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

AGENDA

ITEM NO.			LEAD OFFICER	REPORT NO AND ACTION REQUIRED
1.	**WELCOME**		S Hay	
2.	**APOLOGIES**		S Hay	
3.	**DECLARATION OF INTERESTS**		S Hay	
4.	**MINUTE OF PREVIOUS MEETING**			
	4.1	Minute of the Audit Committee Open Business - 22 June 2017	S Hay	Attached - For approval
	4.2	Action Points Update	L Bedford	Attached - to note update
	4.3	Workplan 2017/18	L Bedford	Attached – to note update
	4.4	Matters Arising	S Hay	
5.	**ASSURANCE**			
	5.1	Letter to Integration Joint Board (IJB) Chairs From Mr Stephen Hay, Chair of Audit Committee	L Bedford	AUDIT59/2017 Attached – to note report
6.	**AUDIT FOLLOW UP**			
	6.1	Audit Follow Up (AFU) – Full Cycle Update Report	L Bedford	AUDIT60/2017 Attached – to note report
	6.2	Internal Audit Report T22/17 Financial Planning and Management Progress Update Report	L Bedford	AUDIT61/2017 Attached – to note progress
	6.3	Follow Up on Internal Audit Annual and Mid Year Reports	L Bedford	AUDIT62/2017 Attached – to note progress
	6.4	Follow Up on External Audit Annual Report 2016/17	L Bedford	AUDIT63/2017 Attached – to note progress
7.	**FTF/INTERNAL AUDIT**			
	7.1	FTF Audit and Management Services Internal Audit Progress Report	J Lyall	AUDIT64/2017 Attached – to note progress
	7.2	T30a/18 Contingency Reviews – Annual Managed Expenditure Provisions	L Bedford	AUDIT65/2017 Attached – to note progress
	7.3	Integrated Joint Boards (IJBs) Sharing of Audit Outputs Protocols	T Gaskin	AUDIT73/2017 Attached – for approval

ITEM NO.		LEAD OFFICER	REPORT NO AND ACTION REQUIRED
8.	**POLICIES**		
8.1	NHS Tayside Adverse Event Management Policy	H Walker	AUDIT66/2017 Attached – for adoption
8.2	Promoting Safe Manual Handling	A Mitchell	AUDIT67/2017 Attached – for adoption
9.	**PROPERTY TRANSACTION MONITORING**	L Lyall	AUDIT68/2017 Attached – to note report
10.	**PAYMENT VERIFICATION: FAMILY HEALTH SERVICE (FHS) CONTRACTORS – Payment Verification Annual Process Update**	J Haskett	AUDIT69/2017 Attached – to note report
11.	**PAYMENT VERIFICATION: FAMILY HEALTH SERVICE (FHS) CONTRACTORS**	J Haskett	AUDIT70/2017 Attached – to note report
12.	**PAPERS/MINUTES FOR INFORMATION**		
12.1	Corporate Governance Review Group Action Note – 17 May 2017 (unapproved)	M Dunning	Attached – for information
12.2	Strategic Risk Management Group Minute – 27 April 2017 (unapproved)	M Dunning	Attached – for information
12.3	Audit Scotland Reports	L Bedford	For information
	• Annual Report and Accounts 2016/17 • http://www.audit-scotland.gov.uk/uploads/docs/report/2017/as_annual_report_1617.pdf • Audit Quality Annual Report 2016/17 • http://www.audit-scotland.gov.uk/uploads/docs/report/2017/as_audit_quality_1617.pdf • Corporate Plan 2017/18 Update • http://www.audit-scotland.gov.uk/uploads/docs/report/2017/as_corporate_plan_1718.pdf • NHS Workforce Planning • http://www.audit-scotland.gov.uk/uploads/docs/report/2017/nr_170727_nhs_workforce.pdf • Technical Bulletin 2017/2 • http://www.audit-scotland.gov.uk/uploads/docs/um/tb_2017_2.pdf		
12.4	Attendance Record	S Hay	Attached – for information
13.	**DATE OF NEXT MEETING:** **Thursday 14 December 2017 at 9:30am** in the Board Room, Conference Suite, Kings Cross.	All	For information

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

SO 28.3
Qualified Exemptions and the Public Interest

14.	**MINUTES OF PREVIOUS MEETINGS**		
14.1	Minute of the Audit Committee Reserved Business - 22 June 2017	S Hay	Attached – for approval
14.2	Action Points Update	L Bedford	Attached – to note update
14.3	Matters Arising	S Hay	

ITEM NO.			LEAD OFFICER	REPORT NO AND ACTION REQUIRED
FOISA 27(1) **Information Intended for Future Publication**				
15.	15.1	Minute of Audit Committee Open Business - 22 June 2017 (Full Minute)	S Hay	Attached – for approval
FOISA 33(1) **Commercial Interests and the Economy**				
16.		**NHS SCOTLAND COUNTER FRAUD SERVICES**		
	16.1	NHS Scotland Counter Fraud Services Update	R Mackinnon	AUDIT71/2017 Attached – to note report
	16.2	Banking and Treasury Management	R MacKinnon	AUDIT72/2017 Attached – to note report
17.		**PRIVATE DISCUSSION**		

Mr S Hay
Chair
August 2017

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	Dr A Cowie
Mr S Hay (Chair)	Mr G Doherty	Miss D Howey
Mr M Hussain	Ms M Dunning	Ms L McLay
	Mr T Gaskin	Dr R Peat
	Mrs F Gibson	Mr H Robertson
	Mr B Hudson	Mrs A Rogers
	Mrs J Lyall	Prof A Russell
	Ms A Machan	Prof M Smith
	Mr R MacKinnon	Mrs S Tunstall-James
	Mr R Marshall	Dr D Walker
	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 9.40 a.m. on **Thursday 22 June 2017** in the Board Room, Conference Suite, King's Cross, 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 Executives and Senior Officers
Mr L Bedford, Director of Finance, NHS Tayside
Prof J Connell, Chair, Tayside NHS Board
Mr G Doherty, Director of Human Resources & Organisational Development, NHS Tayside
Mr R MacKinnon, Associate Director of Finance - Financial Services & Governance/FLO, NHS Tayside
Ms L McLay, Chief Executive, NHS Tayside

External Auditors
Mr B Crosbie, Senior Audit Manager, Audit Scotland
Ms F Mitchell-Knight, Assistant Director, Audit Scotland

Internal Audit – FTF Audit and Management Services
Mr B Hudson, Regional Audit Manager, FTF Audit and Management Services
Mrs J Lyall, Acting Regional Audit Manager, FTF Audit and Management Services

Other Attendees
Mr D Colley, Financial Governance Accountant, NHS Tayside
Mr P Crichton, External Auditor, MMG Archbold (Item 5)
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
Mr S Lyall, Head of Finance, NHS Tayside
Ms G Matthew, External Auditor, MMG Archbold
Mr D Taylor, External Auditor, Henderson Loggie (Item 6)

Apologies
Mr D Cross, OBE, Non Executive Member, Tayside NHS Board
Mr T Gaskin, Chief Internal Auditor, FTF Audit and Management Services
Mr R Marshall, Representative of Area Partnership Forum
Mrs H Walker, Risk Manager, NHS Tayside

Mr S Hay in the Chair

1. WELCOME **ACTION**

Mr Hay welcomed all to the meeting in particular Ms Fiona Mitchell Knight and Mr Bruce Crosbie, External Auditors, Audit Scotland. It was noted that Mr Paul Crichton and Ms Gemma Matthew from MMG Archbold, External Auditors for Endowment Funds and Mr David Taylor from Henderson Loggie, External Auditor for Patients' Funds would be attending for Items 5 and 6 on the Agenda.

Mr Hay advised the Committee that an updated ISA 260 and ISA 580, relating to Item 9 on the Agenda, had been tabled along with a briefing note highlighting further amendments to the Draft Annual Accounts, Item 8 on the Agenda.

The Committee agreed that in order for certain assurances to be provided prior to the Review of the Statement of Internal Control items of reserved business would be taken ahead of open business.

The Committee resumed open business at 9:40am

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 – 11 May 2017

The Audit Committee Minute of the meeting held on 11 May 2017 was approved on the motion of Mrs Linda Dunion and seconded by Mrs Judith Golden.

4.2 Action Points Update

Mr Bedford spoke to the Action Points Update.

Internal Audit T12/17 – Integration Joint Board (IJB) Governance Update – Ms Dunning advised the Committee that following the Audit Committee meeting on 11 May 2017, there had been a further meeting of the working group, held on 15 May 2017, where there was a difference of opinion regarding the models in place. It was noted that Mr Bill Nicoll, Director of Strategic Change, had sought the views of the Scottish Government Health and Social Care Directorate (SGHSCD) in relation to integration schemes in Tayside.

It was noted a further meeting involving the Chairman and Chief Executive had been arranged for 25 July 2017 and an update would be provided to the August 2017 Committee meeting. **MD**

Ms Dunning noted that there was full involvement from Internal Audit colleagues.

Best Value Framework Assurance 2016/17 – Tayside NHS Board – It was noted Ms Dunning and Miss Howey had met with Mr Hay and Mrs Dunion and an update would be provided under Item 14 of the Agenda.

4.3 Work Plan Update

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

The Committee

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

4.4 Matters Arising

There were no matters arising.

9:43am Mr Paul Crichton and Ms Gemma Matthew arrived

ENDOWMENT FUNDS

5. Draft Annual Accounts 2016/17 Tayside NHS Board Endowment Funds (AUDIT42/2017) – *BOARD MEMBERS ONLY*

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

Mr Crichton, External Auditor, MMG Archbold was in attendance to present the Draft Annual Accounts 2016/17 Tayside NHS Board Endowment Funds.

9:51 Mr David Taylor arrived

PATIENTS' FUNDS

6. Patients' Funds – External Audit Report (AUDIT43/2017)

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

Mr MacKinnon advised that the draft Abstract of Receipts and Payments in respect of Patients' Private Funds was presented for consideration by the Committee prior to submission to Tayside NHS Board. It was noted the documentation included the appointed external auditor, Henderson Loggie's draft audit certificate, and the Audit Findings Report.

Mr MacKinnon highlighted the recommendations set out within the report which sought the Committee's approval.

Mr Taylor advised that the Abstract of Receipts and Payments for year ended 31 March 2017 was included as Appendix 1 of the report and detailed Tayside NHS Board Members responsibilities and financial information. The Committee noted the Audit Findings Report was included as Appendix 2 of the report and highlighted, during the course of the audit, visits to cashiers' officer's in Ninewells Hospital, Royal Victoria Hospital, Stracathro Hospital and Perth Royal Infirmary had been carried out. It was noted ward level testing was also carried out at Royal Victoria Hospital and Stracathro Hospital.

Mr Taylor advised that the Audit Findings Report contained an action plan with five minor action points. It was noted management responses had been provided detailing the actions to be taken to mitigate against the weakness contained within the action plan.

It was noted the Patients' Private Fund Letter of Representation and Letter of Confirmation were included as Appendices 3 and 4 of the report.

The Committee

- **Reviewed the draft Abstract of Receipts and Payments**
- **Noted the draft audit certificate from Henderson Loggie**
- **Considered the Audit Findings Report from Henderson Loggie**
- **Recommended that Tayside NHS Board, at its meeting on 29 June 2017, formally adopts the Abstract of Receipts and Payments in respect of Patients' Private Funds for the year ended 31 March 2017 and authorised 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**

The Committee agreed to take Item 13 next on the Agenda as this item was related to the Committee's review of the system of internal control.

13. Best Value Framework Assurance – Tayside NHS Board – 2016/17 - Update (AUDIT55/2017)

Mr Hay advised the Committee was asked to approve the Best Value Framework Assurance for 2016/17 and wished to thank Ms Dunning, Mrs Dunion and Internal Audit for the facilitation of a meeting to further consider the Best Value Framework Assurance for 2016/17.

Ms Dunning expressed her thanks also, and found the meeting to be helpful in producing a Best Value Framework which was more reflective.

Mrs Dunion agreed the meeting had been useful in providing further clarity within the framework.

The Committee noted there had been a number of amendments to the Best Value Framework which focussed on future work and the importance of communications, particularly in relation to transformation work.

The Committee

- **Approved the Best Value Framework Assurance – Tayside NHS Board - 2016/17**

7. EXCHEQUER FUNDS

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

7.1 Exchequer Process – Verbal Introduction

Mr Bedford gave a verbal introduction regarding the Exchequer process.

Mr Bedford advised the Committee that Item 7 of the Agenda had been structured to provide a framework of what was being presented to allow the Committee to review the system of internal control culminating at Item 7.8 in the assurance report to be provided to Tayside NHS Board.

It was noted that Item 7 also supported the Audit Committee as part of the Committee's consideration of the Governance Statement (GS) included within the Accountability Report of the Annual Report and Accounts.

Mr Bedford advised that under Item 10 of the Agenda, the Committee would be asked to recommend adoption of the Annual Report and Accounts to Tayside NHS Board and that authority be granted to the Chief Executive as Accountable Officer to sign the Accountability Report, which included the GS.

The Committee

- **Noted the verbal update**

7.2 Annual Reports and Assurance Statements by Committees including Best Value Assurances for the year ended 31 March 2017 (AUDIT44/2017)

Mr Bedford advised that the main function of the Audit Committee was to provide assurance to Tayside NHS Board that an appropriate system of internal control was in place.

The Committee was asked to consider the overall conclusions reached within each of the Standing Committees, the Board of Trustees and the Governance Review Group Annual Reports.

It was noted that the Staff Governance Committee (SGC) would formally meet in the afternoon following today's meeting and would consider the approved Annual Reports of the Remuneration Committee, the Area Partnership Forum and the Staff Governance Committee. The Committee noted that in order not to inhibit the Audit process, taken into account timings of the release of SGC papers, approval of the SGC Annual Report had been sought and received electronically.

Mr Bedford advised the Audit Committee Annual Report would be considered separately under Item 7.7 of the Agenda and noted that the Best Value Framework was included formally as part of this report.

The Committee

- **Considered the overall conclusion included within each Standing Committee's Annual Report, Board of Trustees and that of the Governance Review Group, and the assurances given therein, in reaching conclusion of the adequacy and effectiveness of Internal Control in the context of its review of the system of internal control**
- **Considered and approved the assessment of Tayside NHS Boards Best Value Characteristics**

7.3 SHARED SERVICES AUDIT REPORTS (AUDIT45/2017)

Mr MacKinnon presented all reports under Item 7.3. It was noted the following reported on the outcome of the three NHS National Services Scotland's Service Audits undertaken for the year 2016/17:

a) Practitioner Services
b) National IT Services
c) NHS Ayrshire and Arran National Single Instance Financial Ledger Services

It was noted full reports were available upon request.

7.3a Practitioner Services – Service Audit Report

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

Mr MacKinnon highlighted the recommendations set out within the report.

The Committee

- **Noted and took assurance from the audit report from the independent Services Auditors**
- **Noted and took assurance from the Introduction by (NSS) Director of Finance and Management Assertion**
- **Noted and took assurance from the management responses to the issues arising set out within the Action Plan**

7.3b National IT Services Contract – Service Audit Report

Mr MacKinnon advised the Committee the purpose of the report was to bring to the attention of the 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.

Mr MacKinnon highlighted the recommendations set out within the report.

The Committee

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

7.3c NHS Ayrshire and Arran National Single Instance Financial Services Ledger – Service Audit Report

Mr MacKinnon advised the Committee the purpose of the report was to bring to the attention of the 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). It was noted the NSI was used by all Health Boards and hosted by NHS Ayrshire and Arran. The report was prepared by BDO UK LLP, and reviewed and approved by the host Board's Audit Committee at its meeting on 3 May 2017.

Mr MacKinnon highlighted the recommendations set out within the report.

The Committee

- **Noted and took assurance from the cover letter from the Director of Finance, NHS Ayrshire and Arran**
- **Noted and took assurance from the Service Audit Report from the NSI independent Service Auditors, BDO UK LLP**

7.4 FTF Annual Internal Audit Report 2016/17 (BOARD46/2017)

Mrs Jocelyn Lyall was in attendance to present the report on behalf of Mr Tony Gaskin, Chief Internal Auditor.

Mrs Lyall advised the Committee the Internal Audit Report 2016/17 was a lengthy report and noted the themes covered during 2015/16 and 2016/17. It was noted the report did not reflect failings of systems and was cognisant that a challenging environment remained.

Mrs Lyall highlighted para 17. Audit Products and Opinions and para 18. Added Value of the report and noted para 16. of the report which provided the overall opinion of the Chief Internal Auditor.

Mrs Lyall extended her thanks to Mr Bedford and the Finance Team for their assistance over the course of the year.

Mr Hay noted the Annual Internal Audit Report 2016/17 was clear and consistent.

Mr Hay advised that the Committee was asked to consider the report as part of the portfolio of evidence provided in support of its evaluation of the internal control environment and the Governance Statement and note the Chief Internal Auditor's conclusion that based on work undertaken throughout the year and building on audit evidence obtained over a five year audit cycle by Internal Audit, he had concluded that subject to matters highlighted within the report narrative and in the appendices to the report that:

- The Board had adequate and effective internal controls in place and
- The 2016/17 Internal Audit Plan had been delivered in line with Public Sector Internal Audit Standards

Mr Hay thanked Mr Gaskin, Mrs Lyall, Mr Hudson and the Finance Team for the work carried out over the course of the year.

The Committee

- **Considered the report as part of the portfolio of evidence provided in support of its evaluation of the internal control environment and the Governance Statement**

7.5 Review of System of Internal Control – Lead Officers Statement to Chief Internal Auditor (AUDIT47/2017) – *BOARD MEMBERS ONLY*

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

Mr Bedford presented the Review of System of Internal Control – Lead Officers Statement to Chief Internal Auditor.

7.6 Annual Report – Patient Exemption Checking (PECS) (AUDIT48/2017)

Mr MacKinnon advised the Committee the purpose of the report was to advise on the work of the 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 identified the amounts recovered and those written off.

The Committee noted that CFS had issued its annual report on PECS for 2016/17 and was included as appendix 1 of the report.

Mr MacKinnon advised the report set out the recoveries and write offs by service for NHS Tayside and NHS Scotland. It was noted CFS had recovered £20,143 (£16,602 – 2015/16) for 2016/17 on behalf of NHS Tayside, which represented 5.7% (5.6% - 2015/16) of the Scotland total.

It was noted the value of write offs had increased from £12,169 in 2015/16 to £12,889 in 2016/17. This represented 4.8% (6.3% - 2015/16) of the Scotland total.

Mr MacKinnon highlighted the recommendations set out within the report.

The Committee

- **Noted the 2016/17 Annual Reporting Package from Counter Fraud Services**
- **Noted the level of recoveries made during 2016/17**
- **Noted the reported level of write offs across the Contractor Groups, which were recorded in the losses for (SFR18) in the 2016/17 Annual Accounts**

7.7 Annual Report of NHS Tayside Audit Committee 2016/17 (AUDIT49/2017)

Mr Bedford presented the Audit Committee Annual Report 2016/17 for approval by the Committee for submission to Tayside NHS Board.

Mr Bedford advised the Committee that the report sought to fulfil the requirement within the Committees Terms of Reference and was structured in a format that fulfilled the requirements of describing the membership, frequency of meetings, business considered and compliance with Best Value Characteristics.

The Committee noted the various appendices included within the report set out detailed information on attendance, the specific business undertaken and responses to the Best Value Characteristics.

Mr Bedford concluded by thanking Mrs Lisa Green as Committee Support Officer for her professional approach to the activities of this Committee.

The Committee

- **Considered and approved its 2016/17 Annual Report for submission to Tayside NHS Board**

7.8 Report to Tayside NHS Board – Assurance to the Committee (AUDIT50/2017)

Mr Bedford advised that this report summarised Items 7.2 to 7.7 and the Committee was required to consider and approve this report for submission to Tayside NHS Board at its meeting on 29 June 2017.

Mr Bedford highlighted a minor error within the report at section 3, point 5. It was noted Service Auditors were BDO UK not PricewaterhouseCoopers.

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

1. The introductory remarks made by Mr Bedford (considered under agenda Item 7.1)
2. The Annual reports and assurances for 2016/17, previously submitted by the Standing and other Committees and summarised for the Audit Committee together with Best Value Assurances (considered under agenda Item 7.2 and Item 13)
3. The assurances provided by Service Auditors in relation to Practitioners Services Division,(considered under agenda Item 7.3a), National IT Services Contract, (considered under agenda Item 7.3b), and the NHS Ayrshire and Arran National Single Instances Financial Ledger Services, (considered under agenda Item 7.3c)
4. Internal Audit, plans and reports considered by the Audit Committee during the year and the Annual Report (considered under Item 7.4)
5. The Audit Committee's Lead Officer's Statement to the Chief Internal Auditor regarding assurances on internal control and the Governance statement,(considered under agenda Item 7.5)
6. The Annual Report of Patient Exemption Checking, provided by Counter Fraud Service (considered under Agenda Item 7.6)
7. The Audit Committee's 2016/17 Annual Report (approved by the Committee under agenda Item 7.7)

The Committee

- **Considered all evidence and was satisfied assurance could be given to Tayside NHS Board with regard to the systems of internal control operating within NHS Tayside**
- **Approved the Draft Terms of its Assurance Report to Tayside NHS Board**

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

8. Annual Accounts for the Year to 31 March 2017 (BOARD51/2017) – *BOARD MEMBERS ONLY*

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

Mr Bedford presented the Annual Accounts for the year to 31 March 2017.

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

9. Audit Scotland – Annual Report on the 2016/17 Audit to the Board and the Auditor General for Scotland (AUDIT52/2017) – *BOARD MEMBERS ONLY*

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

Ms Mitchell-Knight, Assistant Director, Audit Scotland was in attendance to present the Audit Scotland - Annual Report on the 2016/17 Audit to the Board and the Auditor General for Scotland.

10. Recommendation to the Board of Annual Accounts

Mr Hay advised the Committee that having reviewed the system of internal control, the Annual Report and Accounts and considered the view of the external auditor, the Committee was asked for approval of the recommendations detailed within Item 8, Annual Accounts for the year ended 31 March 2017.

The Committee

- **Approved the recommendation to Tayside NHS Board that the summary of Losses and Special Payments contained in SFR 18.0 and separately included under agenda Item 19 be approved.**
- **Approved the recommendation to Tayside NHS Board, the adoption of the annual accounts.**
- **Approved the recommendation to Tayside NHS Board that authority be granted to sign the documentation specified within Table 1 of the cover report at Item 8, as follows:**
  - **a. Performance report – Chief Executive**
  - **b. Accountability Report (including the Governance Statement) – Chief Executive**
  - **c. Balance Sheet – Chief Executive and Interim Director of Finance**
  - **d. Letter of representation to External Auditors – Chief Executive**

11. Notification from Sponsored Body Audit Committees (AUDIT53/2017)

Mr Bedford advised that the purpose of the report was to inform the Committee of the content of the letter received from Scottish Government Health and Social Care Directorate (SGHSCD), attached as Appendix 1 of the report, which intimated the requirement to notify the Health and Wellbeing Audit and Risk Committee of any significant issues of frauds which arose during 2016/17 that were to be considered to be of wider interest.

The Committee was also asked to approve the draft response to SGHSCD and authorise the Chair of the Audit Committee to sign this letter, attached at Appendix 2 of the report.

The Committee

- **Approved the draft nil response to SGHSCD**
- **Authorised the Chair of the Audit Committee to sign the letter attached at Appendix 2 of the report**

12. Updates to the NHS Tayside Code of Corporate Governance (AUDIT54/2017)

Ms Dunning advised that the Committee was asked to approve the amendments and updates, included as Appendix 1 of the report, to the Code of Corporate Governance for consideration by Tayside NHS Board at its meeting on 29 June 2017.

The Committee

- **Scrutinised the amendments and updates to the Code of Corporate Governance and recommended approval of these to Tayside NHS Board at its meeting on 29 June 2017**

14. Audit Follow Up (AFU) – Full Cycle Report (AUDIT57/2017)

Mr Bedford advised the Committee that this report followed the regular reporting arrangements with the Committee receiving either a Mid Cycle or Full Cycle Report. This was the Full Cycle Report.

Mr Bedford advised the purpose of the report was to provide a progress update on the action taken to 30 May 2017, relating to recommendations made in NHS Tayside Internal/External Audit Reports.

The Committee noted Appendix 1 contained a summary listing of the status of Internal and External Audit higher risk action points, Appendix 2 detailed actions with a 'C overdue' status with comments regarding the status from Responsible Officers included and Appendix 3 provided a progress update of remaining high risk actions included within 'D' opinion audit reports.

The Committee

- **Noted the findings for this full cycle to May 2017**

15. Internal Audit Annual Plan 2017/18 (AUDIT58/2017)

Mr Barry Hudson was in attendance to present this report.

Mr Hudson advised that following the decision at the May 2017 Committee meeting to defer submission of the Audit Plan, the Internal Audit Annual Plan 2017/18 was now being presented for approval by the Committee.

