Property Workstream workplan.
T31/16	NHS Tayside Health Fund (Endowments)	Associate Director of Finance	Jun-16	Sep-17	2	3	Management to progress a review of the Endowment fund support section separately from the restructure of the Finance department overall.	**Comment Received 9.6.17:** While various outstanding actions from EAG/BOT are being progressed it has not been possible to address them all within available staff capacity. However, a commitment has been made to progress by September 2017.
	NHS Tayside Health Fund (Endowments)	Associate Director of Finance	Dec-16	Sep-17	2	10	Feedback should be sought from Trustees and members on the format and content of financial information they wish to receive.	**Comment Received 9.6.17**: Progress has been made with the collation of a quarterly report pack which will be issued to EAG members by end June 2017. Members will be invited to provide feedback at the September meeting.

Report Ref	Report Title	Responsible Officer	Original due date	Likely completion date	Priority	Action Point No	Agreed Management Action to Audit Recommendation	Comment from Responsible Officer for September 2016 Audit Committee
	NHS Tayside Health Fund (Endowments)	Associate Director of Finance	Oct-16	Sep-17	2	11	All major sources of income should be included in the consideration of the investment policy and financial reporting	**Comment Received 9.6.17:** A report was presented to BOT in May 2017 setting out a comparison of the Tayside Health Fund performance with that of the Edinburgh & Lothian Health Foundation which found that it had performed well in comparison with this high performing fund and was therefore successfully maximising investment income.Amendments to the investment policy were also agreed and a piece of work by the investment managers designed to test the two investment policies agreed.
T34/16	eHealth Strategy, Planning & Governance	Head of Service - eHealth	Feb-17		2	1	The agreed eHealth strategy for NHS Tayside to move toward unified national systems, provides the opportunity to assess and provide exit strategies for the systems identified in a supported and sustainable manner. The introduction of these applications (predominantly TrakCare) needs to be prioritised prior to any exit strategy being adopted. A collaborative approach, between eHealth and clinical system leads, will be taken to document exit strategies for each system during the introduction of TrakCare. The exit strategies will reflect any changes to practices required to administer patients and record patient information as a result of the system change.	**Comment received 19.6.17:** Trakcare will go live on 23rd June in completion of this action point.
T36C/16	Departmental Reviews - Outpatients	Clinical Services manager	Mar-16		2	4	As at November 2015 the Lead Clinician for Gynaecology plans to meet with each Consultant to discuss their revised job plans and the job plan model. It is anticipated that the new model will be run from February 2016 and the DCAQ tool will be run again 6 weeks after implementation of the new system to check if the new job plans are having a positive impact.	**Comment received 19.6.17:** All consultants have now agreed to their new models of working but there have been further delays implementing this. With the commencement of Trakcare, most IT staff are involved with this so the changes required to our clinics etc have been prioritised to start shortly after implementation. Once complete the DCAQ will be monitored through the DOIT programme.

NHS TAYSIDE
AUDIT FOLLOW UP - FULL CYCLE UPDATE REPORT - TO JUNE 2016 **APPENDIX 3**
Close monitoring of the status of Higher Risk 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
T12/16	Assurance Framework	Board Secretary	D	Apr-17		2	1	Once agreed, the respective responsibility of the Board and the IJB in relation to the operational management of delegated functions and therefore the allocation of and responsibility for the associated risksmust be incorporated into the BAF Framework	Board Secretary to provide update to Audity Committee June 2017
T36A/16	Child & Adolescent Mental Health Services (CAMHS)	General Manager	C-	Dec-16		2	7	Roles and responsibilities should be re-evaluated and clearly delineated in order to minimise the level of ongoing external support required and to maximise the use of available skills and ensure best value.	**Comment received 19.6.17:** Mental Health Strategy 2017-2027 was issued in April 2017. This requires further consideration regarding re-evaluation of roles and responsibilities.

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	Sep-17		4.2	A number of old funds remain unspent. Reserves policy would benefit from a timeframe for spending of old balances.	**Comment received 15.6.17:** Expected completion date September 2017.

AUDIT FOLLOW UP **APPENDIX 4**

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 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 15

AUDIT57/2017
AUDIT COMMITTEE
22 JUNE, 2017

INTERNAL AUDIT ANNUAL PLAN 2017/18

1. PURPOSE OF THE REPORT

The purpose of this paper is to seek approval of the Annual Internal Audit Plan for 2017/18 (Appendix 1) within the context of the Strategic Annual Plan 2014-19 (Appendix 2).

2. RECOMMENDATION

The Audit Committee is asked to:-

i. approve the Annual Internal Audit Plan for 2017/18, and
ii. agree the Annual Internal Audit Plan for 2017/18 will be shared with the three IJBs.

3. BACKGROUND

The plan is designed to provide the Chief Internal Auditor with sufficient evidence to form an opinion on the adequacy and effectiveness of internal controls. This opinion is one of the assurance sources required by the Accountable Officer in their annual review of internal controls and also informs the considerations of the Audit Committee and Tayside NHS Board prior to finalising the Governance Statement.