The Committee noted that feedback from Directors had been incorporated into the internal audit plan, with a detailed mapping exercise carried out to ensure close alignment to the corporate risk register.

Mr Hudson advised that Internal Audit would work closely with the Director of Finance and Chief Executive. Ms McLay expressed her appreciation of the close working relationship with Internal Audit and noted she was looking to see audits around sustainability and close monitoring during periods of change, particularly within high risk areas.

The Committee

- **Approved the Annual Internal Audit Plan 2017/18**
- **Agreed the Annual Internal Audit Plan for 2017/18 would be shared with the three Integrated Joint Boards (IJBs)**

16. ATTENDANCE RECORD

The Committee

- **Noted the Attendance Record**

17. DATE OF NEXT MEETING

The next meeting of the Audit Committee will take place on Thursday 24 August 2017 at 9:30am in the Board Room, Conference Suite, Kings Cross.

The meeting concluded at 11:00am

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 22 June 2017, and approved by the Committee at its meeting held on 24 August 2017.

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CHAIR **DATE**

NHS Tayside Audit Committee – 24 August 2017 Open Business
Action Points Update

New Actions arising from meeting on 22 June 2017

MEETING	MINUTE REF.	HEADING	ACTION POINT	RESPONSIBILITY	STATUS
22 June 2017	4.2	APU – Internal Audit T12/17 – Integration Joint Board (IJB) Governance Update	Ms Dunning to provide update in relation to IJB governance arrangements following meeting on 25 July 2017 with the Chairman and Chief Executive	M Dunning	At the meeting held on 25July 2017, it was agreed that a Governance Framework should be developed. The Board Secretary is taking this forward in conjunction with Internal Audit. A meeting has been arranged to discuss governance arrangements in Perth and Kinross on 4 September 2017. An update will come to the next Audit Committee 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	Agenda Item August 2017 meeting

Completed Actions

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	Completed
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	Completed

Item Number 4.3

AUDIT COMMITTEE

Audit Committee Workplan 2017/18

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

	Responsible Officer	Comment	Meeting 11 May 2017	Meeting 22 Jun 2017	Meeting 24 Aug 2017	Meeting 14 Dec 2017	Meeting 15 Mar 2018	Meeting May 2018	Meeting June 2018
Regular reports submitted to the Audit Committee									
Audit Follow Up									
Full Cycle Reports	L Bedford	**6 Monthly**		**14**	**X**		**X**		
Mid Cycle Reports	L Bedford	**6 Monthly**	**5.1**			**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**		**7.5**					**X**
Review of Annual Accounts for Exchequer	L Bedford	**Annual**		**8**					X
Review of Annual Accounts for Endowments	L Bedford	**Annual**		**5**					X
Review of Annual Accounts for Patient Funds	L Bedford	**Annual**		**6**					X
Losses and Compensation Payments	L Bedford	**Annual**		**19**					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**		**7.2**					**X**
Review Framework of Internal Controls and Corporate Governance	**L Bedford**	**Annual**		**7.1**					**X**
Lead Officer Statement on Governance Statement on Internal Control to Chief Internal Officer	**L Bedford**	**Annual**		**7.5**					**X**
Chief Internal Auditors Annual Report & Assurance Statement	**T Gaskin**	**Annual**		**7.4**					**X**
Code of Corporate Governance									
Updates to Code of Corporate Governance	M Dunning	**As & when available**		**12**					
Governance Review Group Annual Report	M Dunning	**Annual**		**7.2**					**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**		**7.4**					**X**
Internal Audit Annual Plan	T Gaskin	**Annual**		**15**				**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**
Notification from Sponsored Body Audit Committees	L Bedford	**Annual**		**11**					**X**
Annual Report on the previous year audit to the Board and the Auditor General for Scotland	B Crosbie	**Annual**		**9**					**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 with External Auditor Audit Planning Memorandum , Fees & Reporting Arrangements	L Bedford	**Annual**							
Review of Audit Plan of Endowment Funds – External Audit Report (MMG Archbold)	P Crichton	**Annual**		**5**					**X**
Review of Audit Plan of Patients' Funds – External Audit Report (Henderson Loggie)	D Taylor	**Annual**		**6**					**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**		**7.6**					**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**		**7.7**				**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**		**19**		**X**			**X**
Banking and Treasury Management	L Bedford	**Annual**			**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 5.1

AUDIT59/2017
Audit Committee
24 August 2017

LETTER TO INTEGRATION JOINT BOARD (IJB) CHAIRS FROM MR STEPHEN HAY, CHAIR OF AUDIT COMMITTEE

Lindsay Bedford
Director of Finance

August 2017

Director of Finance's Office
Tayside NHS Board
Ninewells Hospital & Medical School
Dundee
DD1 9SY
Telephone Number: 01382 660111
www.nhstayside.scot.nhs.uk

Chairperson
Integrated Joint Boards
Angus, Dundee, Perth & Kinross

Date	14 July, 2017
Your Ref	
Our Ref	LB/LM/
Enquiries to	Miss Alison Stibbles
Extension	32054
Direct Line	01382 632054
Email	alison.stibbles@nhs.net

Dear

ASSURANCES PROVIDED BY TAYSIDE NHS BOARD

At the Tayside NHS Board Meeting dated 29 June, 2017, I provided assurance to the Board following the review of the System of Internal Control operating within NHS Tayside during 2016/17 financial year that had been considered by the NHS Tayside Audit Committee at its meeting on 22nd 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 considered the following:

(1) The review of the System of Internal Control,

(2) The Annual Reports and assurances by Committees including Best Value Assurances;

(3) The Audit Committee considered 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 considered by the NHS Tayside Audit Committee up to and including 22 June 2017;

(4) The Audit Committee considered 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;

(5) The Audit Committee considered the assurance provided by BDO UK LLP 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;

(6) The FTF Internal Audit 2016/17 Annual Report, noting the satisfactory conclusions of the Chief Internal Auditor;

(7) Audit Committee Lead Officer's statement to the Chief Internal Auditor with regard to assurances affecting the Governance Statement;

(8) The Patient Exemption Checking report on progress around Patient Exemption Checking as a direct result of the checks undertaken by Counter Fraud Services;

(9) The Audit Committee Annual Report for 2016/17 previously submitted to the Audit Committee;

Following review, the conclusion of the Audit Committee and the recommendation made to and accepted by Tayside NHS Board, was that adequate and effective governance arrangements were in place throughout NHS Tayside, including those functions delegated to the IJBs, during the year 2016/17.

A copy of the NHS Tayside 2016/17 Annual Internal Audit Report can be found at:-

http://staffnet.tayside.scot.nhs.uk/NHSTaysideDocs/idcplg?IdcService=GET_FILE&dDocName=PROD_279785&Rendition=web&RevisionSelectionMethod=LatestReleased&noSaveAs=1

I trust that this is helpful to your Audit Committee.

Yours sincerely

Stephen Hay (Signed Electronically)

Stephen Hay
Chairperson
On behalf of NHS Tayside Audit Committee

c.c. Chief Finance Officers

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

Item Number 6.1

AUDIT60/2017
AUDIT COMMITTEE
24 AUGUST, 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 July, 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 July 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. The 'E' status, "deferred-not yet due" actions have arisen as a result of requests made by Responsible Officers to extend the due date. In each case the Responsible Officer has provided an explanation of why this 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 all remaining actions included within 'D' opinion audit reports (for definitions 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
- **T36A/16 Child and Adolescent Mental Health Services (CAMHS)** (presented to Audit Committee January 2017). Of the nine high risk action points, seven are completed.

The Audit Committee Agenda provides separately for follow up progress reports in relation to;
- **T22/17 Follow up of Financial Planning & Management** (presented to Audit Committee March 2017).
- **Internal Audit Annual and Mid Year Reports 2016/17 & 2015/16**
- **External Audit Annual Report 2016/17**

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 on all reports with A to C Opinions, are being monitored in-house.

Points Subject to National Initiatives and transfers to Datix
No new action points have been deferred as a result of national initiatives, and 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 July 2017.

Derek Colley
Financial Governance Accountant
August 2017

Lindsay Bedford
Director of Finance

NHS TAYSIDE **APPENDIX 1**

AUDIT FOLLOW UP - FULL CYCLE UPDATE REPORT (cut off to July 2017)

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	5		1		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					
	T25/16	Medical Staff-Management of Attendance	C	30-Nov-16	2	1		1					
	T28A/16	Property Management	C	09-Jan-17	15	10		1	1		✓		
	T31/16	NHS Tayside Health Fund (Endowments)	B	11-May-16	7	4			3				
	T36A/16	Child & Adolescent Mental Health Services (CAMHS)	C-	09-Jan-17	9	7				2	✓		
2016/17	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
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 18.8.17:** Due to the complexities of the audit to be carried out and the capacity required to carry out each area, progress has been slower than planned . An ongoing revenuec resource has been transferred to the asset team to facilitate the required surveys and activity will be monitored to measure improvement.
	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.	
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 the Large Hospital Set Aside Budget. The Chief Finance Officers 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
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.
	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.

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
T36A/16	Child & Adolescent Mental Health Services (CAMHS)	Business Unit Service Manager	Oct-16		2	5	The Business Unit are working with the service improvement team as part of the DOIT programme, to establish a process and programme schedule for the completeion of demand, capacity, activity and queue work supported by improvement support for all specialties across NHS Tayside.	Further work requires to progress with regard to DCAQ
		Head of CAMHS/Clinical Lead/General Manager	Dec-16	Oct-17	2	12	A review of the service will be undertaken in partnership with the Director of Mental Health Services	The establishment level for delivery of the cliincal service continues to be reviewed.
CFE 2/16	Endowment Fund	Associate Director of Finance	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.

NHS TAYSIDE

AUDIT FOLLOW UP - FULL CYCLE UPDATE REPORT - TO JULY 2017

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	Jul-17	Aug-17	2	3	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	Meeting held on 25th July 2017, with agreemement to develop a Governance Framework . The Board Secretary os yaking this forward in conjunction with Internal Audit
	Assurance Framework	Board Secretary & Risk Manager	D	Apr-17	Oct-17	2	4	BAF reporting should be reviewed in consultation with Board members. The Board may choose to receive less detail on each risk and may find an enhanced strategic risk profile summary paper, including risk appetite and exception reporting, more beneficial for scrutiny of the overall strategic risk profile. In the interim, Internal Audit will work with the Risk Manager to identify ways in which the Datix print out report could be shortened by excluding certain sections.	On course for completion by October
	Assurance Framework	Risk Manager	D	Mar-17	Oct-17	3	8	Key Performance Indicator is included in reports to SRMG designed to measure whether risk management covers all areas and activities of the organisation.	On course for completion by October

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.

Item Number 6.2

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

FRC61/2017
AUDIT COMMITTEE
24 AUGUST, 2017

INTERNAL AUDIT REPORT T22/17 FINANCIAL PLANNING AND MANAGEMENT PROGRESS UPDATE REPORT

1. SITUATION AND BACKGROUND

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

2. ASSESSMENT

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

Text highlighted in **bold** in the appendix reflects the current status of the audit recommendations.

3. RECOMMENDATION

The Committee is requested to note the current position.

Lindsay Bedford
Director of Finance
August 2017

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
1.	Internal Audit report T28/14 – Financial Monitoring recommended that "*in order to provide even more up to date information on the most recent position, consideration could be given to scheduling F&R Committee meetings towards the end of each month to allow the same information as just reported to the government to be incorporated in the papers for the F&R Committee."* However, F&RC meetings are still held mid-month. Given the current financial position it is imperative that the F&RC receives information which is as up to date as possible. Meetings are currently scheduled so that 3 are held in the first 9 months with the remaining 3 condensed into the final three months. Whilst this is an overt decision, made for good reasons we would highlight that the Board and Transformation Programme Board also receive regular reports accompanied by verbal updates throughout the year,	As part of the ongoing review of the Finance and Resources Committee operations, consideration should be given to changing the frequency and timing of meetings for financial year 2017/18 to reflect the delivery of savings moving from in-year savings skewed to the final quarter, to a longer term programme of savings linked to transformational change. .	**2**	In conjunction with the Chair of the Finance & Resources Committee the frequency and timing of the meetings will be reviewed.	Director of Finance May 2017 **Discussion with Chair of the Finance and Resources Committee taken place.** **Finance and Resources Committee meetings for 2018/19 will be arranged to be held towards the end of a month.** **The profile of meeting dates will also be considered and where necessary, additional meetings will be constituted outwith the agreed programme of meetings for informal updates.**
2.	From our review of recent Corporate Financial Reports, the use of complex, technical NHS accounting terms was still apparent; issues were often described in	The format of the Corporate Financial Report should be further revisited to ensure that future reports present a	**2**	The Corporate Financial Report will continue to be reviewed to ensure that it provides members with the optimal level of information in order to present a clear	Director of Finance April 2017 **The Corporate**

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
	isolation rather than being presented in a way which would allow the reader to readily understand: • the accumulated financial position of the Board, • the steps required to achieve financial targets and, • the impact that these steps may have on service delivery and performance in both the short and longer term.	clear picture of the accumulated financial position of the Board, the steps required to achieve financial targets and the impact that these steps may have on service delivery and performance in both the short and longer term. Consideration should be given to a glossary of financial terms being provided as a standing appendix to all Financial papers to the Board and F&RC.	**3**	picture of the financial position of the Board and the steps required to achieve financial targets. A glossary will be developed	**Financial Report for 2017/18 will build on the improvements introduced last year, taking cognisance of the audit points raised.** **Technical accounting terms will be defined as required.** Director of Finance April 2017
3.	There is a risk that the income from SGHSCD allocations previously utilised to fund the deferred expenditure from the previous year will not be accessible in the same way that it has been previously.	Whilst the Financial Framework to be presented to the Board in March 2017 contains detailed proposals to reduce the level of deferred expenditure over the 5 year cycle, Board Committed Earmarks should be specifically incorporated into the Finance BAF and specific monitoring arrangements put in place so that the F&R Committee can monitor its status throughout the year and understand its underlying impact on the	**1**	The Financial Framework to be presented to the Board in March 2017 contains detailed proposals to reduce the level of deferred expenditure over the 5 year cycle. The appropriate level of reporting will be put in place for the Finance & Resources Committee to monitor its status throughout the year	Director of Finance April 2017 **NHS Tayside Board approved Financial Framework in March 2017.** **Enhanced reporting will feature in the Finance and Resources Committee reports in 2017/18.**

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
		year-end financial position and on future years.			
4.	The Public Services Reform (Scotland) Act 2010 places a duty onto public bodies to provide information on the exercise of functions including: '*As soon as is reasonably practicable after the end of each financial year each listed public body must publish a statement of the steps that it has taken during that financial year […] to improve efficiency, effectiveness and economy in the exercise of its functions*.' Information relating to 2012/13 has been published on the NHST website, but no such information has been posted in relation to subsequent years.	The information on efficiency, effectiveness and economy required under the Public Services Reform (Scotland) Act 2010 should be published on the Board website.	**3**	The required information will be published on the Board website	Director of Finance June 2017 **This is acknowledged within the External Audit report also. Public Performance reporting will be further developed and made readily available on the NHS Tayside website. This will be considered in full and adopted by December 2017. The Director of Performance and Board Secretary will have a role in implementing.**
5.	There is currently no detailed guidance describing the budget process and NHS Tayside's approach to this. It is acknowledged that Annex 3 of the Standing Financial Instructions (SFIs) does give some brief guidance on this topic but in our view this does not provide sufficient detail for finance staff	Detailed guidance should be developed on the budget process adopted in NHS Tayside to guide finance staff and budget holders through the budget setting process for financial year 2017/18.	**2**	In line with the revised Business Planning process, the Standing Financial Instructions will be updated. Where appropriate more detailed operational guidance will be developed. This will continuously be reviewed.	Director of Finance September 2017 **Detailed guidance once developed will be widely shared prior to seeking approval and adoption by**

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
	or budget holders.				**both Finance & Resources Committee and Audit Committee.**
6.	The new budget setting process for financial year 2017/18 will involve a move away from the incremental, retrospective financial management towards a longer term commitment to the delivery of transformational change and financial sustainability. A shift in emphasis is required to reflect the changing role of finance staff in monitoring and reporting on financial performance but also supporting the delivery of efficiency savings and providing financial support to major transformational change projects. This will be a difficult balance to achieve and maintain given the financial pressures facing all corporate support functions. In order to be successful this change requires to be reflected in a planned approach to the training and recruitment of Finance staff.	A Finance Workforce Plan should be developed to ensure that a planned approach to the training and recruitment of finance staff is in place to ensure that there is sufficient capacity to meet the changing demands which will be placed on Finance staff to support the delivery of transformational change and achieve financial sustainability.	**2**	Recent recruitment approaches and the development of the Finance microsite will continue. Links will be enhanced with the national training resource to support the development of finance staff to create a planned approach to training.	Director Of Finance September 2017 **The approved Finance Function structure will be in place by end of August.** **Additional resources in support of both the revised business planning and budgeting process and the Transformation Programme have been approved and currently being appointed to.** **Links remain with the national training unit**

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
					creating a planned approach to training.
7.	The Corporate Financial Report to the October 2016 meeting of the Board highlights the fact that £3.2m of savings are required from deferred expenditure brought forward and board reserves. However, it is not clear how these savings will be delivered and this has not been explained to the Board.	Future reporting to the Board and the Finance and Resources Committee should clearly explain the steps which are being taken to deliver the £3.2m savings required from expenditure brought forward and board reserves and the impact this will have on the delivery of the projects which the SGHSCD allocation was intended to deliver. In addition, the year end reporting should explicitly highlight the deferral of expenditure into the following financial year, the impact this has had on the achievement of financial targets and the knock-on implications which deferred expenditure will have on future levels of savings required.	**2**	An enhanced level of reporting has already been established as part of the Corporate Finance Report. The year end report will incorporate any impact flowing into the following financial year.	Director of Finance March 2017 **The Deferred Spend target at the end of March 2017 matched the planned level. There are no formal implications going forward into 2017/18.**
8.	The Corporate Financial Report considered by the NHST Board in October 2016 does not differentiate between recurring and non-recurring efficiency savings, although the narrative does recognise that the Financial Framework sets a target of 40% of	The layout of the Corporate Financial Report should be further revisited to include: • a breakdown of recurring and non-recurring savings	**2**	Reports to the most recent standing committees have already incorporated this enhanced level of reporting.	Actioned

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
	efficiency savings on a recurring basis. However, the proportion of savings delivered on a recurring basis is not reported and therefore it is not possible to gauge performance against the 40% target or the impact any shortfall in recurring savings will have on future financial years. A supplementary report on 'Forecast Outturn and Further Actions' was considered in the private session of the NHST Board meeting on 27 October 2016 and this report does differentiate between recurring and non-recurring savings and provides a breakdown by workstream /initiative. However, the report does not make it clear whether these are identified savings to date or the projected savings position as at 31 March 2017.	identified. • The quantified impact of any shortfall against the 40% recurring target on future financial years. Any savings relating to short/ term accelerated actions should be reflected in the calculation of the performance target to ensure accuracy and transparency. • A projected savings position as at 31 March split by recurring and non-recurring. • Performance against the % recurring savings target. • An estimate of the knock-on impact on future financial years of any shortfall in recurring savings.			
9.	Work is ongoing to review both corporate and operational financial risks with input from the Risk Management Department.	It is imperative that the work to refresh and update financial risks is progressed as a matter of urgency and the actions required to effectively manage these risks are reported timeously to the F&RC	**2**	The review of Corporate and Operational Risks is a feature at each and every Finance & Resources Committee meeting. Updates to the Risk Profile and mitigating actions will continue to be highlighted.	Director of Finance Immediate **Update to Strategic Financial Plan Risk reported to NHS Tayside Board 4th**

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
					May
10.	NHS Tayside has agreed with ISD Scotland to become a test site for NSS Discovery. Moving forward it is imperative that the areas of operation where NHS Tayside is out of synch with its peer Boards are explored and appropriately challenged as part of the budget setting process.	The budget setting process for 2017/18 should take account of the outputs from benchmarking activity with peer Boards to identify and address significant variances in spend which cannot be justified.	**2**	Local Delivery Plans require the Board to incorporate a quality and cost assessed improvement pan to respond to Productive Opportunities identified from benchmarked performance. This will inform the efficiency programme.	Director of Finance June 2017 **A programme of Productive Opportunity areas has been established. The Director of Strategic Change continues to review.**

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

ITEM NUMBER 6.3

AUDIT 62/2017
AUDIT COMMITTEE
24 AUGUST, 2017

FOLLOW UP ON INTERNAL AUDIT ANNUAL AND MID YEAR REPORTS

1. SITUATION AND BACKGROUND

The purpose of the report is to advise the Committee of progress with the following Internal Audit Annual and Mid Year Reports:-

i. Annual Internal Audit Report 2016/17;
ii. Interim Evaluation of Internal Control Framework, and
iii. Internal Audit Interim and Annual Reports 2015/16 - Outstanding and In Progress actions as at start of financial year 2017/18

2. ASSESSMENT

Progress with the above Internal Audit Annual and Mid Year Reports are as noted in the attached Appendix. Updated or new comments are highlighted in bold for ease.

3. RECOMMENDATIONS

The Committee is requested to note progress contained within the attached Appendix.

Lindsay Bedford
Director of Finance
August 2017

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 **Complete**
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 commitment to grow talent, skill and leadership capability was noted.	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
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	**2**	Agreed.	Chief Executive 31 December 2017

Ref	Finding	Audit Recommendation	Priority	Management Response/ Action	Action by/Date
		Chief Executive's department, under the auspices of the Board Secretary.			
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 **Proposed three meetings per year with joint chairmanship with Chief Social Worker of Local Authorities.**
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 **Complete**

Ref	Finding	Audit Recommendation	Priority	Management Response/ Action	Action by/Date
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 **Complete**
	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 **On track to deliver within planned 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 22nd 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 **Complete**

Ref	Finding	Audit Recommendation	Priority	Management Response/ Action	Action by/Date
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 **Review of admin systems undertaken by Associate Medical Director for Professional Governance.**
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 **Scheduling of meetings arranged. Review of remit ongoing**
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 **Complete**

INTERIM EVALUATION OF INTERNAL CONTROL FRAMEWORK

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
1.	The Chief Executive presented a report to the Board on 27 October 2016 setting out the new senior management structure and whilst that paper did not provide overt evidence of how the Board can be assured on capacity and capability, we have been informed that the Chief Executive will provide a further paper detailing the final senior management structure to the Remuneration Committee in March 2017 and a more detailed paper to the Board in April 2017, which will provide the necessary assurances.	The Chief Executive's Board paper detailing the final senior management structure should clearly set out the reporting lines and responsibilities of the senior management team in order to provide robust assurance that NHS Tayside has the capacity and capability to deliver its operational and strategic objectives.	**2**	The Chief Executive will update the Remuneration Committee in March 2017 on the emerging direct reports sub structure and provide the appropriate assurances to the April 2017 Board meeting.	Chief Executive April 2017 **Complete**
2.	The unbalanced 2016/17 LDP was not formally approved by the SGHSCD and the Board has not received an LDP progress report during 2016/17.	Tayside NHS Board should be provided with an LDP progress report.	**2**	Financial aspects are reported to the Finance & Resources Committee and the Tayside NHS Board at each meeting. Performance reporting is provided at each meeting of the Tayside NHS Board. A formal LDP mid year report on progress within the six strategic priority areas will be incorporated into the Tayside NHS Board workplan.	Chief Executive October 2017 **To be considered as part of agenda setting.**

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
3.	Whilst progress is being made in agreeing formally set out precise responsibilities of the Health Board, Council and the IJB in relation to operational activities, there is no guarantee that key principles will be agreed before year-end and there is an urgent need to agree year-end assurance arrangements between the Board and the IJBs.	As a priority, key principles for HSCI and year-end assurance arrangements between the Board and the IJBs should be formally agreed and documented.	**1**	Work is ongoing involving the Chief Internal Auditor. An overview document detailing the governance processes will be produced for agreement by the year end.	Board Secretary May 2017 **Year end assurance arrangements were agreed and documented.** **At a meeting held on 25July 2017, it was agreed that a Governance Framework should be developed. The Board Secretary is taking this forward in conjunction with Internal Audit.**
4.	In February 2016 the CCGC authorised the review of the Clinical Governance Strategy, including development of the framework for IJB performance and clinical governance for Health and Social Care. No further update has been received and it is not clear when an updated Strategy is to come forward for approval. This update is not referenced in the Committee's remit or workplan for 2016/17, or that of the CQF.	The review and update of the Clinical Governance Strategy should be progressed and included in workplans for the committees and groups involved.	**2**	An update to the Clinical Governance Strategy is being progressed and will be brought to Committee on completion. The workplan will also be updated.	Medical Director/Nurse Director September 2017 **Complete**

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
5.	Clarification in respect of the clinical governance and reporting arrangements for integrated services remains a work in progress. Arrangements set out in 'Getting it Right for Everyone', have not yet been fully implemented in that the R1 Group has not met and therefore has not provided assurance to the Board and IJBs as originally envisaged.	The updated Clinical Governance Strategy should clarify clinical governance arrangements for integrated services, including the method and level of reporting by the IJBs and for recently established regional services. These arrangements should be included in the CCGC's terms of reference and workplan.	**2**	An update to the Clinical Governance Strategy is being progressed and will be brought to Committee on completion. The CCGC's terms of reference and workplan will also be updated	Medical Director/Nurse Director **Complete**
6.	The reporting line from the CQF to the CCGC provides valuable upward assurance to the committee. However, currently the CQF meetings frequently fall just after a CCGC meeting date, meaning that they may be a time delay on reporting.	Management should consider reviewing the scheduling of meetings to allow CQF minutes and assurance reports to be reported more timeously to the CCGC.	**3**	Actioned	Medical Director/Nurse Director **Complete**

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
7.	A lack of capacity and administration to support performance review meetings has been highlighted to the CQF. Two risks have been recorded on Datix in relation to this. No Mental Health performance review meetings have taken place since April 2016. There is a risk that any defence against the likely prosecution in relation to the deaths by suicide of two patients in Moredun Ward, Murray Royal Hospital could be compromised by an ongoing failure to clarify governance and assurance arrangements and to maintain appropriate review processes in the interim, most particularly through the performance reviews which are intended to be a mainstay of clinical governance arrangements.	Management should ensure there is sufficient capacity and administration to support performance review meetings across all departments and particularly for Mental Health.	**2**	A Mental Health Performance Review will take place in March 2017 with the timetabling of future meetings reflective of the normal cycle of Performance review meetings for operational areas.	Medical Director March 2017 **Complete**
8.	The SGC meets four times per annum and there will only be one further meeting in 2016/17 following agreement of the SGC Terms of Reference and workplan in December 2016. During 2016/17 SGC items have been frequently deferred to the next meeting and this may impact on the Committee's ability to complete their 2016/17 work plan.	Agenda setting for the last SGC of 2016/17 needs to ensure that the committee can demonstrate completion of its workplan.	**2**	Noted	Director of HR & OD March 2017 **Complete**
	The Staff Governance Standard was a Standing Agenda item at each of the SGC meetings in the year so far and three of the five strands of the Standard have been considered. This means that the SGC will have to cover the remaining two strands at their March 2017 meeting.			Noted	Director of HR & OD March 2017 **Complete**

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

Internal Audit Interim and Annual Reports 2015/16 - Outstanding and In Progress actions as at start of financial year 2017/18

Ref.	Control Issue	Audit Recommendation	Priority	Management Response/ Action	Action by/Date	DoF Update
3	**HSCI – this recommendation incorporates 2015/16 Interim Review recommendation 6.**					
	Tayside NHS Board has not overtly considered the impact of HSCI on the accountability structures currently in place, and those required for the future. Following our Interim Review, the HSCI BAF was updated in March 2016 but does not include all of the complex governance and accountability issues referred to above.	In 2016/17 Tayside NHS Board will need to undertake substantial further work to reflect the impact of HSCI on its governance arrangements, including update of the Standing Orders and Scheme of Reservation & Delegation to take account of both revised management structures and HSCI. There needs to be a clear, consistent and coherent understanding of accountabilities so that all parties can design comprehensive assurance systems which reflect that shared understanding, minimise duplication as far as possible and ensure that there are no omissions. The review should include update of the HSCI corporate risk and alignment, as far as practicable, of the IJB and NHS Tayside risk registers.	**2**	The impact of HSCI on the Board's governance arrangements will be reviewed, recognising the complex governance and accountability issues.	Chief Executive/ HSCI Chief Officers 31 Oct 2016	**At a meeting held on 25 July 2017, it was agreed that a Governance Framework should be developed. The Board Secretary is taking this forward in conjunction with Internal Audit.**

Action Ref.	Control Issue	Audit Recommendation	Priority	Management Response/ Action	Action by/Date	DoF Update
	2015/16 Interim Review: The 3 December 2015 Audit Scotland report on HSCI commented on the risks posed by the complex governance and accountability arrangements under HSCI, workforce issues and relating to funding and integrated budgets. The report makes a number of recommendations to help stakeholders, including NHS Boards, address these issues.	The 3 December 2015 Audit Scotland report on HSCI should be presented to Tayside NHS Board to prompt consideration of risks and any necessary actions to be taken i.e. the HSCI BAF should be considered in the light of the Audit Scotland report.	**2**	A report is being prepared for the Clinical and Care Governance Committee to measure the position on HSCI arrangements against the recommendations of the Audit Scotland report.	Director of Primary & Community Care Chief Officers 29 Feb 2016 and ongoing	Once agreement is reached on the Assurance system this can be applied to the clinical governance processes and they can be updated accordingly. **At a meeting held on 25 July 2017, it was agreed that a Governance Framework should be developed. The Board Secretary is taking this forward in conjunction with Internal Audit.**
	At the October 2015 Board meeting, the HSCI strategic risk rating was downgraded from amber to yellow and current progress was assessed as 'On target' based on the timetable in place. Whilst a project plan for IJB compliance with legislation and guidance by April 2016 is in place and is monitored by the Partnership Collaborative, there is no highlight or exception reporting to Board that would flag up any risks to achievement e.g. overdue actions.	The BAF should also be reviewed to ensure that risks to achievement are monitored appropriately.	**2**	The Board Assurance Framework and Risk profile for HSCI will be continuously reviewed and reported through the Strategic Risk management Group and in regular reporting through the NHS Board and Committees.	Director of Primary & Community Care Board Secretary Chief Officers 29 Feb 2016 and ongoing	Once agreement is reached on the Assurance system the Board's Assurance Framework can be reassessed to take account of risks that may no longer be required to be within the Board's Assurance Framework or which risks may now be a shared risk within the Board Assurance Framework. **At a meeting held on 25 July 2017, it was agreed that a Governance Framework should be developed. The Board Secretary is taking this forward in conjunction with Internal Audit.**

Action Ref.	Control Issue	Audit Recommendation	Priority	Management Response/ Action	Action by/Date	DoF Update
			2			
		The Board should also explore its shared understanding of governance under the new arrangements, possibly through the use of various scenarios which could draw out particular aspects of assurance, strategy and control.		The Board will undertake a scenario planning exercise to test wider governance arrangements as previously undertaken as part of the Clinical and care Governance Framework arrangements.	Director of Primary & Community Care Board Secretary Chief Officers	**It has been agreed that scenario planning would be put on hold at present**
5	The Corporate Financial report for the year ended 31 March 2016 shows a 31% increase in agency and bank costs. Although the December 2015 SGC meeting, questioned whether there should be a separate report in relation to spend on Agency staffing, this did not result in an action point or additional reporting.	This issue should be added to the SGC workplan.	**3**	Agreed. Changes to the Staff Governance Committee Terms of Reference will be discussed at its meeting in June 2016, with a view to amendment supporting closer alignment with assurance on key business performance. Final amendments will be adopted at the following meeting of the Committee in September 2016.	Director of HR & OD 30 Sep 2016	**Complete**
6	The Integration Schemes state that '*The Parties will deliver, within 3 months of the establishment of the IJB, a Workforce and Organisational Development Strategy for integrated functions. The Strategy will set out how*	The requirement to develop a Workforce and Organisational Development Strategy for integrated functions needs to be included in SGC remit and appropriate processes established to develop the Strategy.	**3**	Agreed. Changes to the Staff Governance Committee Terms of Reference will be discussed at its meeting in June 2016, with a view to amendment supporting closer alignment with assurance on key business performance. Final	Director of HR & OD 30 Sep 2016	**Action superseded.** **Local Partnership model agreed for IJBs which ensures local consideration of Staff Governance elements, including development of Workforce plans, in partnership, with**

Action Ref.	Control Issue	Audit Recommendation	Priority	Management Response/ Action	Action by/Date	DoF Update
	support and development will be provided for and to the workforce. Reviews of the Strategy will be undertaken in conjunction with the IJB'.			amendments will be adopted at the following meeting of the Committee in September 2016.		**assurance reporting to SGC via APF. Business performance measures and delivery by IJBs included in proposed corporate dashboard, to be considered at March 2017 of the SGC.**
8	The draft Data Quality Strategy was presented to the September 2015 IG Committee meeting and no further updates have been provided since. The draft policy has not yet been formally approved.	NHS Tayside should formally approve the draft Data Quality Strategy at the earliest opportunity.	**3**	The September 2015 IG Committee agreed that to fully develop the draft Data Quality Strategy it would need to be presented to and be discussed with key individuals and relevant groups to progress this to a complete Strategy. Therefore, the progress with the development of this Strategy will be reported to the IG Committee for monitoring and input. Once completed and agreed by the IG Committee the Strategy will be widely circulated for consultation and the proposed final version will be formally approved by the F&R Committee.	Board Secretary & IG Manager 31 Mar 2018	**In progress.** **Draft Data Quality Strategy was reported to the September 2015 meeting of the IG Committee where it was agreed that to fully develop the draft Data Quality Strategy, it would need to be presented to and discussed with key individuals and relevant groups and progress with development of this Strategy would be reported to the IGC for monitoring and input. Once complete and agreed by the IGC the Strategy will be widely circulated for consultation and the proposed final version will be presented to the F&R Committee for final approval.**

Original Ref.	Control Issue	Audit Recommendation	Priority	Management Response/ Action	Action by/Date	DoF Update
2	The Board has received no formal output on the review of the organisation's strategic planning infrastructure to ensure that it was fit for purpose. The 25 June 2015 Board was informed that there was no dedicated planning function within NHS Tayside and that the draft Clinical Services Strategy had been put together in a very short timescale. A Director of Health and Care Strategy has now been appointed.	The process for implementation of the revised strategic planning arrangements, including the workstreams, should be completed and reported to Board. As with the Strategic Transformation Programme referred to above (and finance below), the Board should review the resources and capacity available to deliver the required improvements.	**2**	The Chief Executive is reviewing the corporate structure to ensure all areas are covered in relevant portfolios.	Chief Executive 30 Apr 2016	**The Chief Executive updated the Remuneration Committee in March 2017 on the direct reports sub structure and provided the appropriate assurances to the April 2017 Board meeting.**
	In the context of a financial overspend, performance on key targets has not been remediated and performance on TTG, a statutory obligation requiring disclosure in the 2014/15 accounts, has worsened significantly.	The Board should consider whether Performance Reports should contain more details in relation to the areas in which performance is not acceptable, action being taken to address these and the effectiveness of actions taken to date.	**2**	Performance reporting is being reviewed to address the issues highlighted in this report.	Director of Acute Services/ Medical Director – Operational Unit 30 Jun 2016	**The Performance Reports to Board continue to be enhanced to provide a comprehensive understanding of the effectiveness of actions taken.**

Original Ref.	Control Issue	Audit Recommendation	Priority	Management Response/ Action	Action by/Date	DoF Update
8	The analysis of expenditure shows that staffing issues are having a significant impact on NHS Tayside's financial position, particularly the level of supplementary spend. These issues relate to risks assigned to, and considered by the Staff Governance Committee. However, in line with national guidance, the work of the SGC has been primarily focused on the Staff Governance Standard. The move to more frequent reporting on the relevant BAFs will be important and should provide the opportunity for the SGC to consider the balance of its workload and reflect on whether there is sufficient focus given to these areas particularly the suitability and implementation of the workforce plan.	The SGC should consider its remit, workplan and agenda so that key workforce issues are being addressed and mitigating actions are in place and working effectively. In particular, it should ensure that the Workforce Plan and Staff Governance Action Plan support the Boards achievement of its operational and Strategic objectives, and are being progressed. Consideration should also be given to ways of ensuring that both the F&R Committee and the Staff Governance Committee can provide their own perspective on these important drivers of cost and performance, without duplicating effort.	**2**	A review has commenced of the Staff Governance Committee work plan. This will more clearly focus the work of the Committee on key performance indicators, including agreed workforce cost and outcome measures, as reflected in associated changes in the F&R Committee terms of reference.	Director of Human Resources 30 June 2016.	**Revised Committee Terms of Reference agreed at the December 2016 meeting. SGC and F&R joint reporting work commissioned and considered in full at the SGC at its meeting in March 2017.**

Original Ref.	Control Issue	Audit Recommendation	Priority	Management Response/ Action	Action by/Date	DoF Update
9	The Staff Governance Monitoring Report was noted by the SGC on 20 October 2015 when the Committee highlighted that the action plan did not provide details as to where the organisation currently sat within the Standards. It was noted that this was a working document which would evolve over the coming years and data in relation to Standards would be forthcoming.	Whilst the SGC noted that the Staff Governance Action Plan 2015-17 6 monthly Progress Report is a working document which would evolve over the coming years and data in relation to Standards would be forthcoming, management should ensure that the report provides clear data on achievement of targets within timescales and Key Performance Indicators (KPIs).	**2**	Staff Governance Action Plan key performance indicators and data measures will form part of the Staff Governance Committee work plan, as monitored and actioned by the Local Partnership Foras.	Director of Human Resources 30 Jun 2016	**SAAT responses prepared in partnership, agreed via APF, presented to Staff Governance Committee and submitted as agreed to Scottish Government. National review of SAAT reporting underway; future format to be confirmed. Scottish Government has confirmed it will not undertake a traditional annual Staff Governance Monitoring/SAAT exercise for 2016/17.**
16	Key staff have been lost from the finance team, compounding an overall reduction in senior finance officers in recent years. No formal restructuring of the finance department has yet taken place, nor has there been a comprehensive review of resources and structure.	An exercise should be undertaken to assess the current capability of the Finance Department to determine whether the Department has the resources required, configured in the best way to meet the significant financial challenges faced by NHS Tayside.	**2**	A review is presently underway to consider a revised staffing structure and the outcome will be reported to the appropriate Standing Committee.	Interim Director of Finance 31 Mar 2016	**The approved Finance Function structure will be in place by end of August.** **Additional resources in support of both the revised business planning and budgeting process and the Transformation Programme have been approved and currently being appointed to.**

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

Item Number 6.4

AUDIT63/2017
Audit Committee
24 August 2017

FOLLOW UP ON EXTERNAL AUDIT ANNUAL REPORT 2016/17

Lindsay Bedford
Director of Finance

August 2017

NHS TAYSIDE
2016/17 ANNUAL AUDIT REPORT

Action plan 2016/17

2016/17 recommendations for improvement

Issue/Risk	Recommendation	Agreed Management action/timing	Progress Update
1. Balance Sheet: Revaluation Reserve The NHS Scotland Unified Board Accounts Manual requires an amount equal to the excess of actual depreciation over depreciation based on the historic cost to be transferred from the revaluation reserve to the general fund. The board has not been accounting for this transfer in 2016/17 or in previous years. The board has estimated the value of the transfer for this year to be £7.2 million. **Risk** The classification of reserve balances reported by the board will be incorrect if the annual depreciation adjustment is not made.	The board should introduce a process to ensure the appropriate transfer is calculated and applied from 2017/18.	The methodology has now been applied in 2016/17 and will be used in future years. Responsible officer: Director of Finance March 2018	No further action

Issue/Risk	Recommendation	Agreed Management action/timing	Progress Update
2. Efficiency savings For 2017/18 the board is aiming to deliver £45.8 million (6.4% of baseline RRL) of savings. The board has considered £5 million of these savings as high risk and they may not materialise. From 2017/18, the board is required to make savings of £40 million per annum to repay brokerage and break even. **Risk** The board may not be able to deliver the targeted savings in 2017/18 and later years.	The board should ensure that savings plans are urgently developed which fully detail the delivery of the 2017/18 savings and how the £5 million high risk element will be delivered. Detailed plans showing how the savings requirements of £40 million per annum thereafter will be achieved should also be prepared and progress on savings reported to the Finance and Resources Committee and the Board.	The Board continues to develop and progress efficiency savings plans across the wide spectrum of its cost base together with the exploration of income generation opportunities. Updates will be provided to each Transformation Programme Board, Finance & Resources Committee and the Tayside NHS Board. Work will progress in 2017/18 on the Integrated Clinical Strategy and exploration through collaboration with colleagues on regional working setting a baseline for future year efficiency opportunities. Responsible officer: Director of Finance Ongoing	Forecast outturn following Quarter 1 results and known deliverables prepared and reported. Further actions to contain spend in year considered by Executive Review Team and approved for progression. Regional discussions progressing with joint strategy for cost containment and consistent adoption of measures being considered. These are reported to the Regional Board through the Director of Finance representative. Integrated Clinical Strategy work progressing and remains to be reported to the Tayside NHS Board in December 2017.

Issue/Risk	Recommendation	Agreed Management action/timing	Progress Update
3. Transformation programme			
NHS Tayside is reliant on its five year transformation programme to improve the sustainability of services and enhance the quality of care. It is critical that the pace of change is monitored closely to ensure the programme is successful in delivering these objectives in a timely manner. The work of the Assurance and Advisory Group will inform on the deliverability of the programme. **Risk** The transformation programme may not deliver the changes needed to improve the sustainability of services and enhance the quality of care.	The board should ensure that the pace of transformational change is closely monitored and reports submitted to the Board on the transformation programme. The reports should take account of any findings reported by the Assurance and Advisory Group in their staging report.	The Transformation Programme Board is designed to support the delivery of changes that will result in improving quality, safety and patient outcomes and cost effective service delivery. Cognisance will be taken of the findings from the Assurance and Advisory Group in their staging report. Responsible officer: Chief Executive Ongoing	A tracker document has been developed in response to the Assurance and Advisory Group Recommendations. The Board's response to the 10 recommendations was presented to the Transformation Programme Board in August. In year delivery of efficiencies remains grounded in the effective use and deployment of resources with the service transformation and productive opportunities being less prevalent in terms of cash release in year but driving the opportunity for full year benefit going into 2018/19 and beyond. The revised Business Planning and Budgeting model will assist this process.

Issue/Risk	Recommendation	Agreed Management action/timing	Progress Update
4. Financial capacity 2017/18 is a critical year in delivering efficiencies through the transformation programme and therefore it is essential that an appropriate finance structure is in place and is appropriately skilled to support the transformation process in a timely manner. The Finance Directorate restructuring is currently in transition, with a number of vacancies remaining at management levels. We understand that the revised structure will not be fully in place before the Autumn of this year. **Risk** The board may not have sufficient financial capacity to support the transformation programme as well as the ongoing, routine financial activities.	The board should closely monitor the restructuring of the finance directorate to ensure appropriate financial capacity is in place to support the transformation programme. The board should monitor the pace of change with the restructuring to ensure support is provided in a timely manner.	Updates will be provided to both the Audit Committee and Finance & Resources Committee on the progress towards the agreed revision to the structure. Financial capacity together with other corporate function support, where appropriate, will be agreed with the Chief Executive. Responsible officers: Director of Finance/Chief Executive September 2017 and ongoing	The direct report structure will be fully appointed to by the end of August. Additional resources to support the Transformation Programme and the revised Business Planning and Budgetting work have also progressed with appointments also to be confirmed by the end of August. This bolstering of the financial capacity will support the process of driving the increased pace of change required across the organisation through the provision of robust, accurate and timely financial information and analysis

Issue/Risk	Recommendation	Agreed Management action/timing	Progress Update
5. Risk management Internal Audit reported that there is a lack of clarity of the impact of HSCI on the accountability structures in place and there are a number of elements of the Integration Schemes and risk management systems in each organisation which do not appear to be consistent. An action plan point was raised by Internal Audit recommending that the responsibilities should be agreed and copied into the BAF framework as a matter of urgency. **Risk** Risks in relation to IJB related activities may not be fully understood and managed putting patient care at risk.	The board should ensure that Internal Audit's recommendation in relation to risks arising from IJB related responsibilities is fully implemented and that the respective board and IJB responsibilities are agreed and incorporated into the BAF framework as a matter of urgency.	Actions in relation to this recommendation are being progressed and will be reported to the Audit Committee. Responsible officer: Board Secretary September 2017	At the meeting held on 25 July 2017, it was agreed that a Governance Framework should be developed and the Board Secretary is taking this forward in conjunction with Internal Audit. A meeting has been arranged to discuss governance arrangements in Perth and Kinross on 4 September 2017. An update will come to the next Audit Committee meeting.

Issue/Risk	Recommendation	Agreed Management action/timing	Progress Update
6. Public performance reporting			
The board's performance information is not accumulated and made readily available on the NHS Tayside website. In our experience other organisations have developed a performance page within their website for local residents to obtain ready access to performance information. **Risk** Local residents do not have access to composite performance information.	The board should consider its arrangements for public performance reporting, including developing a performance page that local residents can access on the board's website. The performance page should be well sign posted.	Public performance reporting will be further developed and made readily available on the NHS Tayside website. Responsible officers: Director of Performance/Board Secretary December 2017	Progression of this action is being taken forward in line with the identified timetable.
7. Clinical Strategy			
NHS Tayside does not have an overarching integrated clinical strategy, which clearly articulates and prioritises its clinical aims. The Board has recognised this and plans to address this gap by developing an overarching clinical strategy, however there is a lack of clarity over when this is planned to be delivered. **Risk** Until the board puts an over- arching clinical strategy in place, there is a significant risk that the transformation programme will not deliver the right	An over-arching clinical strategy should be developed as soon as possible and should be approved by the Board. This should form the basis for the board's service and financial planning.	A paper will be presented to the Tayside NHS Board in June 2017 seeking permission to undertake this strategy work. Mental Health and Shaping Surgical Services will be the first aspects to be presented to the Tayside NHS Board. The overarching clinical strategy will be presented to the Board in December 2017. Responsible officers: Chief Executive/Medical Director/Nurse Director December 2017	Progression of this action is being taken forward in line with the identified timetable.

change, at the right time.

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

Item Number 7.1

AUDIT64/2017
Audit Committee
24 August 2017

FTF AUDIT AND MANAGEMENT SERVICES - INTERNAL AUDIT PROGRESS REPORT

1. SITUATION AND BACKGROUND

The aim of this paper is to brief the Audit Committee on the progress on the 2016/17 and 2017/18 internal audit plans.

The Internal Audit year runs from May to April. Since the date of the last meeting the Internal Audit Team has continued to progress the 2016/17 and 2017/18 plans under the supervision of the Chief Internal Auditor. Audit work is planned so as to allow the Chief Internal Auditor to provide the necessary assurances prior to the signing of the accounts.

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

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

2. ASSESSMENT

Progress on the 2016/17 and 2017/18 plans is generally as expected, although there have been some delays due to sickness absence which may result in some audits being delayed, although still delivered in-year.

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

As of 11 August 2017 actual input against the 2017/18 NHS Tayside plan stood at 90 days (16%) of the 561 days planned audit input for 2017/18. Whilst there have been short-term staffing issues within the Tayside team, we can confirm that we will complete audit work sufficient to allow the Chief Internal Auditor to provide his opinion on the adequacy and effectiveness of internal controls at year-end, although some audit products may be delivered later than originally planned.

Completed Audit Work

The following audit products, with the audit opinion shown, have been issued since the Audit Committee meeting on 11 May 2017. A summary of each report is included for information within Appendix 1 'Summary of Report Content'.

		Opinion	Draft Issued	Finalised
2016/17				
T26/17	Tayside Health Fund	A/B	4 May 2017	24 May 2017
T28/17	Information Security Framework	C	24 July 2017	11 August 2017
AN05-17	Post Integration Due Diligence	N/A	26 June 2017	26 June 2017
AN07-17	Angus IJB Financial Management	D-	11 April 2017	19 June 2017
PK06-17	Perth & Kinross IJB Delayed Discharges	B-	20 June 2017	23 June 2017
2017/18				
T06T07/18	Governance Statement & Annual Report 2016/17	N/A	8 June 2017	16 June 2017
T23/18	Post Transaction Monitoring and Property disposals	A	8 August 2017	11 August 2017
T30A/18	Contingency Review – Annual Managed Expenditure Provisions	N/A	24 July 2017	14 August 2017
AN03-18	Angus IJB Annual Report 2016/17	N/A	20 June 2017	20 June 2017
D03-18	Dundee IJB Annual Report 2016/17	N/A	5 July 2017	7 July 2017
PK03-18	Perth & Kinross IJB Annual Report 2016/17	N/A	21 June 2017	23 June 2017

Draft Reports Issued

		Draft Issued
2016/17		
AN04-17	Angus IJB Performance Management	21 August 2017

Work in Progress

The following reflects the work in progress on the 2016/17 and 2017/18 plans, where assignment plans have been approved:-

		Planned Audit Committee date
2016/17		
T16/17	Adverse Events Management	Dec 2017
T18/17	Food, Fluid & Nutrition	Dec 2017
D06-17	Dundee IJB Workforce	Dec 2017
D07-17	Dundee IJB Clinical & Professional Governance	Dec 2017
PK07-17	Perth & Kinross IJB Clinical & Professional Governance	Dec 2017
2017/18		
T17/18	Clinical Governance Strategy & Assurance – Mortality Reviews	Dec 2017
T27/18	National Payroll Maintenance	May 2018

Planning Commenced

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

2017/18	
T12/18	Staff and Patient Environment
T13/18	Environmental Costs
T16/18	HSCI
T18/18	Infection Control
T19/18	Medical Equipment and Devices
T20/18	Medicines Management

3. RECOMMENDATIONS

The Audit Committee is asked to note the progress on the 2016/17 and 2017/18 internal audit plans.