The Scottish Public Finance Manual requires NHSScotland to follow the Public Sector Internal Audit Standards. Section 2010 states that '*The chief audit executive must establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals*'. In addition, Section 2010.A1 states that '*The internal audit activity's plan of engagements must be based on a documented risk assessment, undertaken at least annually. The input of senior management and the board must be considered in this process*', and Section 2010.A2 states that '*The chief audit executive must identify and consider the expectations of senior management, the board and other stakeholders for internal audit opinions and other conclusions*.'

4. PLANNING PROCESS

The planning process is shown in detail in Appendix 4 with further details on the selection and delivery of departmental reviews being given in Appendix 3. Whilst the planning process remains largely unchanged from previous years, we have carried out a detailed mapping exercise to ensure that the annual audit plan is more closely aligned to the corporate risk register. The mapping is detailed in Appendix 2.

On 8 May, 2017, the Chief Internal Auditor presented the draft internal audit plan to NHS Tayside Directors' Group for review and comment. Feedback from Directors has been incorporated into the internal audit plan, which has also been approved by the Chief Executive. Following Audit Committee consideration and approval of this plan, discussions will be held with responsible Directors to refine audit scopes and agree timings, following which detailed assignment plans for each audit are agreed with the responsible Director and with the Director of Finance before the commencement of each audit. Work to progress the 2017/18 internal audit plan will be co-ordinated with fieldwork on the 2017/18 IJB annual plans. In addition, the Chief Internal Auditor and Regional Audit Manager meet monthly to

discuss progress, resources and achievement of service targets. Progress on achievement of the plan and the outcomes of audit assignments are reported to each Audit Committee.

5. PLAN

For 2017/18 the planned number of days to be delivered has been reduced to reflect priorities, risks, resources and planned external audit reviews, as well as the need for efficiency savings to contribute to NHS Tayside's overall savings programme. The order of delivery of overall days over five years has changed to meet operational needs, whilst providing appropriate assurance over the audit cycle and within each financial year, including 2017/18.

Internal Audit will continue to work with the Chief Executive and Director of Finance in order to design an audit plan that, with particular regard to areas where operational efficiency can be optimised, maximises the professional input and value to be derived.

The draft operational plan for 2017/18 has been designed to target the priority issues identified by the Audit Risk Assessment, summarised as follows:-

	Days	**%**
Audit Process	64	12
Corporate Governance		
Accountability & Assurance	61	11
Control Environment	18	3
Risk Management	25	4.5
Health Planning	30	5
Health & Social Care Integration	80	14.5
Clinical Governance	85	15
Staff Governance	45	8
Financial Governance		
Financial Assurance	30	5
Financial Management	0	0
Capital Investment	10	2
Transaction Systems	23	4
Endowments	30	5
Information Governance	10	2
Contingency/Departmental Reviews	50	9
Total Audit Days	**561**	**100**

A Gaskin BSc ACA
Chief Internal Auditor
June 2017

Lindsay Bedford
Director of Finance

Appendix 1 Annual Internal Audit Plan 2017/18
Appendix 2 Strategic Audit Plan 2014/19
Appendix 3 Departmental Reviews
Appendix 4 Detailed Internal Audit Strategic Planning Process

		NHS Tayside Operational Internal Audit Plan 2017-2018				
Reference			Description	Scope	2017/18	
					Days	
		AUDIT PROCESS			**64**	
T	1	18	Audit Risk Assessment & Planning	Audit Risk Assessment & Operational Planning	13	
T	2	18	Audit Management & Liaison with Directors	Audit Management, Liaison with Directors of Finance and other Officers	16	
T	3	18	Liaison with External Auditors	Liaison and co-ordination with External Audit	4	
T	4	18	Audit Committee	Briefings, preparation, attendance and action points	16	
T	5	18	Clearance of Prior Year	Provision for clearance and reporting of 2016-17 Audit Reports	15	
		CORPORATE GOVERNANCE			**104**	
			Accountability and Assurance			
T	6	18	Annual Internal Audit Report	CIA's annual assurance to Audit Committee	18	
T	7	18	Governance Statement	Preparation of portfolio of evidence to support governance statement	18	
T	8	18	Interim Review	Report to show progress and allow remedial action in-year	20	
T	9	18	Audit Follow-up	Review of the audit follow-up mechanism & selective examination	5	
			Control Environment			
T	10	18	Code of Corporate Governance (SOs, SFIs and SoD)	To include assistance with development at Governance Review Group, provision of ad-hoc advice (inc. Risk Management)	8	
T	11	18	Board, Operational Committees and Accountable Officer	CIA attendance at Board meetings and provision of advice	10	
			Risk Management			
T	12	18	Staff and Patient Environment	Including Health and Safety, Fire and Security	15	
			Sustainability			
T	13	18	Environmental Costs	Review of Carbon Reduction Commitment	10	
		HEALTH PLANNING			**110**	
			Health Plan			
T	14	18	Strategic Planning	Advice and assistance from CIA around NHS Tayside design of system	10	
			Service Monitoring			
T	15	18	Organisational Performance Management	Benefits realisation for workstream programmes	20	
			Effective Partnerships and Integrated Care			
T	16	18	Health and Social Care Integration	Working with Local Authority Partners to deliver IJB Internal Audit plan. Ongoing review of Health Board HSCI risk and associated controls.	80	
		CLINICAL GOVERNANCE			**85**	
			Quality of Care			
T	17	18	Clinical Effectiveness	Review the processes in place for Mortality reviews across the Surgery Directorate	20	
			Patient Safety			
T	18	18	Infection Control	Review of arrangements to manage the Corporate risk on control of HAI and adherence to policy	15	
T	19	18	Medical Equipment and Devices	To include follow up of previous report T21-14 including Ransomware issue	20	
T	20	18	Medicines Management	Arrangements for efficient and effective prescribing. Increased to 30 to cover PMG/Homecare/ Formulary compliance/Improving repeat prescribing systems	30	
		STAFF GOVERNANCE			**45**	
			Staff Governance Arrangements			
T	21	18	Staff Governance (inc Remuneration Sub-Committee)	To include bi - annual review of Remuneration Committee Self assessment checklist	10	
T	22	18	Workforce planning including capable and effective workforce	Review of workforce planning and monitoring to deliver the right workforce in the short, medium and long-term. Bench marking of investigations process. Benefits realisation of rostering changes	35	
		FINANCIAL ASSURANCE			**30**	
			Accountability			

T	23	18	Fraud & Probity arrangements	Input of Regional Audit Manager as the Board's Deputy Fraud Liaison Officer and input to National Fraud Initiative	10	
			Use of Resources			
T	24	18	Savings Programme	Identification, delivery and reporting of savings	20	
		CAPITAL INVESTMENT			**10**	
T	25	18	Property Transaction Monitoring and Property disposals	Post Transaction Monitoring	10	
		TRANSACTION SYSTEMS			**23**	
T	26	18	Financial Process Compliance	Compliance testing of central payroll, travel, accounts payable, account receivable, bank arrangements	15	
T	27	18	National Payroll Maintenance	Assurance on the maintenance of the Scottish Standard Payroll System	8	
		ENDOWMENT FUNDS			**30**	
T	28	18	Endowments	Review of endowments on 5 year risk based audit plan	30	
		INFORMATION GOVERNANCE			**10**	
			Data			
T	29	18	NHS Scotland Waiting Times Methodology	Annual independent assurance over the monthly audit process and control matrix evaluation of Trakcare	10	
		CONTINGENCY			**50**	
			Contingency			
T	30	18	Contingency	Contingency reserve for investigations and reviews	10	
T	31	18	Departmental Reviews	Tailored reviews of individual departments/wards/programmes selected following detailed discussion with management	40	
		TOTAL			**561**	