Barry Hudson BAcc CA
Regional Audit Manager

Lindsay Bedford
Director of Finance

Jocelyn Lyall BAcc CPFA
Acting Regional Audit Manager

August, 2017

Tayside NHS Board
Summary of Report Contents

<table>
<tr><th>Ref</th><th>Audit</th><th>Grade</th><th>Report Summary</th></tr>
<tr><td>T26/17</td><td>Tayside Health Fund</td><td>Various</td><td>The 2016/17 Tayside Health Fund Report was presented to and discussed by the Endowment Advisory Group on 6 June 2017.
<table>
<tr><th></th><th>A</th><th>B</th><th>C</th><th>D</th><th>E</th><th>F</th></tr>
<tr><td>Governance</td><td></td><td>X</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Operational Risks</td><td></td><td>X</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Financial Risk</td><td></td><td>X</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Environmental/External Factors</td><td>X</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Compliance Risk</td><td>X</td><td></td><td></td><td></td><td></td><td></td></tr>
</table></td></tr>
<tr><td>T28/17</td><td>Information Security Framework</td><td>C</td><td>In 2015 the Scottish Government issued DL (2015) 17 – Information Governance and Security Improvement Measures 2015-17 which tasked NHS Boards with improving Information Governance and Information Security by working towards an Information Security Framework in line with ISO 27001. We considered whether the requirements of DL (2015) 17 are being progressed by evaluating the content of the NHS Tayside Information Security Policy Framework Improvement and Action Plan (ISPF I&A Plan) and progress reporting associated with this.

In relation to the key requirements of DL (2015) 17 NHS Tayside has:-

• Assigned the role of SIRO to the Board Secretary
• Taken steps to ensure its ISMS conforms to the NHS Scotland Information Security Policy Framework (NHSS ISPF), albeit the steps will not be completed within the two years directed by the Scottish Government
• Developed plans to implement controls to safeguard the confidentiality, integrity and availability of information necessary for the delivery of health and care
• Provided reports to the NHS Tayside Information Governance Committee (IGC) regarding NHS Tayside's progress towards conforming to the NHSS ISPF.

We identified improvements that NHS Tayside should make to make further progress towards conformity with the NHSS ISPF including improving the accuracy of progress reporting, including more specific actions in the ISPF I&A Plan and allocating responsibility for these to specific senior managers with identified timescales for delivery.</td></tr>
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Tayside NHS Board
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AN05-17	Post Integration Due Diligence	N/A	Detailed supplementary Statutory Guidance on financial assurance was published in May 2015. This includes the following requirement for the period post integration:- • The post-integration period is a critical stage of the change process and the audit committees (or the committee(s) carrying out an equivalent function) have a key role in assessing whether the objectives of integration are on line to be achieved. We can provide assurance that in our opinion the post integration due diligence work undertaken covered the requirements of the national financial assurance guidance and the report to the Angus Integration Joint Board (IJB) provided a full picture of the risks and assumptions.
AN07-17	Angus IJB Financial Management	D-	As agreed as part of the 2016/17 internal audit plan for Angus IJB, Internal Audit reviewed the provision of Financial Management support from Angus Council regarding Adult Services. The audit was carried out by Angus Council Internal Audit on behalf of FTF as part of the agreement of shared services. The audit was carried out in the Resources Directorate (Finance section) of Angus Council and the Angus Health and Social Care Partnership. Findings therefore do not directly affect NHS Tayside. An action plan to addresses the identified weaknesses has been agreed and implementation will be followed up as part of 2017/18 work.
PK06-17	Delayed Discharges	B-	The scope of this review was to review arrangements within the Partnership to plan, support and deliver an improvement in the level of hospital and community delayed discharges. Our overall opinion was based on a positive view of arrangements at management level, albeit governance reporting at governance level required improvement.
T06/18 & T07/18	Governance Statement & Annual Report 2016/17	N/A	Report was presented in full to the June 2017 Audit Committee.
T23/18	Post Transaction Monitoring and Property Disposals	A	See report presented in full under agenda item 9
T30A/18	Contingency Review – Annual Managed Expenditure Provisions	N/A	See report presented in full under agenda item 7.2
	IJB Annual reports - overall	N/A	**Background** Guidance issued in April 2017 requires IJBs to prepare their annual accounts and governance statements in accordance with Local Authority Accounts (Scotland) Regulations 2014. To comply with these regulations and inform the preparation of the governance statement, as stated in the CIPFA framework on Delivering Good Governance in Local Government, Internal Audit is required to provide an annual assurance statement on the overall adequacy and effectiveness of the framework of governance, risk management and control.

			These separate reviews for each IJB examined the framework in place during the financial year 2016/2017 to provide assurance to the IJB Chief Officer, as Accountable Officer, that there is a sound system of internal control that supports the achievement of each IJB's objectives. To inform our assessment of the internal control framework, we developed a self assessment governance checklist for completion by management. The checklist was based on requirements of the Integration Scheme, guidance issued by the Scottish Government to support Health and Social Care Integration and best practice. It was also cross referenced to the requirements of the CIPFA 'Delivering Good Governance in Local Government Framework 2016' and supporting guidance notes for Scottish Authorities. Internal Audit validated the assessments reached through discussion with management and examination of the supporting evidence and documentation. The 2015/16 IJBs Annual Internal Audit Reports recommended that accountability and responsibilities of the IJB in respect of all governance arrangements should be clarified and agreed by the IJB, and thereafter flow through to risk management and assurance arrangements. While the challenges to describing the new HSCI relationships and governance arrangements are well understood by the parties, there remains a need to document a clear, consistent and coherent understanding of HSCI risks and accountabilities, so that comprehensive assurance systems can be developed which reflect shared understanding, minimise duplication as far as possible and ensure there are no omissions. Whilst not all key principles were formally agreed by year-end and there is no formal agreement setting out the precise responsibilities of the IJBs, Tayside NHS Board and the Councils in relation to operational activities and the exact nature of the delegation of functions to the IJBs, significant progress has been made. 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 as a clear understanding around the tripartite roles of IJB Chief Officers. Based on work undertaken the Chief Internal Auditor concluded that reliance can be placed on the IJBs governance arrangements and systems of internal controls for 2016/17 and he did not advise management of any concerns around the following: • Consistency of the Governance Statement with information that we are aware of from our work; • The format and content of the Governance Statement in relation to the relevant guidance; • The disclosure of all relevant issues. Based on our validation work, we provided assurance on key arrangements in place by 31 March 2017; as well as ongoing and planned work in 2017/18. Based on our assessment, we also recommended further issues for consideration by management. An action plan setting out a timetable for implementation will be drawn up and progress reported to each IJB Audit Committee.

Tayside NHS Board
Summary of Report Contents

AN03-18	Angus IJB Annual Report 2016/17	N/A	**Recommended further issues for consideration by management:** ◊ Formal agreement on accountability and responsibilities of the IJB in respect of all governance arrangements ◊ IJB membership (non-voting members' positions) ◊ Risk management and assurance ◊ Formal deputising arrangements ◊ Best Value ◊ Clinical, Care & Professional Governance - assurance on implementation and reporting arrangements ◊ Reporting on workforce issues, needs and opportunities
D03-18	Dundee IJB Annual Report 2016/17	N/A	**Recommended further issues for consideration by management:** ◊ Report updates on the Participation and Engagement Strategy ◊ Further work is required on both a Tayside and Dundee basis to update the Memorandum of Understanding for Hosted Services ◊ Formal agreement on accountability and responsibilities of the IJB in respect of all governance arrangements ◊ Risk management, especially assurance on controls ◊ Formal deputising arrangements. ◊ Action points update on decisions taken at previous meetings to be a standing agenda item for the IJB and Performance and Audit Committee ◊ A Scheme of Further Delegation needs to be documented for IJB services directed to NHS Tayside and Dundee City Council. ◊ Reporting arrangements against the Workforce and Organisational Development Strategy, as well as the partnership forum. ◊ Developments in relation to clinical and care governance should take into account the Social Work Scotland guidance document on Governance for quality social care in Scotland. ◊ Consideration should be given to arrangements required by the IJB to comply with Freedom of Information and Public Records legislation.
PK03-18	Perth & Kinross IJB Annual Report 2016/17	N/A	We commend the robust approach by Perth & Kinross Heath and Social Care Partnership who independently developed a governance self assessment including a library of supporting evidence which sets out a risk assessment as well as responsible officers and timescales for identified improvement actions. A high level Transforming Governance Action Plan was also developed to be taken forward by a short life working group during 2017/18. Whilst the important broad areas we would expect to see based on identified gaps are all already included in the 'Transforming Governance Action Plan' developed we recommended additional details to be included in this work: ◊ Governance arrangements: Standing orders should be reviewed and updated as required following on from the governance review ◊ Risk management - We would recommend that the risk template is adjusted to also include information on assurances against the controls listed in line with Appendix 2 of the Risk Management Strategy ◊ Work on the required assurances for clinical and care governance should include reporting from the Chief Social Work Officer ◊ Consideration should be given to arrangements required by the IJB to comply with Freedom of Information

Tayside NHS Board
Summary of Report Contents

			and Public Records legislation

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

Item Number 7.2

AUDIT65/2017
Audit Committee
24 August 2017

T30A/18 CONTINGENCY REVIEW – ANNUAL MANAGED EXPENDITURE PROVISIONS

Lindsay Bedford
Director of Finance

August 2017

FINAL REPORT

NHS TAYSIDE
INTERNAL AUDIT SERVICE

CONTINGENCY REVIEW - ANNUALLY MANAGED EXENDITURE PROVISONS

REPORT NO. T30A/18

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

S Lyall, Associate Director of Finance - Financial Planning and Operational Services

M Dunning, Board Secretary
D Colley, Financial Governance Accountant
A Napier, Head of Clinical Governance & Risk
L Green, Audit Committee Members' Library Copy

Tayside Audit Follow-Up

Audit Committee
External Audit

Date: 14 August 2017

INTRODUCTION & SCOPE

OBJECTIVES

1. The NHS Tayside 2016/17 Audit Scotland Annual Audit Report stated that Audit testing identified an error of £1.2 million in the figure included in the unaudited accounts for Annually Managed Expenditure (AME) – Creation of Provisions, shown as £20.5 million. The figure should be £19.3 million. This error impacted on the non-core and core revenue resource outturn figures shown in the summary of revenue resource outturns. The management response stated that '*Management has tasked Internal Audit with identifying how the error in the AME provision was not identified internally. Internal Audit will report their findings to management in due course*.'

2. AME expenditure arises from movements in the provision for liabilities. Certain expenditure is funded by the Scottish Government and is designated as non-core expenditure and therefore is accounted for as revenue; it primarily consists of movements in the provision for:

    ◊ Compensation payments above the £25,000 threshold at which level the CNORIS scheme funds all payments

    ◊ Employment disability benefits. It should be noted that in 2015/16, NHS Tayside received income of £4m due to changes in the accounting treatment of these benefits, which necessarily creates an increase in future core(revenue) costs in this area.

3. This audit is intended to identify the underlying reasons for the error and establish why internal processes did not identify the issue earlier and to provide additional information to inform the ongoing review of systems and processes in this area.

AUDIT OPINION AND FINDINGS

4. This review was to investigate the reasons for a specific error and therefore, as with other contingency investigations of this type, it would not be appropriate to provide an audit opinion on the overall system. We have, however, identified control weaknesses in relation to this issue and have made appropriate recommendations. Our overall conclusion is that the issue arose due to a simple miscommunication combined with a series of issues and circumstances which were, in themselves, not necessarily material, but which combined to create a 'perfect storm', in which the error could both occur and not be identified until after the accounts were closed.

5. The error was initially identified during the audit of the 2016/17 NHS Tayside accounts, when Audit Scotland asked for further details of the figures in the Annually Managed Expenditure (AME) Provisions account. At this point it was realised that the figures within the Summary of Non-core Revenue Outturn (SORO) did not match those within the provisions budget report. This had not been identified at the time the accounts were prepared because the SFR1 is not routinely reconciled to the SORO at year-end.

6. The error arose when a request was made for confirmation of additional non-core funding to be requested from SG. However, the response provided related to the total AME funding required of £1,151,558. This was interpreted as the total additional funding required for the year, above and beyond the 1.2m already drawn down at the beginning of 2016/17. As a consequence, NHS Tayside over-

stated its non-core funding by £1.2m. As the core expenditure figure shown in the accounts is simply derived from the difference between the total provisions figure and non-core expenditure, core expenditure was understated by £1.2m.

7. From discussions with officers, it is clear that the core expenditure associated with AME provisions is not monitored as closely as other revenue expenditure. The view appears to be that that any changes from the predicted amount could be managed through year-end adjustments. Where the variation is relatively minor, this may not be a significant issue, albeit there is no technical reason why this expenditure, although not amenable to normal controls should not at least be monitored and factored into financial reporting and consideration of overall financial control. However, when the variations are significant, as in this year, there can be a considerable financial impact and any actions taken to mitigate the impact of core expenditure are not then available to offset any other overspends or pressures.

8. Whilst the expected value of core expenditure had taken account of the impact of the decision made in relation to AME funding for Injury Benefits in 2015/16, there were other factors in play which impacted on the assessment and the reliance on heuristics, rather than detailed analysis, meant that the change in actual core expenditure was not fully identified in-year and it is possible that monitoring of the code was also impeded due to the misallocation of non-core budgets to core expenditure.

9. Although there is a spread-sheet maintained which would allow the costs of injury benefits to be ascertained at any given time, there is no similar record of core expenditure relating to CNORIS, although we do recognise that that these payments are outwith the control of the Board and can be time consuming to monitor.

10. Not all officers involved in the system were fully cognisant of the amounts which had been drawn down from the SGHSCD for non-core expenditure during the year, which could, in theory, increase the risk of recurrence.

11. We highlight that this issue did not arise from any errors in the calculation of compensation payments or injury benefits, merely in the understanding of non-core funding requirements as above.

12. There have already been a number of changes to structures and systems within the relevant department. We have been assured that action has been taken to prevent a recurrence of these specific circumstances. An additional senior Finance post has been appointed, with a core part of their remit being a review of systems and processes across the Finance function and the development of an improvement plan, which will consider and address the identified actions within this review.

ACTION

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

ACKNOWLEDGEMENT

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

A Gaskin BSc ACA

Chief Internal Auditor

Action Plan

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
1.	Core expenditure for injury benefits and CNORIS payments is not monitored throughout the year in the same way as other revenue expenditure.	Expenditure should be monitored against expectations at least quarterly with more frequent review in the approach to year-end.		A system for periodic review will be implemented recognising more frequent reviews are required at year end.	Associate Director of Finance-Financial Planning & Operational Services September 2017
2.	Although there is a spread-sheet maintained which would allow the costs of injury benefits to be ascertained at any given time, there is no similar record of core expenditure relating to CNORIS, although we do recognise that that these payments are outwith the control of the Board and can be time consuming to monitor.	NHS Tayside should explore options for proportionate reporting and forecasting of core CNORIS expenditure.		Options for proportionate reporting and forecasting of core CNORIS expenditure will be explored.	Associate Director of Finance-Financial Planning & Operational Services September 2017
3.	Core expenditure at year-end was calculated simply by deducting non-core income from the overall movement in the account and was not reconciled to supporting documentation.	Core expenditure should be independently calculated with reference to the supporting records for CNORIS payments and injury benefits.		Controls will be implemented through reconciliation of costs and funding to financial ledger and supporting spreadsheets.	Associate Director of Finance-Financial Planning & Operational Services September 2017

Action Plan

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
4.	Not all staff involved in the system were aware of SGHSCD draw-downs of non-core income and there was no formal system for identifying additional requirements.	The system should be formalised such that there is clear evidence for requested draw-downs which should be shared with all relevant officers.		The process for draw down of funds has been amended to ensure no repeat of communication error.	Associate Director of Finance-Financial Planning & Operational Services Complete

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 7.3

AUDIT73/2017
AUDIT COMMITTEE
24 AUGUST, 2017

INTEGRATED JOINT BOARDS – SHARING OF AUDIT OUTPUTS PROTOCOLS

1. SITUATION AND BACKGROUND

Following the creation of the three IJBs within the NHS Tayside area, there has been a corresponding need, informed by Integrated Resource Advisory Group (IRAG) guidance, for each of these bodies to have an Internal Audit function. The nature of Health and Social Care Integration is such that the control systems of the Health Board, the Integrated Joint Boards (IJBs) and the three Local Authorities are inextricably linked and it is, therefore, necessary to consider how relevant audit outputs of each of these bodies should be shared.

Following discussions with Local Authority Chief Internal Auditors, the attached paper has been prepared for consideration by the Audit Committee.

In addition there is the need to consider the rights of IJB audit staff who may require access to Health Board employees, documents and property. Currently, under the Standing Financial Instructions (SFIs) and the NHS Tayside Internal Audit Charter, such rights are granted to NHS Tayside designated Auditors conducting audits within NHS Tayside. SFIs and the Audit Charter state that:-

"*The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:-*

- *Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;*
- *Access at all reasonable time to any land, premises or employee of each organisation;*
- *The production of any cash, stores or other property of each organisation under an employee's control; and*
- *Explanations concerning any matter under investigation."*

2. ASSESSMENT

IRAG guidance requires the sharing of IJB Internal Audit plans and annual reports with the parent bodies. The attached paper extends that principle to allow for relevant assurances to be provided to each body within the system. Additional consideration will also need to be given to the scope of the information provided; NHS Tayside's Internal Audit Reporting protocol allows all Audit Committee members full access to all NHS Tayside Internal Audit Reports, and all reports graded 'D' or below are presented in full to the Audit Committee. The same systems do not apply within all Local Authority Partners, and there will need to be further discussion on the issue of whether IJB Audit Committee members will be entitled to receive full reports from the parent bodies and vice-versa.

NHS Tayside's Chief Executive has agreed that it would be sensible to grant IJB Internal Auditors the access required to fulfil the IJB Internal Audit plans. In discussion with Local Authority Chief Internal Auditors, it became clear that this principle may not be as readily accepted by Local Authorities and they agreed to consult with their legal teams.

3. RECOMMENDATIONS

The Audit Committee is asked to:-

i. comment on the attached paper as a basis for agreement with partner IJB and Local Authority Audit Committees, and

ii. authorise the Director of Finance, through the NHS Tayside Chief Internal Auditor to designate IJB auditors as having the same rights of access whilst conducting relevant IJB Internal Audits

Tony Gaskin
Chief Internal Auditor

Lindsay Bedford
Director of Finance

August 2017

Tayside IJBs / NHS Tayside / Tayside Local Authorities – Sharing of Audit Outputs Protocol

Introduction

FTF Audit, the Internal Audit service providers for NHS Tayside, were appointed to provide the Chief Internal Auditor function for all Tayside IJBs with the Internal Auditors of both parties providing input to the delivery of the IJB audit plans. This arrangement will be reviewed by all Tayside IJBs in 2017/18.

In the new integrated environment, there may be a need to share internal audit outputs beyond the organisation that commissioned the work, in particular where the output (e.g. internal audit reports, follow-up reports, internal audit plans and internal audit annual report / opinion) is considered relevant to one or more of the other partners for assurance purposes. It is important that this sharing of information happens in a controlled manner to facilitate joint working, protect confidentiality and avoid duplication of effort.

Integrated Resource Advisory Group (IRAG) guidance states that '' *To ensure that the risk based audit plans for the Integration Joint Board, Local Authority and Health Board are co-ordinated to ensure proper coverage, avoid duplication of efforts and determine areas of reliance from the work of each team, it is recommended that the Chief Internal Auditors for each of the respective bodies share information, co-ordinate activities with each other and with other external providers of assurance and consulting services.*

This paper sets out principles in relation to the sharing of Internal Audit outputs and granting of access, in order that all parts of the system receive appropriate information on the adequacy and effectiveness of internal control within their purview, including controls operated by other bodies which impact on their control environment. Throughout this paper, Audit Committee refers to the Standing Committee of the organisation charged with responsibility for audit and assurance.

Audit Planning

IRAG guidance states that '*The risk based audit plan should be developed by the Chief Internal Auditor of the Integration Joint Board and approved by the Integration Joint Board or other committee (see 2.6 Audit Committees). It is recommended that it is shared with the relevant committees of the Health Board and Local Authority.'* This principle is agreed and the approved IJB annual internal audit plans will be shared with the relevant committees of NHS Tayside and the Tayside Local Authorities.

Given that the IJBs are reliant on assurances provided by the parties on their systems and also to ensure that plans can be seen to be coherent over the whole system, the Internal Audit plans of the Health Board and Local Authorities will also be presented to the IJB Audit Committee for noting. This will also provide each Audit Committee, whilst respecting the primacy of the organisation for whom the report is prepared, with the opportunity to identify any relevant audits from another body which they may wish to receive assurance from and to highlight any areas where they might wish to ensure that particular issues, relevant to their IJB are taken into account.

Individual Audit Reports

IJB Audits

When conducting audits of the IJB, FTF and Local Authority Internal Auditors will use their respective methodologies, both of which are compliant with Public Sector Internal Audit Standards (PSIAS). However, an agreed standard report format will be used for all IJB Internal Audit Reports. The Internal Auditors have separately agreed a joint working protocol which sets out the audit process for all work which will be conducted within the terms of Internal Audit Charter approved by each IJB Audit Committee and the requirements of PSIAS.

A summary final report for each audit assignment will be presented to the IJB Audit Committee for scrutiny purposes, with a full copy available to IJB Audit Committee members on request. These summary reports shall also be shared with the NHS Tayside and relevant council Audit Committee(s).

NHS and Local Authority Internal Audits

At the beginning of each audit year, and on an ongoing basis, the respective internal auditors, taking into account the views of the IJB Chief Officer, IJB Chief Internal Auditor and IJB Audit Committee, will review their audit plans to identify any audits of the parent bodies (NHS Tayside and Dundee City Council, Perth & Kinross Council, Angus Council) that may be of relevance to the IJB. For these audits, summaries of the final reports, or relevant issues from within those reports, will be presented to the IJB Audit Committee.

If, for any other completed audits, the auditor believes there may be issues which impact on the IJB control environment, the IJB Chief Internal Auditor will be notified so that arrangements can be made to report the relevant findings to the IJB Audit Committee.

The final audit reports issued shall follow the normal reporting routes established for internal audit reports within the parent bodies; this shall include being presented to their respective Audit Committees. The parent body Audit Committee shall be advised if the report, or any part thereof, is to be shared with the IJB Audit Committee.

When either an NHS Tayside or a Dundee City Council/ Perth & Kinross Council/ Angus Council final internal audit report has been identified as relevant to the IJB, the audit report shall be presented in summary at the next meeting of the IJB Audit Committee. These summary reports shall also be shared between NHS Tayside and Dundee City Council / Perth & Kinross Council / Angus Council internal audit services.

Annual Internal Audit reports

IRAG guidance states that '*It is recommended that the Integration Joint Board annual internal audit report is shared with the partner Health Board and Local Authority through the reporting arrangements in those bodies for internal audit*.' The IJB Chief Internal Auditor shall prepare an IJB Internal Audit Annual Report and opinion and in accordance with IRAG guidance, it will be shared with the parent bodies and reported through their own internal audit reporting procedures. Again, this principle will be extended and reciprocated so that Local Authority and Health Board Annual Internal Audit Reports are presented to the IJB Audit Committee for noting as part of the overall assurance portfolio in support of the governance statement.

Review Date: September 2018

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

Item Number 8.1

AUDIT66/2017
Audit Committee
August 2017

NHS TAYSIDE ADVERSE EVENT MANAGEMENT POLICY

1. PURPOSE OF THE REPORT

To seek adoption of the reviewed and updated NHS Tayside Adverse Event Management Policy to bring it in line with organisational change and national guidance as produced by NHS Healthcare Improvement Scotland (HIS).

2. RECOMMENDATIONS

The Audit Committee are asked to adopt the revised Adverse Event Management Policy:

- Acknowledging that this was approved at the Chief Executive and Directors' Meeting held on 17 July 2017.
- Note that a comprehensive AEM Policy Action/Project Plan is under development by the Clinical Governance and Risk Management Department that will ensure a programme of work is completed and a further review of the Policy will be concluded within the next six months taking into account Health and Social Care Partnerships, streamlining of process and legislative requirements such as Duty of Candour.
- Recognise that implementation of any actions will commence following adoption by the Audit Committee

3. EXECUTIVE SUMMARY

The National Approach to Learning from Adverse Events Framework (HIS, 2013) was first published and circulated to all Health Boards with CEL 20 (2013) in September 2013. The Framework was revised and the 2nd edition launched in April 2015 and aims to provide a standardised approach for managing and learning from adverse events. The NHS Tayside Adverse Event Management Policy was updated to take cognisance of this framework.

4. REPORT DETAIL

The Adverse Event Management Policy has been reviewed and updated to take account of ongoing work, improvements and guidance being made available.