Main-Heading	Sub-Heading	Scope	Rating	812 2014/15	706 2015/16	438 2016/17 *Days*	561 561 2017/18	561 561 2018/19	Corporate risk
AUDIT PROCESS				**75**	**87**	**75**	**64**	**64**	
Audit Management	Audit Risk Assessment & Planning			10	15	15	13	13	
	Audit Management & Liaison with Directors			20	22	18	16	16	
	Liaison with External Auditors and other review bodies			5	5	4	4	4	
	Audit Committee			20	20	18	16	16	
	Clearance of Prior Year			20	25	20	15	15	
CONTINGENCY				**140**	**95**	**45**	**50**	**55**	
Contingency	Contingency reserve for investigations and reviews			20	2	20	10	15	
	Departmental Reviews	Holistic reviews of individual departments/wards selected following detailed discussion with management		120	93	25	40	40	
ORATE GOVERNANCE									
GOVERNANCE AND ACCOUNTABILITY				**151**	**146**	**77**	**79**	**94**	
Assurance	Annual Internal Audit Report	CIA's annual assurance statement to Audit Committee		8	9	12	18	18	
	Governance Statement	Preparation of portfolio of evidence to support Governance Statement		20	20	20	18	18	
	Interim Review	Report to show progress and allow remedial action in-year		20	25	20	20	20	
	Audit Follow-up	Review of client's follow-up system and/or checking of specific responses		5	6	5	5	5	
Control Environment	Code of Corporate Governance (SOs, SFIs and SoD)	To include assistance with development where requested by client	L	8	19	10	8	8	
	Board, Operational Committees and Accountable Officer	Review of application of governance requirements	L	35	27	10	10	10	
	Assurance Framework	Assurance structures (inc Audit Committee); relevance, reliability, timeliness and quality of evidence	M	55	40				
	Policies and Procedures	Identification, review, approval, communication and implementation	L					15	
RISK MANAGEMENT				**60**	**18**		**25**	**25**	
Risk Management	Risk Management Strategy, Standards and Operations	Review of strategy and supporting structures in order to conclude on risk maturity	M	15	18				
	Staff and Patient Environment	Including Health and Safety, Fire and Security	M				15	15	
	NHS Resilience; Business Continuity and Emergency Planning	Compliance with NHS Scotland Resilience: Preparing for Emergencies guidance	L	20					Risk 313 - Capacity and Flow (Winter Plan) - Very High - risk relates to unable to recruit additional workforce to support services leading to damage to the oraganisation - ie delayed discharge
Sustainability	Environmental costs	Efficient and sustainable management of carbon reduction, waste management, water and energy, fleet management costs	L	25			10	10	
HEALTH PLANNING				**95**	**80**	**70**	**110**	**125**	
	Strategic planning	Business and clinical strategies and priorities supporting the 2020 vision and delivery of SGHSCD targets	H	20	10		10		1. Risk 26 - Waiting Times and RTT - High; 2. Risk 201 - Health Equity - High;2. Risk 22 - Health Protection of Children and Young People - High; 2. Risk 15 - Delivering Care for Older People - High; 3. Risk 395 - Mental Health -Sustainability of Safe and Effective Services - Very High; 4. Risk 144 Maternity Services - High; 5. Risk 302 PRI/Patient Flow - Very High; 6. Risk 21 - Managed/2c Practices -High.
	Improvement, innovation and operational planning	Delivering effective and efficient person-centred services, including service redesign	H	45				25	1. Risk 353 - Sustainable Primary Care Services - Medium - failure to maintain in and out of hours services may result in a failure to achieve 20/20 vision, national clinical strategy and patients not accessing PCS. Gaps identified include establishment of Performance System specifically for Primary Care and no reporting to CQF re prisoner healthcare and foreensic medicine.
Service Monitoring	Organisational Performance Reporting	Accurate, relevant and reliable reporting to the Board, staff, the SGHSCD and the public	M		30			20	
	Organisational Performance Management	Identification of priorities for improvement and effective remedial action	H				20		
Effective Partnerships and Integrated Care	Health and Social Care Integration	Working with Local Authority Partners to deliver IJB Internal Audit plan. Ongoing review of Health Board HSCI risk and associated controls.	H	30	40	70	80	80	
CAL GOVERNANCE									
CLINICAL GOVERNANCE				**70**	**37**	**40**	**85**	**10**	1. Risk 16 - Clinical governance - High - gaps in assuruance identified - GDET re capturing measurement across all patient safety programmes; formal KPI reporting to CCGC; Business Unit support due to staff reduction is impacting on development of data framework that supports CG from ward to Board; performance reviews not spread to Board functions and IJBs and framework for IJBs re CGG strategy around R1/R2/R3 groups not fully implemented. 2. Risk 121 - Person Centredness - High
Clinical Governance Committee	Clinical Governance Strategy and Assurance	Clinical governance and improvement, clinical risk management and assurance	M	25	20				
Quality of care	Patient safety programme	Accurately reporting and using SPSP and SPSI data to improve patient safety	M	20	15				
	Clinical Effectiveness	Systems, including Clinical Audit, to eliminate waste, variation and harm; learning from elsewhere	M	25	2		20		
	Adverse Event Management	Recording and learning from incidents, complaints and feedback	M			25		10	
Patient safety	Infection Control	HAI, cleaning and decontamination, food hygiene	M				15		Risk 14 - Infection Management - Very High
	Medical Equipment and Devices	Maintenance, control and acquisition of medical devices.	M				20		
	Food, Fluid and Nutritional Standards	National standards around the importance of high quality nutritious food for patient care, impact it has on the health and functional ability of patients	L			15			
	Medicines Management	Arrangements for efficient and effective prescribing. Accountable Officer duties including CEL (2014) 17	M				30		
' GOVERNANCE									

Main-Heading	Sub-Heading	Scope	Rating	812 2014/15	706 2015/16	438 2016/17 *Days*	561 2017/18	561 2018/19	Corporate risk
STAFF GOVERNANCE				**20**	**44**		**45**		
Staff Governance arrangements	Staff Governance (inc Remuneration sub-Committee)	Staff Governance Standard monitoring	M		16		10		
	Workforce planning including capable and effective workforce	Planning and implementation of 2020 workforce vision for a sustainable workforce and delivery of everyone matters	H	20	28		35		1. Risk 95 Medical workforce - Very High; 2. Risk 58 - Workforce optimisation - Very High; 3. Risk 280 Nursing and Midwifery Workforce - Very high.
CIAL GOVERNANCE									
FINANCIAL ASSURANCE				**10**	**13**	**10**	**30**	**30**	
Accountability	Fraud & Probity Arrangements	Bribery Act, Standards of Business Conduct, annual fraud checklist, responding to fraud risk	L		13	10	10	10	
	Losses and Compensations	Arrangements for investigating losses and preventing unnecessary recurrence	L	10					
Use of resources	Savings programme	Identification, delivery and reporting of savings	H				20	20	
FINANCIAL MANAGEMENT					**47**	**20**		**35**	
Financial Control	Financial Planning	Strategic financial planning and prioritisation to support Corporate strategies and priorities	H		10	20		20	1.Risk 36 - Strategic Financial Plan - Very high - gaps identified to enhance existing control measures in relation to reducing spend and risk assessment criteria that provides permissions to incur spend only when relevant conditions have been met
	Financial Management	Budgetary control; reporting, remediation and data accuracy	H		37			15	
CAPITAL INVESTMENT				**33**	**32**	**18**	**10**	**25**	
Capital Strategy	Property Management Strategy	Property strategy to support organisations strategies and priorities: purchase, disposal and maintenance.	H	20	15			15	1. Risk 312 - Estate Infrastructure Condition - High - Gaps identified - link between Clinical Strategy and PAMS, availabiklity to allow maintenence of theatres 24 wek maintenance programme, planned electrical maintenance not achieved die to difficukties in shut downs and availability of decant facilities across NHST for use during upgrades.2.Risk 14 - Infection Management - Very High - gaps identified re property services progesss with SCART as it applies to inffection control
Capital and Property	Contract Management	Project appraisal, pre-contract arrangements, contract management and post implementation review	L						
	Property Transaction Monitoring and Property disposals	Post Transaction Monitoring. Efficient effective planning for property disposal.		13	17	18	10	10	
Capital Finance	Asset control	Recording, identification and monitoring of assets.	L						1. Risk 37 Impact of reduction in capital resources - High - links to clinical strategy and PAMS re delivery of safe and effective care in an appropriate environment.
TRANSACTION SYSTEMS				**68**	**20**	**33**	**23**	**38**	
Central Financial Systems	Financial Process Compliance	Central, payroll, travel, accounts payable, accounts receivable, banking arrangements.		28		18	15	20	
	National Payroll Maintenance			20	20	15	8	8	
Non Pay Expenditure	Ordering, Requisitioning & Receipt	Purchasing and requisitioning	L						
	Service contract expenditure	Contracts for services received including arrangements for PFI/PPP and the 3rd sector	L					10	
Income	Non SGHSCD Income	Analysis and review of overseas visitors, private patients, accommodation etc.	L	20					
	Service Contract income	As applicable, contracts for services provided (provide local detail)	L						
ENDOWMENT FUNDS				**40**	**40**	**30**	**30**	**30**	
Endowment Funds	Endowment Funds/Patients funds	Operation of endowment committee and compliance with national endowment guidance.		40	40	30	30	30	
MATION GOVERNANCE				**50**	**47**	**20**	**10**	**30**	
Information Governance Standards	Information Assurance	DPA, FOI, Caldicott,secure and confidential management of personal information including admin and	M					18	Risk 38 - Information governance - High -
Information Security	Information Security Framework	Implementation of NHS Scotland Information Security Policy Framework including ICT Asset	M	20		20			Risk 38 - Information governance - High -
eHealth	eHealth Strategic Planning and Governance	Alignment of local eHealth strategic plans with the Board's overall strategy, the National eHealth Strategy and review of supporting governance processes.	M		40				Risk 415 - Implementation of trackcare - High
	eHealth Project Management, Development, Procurement, Implem	eHealth Project Management and procurement processes including implementation stage of eHealth	L	15					Risk 415 - Implementation of trackcare - High
	eHealth Service Management	eHealth Service Management Processes.	L						Risk 415 - Implementation of trackcare - High
Data	Data quality	Processes to ensure data is collated appropriately and reported accurately and timeously to the right people	M	15				12	
	NHS Scotland Waiting Times Methodology	Annual independent assurance over the monthly audit process	H		7		10		1. Risk 26 - waiting times and RTT targets - High 2. Risk 416 Implemetation of Trackcare - High.
TOTAL				812 1624 TRUE	706 1412 TRUE	438 876 TRUE	561 1122 TRUE	561 1122 TRUE	
			9 16			408			

Appendix 3

INTERNAL AUDIT DEPARTMENTAL REVIEWS

1. CRITERIA FOR CONSIDERATION

The following criteria will be considered in selecting an area for review using data available to the audit team and discussion with management:

- Areas of concern identified by the Strategic Management Team, Board or Standing Committee
- Areas of strong performance or improvement which could be disseminated more widely
- New, corporate, high residual or significantly increased risk
- Level of complaints
- Number and frequency of reported incidents
- Failure to hit national or local targets
- Incident(s) of fraud or irregularity
- External inspection imminent or concerns raised in previous inspection
- New risks or significant increase in risks
- High levels of sickness absence, grievances or staff turnover
- Adverse media coverage
- Organisational change or significant service or capital development

It is anticipated that data on many of these criteria will be available through local dashboards, which are currently in development.

2. AREAS TO BE INCLUDED IN DEPARTMENTAL REVIEWS

Not all areas can or should be covered within each departmental review. Priority is given to those elements most directly related to the reasons for selection of the department and the areas of highest audit risk rating following analytical review. The audit considers the local implementation of controls within the department which allows reporting on the local control environment as well as the effectiveness of organisation–wide controls.

<u>Corporate Governance</u>

- Organisational Culture
- Risk Management
- Performance Management
- Staff and Patient Environment

<u>Clinical Governance</u>

- Clinical Governance
- Medicines Management

<u>Staff Governance</u>

- Staff Management and Payroll

<u>Financial Governance</u>

- Financial management
- Service contracts
- Ordering, requisition and receipt of goods and services
- Non-exchequer

<u>Information Governance</u>

- Information Governance

AUDIT RISK ASSESSMENT AND PLANNING

Introduction

The objective of this paper is to explain the assessment criteria and methodology employed in formulating an Audit Risk Assessment and how this is used to produce strategic and operational plans that allow us to conclude on the overall systems of internal control within the Annual Internal Audit Report. The requirement for the Chief Internal Auditor to provide a clear statement of assurance on the adequacy and effectiveness of internal control in the Annual Audit Report provides a clear focus for the audit plan. To plan for such an assurance it is therefore necessary to consider the whole internal control system and the magnitude and incidence of the risks, which the control system is designed to mitigate.

The audit risk assessment is an essential part of the audit planning process used to ensure there is a proper link between the level of risk associated with a particular area and its relative priority within the strategic audit plan.