A summary of the improvements implemented into our local Policy during this review are highlighted below:

Section 2.1, Page 5 – Revision of definitions

Section 3.1, Page 6 – Revision of section to reflect NHS Tayside Collective Leadership Culture.

Section 5.6, Page 10 – Inclusion of additional information relating to external reporting of adverse events. Specific additions have been made relating to Healthcare Improvement Scotland and Patient Suicides and NHS 24 for Infectious Diseases

Section 7.1, Page 11 – Revision of table within this section to reflect national timescales for reviews inclusive of local milestones to ensure these are delivered upon. Also addition in relation to sharing the learning from adverse events.

Section 7.2, Page 12 – Addition of a section entitled Sharing the Local Adverse Event Review reports with patient, families or carers which also includes guidance on the principles for redaction of Adverse Event Review reports.

Section 7.3, Page 14 – Section previously referred to Significant Clinical Event Analysis (SCEA), this has been reviewed and updated to reflect a focus on events which have significant organisational learning, a streamlined process and on moving forward that these will be referred to as Organisational Adverse Event Review (OAER).

Section 7.4, Page 15 – Inclusion of new section with information relating to Adverse Events which require a multi Board approach.

Section 8.1, Page 15 - Inclusion of new section with information relating to Never Events as a Type of Adverse Event.

Section 8.2, Page 15 – Review of information in relation to Child Protection Adverse Events and update to include guidance in relation to Significant Case Reviews.

Section 8.4, Page 16 – Review of section previously entitled Prisoner Healthcare to now focus on Death in Custody Adverse Events.

Section 8.5, Page 16 – Review of and slight amendment to section Drug Related Death Adverse Events.

Section 8.7, Page 17 - Inclusion of new section with information relating to Adverse Events for Clinical Trials of Investigational Medicinal Products.

Section 9.1b, Page 19 – Section entitled Release of Adverse Event Report Forms/Adverse Event Reports updated into table format and moved to an appendix to ensure this is more user friendly and easily accessible.

Section 10, Page 20 – Review and update of section on Support for staff following an adverse event to bring this in line with current organisational structure and initiatives

Section 11, Page 20 - Review and update of section on Feedback/Closing the loop. This has resulted in an additional flowchart being added to the Policy at Appendix 7.

Appendix 3, Page 25 – Review, update and replacement of Adverse Event Management Toolkit ensuring it meets national guidance and reflects current best practice.

Appendix 4, Page 43 – Review, update and replacement of template for Learning Summaries.

Appendix 5, Page 44 – Inclusion of NHS Tayside List of Never Events.

Appendix 6, Page 49 – Review and updated of Flowchart in relation to Prisoner Healthcare Adverse Events. Links directly to section 8.4 on page 16, referred to above.

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. The revised and enhanced policy as part of a robust set of risk management arrangements allows these to be achieved.

6. MEASURES FOR IMPROVEMENT

A series of measures in relation to Adverse Event Management are contained within Performance Reviews contain for all Directorates and data can be viewed within Qlikview. These are also included in the Clinical Governance & Risk Management Reports for each Directorate/HSCP.

As part of the action plan developed for 2017/18 it is the intention to review and enhance these.

7. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

An equality and diversity impact assessment has been completed and is included as part of the revised Policy.

A number of individuals were consulted on in relation to the content of this report including Executive Directors, Senior Leadership Team, Audit Committee, Clinical and Care Governance Committee, Area Partnership Forum, Area Clinical Forum, Clinical Quality Forum, Strategic Risk Management Group, Chairs of Clinical Governance Committees, Internal Audit colleagues and Clinical Governance and Risk Staff.

Recommendations for improvement where relevant have been incorporated into the Policy.

8. PATIENT EXPERIENCE

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

9. RESOURCE IMPLICATIONS

Financial and Workforce

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

10. RISK ASSESSMENT

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

An operational risk in relation to NHS Tayside Adverse Event Management is also recorded within the Datix system and underpins the Clinical Governance Strategic Risk.

Risk Description: As a result of the new National Framework for the Management of Adverse Events and other ongoing improvements relating to this, there is a risk that NHS Tayside will fail to have in place adequate and effective arrangements for Adverse Event Management and implement these out throughout the organisation. This may result in an inability to learn from adverse events and continually improve person centered, safe and effective care and adverse publicity.

Inherent Risk Exposure Rating: Medium/Yellow (2x4)

Current Risk Exposure Rating: Medium/Yellow (2x3)

Planned Risk Exposure Rating: Medium/Yellow (2x2)

Mitigating Actions: There is only one outstanding mitigating action which is to conduct a full annual review of Adverse Event Management Policy which will be completed upon adoption by the Audit Committee.

However, the risk will be reviewed and updated following adoption of the Policy at Audit Committee and a series of new mitigating actions to complement the action plan for 2017/18.

Associated Resources: Within current resource.

11. LEGAL IMPLICATION

Chief Executives, as Accountable Officers, have responsibility for maintaining a sound system of Internal Control and reviewing the effectiveness of the system within their organisation culminating in the preparation of an annual Governance Statement.

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

This Policy will be presented to the Audit Committee for adoption following approval from the Directors Meeting.

12. INFORMATION TECHNOLOGY IMPLICATIONS

There are no IT implications associated with this paper.

13. HEALTH & SAFETY IMPLICATIONS

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

14. HEALTHCARE ASSOCIATED INFECTION (HAI)

There are no HAI issues associated with this paper.

15. DELEGATION LEVEL

Ms Lesley McLay, is Chief Executive and Accountable Officer.

Dr Andrew Russell, Medical Director and Mrs Gillian Costello, Nurse Director are Executive Leads for Adverse Event Management.

16. TIMETABLE FOR IMPLEMENTATION

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

A further review of the Adverse Event Management Policy will take place during 2017/18 to take cognisance of Duty of Candour. In preparation for the introduction of this legislation, a Vital Signs was issued to the organisation on 28 November 2016. In addition, workshops and training for staff are being developed and will be running over the course of the next six months in the run up to the introduction of the Act.

17. REPORT SIGN OFF

Hilary Walker
Risk Manager

Lindsay Bedford
Director of Finance

Prof A Russell
Medical Director

Gillian Costello
Nurse Director

August 2017

RISK MANAGEMENT

Adverse Event Management Policy (AEM)

Policy Manager	Policy Group
Risk Manager	Audit Committee

Policy Established	Policy Review Period/Expiry	Last Updated
	January 2019	January 2017

This policy does apply to Medical/Dental Staff

UNCONTROLLED WHEN PRINTED

Adverse Event Management (AEM) Policy
Version Control

Version Number	Purpose/Change	Author	Date
1.0	Policy Established - Adverse Incident Management Policy		August 2001
2.0	Policy review and change of title - Significant Event Management Policy		August 2011
3.0	Policy update to align to national guidance – has resulted in change of title		August 2014
4.0	Policy update to align to review of national guidance		August 2015
5.0	Policy update: To align with national guidance and updated organisational systems and processes		January 2017

CONTENTS

ADVERSE EVENT MANAGEMENT POLICY (AEM*)*

1. Foreword

Our care system in Scotland is amongst the best in the world, but sometimes things will go wrong. Care will never be risk-free but we can minimise these risks in order to provide high quality care for the population of NHS Tayside.

Learning from adverse events is crucial to continually improve person-centered, safe and effective delivery of care.

"Even apparently simple human errors almost always have multiple causes, many beyond the control of the individual who makes the mistake. Therefore, it makes no sense at all to punish a person who makes an error, still less to criminalise it. The same is true of system failures that derive from the same kind of multiple unintentional mistakes. Because human error is normal and, by definition, is unintended, well-intentioned people who make errors or are involved in systems that have failed around them need to be supported, not punished, so they will report their mistakes and the system defects they observe, such that all can learn from them"

Don Berwick (August, 2013)

Supporting cultural change is at the heart of this AEM policy. We all want to achieve a positive safety culture that is open, just and informed, in which reporting and learning from adverse events is the norm. Achieving cultural change is challenging and will take time, but this approach and the tools developed will support the behavioural changes we would like to see within NHS Tayside.

Ms Lesley McLay
Chief Executive
NHS Tayside

Professor John Connell FMedSci FRSE
Chairman

2. Introduction

NHS Tayside recognises and accepts that it has legal and other requirements for managing all adverse events. The organisation seeks to establish a balance of proactive and reactive risk management processes to enable early identification of potential problems thus creating prevention cycles to enhance patient and staff safety.

Many adverse event reporting systems rely on data capture, recording trends, in particular adverse events, followed by reviews to determine the cause of particular adverse events. While the focus of counting numbers is important, changes in practice will only occur where there are established systems to learn from adverse events to prevent them recurring.

Emphasis on error prevention in healthcare is a national priority demonstrated, for example, in the publications An Organisation with a Memory (Department of Health (DoH), 2000), Doing Less Harm (DoH, 2001) and Building a Safer NHS (DoH, 2001), Safety First: A Report for Patients, Clinicians, Healthcare Managers (DoH, 2006), Better Health, Better Care Action plan: What it Means for you (Scottish Government, 2008).

Research has been conducted in NHSScotland to establish a coherent framework for risk assessment. Following the consultation paper "Learning from Experience: How to Improve Safety for Patients in Scotland" (Scottish Executive, 2004) a framework document has been published, by NHS Quality Improvement Scotland (NHS QIS) to address the key themes identified. Improving the safety of patients and staff in NHSScotland through adverse event reporting was highlighted as a priority within this publication.

In addition, Learning from adverse events through reporting and review: A national framework for NHSScotland (NHS HIS, 2015) is built on the views of patients, clinicians, NHS Boards and others involved in delivering high quality healthcare.

These documents all provide structure and direction for the development of local adverse event reporting systems **focused on learning**.

2.1 Definitions

The following definitions apply to this document:

The term adverse event refers to an unexpected occurrence or event arising that did result in harm, loss or damage to persons, property or organisational reputation. It can include any event that may give rise to physical, emotional, psychological harm or death.

A near miss is any situation that could have resulted in an adverse event but did not due to either chance or intervention. This should be considered as an opportunity to review and learn from the circumstances of what happened before those circumstances result in an adverse event at some point in the future.

Harm is an outcome with a negative effect. Harm to a person (service users; patients; members of staff; carers; family members, volunteers and visitors) or groups of people (including organisations) may result from worsening of a medical condition, the inherent risk of an investigation or treatment, system failure, provider performance issues, service disruption, financial loss or adverse publicity. (NHS HIS, 2015).

However, not every adverse event which occurs has associated harm and for this reason NHS Tayside captures the following within the adverse event and near miss recording database (Datix):

- Adverse event WITH harm: An event which has ACTUALLY happened and caused harm.
- Adverse event WITHOUT harm: An event which has ACTUALLY happened but caused NO harm.

Never Events are serious, largely preventable patient safety events that should not occur if the available preventative measures have been implemented (NPSA, 2015).

3. Aims and Objectives

The NHS Tayside Adverse Event Management Framework covers all accidents, adverse events and system failures which either caused, or could have caused, harm or death to people or groups of people or damage or loss to NHS Tayside property.

This document sets out a policy framework for recognising, reporting and reviewing all adverse events within the organisation. This includes clinical events involving patients, families, staff and carers (including health and safety, accidents or adverse events) and non-clinical events (including information governance, adverse publicity and finance). Our **aim** in NHS Tayside is to **minimise** the risk of adverse events occurring and **maximise** our opportunities to learn and keep patients safe and support staff.

The primary purpose of our adverse event management framework is to improve systems, practice and care and NOT to apportion blame. All staff have a responsibility to report adverse events and take appropriate remedial action where relevant. However, in the event of negligence, intended harm and professional mal-practice the reporting framework will convert to a disciplinary procedure where appropriate. It is important to

remember that adverse event reporting/investigation is distinct from disciplinary procedures.

The purpose of this is to encourage staff to recognise a fair and just reporting culture as the bedrock for sustained changes in practice to improve patient care and services where respect and fairness come first for everyone.

3.1 NHS Tayside Collective Leadership Culture

NHS Tayside have committed to developing a culture of collective leadership. Collective leadership is the engagement of all staff and service users in the leadership process and means everyone taking responsibility for the success of the organisation as a whole, not just for their own jobs or work area.

Collective leadership cultures are characterised by all staff focusing on continual learning, and the improvement of patient care (Kings Fund, 2014). There is an expectation that all staff adopt leadership roles in their work, taking individual and collective responsibility for delivering safe, effective, high quality and compassionate care for patients and service users.

Collective leadership cultures are places where people accept responsibility for their actions, welcome learning from errors and base relationships on transparency, openness and candour. They exist where there is an overriding commitment to learning, improvement and innovation at all levels (Kings Fund 2014).

The cultural approach to adverse event management within Tayside will be one that supports and encourages staff to report adverse events and near misses without retribution, helping the organisation to learn from these and prevent future errors. The shared goal of adverse event management will be to identify and discuss problems in a safe environment with curiosity and respect. There will be recognition of service and process failures, improvement taken to prevent recurrence and sharing the learning with others.

4. Roles and Responsibilities

4.1 Tayside NHS Board

Tayside NHS Board is responsible for ensuring governance systems are in place with clear lines of accountability and clearly defined roles and responsibilities to support the effective management of adverse events. Tayside NHS Board has devolved responsibility for risk management to the Audit Committee and for Adverse Event Management to the Clinical and Care Governance Committee. It will receive assurances through the provision of minutes and annual committee reports.

4.2 The Standing Committees of the Board

In accordance with the NHS Tayside Code of Corporate Governance, the Standing Committees of Tayside NHS Board will address each area of risk as appropriate.

In particular, the Audit Committee has a duty:

- To review the organisations risk management arrangements, systems and processes
- To review biannual reports from Strategic Risk Owners with risks aligned to this Committee
- To review and approve the risk management workplan
- To approve the Committee Annual Report of the Strategic Risk Management Group
- To receive the minutes from the Strategic Risk Management Group

- To approve the bi-monthly clinical governance and risk management reports on effectiveness, adequacy and robustness of the systems.

The Clinical and Care Governance Committee seeks to provide Tayside NHS Board with assurance in respect of clinical risk management arrangements by seeking assurance that there are adequate systems and processes in place across NHS Tayside to ensure that:

- Robust clinical control frameworks are in place for the effective management of clinical risk and that they are working effectively across the whole of NHS Tayside
- Adverse event management and reporting is in place and lessons are learned from adverse events

4.3 The Chief Executive

The Chief Executive of Tayside NHS Board is the Accountable Officer responsible for the implementation and management of adverse event processes throughout the organisation and is answerable to the Scottish Government for the propriety and regularity of activities under his/her control through the production of an annual Governance Statement. Overall executive responsibility is delegated strategically to the Medical and Nurse Directors who are charged with providing assurance to the Board that mechanisms they have deployed to produce, implement, manage and monitor effective policies/procedures are in place.

4.4 Directorate Management Team Responsibility

Accountability for managing the adverse event management process lies with local management teams, i.e. General Manager, Associate Medical Director, Associate Nurse Director, Clinical Leads, Head of Nursing, Clinical Service Manager and Director of Public Health through local Clinical Governance and Risk structures.

4.5 Line Manager Responsibility

All staff in NHS Tayside, who carry a management responsibility regardless of title, have a responsibility to encourage staff to manage adverse events appropriately and to escalate these when necessary. They must ensure their staff have access to relevant adverse event management education, training and support.

4.6 All Staff

All staff (including volunteers, bank/agency, locum, medical students, General Practitioners and General Dental Practitioners) are accountable for following the procedures defined within this Policy and have a responsibility to report adverse events and to take appropriate remedial action where relevant. All staff are also accountable for participating in adverse event management education and training appropriate to their area of work.

5. Adverse Event Reporting

5.1 Identification and immediate actions following an adverse event

There are several immediate actions that must be undertaken following an adverse event:

- Ensure a safe environment is re-established as soon as possible
- Any urgent clinical care that may reduce the harmful impact of the event must be given immediately
- The needs of patients and their families and carers should be met and support provided (including Communication – see section 9.1)
- Colleagues should be informed and support secured from other professionals

- Any faulty machine or equipment along with any consumables and patients leads etc should be removed and labelled to prevent future use
- A timely, factual and objective entry should be made in the patient's clinical records (detailing type of adverse event and the identification number only – copies of DATIX reports should not be filed in the patients clinical records)
- Any actions to reduce the risk of recurrence should be taken immediately

5.2 Reporting

The Board currently use a web-based system for adverse event reporting. This system allows prompt, thorough reporting and requires line manager review/verification and recording of action taken, so learning from the adverse event can be disseminated.

The reporting system **must** be utilised to record all accidents and adverse events. **Adverse Event reporting forms can be completed by any member of staff with access to Staffnet.**

The first person to recognise or become involved in the adverse event, irrespective of domain, department or position within the organisation or areas in which the adverse event occurs, is responsible for completing the adverse event reporting form within the web-based system as soon as possible after the event but within one working day for all adverse events, unless there are exceptional circumstances for the delay. The adverse event reporting system will send an alert to the Chief Executive, Deputy Chief Executive/Medical Director, Director of Strategic Change, Board Secretary and Associate Director of Clinical Governance and Risk Management for every red adverse event reported.

The system is designed to be confidential but not anonymous thus supporting the ethos of the organisation that our aim in NHS Tayside is to minimise the risk of adverse events occurring and maximise our opportunities to learn; to improve systems and practice, care and outcomes and NOT to apportion blame.

It is imperative that the person(s) reporting the adverse event, whilst maintaining a person centred approach, reports on **fact**. Opinion or assumptions should not be included and details must be accurate for any future review.

The adverse event reporting system will record the following as a **Minimum Data Set:**

- The location of where the adverse event occurred (Where)
- The date and time of the adverse event (When)
- Description of the adverse event (What, Why and How)
- Any immediate action taken
- Personal details relating to the person/people involved in the adverse event (victim/injured party)
- The outcome of the person/people involved (Injury/result)
- The immediate treatment given to the person/people involved
- Any remedial action taken to minimise risk of recurrence
- Others who were involved in observing or reporting the adverse event

5.3 Grading Harm Caused In This Adverse Event

The consequence of the adverse event must be determined at the time of occurrence. A score is chosen from 1-5 to describe the harm caused/determine the severity of the event. Recurrent themes which have potential to cause major/extreme harm should also be reviewed. The consequence score matrix is attached in **Appendix 1**.

5.4 Could This Adverse Event Recur?

Following the initial impact consider if this adverse event were to happen again how frequently you believe it will happen (likelihood) and what the outcome (consequences) would be.

Likelihood Score

Descriptor	Frequency of event occurring	Timescales (Guide Only)
Rare	Can't believe this event would happen	5-10 years or more
Unlikely	Not expected to happen but might	2-5 years
Possible	May occur occasionally	Annually
Likely	Could occur several times	Quarterly
Almost certain	Could occur frequently	Daily / Weekly / Monthly

Adding the likelihood of recurrence will result in a Potential Risk Exposure Rating of red, amber or green which will also help to identify those adverse events which have not caused harm but potentially could in the future.

Potential Risk Exposure Rating

		CONSEQUENCE				
		Negligible	Minor	Moderate	Major	Extreme
LIKELIHOOD	Almost Certain	Medium	High	High	Very High	Very High
	Likely	Medium	Medium	High	High	Very High
	Possible	Low	Medium	Medium	High	High
	Unlikely	Low	Medium	Medium	Medium	High
	Rare	Low	Low	Low	Medium	Medium

A traffic light system has been designed to provide guidance and direction of the types of adverse events which should be reported within the adverse event reporting system as red, amber and green events. This should be used with some discretion**. (Appendix 2).**

5.5 Verification

The electronic adverse event form must be sent in the first instance to the immediate line manager. The line manager will verify adverse events **within 72 hours of receipt**, manage, review, escalate and share the adverse event in accordance with the grade and type of adverse event. Discussion with colleagues may be necessary to confirm the type, grade and impact of the adverse event.

5.6 Reporting to External Agencies

RIDDOR Reporting to Health and Safety Executive (HSE)

In addition to the electronic adverse event reporting noted above, certain adverse events require to be notified to the Health and Safety Executive (HSE) under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995. Reports

must be made online at www.hse.gov.uk/riddor to the HSE within 15 days of the adverse event.

Typical adverse events which need to be reported include work related fatalities, major injuries, certain dangerous occurrences and adverse events where a staff member is unable to attend work or perform their normal duties due to injury for more than 7 days.

Healthcare Improvement Scotland – Patient Suicide

The Responsible Medical Officer for a patient is required to notify the Suicide Reporting Officer, based within Healthcare Improvement Scotland, when a patient has completed suicide (or when suicide is the probable cause of death), and that patient has had contact with mental health services within 12 months before their death or where otherwise appropriate.

Notification must be completed within 10 working days of date of death/notification of the patient's death.

Information to be included in the suicide notification is contained within the Notification Checklist available on the website: Reporting a Suicide.

It is expected that clinicians will co-operate fully with the provision of information to the National Confidential Inquiry into Suicide and Homicide.

NHS 24 – Infectious Diseases

If there is any ongoing issue in NHS Tayside that could result in members of the public contacting NHS 24 without any professional intervention as a result of their own concern then early warning should be provided to NHS 24 to ensure patients receive the most appropriate contextual advice.

Reporting to other external agencies also takes place and is routinely carried out by relevant designated officers within the organisation:

- Incident Reporting and Investigation Centre (IRIC) for events involving estates and facilities equipment
- Medicines and Healthcare Products Regulatory Agency (MHRA) for events relating to blood and adverse drug reactions via the Yellow Card Scheme
- Procurator Fiscal for deaths associated with medical or dental care
- Scottish Government and Information Commissioners Office for information governance events
- Warranted Inspector for IR(ME)R for Ionising Radiation adverse events

6. Categories of Adverse Events

Local adverse event reviews aim to determine what happened, how it happened, why it happened, establish the contributing factors with a view to reducing the likelihood and/or impact of similar future events and if there are learning points for the service, the wider organisation or nationally. Following reporting and verification of an adverse event, the relevant manager will assess the adverse event report to consider whether a more in depth review of the event is required.

It is important that the level of review is proportionate to the severity of the adverse event and the potential for learning from adverse events should be categorised to support decision making processes to determine the level of review required. The following categories are used to group adverse events.

Category 1 – Events that may have contributed to or resulted in permanent harm, for example death, major or extreme impact, intervention required to sustain life, severe financial loss (£>1m), ongoing national adverse publicity (Major or Extreme Impact or Red Event).

Category 2 – Events that may have contributed to or resulted in temporary harm, for example initial or prolonged treatment, intervention or monitoring required, temporary loss of service, significant financial loss, adverse local publicity (Minor or Moderate impact/Yellow or Amber Event).

Category 3 – Events that had the potential to cause harm but, i) an error did not result, ii) an error did not reach the person, iii) an error reached the person but did not result in harm (Negligible impact/Green Event).

The category of the event will largely determine the level of review required i.e. Red or Category 1 events that result in permanent harm are likely to require a more extensive review than category II events that result in temporary harm. However, consideration of the potential for learning from the event should also determine the level of review required.

7. Adverse Event Reviews

7.1 Local Adverse Event Review (LAER)

The table below provides a guide. It is important to clearly document the decision for the level of review undertaken.

Adverse Event Category	Suggested minimum level of review	Review Team	Reporting of findings and learning	Guidance Timescale
Category I or Red (including never events)	**Level 1** Comprehensive and robust adverse event analysis and review. Use of validated analysis tools (refer to reviewer tool-kit)	Full multidisciplinary team review required including external agencies pertinent to the adverse event. If event is clinical, the review must have clinical and managerial input. The review team should be sufficiently removed from the event, have no conflict of interest and be able to provide an objective view.	Improvement plan to be developed with actions, timescale and named leads identified by the team department where the adverse event took place. Action plan agreed and follow-up/ reporting through directorate clinical governance structures.	Adverse event recorded on web-based system within 24 hrs. Verified within 72 hrs. Instigate review of evidence within 10 days. Plan review within 30 days, carried out robust LAER within 60 days, final report to be completed and recorded on Datix within 90 days from date of event.
Category II or Amber/ Yellow	**Level 2** Local management led adverse event review in consultation with Head of Nursing or Professional Lead.	Responsible Manager of the department or area in consultation with staff. If event is clinical, the review must have clinical and managerial input.	Improvement/actio n plan to be developed and reported through service clinical governance structures.	Adverse event recorded on web-based system within 24 hrs. Verified within 72 hrs. Instigate review of evidence within 10 days.

				Plan review within 30 days, carried out robust LAER within 60 days, final report to be completed and recorded on Datix within 90 days from date of event.
Category III or Green	**Level 3** Further enquiries/ questions by Team Lead. Trends should be considered for further review.	Managers/staff locally. If further review required then local management review process.	Via aggregated reports and learning points to management and clinical governance structures.	Adverse event recorded on web-based system within 24 hrs. Verified within 72 hrs. Adverse event approved and closed within 10 working days of being reported.

The basic process of adverse event review and analysis should be essentially the same. However, the review team can choose whether to quickly run through the main issues or to carry out a full, detailed review over several weeks making full use of all associated techniques to comprehensively examine the chronology, care delivery problems and contributory factors.

The review team should ensure engagement and involvement with all people involved in the adverse event during the review process. Patients/Families/Carers must also be given the opportunity to contribute to the LAER. They should be contacted in advance by the appropriate clinician/manager to determine any concerns they would wish to have raised at the review.

At least one member of the review team should be trained in review methodologies and their application. Some examples of tools which can be utilised during the adverse event review process are provided in the Guidance for Lead Reviewers (**Appendix 3**).

A report presenting the findings, conclusions and recommendations of the review should be produced using the template provided in **Appendix 3.** It is expected that the lead reviewer will engage with those involved in the review whilst preparing and approving the final report, a copy of which must then shared with the review team and all staff involved in the adverse event.

The lead reviewer should also consider how the learning from the LAER will be disseminated. A one page learning summary (**Appendix 4**) must be produced. In addition learning may also be shared through newsletters or other mediums such as briefings to Clinical Governance Chairs. These should be added to the agenda of and discussed at local Clinical Governance and Risk Management meetings. One page learning summaries should be uploaded onto HIS Community of Practice and local intranet pages.

Complaints are ‘adverse events’ and must be managed in the same way ensuring that Local Adverse Event Reviews (LAER) and Organisational Adverse Event Review (OAER) methodologies are applied to relevant cases to enable local and organisational learning. In addition communications with the patient/family point of contact/carer are vitally important to ensure they are kept informed of the process and receive direct and accurate responses.

7.2 **Sharing the Local Adverse Event Review reports with patient, families or carers**

The Local Adverse Event Review process must be "transparent and include all those involved in the adverse event: patients, service users, families and carers, and staff. To support this, local adverse event review reports should be shared with everyone involved in the event, and a one-page learning summary completed and published in order to share key learning points more widely" (HIS 2015).

The above statement means that patients, families and carers may request (through a Data Protection Subject Access Request) and be entitled to a copy of the Local Adverse Event Review report. **For further guidance and details please refer to** Section 9.1b – Release of Adverse Event Report Forms/Adverse Event Reports.

To facilitate this process Local Adverse Event Review reports should be written in such a manner that they are accurate, factual, sensitive, professional, in plain English and anonymised to protect both patient and staff identity.

These reports should be in a format that can be shared with patients, families and carers and also any external agency who requests the report, such as the Mental Welfare Commission or Procurator Fiscal.

The table below outlines the fundamental principles in redacting a Local Adverse Event Review report. However, the Guidance on Data Redaction and Standardised Adverse Event Review Reports.pdf (HIS 2015) **must** be referred to whilst redacting a report. Support may also be sought from the Clinical Governance and Risk Management Team and the Information Governance Team during the preparation and finalising of reports.

The guiding principles for redaction of Local Adverse Event Review report are:

Category of Data	**Must be redacted**	**Consideration to be given to redaction on an individual basis**
Patient personal details	• Name (both surname and forename) • Date of birth • Specific age reference • Hospital number • CHI number • Address (own or associated) • Postcode • GP • 'Direct lift' clinical information taken from patient /deceased patient's medical records • Detailed clinical investigation results • Full medical history • Date adverse event happened	Assess the uniqueness of the disease/diagnosis/testing - some common diagnoses combined with other data may risk identification. For example, • childhood leukaemia is not unique, but is rare, and when given with other details such as a single hospital in a small NHS board area, it potentially identifies individuals • Consider providing the following if it would help provide context and support understanding and learning (unless, with other information, it could identify people) • relevant medical history or clinical information • patient's age range, for

		example '60-70 year old', and • the month and/or year the adverse event happened
Family, carer or donor details	Name (both surname and forename) Address (own or associated)	
Gender identification or relationship terms for patients, family, carer, donor or Staff.	The following must be redacted if, with other information, it could potentially identify people involved: • His/Her • He/She • Male/female • Relationship terms, such as mother, wife, grandfather, partner or boss	Consider including gender reference if the context is relevant and gender specific, for example the adverse event involved a pregnant woman
Staff personal details (does not apply to staff identified as investigator or report author	• Name (both surname and forename) • Specific age • Years of service • Qualifications	Generic job title or occupation can be retained, for example Nurse A, Doctor B or Consultant C Consider providing a general indication of staff's level of experience or skills if it would support learning, for example 'an experienced senior nurse' (unless, with other information, it could identify people)
Hospital/Site	Ward	Consider the description of specific, specialist or small services, departments, clinics or hospitals - replace with more generic terms, for example 'community services', 'clinic A', 'Health Centre B'
Other identifying factors	The following must be redacted if, with other information, it could potentially identify people involved: • third party contractors/ specialists • named contracted/ commercial companies	Third party hospitals providing specialist services

Please refer to release of LAER reports flowchart (**Appendix 5**). This provides guidance for staff and ensures that General Managers have reviewed and approved the report before it is released to the patient/family point of contact.

7.3 Organisational Adverse Event Review (OAER)

OAER (previously Significant Clinical Event Analysis (SCEA)) focus on events which have significant organisational learning. There is no pre-determined list of events for which OAER will be conducted, however, if after completion of the LAER process, the review team consider there to be organisational learning then an OAER should be requested.

Every OAER request will be considered on a case by case basis and a decision on whether to proceed reached by a group of senior managers inclusive of clinical representation.

All OAER requests must be accompanied by the LAER report, an improvement plan, evidence of updated and completed LAER actions and evidence of sharing the learning within team. Failure to provide this will result in the request being rejected until all relevant information is available.

Where a request has been received and an OAER has previously been carried out for a similar set of circumstances, an examination will be undertaken to ascertain and provide assurance in relation to the implementation of actions arising from that OAER.

OAERs should be held within 3 months (90 days) of the date of the request and will be chaired by a senior clinical leader with the appropriate independence, organisational authority, skills and knowledge to carry out an effective and robust review. The final report should be completed within 5 months of the OAER being held.

The clinical representative who is part of the commissioning process will be unable to chair the OAER.

The final OAER report will be shared with those involved in the OAER and the Clinical Governance Chair of the Clinical Group where the adverse event arose.

Any actions arising from an OAER will be uploaded onto the actions module of the Datix system. This will allow for system generated emails to be distributed to the responsible person both at the time of creation and at the time the action is due. The CGRM team will monitor the completion of these actions and monitoring will be undertaken through Performance Review meetings.

Learning from every OAER will be considered and disseminated appropriately. A one page learning summary **(Appendix 4)** may be used, or learning shared through newsletters or other mediums such as briefings to Clinical Governance Chairs. These should be added to the agenda of and discussed at local Clinical Governance and Risk Management meetings. If a one page learning summary is produced this may also be uploaded onto HIS Community of Practice and local intranet pages.

7.4 Multi-board approach to adverse event reviews

Healthcare Improvement Scotland have issued guidance for use in reviewing adverse events where a Multi-Board or Multi-Agency approach is required.

The principles describe a collaborative NHS approach but the guidance can also be applied to external organisations involved in adverse events, such as social care, local authorities or Police Scotland.

The approach makes the assumption that the lead NHS board will be the NHS board where the adverse event occurred but this may not always be the case. This should be considered on a on a case by case basis and take in to account the circumstances of the adverse event.

8 Types of Adverse Events

8.1 Never Events

Never Events are defined as those which have clear potential for or have caused severe harm/death; there is evidence of occurrence in the past; are largely preventable if guidance had been implemented; occurrence can be easily defined, identified and continually measured. The list of never events monitored by NHS Tayside was agreed at the Strategic Risk Management Group in November 2015 and a copy can be found in **Appendix 6**. Any instances must be recorded in Datix and are automatically graded as RED. These must have a LAER carried out which is submitted to the Clinical Risk Management Group via the Clinical Governance and Risk Management Team for approval and monitoring of actions.

8.2 Child Protection Adverse Events

Adverse events relating to the protection of children require to be reported via the NHS Tayside electronic adverse event reporting system. The local manager (verifier) is responsible for ensuring that their Head of Service is fully informed of the adverse event.

The Head of Service will then be responsible for ensuring appropriate action is taken in line with NHS Tayside Child Protection Policy. Where adverse events require to be escalated within the organisation, the Head of Service in collaboration with the Lead Nurse Child Protection and/or Associate Nurse Director (Children, Young People, Families, Primary Care, Protection), will require to complete an SBAR in accordance with the Guidance for the use of an SBAR in cases of Child Protection.

Some child protection adverse events may require a Significant Case Review (SCR) to be carried out. A Significant Case Review is a multi-agency process for establishing the facts of, and learning lessons from, a situation where a child has died or been significantly harmed. A decision to initiate an SCR will be taken through a local Child Protection Committee. *(Scottish Government (2015) National Guidance for Child Protection Committees Conducting a Significant Case Review)*

The SCR process applies across Scotland and involves all agencies. Within NHST, the SCR process will be applied in addition to the existing AEM processes outlined in this policy. This means that any incidents which are progressing or likely to progress to an SCR will also be required to have a Local Adverse Event Review (LAER), and the LAER should take place first. The scope of the LAER should be to review the events which occurred at a local level; the SCR will then review the case more broadly with full multi-agency representation.

It may be that it is not appropriate for a member of staff to attend the LAER because they are a key individual who will be asked to attend the SCR. For this reason, the Child Protection Committee should be consulted on the intended invitees for the LAER, and they will advise on any staff which should be excluded. Further advice can be provided by Lead Nurse Child Protection and/or Associate Nurse Director (Children, Young People, Families, Primary Care, Protection).

8.3 Adult Protection

Adverse events relating to support and protection of adults should be reported in accordance with the NHS Tayside Operational Procedures for the Support & Protection of Adults at Risk of Harm.

Any member of staff who is alerted to a risk of harm or self-harm must keep detailed records of the initial cause of concern and should inform and consult the appropriate Line-Manager/Duty Manager or equivalent.

After gathering relevant information the appropriate Line-Manager/Duty Manager or equivalent should note all concerns and/or allegations and send a written report to his/her immediate Senior Manager and escalate to the relevant Clinical/Service manager immediately. The appropriate Line-Manager/Duty Manager or equivalent must also report to an appropriate council officer and, where necessary, NHS Tayside staff must co-operate with the procedures of the respective council thereafter.

All members of staff should be aware that reports may be required later as part of a legal action.

8.4 Death in Custody Adverse Events

All Deaths in Custody in a prison environment must have a robust Local Adverse Event Review and a DIPLAR (Death in Prison Learning Audit & Review) undertaken within 8 weeks of the event occurring. Dependant on the information known with regards to the adverse event, the DIPLAR review will be one of the following levels:

- Self-Inflicted Death in Prison Review
- Event of Undetermined Intent Review
- Natural Causes Death Review

Guidance with regards to the process to be followed for each of these levels of review is provided in the SPS "Death in Prison Learning, Audit & Review (DIPLAR) Process Guidance".

All Deaths in Custody are subject to a Fatal Accident Inquiry and a review by the Police Independent Review Commissioner (PIRC).

For all other adverse events relating to Prison Healthcare, the flowchart in **Appendix 7** should be followed.

8.5 Drug Related Death Adverse Events

A drug death is defined as a death directly resulting from the presumed non-intentional overdose of illicit (or illicitly obtained) controlled substances. There are two exceptions to this namely those deaths resulting from New Psychoactive Substances (NPS) or those due to the use of volatile substances.

The Tayside Drug Deaths Group (TDDG) is a multi-agency group which undertakes reviews of all suspected drug deaths notified by the police, regardless of whether the deceased had contact with NHS, local authority or other services. Through its case reviews, the TDDG brings a multi-agency perspective that adds to local adverse event review undertaken within NHS services for relevant cases.

The TDDG meets at intervals of approximately 6-8 weeks. The number of cases to be reviewed at each meeting will vary.

All suspected drug deaths where the individual is an existing client of any NHS service or team, or has been a client in the 12 months prior to death or where otherwise appropriate, will be classified as a RED adverse event and will be reviewed internally by the relevant service through Local Adverse Event procedures. In all cases, drug deaths should be reported on the adverse event reporting system.

Following this process a drug death may be referred directly for OAER. NHS Services and/or TDDG may also request OAER if a series of drug deaths which individually may not warrant OAER, but as a group raise similar issues that may point to systems failings.

8.6 **Breach of the Equality Act 2010 and the Public Sector Equality Duty**

The Equality Act 2010 put a public sector equality duty on all public authorities for the 8 protected characteristics: Age, Disability, Gender-reassignment, Pregnancy/Maternity, Race, Religion/Belief, Sex and Sexual Orientation.

Public authorities have to pay due regard to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who don't share it
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it

An adverse event which may lead to NHS Tayside being challenged on unlawful discrimination of a patient on the grounds of one or more of the protected characteristic(s) requires to be reported via the NHS Tayside electronic adverse event reporting system. The local manager (verifier) is responsible for ensuring their Head of Service is fully informed of the adverse event. The Head of Service will then be responsible for ensuring that appropriate action is taken in line with the NHS Tayside Governance and Accountability Framework for Equality and Diversity. Where adverse events require to be escalated within the organisation, the Head of Service will be required to complete an SBAR in line with NHS Tayside's responsibilities under The Equality Act 2010.

8.7 **Adverse Events for Clinical Trials of Investigational Medicinal Products**

For adverse events relating to Clinical Trials of Investigational Medicinal Products please following the guidance provided in the Standard Operating Procedure for Identifying, Recording and Reporting Adverse Events for Clinical Trials of Investigational Medicinal Products.

9. Communication

In the event of an adverse event involving a patient, the adverse event identification number should be noted in the patient case record. In addition, an adverse event report (form) must be completed in the Electronic Adverse Event Reporting System **as soon as possible after the event but within 1 working day.** As all reports are legal documents the information recorded, whilst maintaining a person centred approach, must be factual. **On advice from the Central Legal Office staff must not file a paper copy of the adverse event form or the local adverse event review report in the patient case record**.

9.1 **Patient/Family/Carer**

A full, frank and factual explanation must be shared with the patient as soon as possible after the adverse event occurs. For particular patient groups, e.g. children, ventilated patients or vulnerable adults, this may not be possible. In these circumstances discussion with carer, guardian or relative is appropriate. In all other circumstances adverse events should not be disclosed to the next of kin, carer or GP etc without the patient's consent.

The discussion should be done by a team of at least 2 staff members including a clinician who has a pre-established relationship with the patient with a clear team leader identified and documented in the patient records. State what happened, why it happened and what is being done to prevent it from happening again (IHI, 2010). Address any concerns the patient and/or family have as soon as possible. This team should inform the patient and

family point of contact as soon as the organisation has any new information pertaining to the event.

Essential messages can, when appropriate, include the following:

- The hospital apologises and regrets that the adverse event happened (see table 1 for language to use in such communication)
- We will disclose to the patient and family everything we know, keeping them informed as a priority
- We will work with appropriate authorities and use this as an opportunity to make the organisation a better and safer place for our patients, family and staff.

Table 1: Communicating after an adverse event: Words of Compassion, Concerns, Empathy and Remorse

Alarmed	Tragic	Let you down
Unfortunate	Concerned	Unhappy
Regret	Unintended	Disappointed
Sad / Saddened	Unnecessary	Unsatisfactory
Empathised	Sorrowful / Sorrow	Failed / Failure
Sympathetic		

a) External Enquiries

External media enquires regarding any adverse event must be referred to the NHS Tayside Communications Team in all instances.

The Communications Manager and the relevant Executive Director will agree a response to media enquiries.

In the event of possible media interest, the Board Secretary will inform the Directors and Non-Executive Directors of NHS Tayside and will share the media response.

The communication team provides communication support and advice across NHS Tayside to any emergency situation. This includes:

- Crisis Management
- Internal Communications
- Issuing of proactive Press Release
- Responding to and dealing with multiple media enquiries

There is one telephone number for all calls including media calls – 01382 424138. The communications team also operate an out of hour's rota to ensure cover 24 hours a day, 365 days a year.

Out of hours – anyone calling 01382 424138 will be redirected to the on call Communications Manager. The switchboard at Ninewells Hospital will also hold out of hours contact numbers.

b) Release of Adverse Event Report Forms/Adverse Event Reports

For guidance on the release of adverse event report forms and Adverse Events Reports please refer to **Appendix 8**.

Any requests for information in relation to Adverse Event Management should be directed to the Clinical Governance and Risk Management Department who will liaise

with the Chief Executive as Accountable Officer, Board Nurse and/or Medical Director, Information Governance Team and OHSAS.

10. Support for Staff following an adverse event

NHS Tayside has a duty of care to all employees following an adverse event which has occurred within the workplace. In such instances there is a range of support available and managers may:

- Refer to and where appropriate follow the NHS Tayside Critical Incident - Employee Support Policy
- Establish contact with the Employee Director's Office to ensure the associated staff side representatives can be alerted and actively provide support
- Contact the Health and Safety Team if applicable
- Contact the Wellbeing Centre which is also available for staff, offering one to one confidential conversations, telephone support and group support including Values Based Reflective Practice (VBRP®). This service is available 24/7 through an on call system

11. Feedback/Closing the Loop

As demonstrated in the adverse event flowchart **(Appendix 9**), feedback to frontline staff is a key element of the Adverse Event Reporting Mechanism.

Learning outcomes from adverse events can be disseminated across the organisation in a number of ways including:-

- Getting it Right Newsletter – articles for which can be submitted to the Clinical Governance and Risk Management Team who will create and circulate the newsletter within the Organisation on a monthly basis
- Learning Summaries - The lead reviewer should complete a one page learning summary to share key learning points from LAER. This should be submitted to the Clinical Governance and Risk Management Team, who will upload the document onto local intranet pages and HIS Community of Practice website
- Clinical Groups – All clinical groups have a Clinical Governance and Risk Management structure which should be used as a forum for discussing adverse events, sharing learning and monitoring and following up of actions/changes in practice

12. National Patient Safety Agency's (NPSA) Incident Decision Tree

The Incident Decision Tree is a key component of the National Patient Safety Agency's (NPSA) drive to help the NHS move away from asking "Who was to blame?" to "Why did the individual act in this way?" when things go wrong.

This tool has been utilised to aid the decision making to determine whether or not the adverse event was deliberate harm or malpractice and thus handled via a disciplinary route, or unintended harm or system error and thus handled via the Adverse Event Reporting Mechanism.

It has been created to help NHS Managers and Senior Clinicians decide initial action to take with staff involved in a patient safety adverse event and to identify appropriate management action. It is intended to promote a consistent and fair approach, avoiding unnecessary and costly suspensions and exclusions.

If at any stage in the adverse event review process it is deemed that disciplinary/conduct processes are required, the HR department should be informed for the disciplinary process to commence and this should not be part of the adverse event review.

The Incident Decision Tree is based on a flowchart **(Appendix 10)** and takes you through a series of structured questions about the individual's actions, motives and behaviour at the time of the adverse event.

These questions move through four sequential 'tests':

- the Deliberate Harm Test;
- the Physical/Mental Health Test;
- the Foresight Test;
- the Substitution Test.

In the majority of cases system failure turns out to be the cause of the adverse event. Depending on the nature of the adverse event and the amount of information gathered, it usually takes 30 to 60 minutes to work through.

13. Summary

The NHS Tayside Adverse Event Management Policy aims to provide clarity around the systems and processes in existence to report, investigate and share learning from adverse events.

The Clinical Governance and Risk Management Team may be contacted for further advice or guidance on any of the topics within this policy:

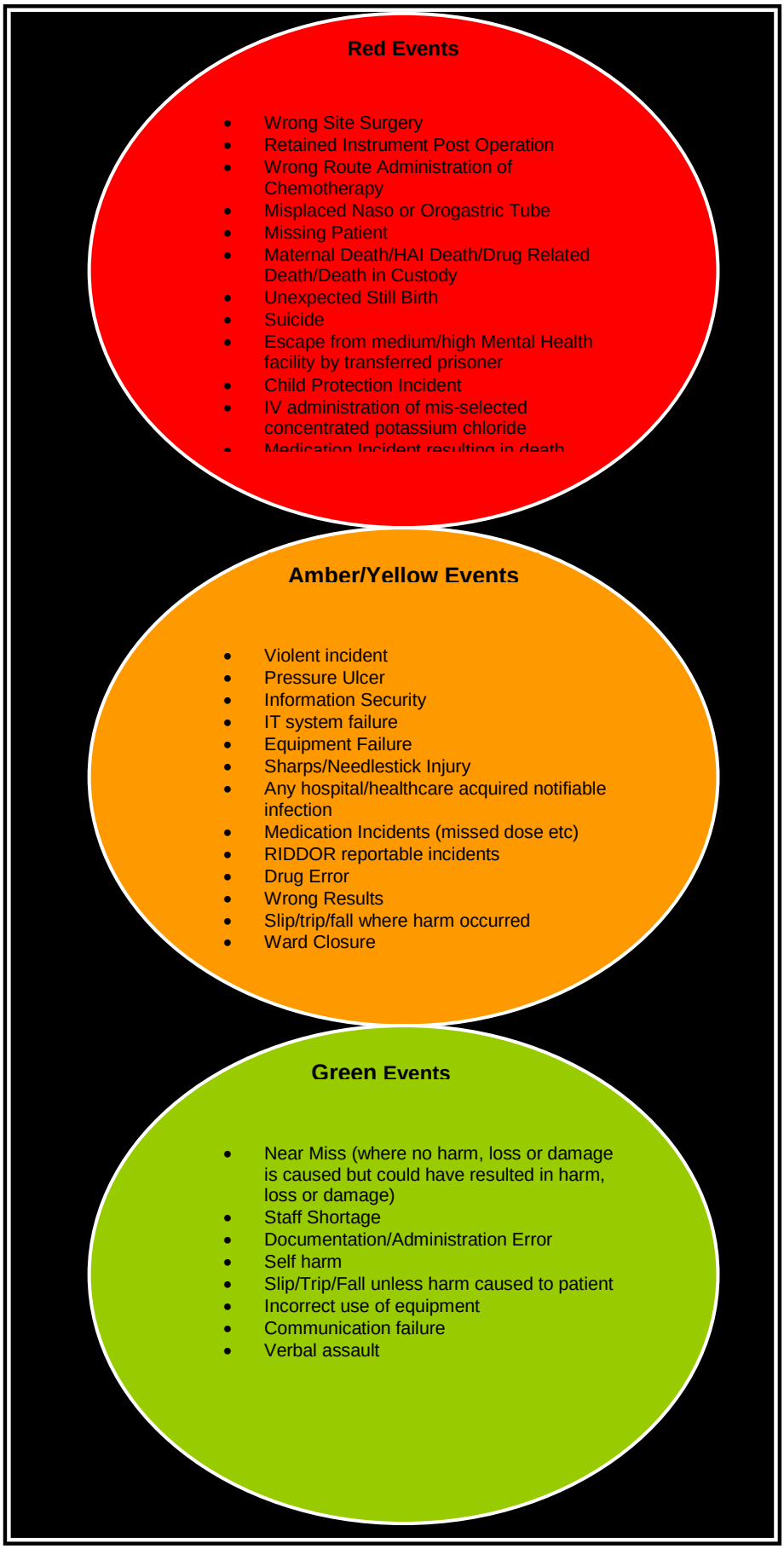
Clinical Governance and Risk Management
Ground Floor
East Day Home
Kings Cross
Clepington Road
DUNDEE
DD3 8EA
Tel: 01382 424079 or Ext 71079
Email: clinicalgovernanceriskdept.tayside@nhs.net

Adapted NHSQIS Core risk assessment matrix: Consequence score descriptors (February 2008)

	1 – Negligible (Green)	2 – Minor (Yellow)	3 – Moderate (Amber)	4 – Major (Red)	5 – Extreme (Red
Patient Experience	Reduced quality of patient experience/clinical outcome not directly relative to delivery of clinical care	Unsatisfactory patient experience/clinical outcome directly related to care provision – readily resolvable	Unsatisfactory patient experience/clinical outcome; short term effects – expect recovery <1 week	Unsatisfactory patient experience/clinical outcome; long term effects – expect recovery >1 week	Unsatisfactory patient experience/clinical outcome; continued ongoing long term effects
Objectives/Project	Barely noticeable reduction in scope, quality or schedule	Minor reduction in scope, quality or schedule	Reduction in scope of quality of project; project objectives or schedule	Significant project over-run	Inability to meet project objectives; reputation of the organisation is seriously damaged
Injury (Physical and psychological to patient/visitor/staff)	Adverse event leading to minor injury not requiring first aid	Minor injury or illness, first aid treatment required	Agency reportable, e.g. Police (violent and aggressive acts) Significant injury requiring medical treatment and/or counselling	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling	Adverse event leading to death or major permanent injury
Complaints/Claims	Locally resolved verbal complaint	Justified written complaint peripheral to clinical care	Below excess claim. Justified complaint involving lack of appropriate care	Claim above excess level. Multiple justified complaints.	Multiple claims or single major claim. Complex justified complaint.
Service/Business Interruption	Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service.	Short term disruption to service with minor impact on patient care	Some disruption in service with unacceptable impact on patent care. Temporary loss of ability to provide service.	Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being involved	Permanent loss of core service or facility. Disruption to facility leading to significant 'knock on' effect
Staffing and Competence	Short term low staffing level temporarily reduces service quality (<1 day). Short term low staffing level (<1 day), where there is no disruption to patient care.	Ongoing low staffing level reduces service quality. Minor error due to ineffective training/implementation of training.	Late delivery of key objective/service due to lack of staff. Moderate error due to ineffective training/ implementation of training. Ongoing problems with staffing levels.	Uncertain delivery of key objective/service due to lack of staff. Major error due to ineffective training/ implementation of training	Non-delivery of key objectives/ service due to lack of staff. Lack of key staff. Critical error due to ineffective training/ implementation of training
Financial (including damage/loss/fraud) **Please adjust for context**	Negligible organisational/personal financial loss (<£1k)	Minor organisational/personal financial loss (£1-10k)	Significant organisational/personal financial loss (£10-100k)	Major organisational/personal financial loss (£100k-1m)	Severe organisational/personal financial loss (£>1m)
Inspection/Audit	Small number of recommendations which focus on minor quality improvement issues	Recommendations made which can be addressed by low level of management action	Challenging recommendations that can be addressed with appropriate action plan	Enforcement action. Low rating. Critical report.	Prosecution. Zero rating. Severely critical report.
Adverse Publicity/Reputation	Rumours, no media coverage. Little effect on staff morale.	Local media coverage – short term. Some public embarrassment. Minor effect on staff morale/public attitude.	Local medial – long term adverse publicity Significant effect on staff morale and public perception of the organisation	National media/adverse publicity, less than 3 days. Public confidence in the organisation undermined. Use of services affected.	National/International medical/adverse publicity, more than 3 days. MSP/MP concern (Questions in Parliament), Court Enforcement. Public Inquiry/FAI

Appendix 2

This sheet has been designed to provide guidance and direction on the types of adverse events which should be reported within the Electronic Reporting System as Red, Amber and Green Events. It should be used with some discretion



CLINICAL GOVERNANCE & RISK MANAGEMENT TEAM

Local Adverse Event Review (LAER)
Guidance to Support LAER Toolkit

PURPOSE OF THE DOCUMENT

To provide staff guidance and timescales to support the current Local Adverse Event Review (LAER) process. The Clinical Governance and Risk Management Team can advise and provide the reviewer with appropriate tools and techniques to draw out the root cause/s and conclusions from the review, as well as identifying areas of good practice and the development of action plans.