Internal control

As Accountable Officer, the Chief Executive is responsible for reviewing the adequacy and effectiveness of the system of internal control. At a minimum, this review should comprise an assessment of the overall effectiveness of governance, risk management and internal control arrangements and four specific strands of governance:

- Clinical Governance
- Staff Governance
- Financial Governance
- Information Assurance.

Whilst focused on specific elements, these strands of governance are not mutually exclusive and should be linked through an integrated risk management and internal control framework which should incorporate the following guidance:

- Scottish Public Finance Manual (SPFM);
- Accountable Officer Memorandum;
- Good Governance Standard for Public Services;
- Staff Governance Standard and Self-Assessment Audit Tool;
- Standards for Clinical Governance, Risk Management and the NHSScotland Quality Strategy;
- Information Assurance Standards;
- Scottish Government Audit Committee Handbook.

Audit Planning Methodology

For optimum effectiveness, internal audit should operate in partnership with the client health organisation. Securing joint ownership of the internal audit plan is a key ingredient of such a partnership and therefore a common understanding should exist between the Audit Committee, Management and Internal Audit, of the audit risk assessment process as a basis for informing the Strategic Internal Audit Plan and for the appropriate use of credible external review evidence.

The overall planning process is set out below:

STAKEHOLDERS

Step 1 Identification of auditable areas (The Audit Universe)	Identify all the functions, activities, systems and processes within the operation of the organisation
Step 2 Review of Risk Register	Review of risk register to ensure complete Audit Universe, inform control risk & highlight potential gaps
Step 3 Assessment of Materiality	Management score auditable areas through assessment of corporate importance and corporate sensitivity.
Step 4 Assessment of Inherent and Control Risk	FTF score inherent risk annually Score Control risk based on previous audit knowledge
Step 5 Calculate Audit Risk Index	Assign scores based on materiality and risk and prioritise audits accordingly
Step 6 Update Strategic Plan	Formulate the strategic audit plan within the planning constraint of the agreed number of audit days per year
Step 7 Produce and Scope Operational Plan	Produce the operational plan relevant to year in strategic plan including any adjustments to the strategic plan
Step 8 Determine Areas for departmental review	Senior Management determine areas in accordance with agreed principles (Appendix 2)
Step 9 Review and Approval	Audit Committee approves the Audit Plan

RISK REGISTER

The Audit Universe

The Audit Universe simply collates the Board's the functions, activities, systems and processes grouped by governance requirements, strategic objectives and key control systems. This list of auditable areas is updated annually and mapped to the clients own corporate objectives, heat targets and risk register.

Relationship with client's Risk Management processes

Prior to scoring process, the Regional Audit Manager (RAM) reviews the clients Risk Register to:

- ensure that the Audit Universe is complete for their organisation;
- inform their view of control risk;
- highlight potential gaps in the risk register.

Assessment categories

The model takes account of four assessment categories to produce a risk index for each auditable area, which are fully defined in assessment criteria based on the HIS Risk Assessment Matrix. The auditable area is scored on a sliding scale in each category using assessment criteria to gauge the degree of risk or materiality associated with the particular area. The table below summarises the four assessment categories and what each is intended to measure.

	Assessment category	**Measure**
A.	Corporate Importance	Corporate consequence
B.	Corporate Sensitivity	Political consequence
C.	Inherent Risk	Inherent likelihood
D.	Control Risk	Control effectiveness

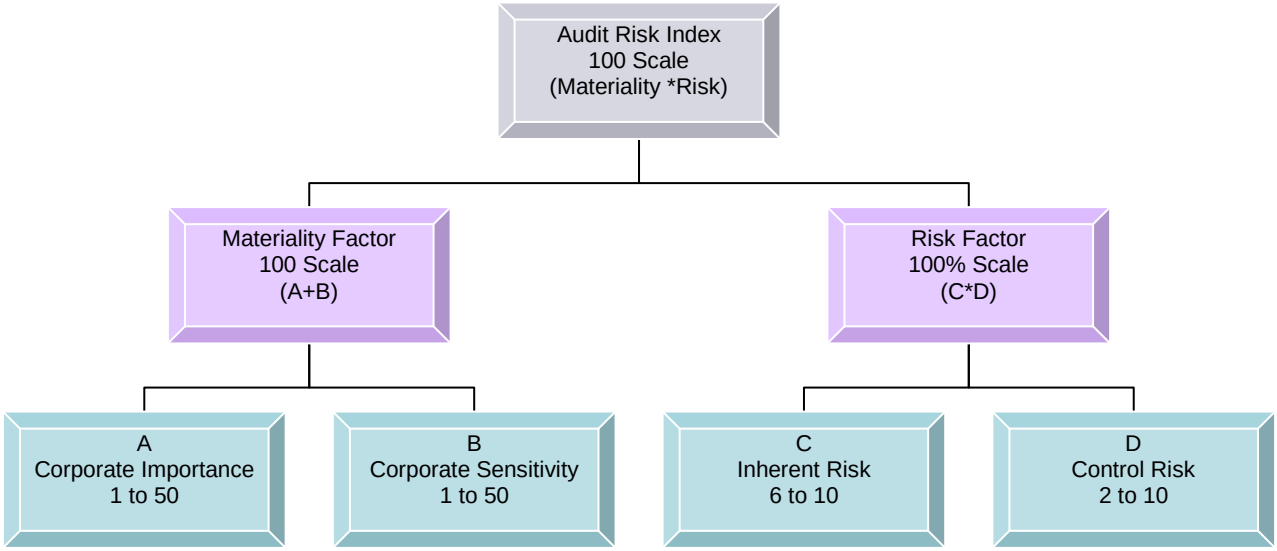
Assessment process

Corporate Importance and Sensitivity criteria are issued to the Director of Finance who scores them in consultation with other Directors and the Chief Executive. Where possible the Directors are asked to provide information on recent, current and forthcoming external reviews of the auditable areas.

Inherent risk is consistent across FTF and updated annually by the FTF Management Team.

Control risk is based upon previous audit knowledge and known developments in the management control environment, including the relevant areas of the organisation's own Risk Register and key external reviews e.g. External Audit & HIS.

The Audit risk index is calculated as follows



Cyclical coverage determined by Risk Index

The risk assessment which ranks the relative risks of the organisation's activities and systems is then used to determine the audit coverage of each system within the five year strategic audit plan. The scores are banded into natural grouping based on the pareto principle so that the top 20% of scores are ranked as high risk with the next 40% shown as medium and the final 40% as low.

In this way, the risk assessment process determines the frequency with which systems are to be audited in the 5 year strategic planning cycle; in general high priority areas are audited 3 times, medium priority areas twice and low priority areas once. When considering the timing of reviews in detail, coverage by External Audit and other formal review processes (management or external) is taken into account as well as client views on when Internal Audit work is likely to add most value.

Items outside of the Risk Assessment process

An allocation of internal audit resources is reserved within each year of the strategic audit plan for audit management, planning, reporting (including annual and interim reviews) and follow-up, and Audit Committee preparation and attendance.

In addition we are required to undertake Post-Transaction Monitoring every year and, Internal Audit may undertake work which will reduce External Audit input in areas such as Endowment Funds and Patients Funds.

Areas subject to external review

Many auditable areas, will be subject to external review. It is the duty of the auditor to ensure that audit effort does not duplicate work already undertaken. Therefore, where credible work has been undertaken, Internal Audit activity will be confined to one or more of the following areas:

- Confirming the scope and quality of the work undertaken;

- Ensuring that the review has been reported properly within the organisation and appropriate action taken where required including updating of the risk register where necessary;
- Ascertaining whether there are any issues which require highlighting to the Audit Committee and/or inclusion within the annual report;
- Updating the audit risk assessment for the area in question;
- At client request, assisting in preparing for a forthcoming review or in implementation of the action plan;
- Where an external body requires the client to have internal audit review of the area e.g. infection control.

At the start of the planning process IA will engage with External Audit as the most appropriate body to be aware of impending external reviews. Consultation with Directors will also seek information on forthcoming external reviews/inspections where known.

Allocation of resources

The strategic audit plan is formulated from the audit risk assessment within the planning constraint of the agreed number of audit days per year. The quantum of resource required for an area is not a function of the risk index. The risk index only indicates the frequency of audit attention that is appropriate. Professional judgement is therefore required in allocating necessary resources to each auditable area and in doing so opportunities will be found for identifying audit themes where a number of related auditable areas could be addressed within the scope of a particular audit assignment.

The approach will involve the targeting of the high and then medium priority areas to provide a balanced cyclical cover for the period of the plan before considering the low priority items.

It is possible be that some low risk areas cannot be visited at all during the strategic cycle due to resource constraints. These will be identified to the Audit Committee and Accountable Officer with a clear explanation of the impact on the Governance Statement.

The audit plan reflects the need for continuous improvement by showing reductions in days allocated to audit process as well as demonstrating efficiencies where stable systems are re-visited and in areas subject to ongoing review, wherever possible.

Relationship between strategic and operational planning

A full strategic plan and Audit Universe update is produced once every 5 years or following a major NHS re-structuring that renders previous strategic plans obsolete. The first year's operational plan is simply Year 1 of the approved strategic plan, detailing the expected scopes of the reviews, in consultation with the focus lead and highlighting where the audit is expected to add value.

In subsequent years the strategic plan is revisited by updating scores e.g. revised control risks based on actual audits, updated Director of Finance scores and changes to inherent risks. The operational plan will then be based on the respective year of the approved strategic plan, adjusted for any significant changes arising from revisiting the strategic plan and any in-year amendments to prior operational plans.

Generic scopes are available for each auditable area but these will be adjusted in the first instance by areas highlighted within the Board's Risk Register and through discussions with management. More detailed consideration of the control environment, risks and objectives is undertaken within the detailed assignment planning at the start of each audit.

Departmental Reviews

Time is set aside for Departmental reviews, which consider an area holistically across a range of defined elements of the audit universe. The departments/wards/areas are determined by senior management in accordance with an agreed set of principles (see Appendix 3).

Cross-cutting themes

The process for considering the exact scope of each audit includes a number of cross-cutting themes which are considered for every audit including:

- Performance Management;
- Data quality;
- Communication and engagement;
- Waste, variation and harm;
- Risk;
- Equality and diversity;
- Quality of Care;
- Health of the population;
- Compliance with regulations, policies and procedures;
- Best value;
- Stock Management;
- Values and whistleblowing.