A high quality LAER is one which:

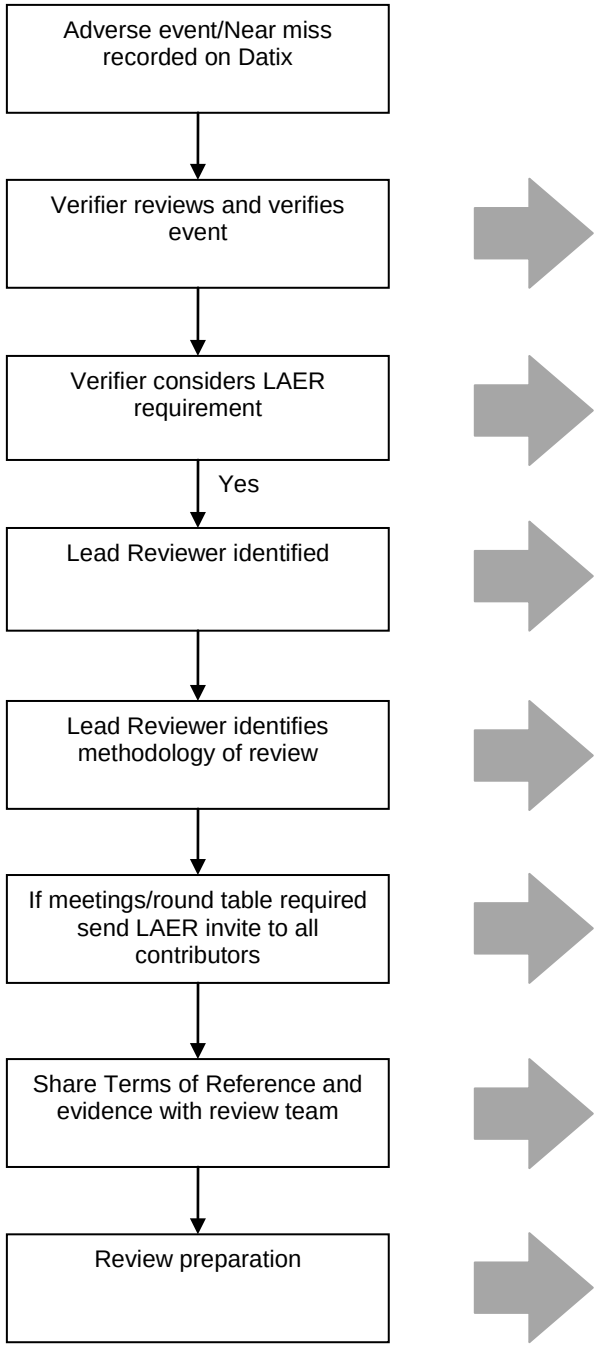
- Identifies ALL the contributing factors and any root cause(s).
- Identifies areas for improvements to strengthen the systems and processes in place.
- Highlights effective mechanisms to reduce the chances of similar adverse events occurring in the future within the Organisation.
- Has a review team sufficiently removed from the event, has no conflict of interest and are able to provide an objective view.

The following guidance will help reviewers through the LAER process and provide them with tools and techniques that are useful during reviews. It is intended as a support document and if further support/ guidance on undertaking a LAER is required, please contact the Clinical Governance and Risk Management team on 01382 424079 or clinicalgovernanceriskdept.tayside@nhs.net.

Original Creation: 01 January 2015 **Created by: Donna Kelbie**

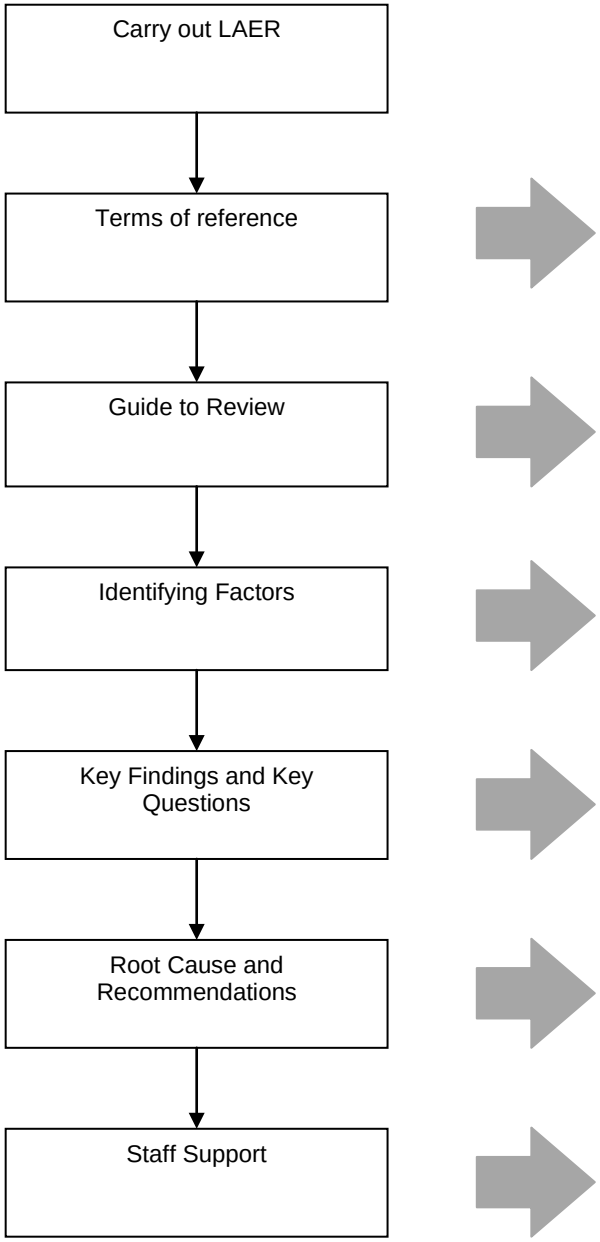
Date Modified	Version	Modified By	Modifications
27.06.2016	1.1	Stephanie Stewart	Updated toolkit
13.02.2017	2.0	Adele Elder	LAER flowchart process details added. Guidance added from AEM policy on review methods. Redaction guidance added. Report template amended.

LAER – Before



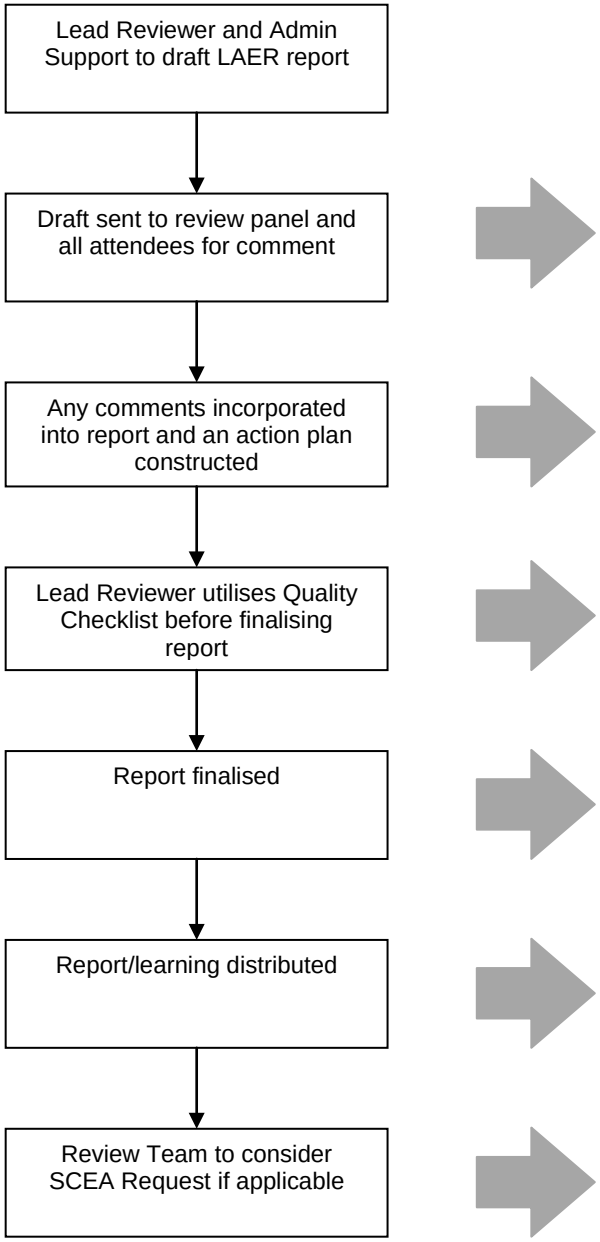
Process	Task	Responsible Person	Timescale
Verify Datix	• Confirm details within Datix • For suspected drug related deaths complete the Drug Death Questionnaire and upload to Datix and inform the Tayside Drug Death Group • Inform procurator fiscal if event resulted in fatality • Link all appropriate staff to the Datix record to enable them to view event record	Verifier	**72 hours**
Is LAER Required?	• If no – update progress notes within Datix if applicable and complete event record • **A LAER must be carried out for all RED events**	Verifier	**10 days**
Identify Lead Reviewer	• Does not need to be the event verifier • Click here for Role of Lead Reviewer	Verifier to identify appropriate Lead	
LAER Methodology	• Complete Review Plan • Identify Review Team, Attendees, Admin Support • Contact Patient/Family Point of Contact if applicable • Decide on the best tools for review i.e. Five Why's, Brainstorming, Nominal Group, Fresh Eyes	Lead Reviewer	**30 days**
LAER Invite	• Send invite to all contributors/required attendees using the template	Lead Reviewer	
Terms of Reference & Evidence	• Share the Terms of Reference • Share any relevant evidence so that key questions/findings can be identified prior to review • Share Staff Support information	Lead Reviewer	
Review Preparation	• Using facilitation tools such as the Tabular Timeline will be of benefit prior to review to detail the chronology of the event • If any delays are expected ensure Patient// are kept updated	Lead Reviewer	

LAER – During



Process	Task	Responsible Person	Timescale
Terms of Reference	• Discuss the Terms of Reference with all attendees • The purpose of the review is not to find blame and the Lead Reviewer will ensure that this is upheld by concentrating on system/contributing factors • Outcome and learning will be the main focus of the review	Lead Reviewer	**60 days for review to be held**
Guide to Review	• Use the Report Template as a guide to what should be included in the review meeting. • Define the objectives and purpose of the review • Include a factual summary of the event • Include areas of good practice	Lead Reviewer	
Identifying Factors	• It may be helpful to use the Fishbone Diagram to map the contributing factors and highlighting possible root cause • What to include in each factor section is detailed in the Report Template and the Fishbone Guidance	Lead Reviewer or assigned person	
Key Findings and Key Questions	• Detail any questions raised by patient / family / carer and the answers to each • Detail any other key questions raised at the review and the answers to each • Details the key findings of the investigation • More details on what to include are found in the Report Template	Lead Reviewer	
Root Cause and Recommendations	• If the Fishbone Diagram has been used this will facilitate the identification of the root cause • Detail any conclusions and contributing from the review • Highlight areas of improvements and recommendations	Lead Reviewer	
Staff Support	• Ensure all staff involved are offered support and given the Staff Support details if not provided prior to review	Lead Reviewer	

LAER – After



Process	Task	Responsible Person	Timescale
Draft LAER report	• Use report template • Click here for guidance on redacting the report (further guidance can be obtained by clicking the link at the top of the report template) • Draft to be sent to review panel and all attendees for comment • If any delays ensure Patient/Family Point of Contact are kept updated	Lead Reviewer	**90 days**
Comments and Action Plan	• Amend report as per comments • Use the LAER Action Plan template • Actions to be SMART (Specific, Measurable, Assignable, Realistic, Time-Related) and have a responsible person and timescale	Lead Reviewer	
Quality Checking	• Use the Quality Checklist • Ensure all necessary information is included	Lead Reviewer	
Finalised Report	• Send finalised report out to all attendees • Upload report to the event record in Datix • Assign any actions to responsible persons via Datix • Contact Patient/Family Point of Contact if applicable to share outcome of LAER and offer copy of report and/or follow up meeting • Ensure staff are supported throughout the process and arrange any follow up support as required	Lead Reviewer	
Distribution of Report / Learning	• Distribute report and any learning as identified in LAER report • Use the Learning Summary template to do this. For guidance on distributing Learning Summary click here.	Lead Reviewer	
SCEA Request	• Refer to the Adverse Event Management policy for guidance • If no SCEA requested then complete event record in Datix • If SCEA is to be considered complete the SCEA Request form and send with the LAER report and supporting evidence	Review Team/ Lead Reviewer	

IDENTIFYING A LEAD REVIEWER

To ensure a LAER is high quality and robust it is important for a Lead Reviewer to be identified. They do not necessarily need to be the verifier of the event, however for most reviews this will be the case.

The role of the lead reviewer is to:

- Provide leadership to the investigation and review team.
- Complete the review plan – identifying review team, attendees, methodology and key questions/ discussions.
  NB it is important that the review team are able to provide an objective view.
- Identify administrative support within their team to assist with the arrangement and completion of the LAER.
- Share the Terms of Reference for the LAER with the review team.
- Ensure the Terms of Reference for the LAER are followed and adhered to.
- Ensure all documents/evidence (e.g. tabular timeline, relevant case notes, Datix report) is available to the review team and contributors.
- Oversee and have responsibility for the completion of the LAER report.
- Ensure all actions are assigned to the most appropriate person and completed within the timescale.
- Offer support to all staff involved in the event and signpost where necessary to the most appropriate resource e.g. OHSAS, Wellbeing Centre.

It is important that the person is competent in root cause analysis techniques and/or has undertaken LAER training. If they have not, they should secure support from someone else that has undergone this training. The Clinical Governance and Risk Management Team can provide support to the lead reviewer or assist with identifying another suitable person.

The lead reviewer will need to decide the most appropriate method in collating information pertinent to the level of review required and the individual circumstances surrounding the adverse event. There are various methods of conducting a review i.e. table top exercise, 1:1 discussions, written documentation/staff personal reflections, telephone interview.

The following tools may be useful to use when undertaking a LAER, there is no right or wrong tool to use and there may be times that no identified tool is used. This is also acceptable providing the purpose of the LAER is met. For more information on the tools and how to use these please click on the link alongside them:

- The Five Why's (Click Here)
- Cause and Effect – Fishbone (Click Here) Template (Click Here)
- Brainstorming technique (Click Here)
- Nominal group technique (Click Here)
- Tabular timeline (Click Here) Template (Click Here)
- Fresh Eyes (Click Here)

Facilitation is important during LAER's to ensure they are as robust as possible and fulfil the objectives. A Handy Guide to Facilitation can be found here.

LOCAL ADVERSE EVENT REVIEW PLAN (LAER)
(Template)

Datix Number:

Adverse Event Date:

Date/Venue:
If applicable

Purpose:
The purpose of this LAER is to identify and detail the contributing factors, any root causes and key learning from this adverse event. The information gathered from undertaking this LAER will be used to significantly reduce the likelihood of future harm to patients and will be shared accordingly to ensure wider learning.

Review Team:
Lead Reviewer, Facilitator, Head of Service/Clinical Services Manager, independent person(s) that can remain objective throughout the review.

Contributors:
Key staff who are aware of and have been involved in the adverse event. Also Management who can influence the decision making process and implement any new methods of working that are actioned from the learning of the review.

Methodology:
The Lead Reviewer must determine the most suitable method of undertaking the review, taking into consideration that it may not be appropriate or practical to employ traditional round table discussions.

Example:
Round table discussion
Collation of staff personal reflections
Individual discussions with key staff (via telephone, 1:1 discussions and/or email correspondence)
Concerns raised by patient/family/carer

Evidence/Documentation to gather prior to LAER:
For example, tabular timeline, case note review, patient/family concerns.

Key Questions to Consider:
Questions that have been identified while reviewing the evidence that need addressed during the review and will form the basis of the LAER report.

Patient/Family/Carer Contact:
Identify whether required, if not state reason.
If required, identify responsible person for this and how it will be done. Ensure contact is made pre and post LAER and regular updates are provided in case of any delay.

INVITE TO LOCAL ADVERSE EVENT REVIEW

Dear Colleague

LOCAL ADVERSE EVENT REVIEW: DATIX ID No ……..

Please be advised that our service will be holding a Local Adverse Event Review in connection with the above.

The purpose of the Local Adverse Event Review is to discuss and identify the contributing factors that led up to this event and detail the root cause(s) and key learning from this.

Arrangements have been made to meet and review this adverse event on:

DATE, TIME AND VENUE

Your contribution and expertise to this review is necessary to ensure we discuss all aspects of care and service delivery.

Please can you confirm your attendance on the number below or by way of return email.

Thank you

For multi-board attendance please use the Multi-board Approach to Significant Adverse Event Reviews template by click here.

TERMS OF REFERENCE FOR LOCAL ADVERSE EVENT REVIEW (LAER)

The review team (including the Lead Reviewer) are responsible for ensuring that the quality of a LAER is of a high standard, the root cause(s) and conclusions are identified and the investigation outcome is documented.

The review team's **purpose** is to:

- Establish clear and complete chronology of what happened
- Examine:
    - Factual summary of the adverse event, background and context clearly documented
    - Identify risk assessments and risk management plans
    - Identify key contributing factors i.e. human and system
    - Identify conclusions and root cause(s)
    - Identify investigation outcomes
    - Make recommendations to address the most influencing factors, are these SMART (specific, measurable, assignable, realistic and time related)?
- Collate an investigative report using the LAER template, this clearly sets out the team's findings, conclusions and recommendations
- Develop an action plan (if required)
- Communicate the findings and recommendations of the review with interviewees and allow their feedback/comments before the report is finalised and complete. Upon completion the report should be uploaded onto the adverse event reporting system (Datix)
- Decide whether the event should be considered for a Significant Clinical Event Analysis (SCEA). For further information please refer to the Adverse Event Management Policy
- Consider the learning from the review and how this can be shared locally, at directorate level and across the Organisation. The Learning Summary template can be used for this

Ground Rules for LAER Reviews

- Contribution from everyone involved
- Respect opinions and views
- No blame – look at system/contributing factors
- Focus on outcome and learning

STAFF SUPPORT FOLLOWING AN ADVERSE EVENT

Adverse events can and do occur during the course of service provision. NHS Tayside has a duty to support **all** staff during and following an adverse event and the investigation process.

NHS Tayside employees must report any adverse event which they have been involved or connected with as a result of their employment or work activities as soon as is practical after the event. This must be reported to their line manager and in line with the Adverse Event Management Policy, where appropriate.

Employees who are affected by their experience of an adverse event should seek **support** from the following:

- Line Manager
- Wellbeing Centre
- Department of Spiritual Health
- Trade Union Representative
- GP
- Occupational Health
- Doctor, Nurse, Counsellor, Clinical Psychologist or Counselling Psychologist

Managers should also meet with staff to monitor the effects of an adverse event. The form 'Record of Initial Support Meeting' from the Clinical Incident Employee Support Policy can be used to note any actions or outcomes of the meeting.

The Critical Incident Employee Support Policy can be accessed here.

The Staff Support Leaflet has been produced to help staff understand their thoughts, feelings and reactions to a recent adverse event in which they were involved in. This can be accessed here.

The purpose of the LAER process is not to apportion blame but to learn from and identify improvements to prevent similar events occurring in the future and staff should feel supported during this process. A document has been developed with frequently asked questions about the LAER process which some staff may find useful. This can be found here.

NB: LAER REPORTS MUST BE REDACTED, PLEASE CLICK HERE FOR GUIDANCE

NHS Tayside

LOCAL ADVERSE EVENT REVIEW (LAER) REPORT *(Template)*

1. Adverse Event Reference Number: **Date LAER held:**	*Include in this section the adverse event reporting details.*	
2. Introduction / Purpose	*The purpose of this report is to identify and detail the root causes and key learning from an adverse event. The information in this report will be used to significantly reduce the likelihood of future harm to patients and to share learning.*	
3. Objectives	• *To establish the background and sequence of events that led up to the adverse event* • *To identify underlying contributing factors in management and organisational systems* • *To identify lessons learned and develop a list of recommendations that would prevent similar adverse events occurring in the future* • *To provide a report and record of the investigation process and outcomes* • *To communicate any findings and recommendations across the organisation including those individuals directly affected or involved* • *To provide a means of sharing learning from the adverse event*	
4. Review Team / Contributors (Anonymised)	*Identify the individuals participating in the adverse event review and indicate their role (such as lead investigator, clinical advisor etc)* *Assign all persons involved a coded reference e.g. Cons A which must be used throughout the report.*	
5. Were all the key individuals involved?	**YES**	**NO**
	Provide details if No	
6. Review Methodology and Documentation	*State review methodology and what documentation informed the review e.g. review of adverse event report forms, review of individual statement, review of related documentation and health records, review of relevant policies/SOP's, timeline construction.* *Also state any facilitation tools used e.g. Cause and Effect – Fishbone, Five Why's, Tabular Timeline etc.*	
7. Patient / family / carer contact prior to LAER	*Include in this section the interaction with the patient / family / carer and any questions / concerns they wish raised / answered as part of the LAER process (if a decision has been made not to inform the*	

	patient /family point of contact / carer the reason for this must be detailed here)
8. Response to patient / family / carer questions / observations / issues raised	*Include the questions / observations / issues raised and the answers to each.*
9. Provide a factual summary of the Adverse Event	*<u>Background and Context</u>* *Provide a brief factual background to the adverse event, include relevant information i.e. patient clinical history but do not use the patient's name.* *<u>Description of Events</u>* *Provide a description of the adverse event (what actually happened), including events preceding the adverse event and any immediate action taken in response (Who, What, When and Why).* *<u>Adverse Event Timeline</u>* *Adverse event timeline should be included. This can be moved to appendices and referenced if more appropriate.*
10. Findings and Key Questions	*Detail the key questions and findings of the investigation based on analysis of the information, highlighting any areas where issues are identified (it is good practice to use cause and effect analysis here to allow understanding of the nature of issues for example if a system error has occurred).*
11. Identify the human and system factors which contributed to the adverse event as detailed below:	*Each contributory factor may be specific to that adverse event or, more importantly, may reflect more general problems.*
Patient Factors • **Condition (complexity and seriousness)** • **Language and communication** • **Personality and social factors**	
Task Factors • **Task design and clarity of structure** • **Availability and use of protocols** • **Availability and accuracy of test results**	
Individual (Staff) Factors • **Knowledge, skills and competence** • **Motivation and attitude** • **Physical and mental health**	
Team Factors • **Verbal and written communication** • **Supervision and seeking help** • **Team structure and leadership**	

Working Conditions • **Staffing levels, skill mix and workload** • **Availability and maintenance of equipment** • **Administrative and managerial support**		
Organisation and Management Factors • **Financial resources and constraints** • **Organisational structure** • **Policy, standards and goals** • **Safety culture and priorities**		
12. Provide details of good practice identified		
13. Conclusions / Root Causes	*Detail here conclusions made by the team of the above issues identifying all contributing factors and any root cause(s).* *Highlight the areas of improvements that have been identified during the review.*	
14. Was the adverse event avoidable?	**YES**	**NO**
15. Actions	*Present actions to address each of the issues/conclusions made by the review team. Are the actions linked to the root cause/contributing factors i.e. would they prevent the adverse event from happening again.* *Ensure all actions are SMART (Specific, Measureable, Assignable, Realistic, Time-Related) and have a responsible person and achievable timescale assigned to them. Once agreed, ensure actions are assigned through the Datix system to responsible persons.* *It is useful to consider the differing levels of actions i.e. do they only impact area of adverse event or wider? Present information to show this.* *<u>Local</u> – those affecting area of adverse event.* *<u>Directorate/Health & Social Care Partnership</u> – those which go beyond affected area but within Directorate/Health & Social Care Partnership.* *<u>Board</u> – issues which go beyond the Directorate.* *This would include the submission of a SCEA request if appropriate.*	
16. Give details of how the learning (including good practice) will be shared across the organisation	**Directorate/Health & Social Care Partnership** **Across Organisation**	
17. Give details of how feedback from the review will be communicated to the patient / family point of contact / carer following the review	*Also identify the responsible person for sharing the findings of the LAER to the patient/family point of contact/carer.*	

18. Staff support	*Include in this section the interaction with staff who were directly involved in the adverse event, the support offered and how feedback will be given to staff following the LAER.*

Date adverse event recorded on / or form uploaded onto Datix		
Has a SCEA been considered?	**YES**	**NO**
	Provide details for rationale of decision	

Report Led By:	**Designation:**
	Location:
Persons Notified:	
Date:	

Has the report been circulated to all attendees for comment?	**YES**	**NO**
	Provide details if No	

Has the report been signed off by General Manager/Chief Officer/ Deputy?	**YES**	**NO**
	Provide details if No	

<u>Once this document has been uploaded onto the Datix system, please ensure the following fields are completed within the LAER section of the adverse event record:</u>

- Date Event Review Started
- Date Event Review Completed
- Lessons learned as a result of review. Conclusions and root cause(s). You must enter a value in this field.
- Action taken as a result of review
- Outcomes and recommendations. You must enter a value in this field.
- Investigation Outcome
- Was the Adverse Event preventable?