Review and approval

The first draft plan produced by the Acting RAM is discussed with the Chief Internal Auditor before being issued to the Director of Finance and where required, further discussion with the External Auditor shall take place. The draft plan should be circulated to all Directors to allow for appropriate discussion, identification of external reviews, key risks etc, with approval of the plan being given by the Director of Finance.

Once agreed with the Director of Finance the plan should be presented to the Audit Committee for approval. Any significant amendment to the approved plan must be notified to the Audit Committee and wherever practicable, approved in advance.

Post approval meetings

Discussions are held with key directors, collectively and individually as soon as possible in order to:

- maximise efficiency;
- ensure the purpose and scope of the audits is understood;
- agree timings;
- agree which areas will be selected for departmental reviews.

Annex A
Public Sector Internal Audit Standards

2010 Planning

The chief audit executive must establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals.

Interpretation:

The chief audit executive is responsible for developing a risk-based plan. The chief audit executive takes into account the organisation's risk management framework, including using risk appetite levels set by management for the different activities or parts of the organisation. If a framework does not exist, the chief audit executive uses his/her own judgment of risks after consideration of input from senior management and the board. The chief audit executive must review and adjust the plan, as necessary, in response to changes in the organisation's business, risks, operations, programs, systems, and controls.

Public sector requirement

The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be delivered and developed in accordance with the internal audit charter and how it links to the organisational objectives and priorities.

2030 Resource Management

The chief audit executive must ensure that internal audit resources are appropriate, sufficient and effectively deployed to achieve the approved plan.

Interpretation:

Appropriate refers to the mix of knowledge, skills and other competencies needed to perform the plan. Sufficient refers to the quantity of resources needed to accomplish the plan. Resources are effectively deployed when they are used in a way that optimises the achievement of the approved plan.

Public sector requirement

The risk-based plan must explain how internal audit's resource requirements have been assessed.

Where the chief audit executive believes that the level of agreed resources will impact adversely on the provision of the annual internal audit opinion, the consequences must be brought to the attention of the board.

2050 Coordination

The chief audit executive should share information and coordinate activities with other internal and external providers of assurance and consulting services to ensure proper coverage and minimise duplication of efforts.

Public sector requirement

The chief audit executive must include in the risk-based plan the approach to using other sources of assurance and any work required to place reliance upon those other sources.

Public sector definition: Assurance Framework

This is the primary tool used by a board to ensure that it is properly informed on the risks of not meeting its objectives or delivering appropriate outcomes and that it has adequate assurances on the design and operation of the systems in place to mitigate those risks.

Added Value

The internal audit activity adds value to the organisation (and its stakeholders) when it provides objective and relevant assurance, and contributes to the effectiveness and efficiency of governance, risk management and control processes.

Record of Attendance

NHS Tayside

Audit Committee Record of Attendance 1 April 2017 – 31 March 2018

Name	Designation	Organisation	Meeting Date	Meeting Date	Meeting Date	Meeting Date	Meeting Date
			11 May 2017	22 Jun 2017	24 Aug 2017	14 Dec 2017	15 Mar 2018
Members							
Mr D Cross OBE	Non Executive Member	NHS Tayside	Apologies				
Mrs L Dunion	Non Executive Member	NHS Tayside	Present				
Mrs J Golden	Non Executive Member & Employee Director	NHS Tayside	Present				
Mr S Hay	Non Executive Member (Chair)	NHS Tayside	Present				
Mr M Hussain	Non Executive Member	NHS Tayside	Present				
In Attendance							
Mr L Bedford	Director of Finance	NHS Tayside	Present				
Ms M Dunning	Board Secretary	NHS Tayside	Present				
Mr T Gaskin	Chief Internal Auditor	FTF Audit & Management Services	Present				
Regular Attendees							
Mr D Colley	Financial Governance Accountant	NHS Tayside	-				-
Mr B Crosbie	Senior Audit Manager	Audit Scotland	Present				
Mr G Doherty	Director of Human Resources	NHS Tayside	Present				-
Mrs F Gibson	Head of Financial Servicew	NHS Tayside	Present				
Mr B Hudson	Regional Audit Manager	FTF Audit & Management Services	-				
Mrs J Lyall	Principal Auditor	FTF Audit & Management Services	Present				
Mr R MacKinnon	Associate Director of Finance, Financial Svs & Governance/FLO	NHS Tayside	Present				
Ms F Mitchell-Knight	Asst Director, Audit Services	Audit Scotland	-				-

Record of Attendance

NHS Tayside

Mrs H Walker	Risk Manager	NHS Tayside	Present				
Mr R Marshall	Representative Area Partnership Forum	NHS Tayside	Present				
For Information							
Prof J Connell FMedSci FRSE	Chair, Tayside NHS Board	NHS Tayside	Present				
Mrs G Costello	Nurse Director	NHS Tayside	-				
Mrs L Green	Committee Support Officer	NHS Tayside	Present				
Miss D Howey	Head of Committee Administration	NHS Tayside	Present				
Ms L McLay	Chief Executive	NHS Tayside	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	-				