LOCAL ADVERSE EVENT REVIEW (LAER) ACTION PLAN *(Template)*

For Guidance on SMART Actions Click Here

Action	Responsible Person	Due Date	Completed Date	Progress Notes

SMART ACTIONS GUIDANCE

Actions assigned from the Local Adverse Event Review must be SMART.

- **S** Specific – target a specific area for improvement
- **M** Measureable – quantify or at least suggest and indicator of progress
- **A** Assignable / Attainable – specify who will do it and how
- **R** Realistic – state what results can realistically be achieved given available resources
- **T** Time-related – specify when the result(s) can be achieved

Specific

A specific goal will usually answer the five 'W' questions:

- **What** – what do I want to accomplish?
- **Why** – specific reasons, purposes or benefits of accomplishing the goal
- **Who** – who is involved?
- **Where** – identify a location
- **Which** – identify requirements and constraints

Measurable

A measurable goal will usually answer such questions as:

- How much?
- How many?
- How will I know when it is accomplished?
- Indicators should be quantifiable

Assignable / Attainable

An achievable goal will usually answer the question 'How':

- How can the goal be accomplished
- How realistic is the goal based on other constraints

Realistic

A realistic and relevant goal can answer yes to these questions:

- Does this seem worthwhile?
- Is this the right time?
- Does this match our other efforts/needs?
- Is the assigned person the right person?
- Is it applicable in the current social-economic environment?

Time-Related

A time-bound goal will usually answer the questions:

- When?
- What can the assigned person do six months from now?
- What can the assigned person do six weeks from now?
- What can the assigned person do today?

REDACTION CHECKLIST

All of the items below should be considered on a case by case basis, taking into account the context and potential privacy impact. If in doubt, contact the Clinical Governance and Risk Management Team.

Category of Data	Must be redacted	Considerations to be given to redaction on an individual basis
Patient personal details	• Name (both surname and forename) • Date of birth • Specific age reference • Hospital number • CHI number • Address (own or associated) • Postcode • GP • 'Direct lift' clinical information taken from patient/deceased patient's medical records • Detailed clinical investigation results • Full medical history • Date adverse event happened	• Assess the uniqueness of the disease/ diagnosis/testing – some common diagnoses combined with other data may risk identification. For example, childhood leukaemia is not unique, but is rare, and when given with other details such as a single hospital in a small NHS board area, it potentially identifies individuals • Consider providing the following if it would help provide context and support understanding and learning (unless, with other information, it could identify people): o Relevant medical history or clinical information o Patient's age range, for example '60-70 year old' o The month and/or year the adverse event happened
Family, carer or donor details	• Name (both surname and forename) • Address (own or associated)	
Gender identification or relationship in terms for patients, family, carer, donor or staff	• The following must be redacted if, with other information, it could potentially identify people involved: o His/her o He/she o Male/female o Relationship terms such as mother, wife, grandfather, partner or boss	• Consider including gender reference if the context is relevant and gender specific, for example the adverse event involved a pregnant woman
Staff personal details (does not apply to staff identified as investigator or report author)	• Name (both surname and forename) • Specific age • Years of service • Qualifications	• Generic job title or occupation can be retained, for example Nurse A, Doctor B or Consultant C • Consider providing a general indication of staff's level of experience or skills if it would support learning, for example 'an experienced senior nurse' (unless, with other information, it could identify people)
Hospital/site	• Ward	• Consider the description of specific, specialist or small services, departments, clinics or hospitals – replace with more generic terms for example 'community services', 'Clinic A', 'Health Centre B'
Other identifying factors	• The following must be redacted if, with other information, it could potentially identify people involved: o Third party contractors/ specialists o Named contracted/ commercial companies	

Health Improvement Scotland, Data Redaction and Standardised Adverse Event Review Reports Guidance Paper, December 2014

LOCAL ADVERSE EVENT REVIEW QUALITY CHECKLIST

Adverse Event Date: ..... Datix Number: ..... Date of LAER: ..... Lead Reviewer:		Reviewer		CGRM Team **Department Use Only**	
		Yes	No	Yes	No
1.	Have the roles of all individuals involved in the LAER been recorded and anonymised?	☐	☐	☐	☐
2.	Has the data gathering process and facilitation tools used been outlined in the report?	☐	☐	☐	☐
3.	Have the patient/relatives been contacted prior to the LAER?	☐	☐	☐	☐
4.	Has a factual summary of the adverse event been outlined to include the following:				
	• Background and context	☐	☐	☐	☐
	• Description of events	☐	☐	☐	☐
	• Adverse event timeline (if appropriate)	☐	☐	☐	☐
5.	Have the human and system factors been identified?	☐	☐	☐	☐
6.	Have areas of good practice been identified?	☐	☐	☐	☐
7.	Has the root cause(s) of the problem been identified and a conclusion provided?	☐	☐	☐	☐
8.	Does the report clearly state if the adverse event was avoidable or not?	☐	☐	☐	☐
9.	Does the report clearly outline the LAER actions?	☐	☐	☐	☐
10.	Has an action plan been produced which identifies who is responsible for ensuring the actions are completed?	☐	☐	☐	☐
11.	Does the action plan have specific timescales for implementation?	☐	☐	☐	☐
12.	Does the report detail how learning will be shared across the service/organisation?	☐	☐	☐	☐
13.	Has an individual been identified to share the findings of the LAER report to the patient/family point of contact?	☐	☐	☐	☐
14.	(a) Is there evidence of support offered to staff?	☐	☐	☐	☐
	(b) Has feedback been provided to staff?	☐	☐	☐	☐
15.	Has the LAER report been uploaded to Datix?	☐	☐	☐	☐
16.	Has the investigation outcome/outcome code been identified in Datix?	☐	☐	☐	☐
17.	If appropriate, has a SCEA been considered?	☐	☐	☐	☐
18.	Were all attendees given the opportunity to comment on and approve the LAER report?	☐	☐	☐	☐

LOCAL ADVERSE EVENT REVIEW QUALITY CHECKLIST

Questions to consider in assessing quality of Local Adverse Event Review

Individuals involved in LAER:

- Was there anyone missing?

Data gathering process / facilitation tools:

- Was it clear what facilitation tools were used?
- Were they appropriate for the type of review?

Factual summary of the incident:

- Was there sufficient information on the background / context?
- From reading the report, did I fully understand what happened?
- Was it clear to someone not involved in the event/review what happened?

Key questions:

- Have key questions been identified and are they answered within the report?

Human and system factors:

- Have all the contributing factors been considered?

Conclusions / root cause:

- Has the root cause(s) been identified and explained fully?

Avoidable / unavoidable:

- If the adverse event was avoidable, does the report explain how?

Actions:

- Do the actions relate to the review findings?
- Would the actions prevent the event from happening again?
- Do the actions stipulate clear timescales and responsible people for taking this forward?

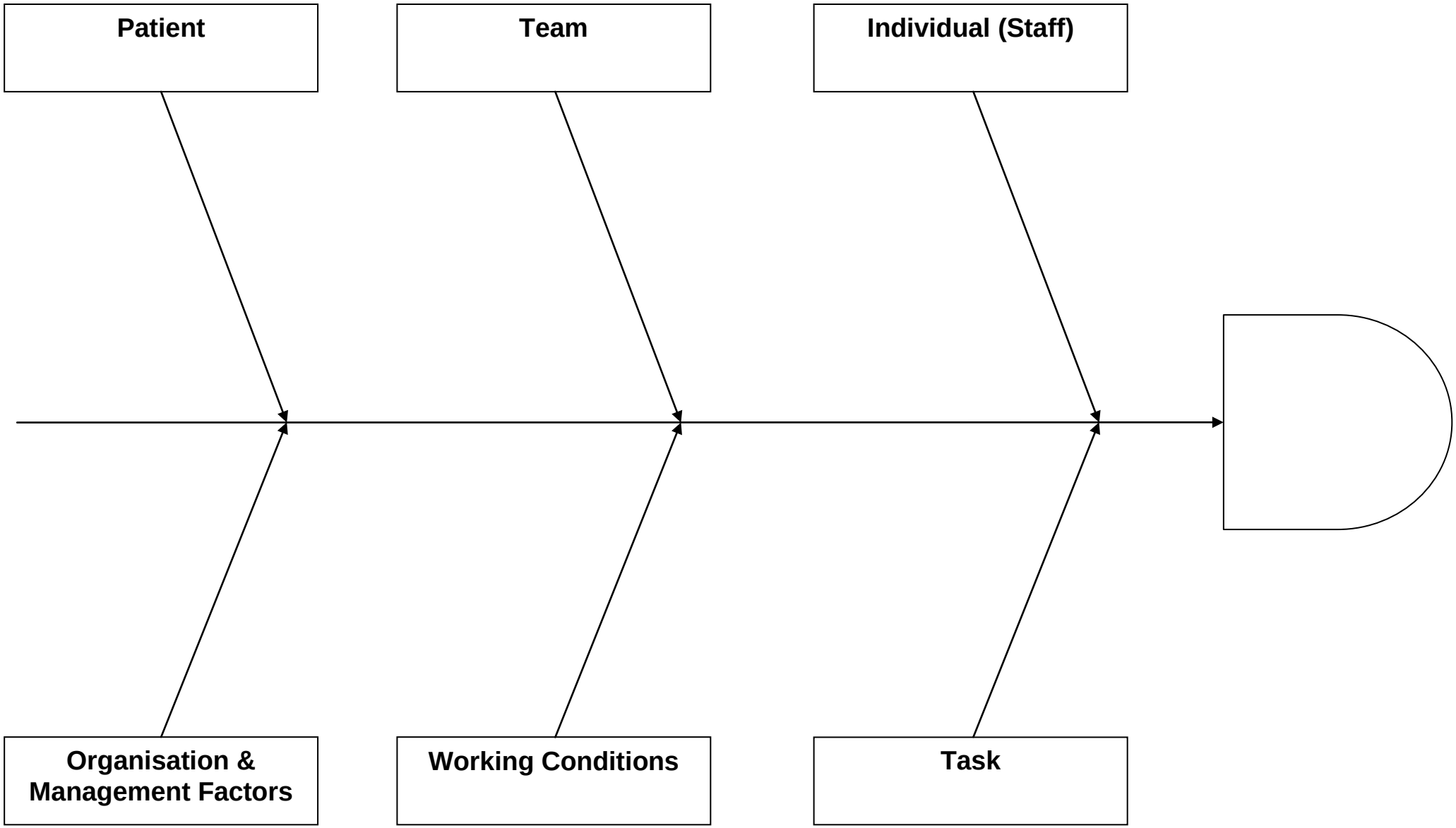
Additional questions:

- Was there evidence of review planning?
- Would I have done it any differently? i.e. different methodology, data gathering
- Was the review report written in a person centred language?
- Was the level of review appropriate to the incident grading?
- Were there any terms used throughout the report that I didn't understand and weren't explained?
- Is there a clear plan outlined for sharing the learning at local, directorate and organisational level and has an accountable person been identified to ensure this is completed?

Comments:

CAUSE AND EFFECT – FISHBONE *(Template)*

For Guidance on Using this Template Click Here



FISHBONE – PURPOSE AND GUIDANCE

Using the fishbone for cause and effect analysis can be useful to think through the causes of a problem thoroughly including its possible root causes. It can help identify areas of further improvement/investigation and can help understand the problem more clearly.

Things to consider under each heading of the fishbone diagram:

Patient
- Condition (complexity and seriousness)
- Language and communication
- Personality and social factor

Team
- Verbal and written communication
- Supervision and seeking help
- Team structure and leadership

Individual (staff)
- Knowledge, skills and competence
- Motivation and attitude
- Physical and mental health

Organisation & management factors
- Financial resources and constraints
- Organisational structure
- Policy, standards and goals
- Safety culture and priorities

Working conditions
- Staffing levels, skill mix and workload
- Availability and maintenance of equipment
- Administrative and managerial support

Task
- Task design and clarity of structure
- Availability and use of protocols
- Availability and accuracy of test results

For further information and guidance click here.

TABULAR TIMELINE *(Template)*

For Guidance on Using this Template Click Here

Date: **Time:**	**Date:** **Time:**	**Date:** **Time:**
Event	**Event**	**Event**
Supplementary Info	**Supplementary Info**	**Supplementary Info**
Positive Points	**Positive Points**	**Positive Points**
Problems	**Problems**	**Problems**
Further Info Required	**Further Info Required**	**Further Info Required**
Background Info	**Background Info**	**Background Info**
Areas for Improvement	**Areas for Improvement**	**Areas for Improvement**

Six Steps to Root Cause Analysis (3rd Edition), M Dineen, Consequence UK, 2011

TABULAR TIMELINE – PURPOSE AND GUIDANCE

The tabular timeline is an alternative way to provide a structured chronology, while also exploring each key point leading up to the event.

As with any timeline there is essential data that should be included, this includes the date, time and what was happening at that point. In addition to this, other recommended points to include are:

- Background information – to better understand the context
- Positive points – to highlight good practice
- Problems – to identify areas of concern
- Further information
- Areas for improvement

These additional points ensure that a greater degree of detail into each key point is provided. The template of this document can be adapted as there may be other fields that reviewers may find useful and pertinent to the event that is being reviewed e.g. risk assessment, medication, insight from staff members.

Although constructing a tabular timeline can be a time consuming process, a well mapped tabular timeline is a powerful tool that allows all staff involved to view the event as a whole creating an open and transparent investigation. It allows them to expand their thinking around the event and identify the key questions and areas for improvement, to assist in meeting the objectives of a high quality LAER.

Key guidance for constructing a tabular timeline is as follows:

- The review team should start populating the timeline prior to the LAER as part of the data gathering process
- Decide at what point in the care / case pathway you want to start the timeline. The timeline needs to start early enough to allow everyone to fully understand the event and the key points leading up to it
- Adapt the timeline template to include what is relevant for the event in question
- Take a note of any questions that arise while constructing the timeline, these will form the basis of the key questions that will be posed during the LAER process
- Ensure the timeline is detailed, there is no such thing as too much detail when undertaking LAER's
- Gaps in the timeline are acceptable, these may not be relevant to populate or may be populated throughout the review process by the contributors
- Ensure the timeline is shared with all contributors prior to holding the LAER so they can be prepared and start to answer any questions and / or consider their own findings / questions

Six Steps to Root Cause Analysis (3rd Edition), M Dineen, Consequence UK, 2011

THE FIVE WHY'S – PURPOSE AND GUIDANCE

Think about children, they always question why? Over and over again!

This is a very simple technique which is probably best suited to non-complex problems.

The nature of the five why's technique is to delve deeper into a problem asking why for each cause that is offered until there are no more causes forth coming.

Don't get too hung up on technique, if after so many why's you are getting nowhere then perhaps this is not the most suitable tool to use. Also it is not set in stone that you must ask why five times; you can why as many times as necessary.

For more information click here.

Back to methodologies click here.

BRAINSTORMING TECHNIQUE – PURPOSE AND GUIDANCE

A chance for everyone involved to share their thoughts/suggestions/ideas. Record the ideas on flip charts or post-it notes where everyone can see them.

Advantages of brainstorming:

- It can generate a list of problems, influencing factors, possible solutions
- It involves everyone, promoting a sense of ownership

Disadvantages of brainstorming:

- Can be difficult to explore sensitive issues
- Can lead to periods of silence
- It's not anonymous

For more information click here.

Back to methodologies click here.

THE NOMINAL GROUP TECHNIQUE – PURPOSE AND GUIDANCE

This tool can be used to assist participants to prioritise the problems they consider to be the most significant in contributing to the event occurring. It can assist the group in identifying the most fundamental causal factors contributing to each of the problems identified.

This technique is used in conjunction with the brainstorming technique. There are variations of this technique but generally each person is asked to identify problems or issues on post-it notes or paper of sorts. All of the same colour to keep suggestions anonymous.

The facilitator will then record each of the suggestions on a flip chart, omitting duplications. The group will then be asked to give a score to the most import issues (can be 5-7 issues), a ranking of problems/issues.

For more information click here.

Back to methodologies click here.

FRESH EYES TECHNIQUE – PURPOSE AND GUIDANCE

It is easy to follow the same routines and do things the way that they have always been done. How often do you stop and consider whether there is an alternative way of doing things.

This tool is useful to look at the problems/issues from a different perspective. We often view situations from our own personal perspectives so using this tool to look at it from another viewpoint is beneficial.

For more information click here.

Back to methodologies click here.

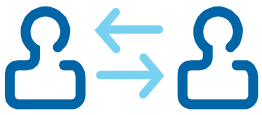
NHS Institution for Innovation and Improvement, Quality and Service Improvement Tools, 2008

LEARNING SUMMARY

Directorate: **Contact:**

Category: **Preventing:**

Sharing the Learning



What happened?

What went well?

What, if anything, could we improve?

What have we learned?

Lead Reviewer:

If you have any comments or want to know more about this OAER or any other similar adverse events please contact: **(NAME) – CGRM (Role)**
clinicalgovernacnerisk.tayside@nhs.net

LEARNING SUMMARY – PURPOSE AND GUIDANCE

Sharing learning from local adverse events reviews or complaints is a key component of reducing the risk of a similar event occurring to someone else. Learning points that are worth sharing prevent the risk of re-occurrence, share good practice and promote quality improvement and safe care.

The learning summary template can be used to share learning from adverse event reviews and complaints across teams, Directorates, Organisation and Nationally. NHS Tayside has adapted the learning summary template used by Health Improvement Scotland (HIS) to use locally. Learning summaries can also be used to share learning nationally with other Health Boards on the HIS Community of Practice Web-site.

The lead reviewer may complete a one page learning summary to share key learning points from LAER

Checklist for sharing Learning Summaries

- Use agreed template. (This can be found on Intranet/safe&effective working/clinical governance/adverse event management/learning summary template
- Give a brief outline of the adverse event, what happened?
- Highlight any good practice that was identified from the review
- Share areas for improvement and learning identified from the review. In most cases you can use conclusion from the LAER report

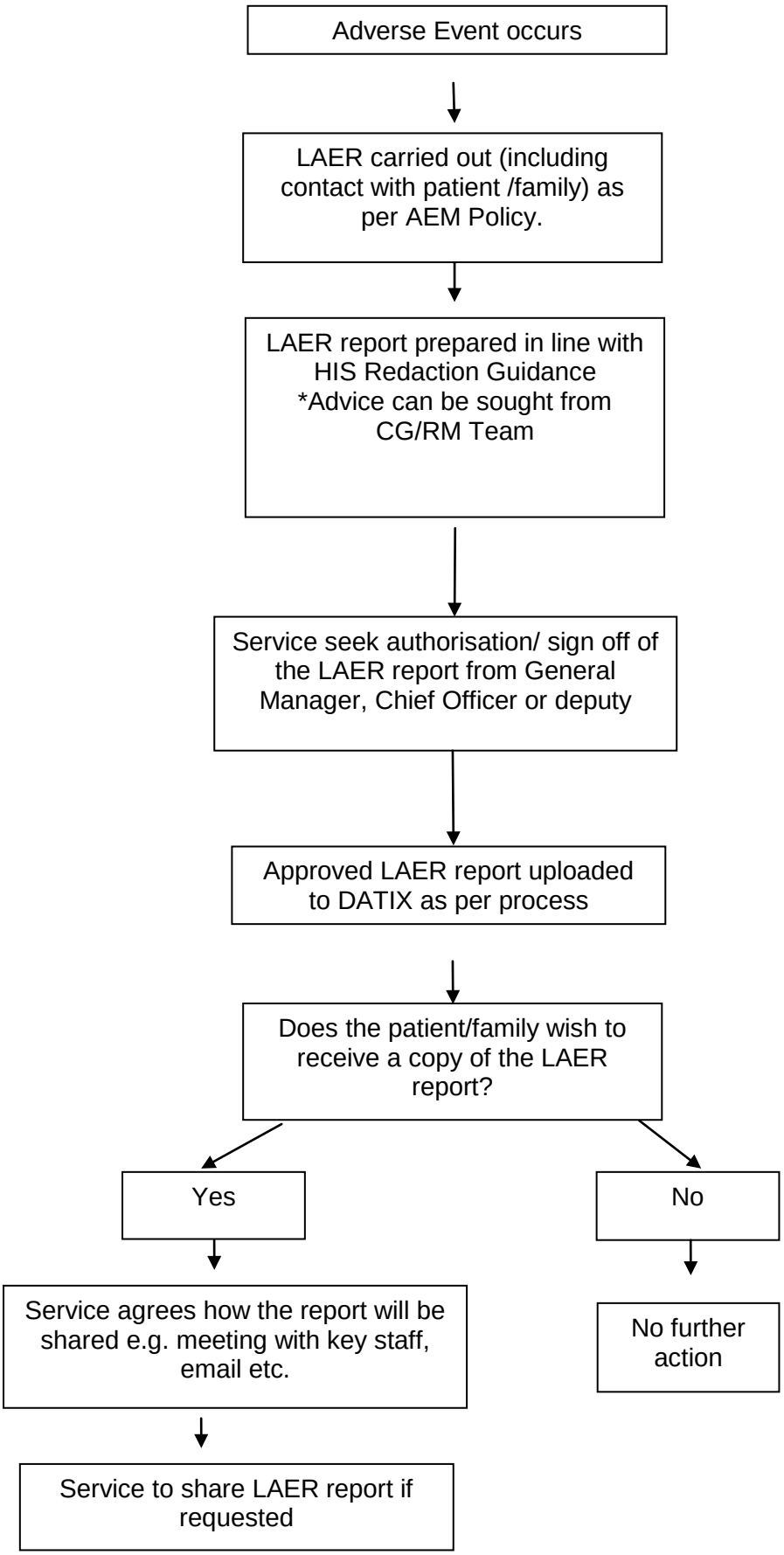
  ***Please consider further redaction** when completing the learning summary template*.

Completed learning summaries should be submitted to the Clinical Governance and Risk Management Team, who will upload the document onto local intranet pages and wider learning, HIS Community of Practice website

Learning from adverse events reviews can be disseminated across the Organisation in a number of ways. Please consider sharing the learning you have identified through using the template and also:

- Getting it Right Newsletter – articles for which can be submitted to the Clinical Governance and Risk Management Team who will create and circulate the newsletter within the Organisation on a monthly basis.
- Clinical Groups – All clinical groups have a Clinical Governance and Risk Management structure which should be used as a forum for discussing adverse events, sharing learning, monitoring and following up of actions/changes in practice.

Process for sharing LAER reports



The never events list 2016/17

The following never events list is the list that NHS Tayside should use. It is applicable for all adverse events that occur on or after 1 April 2016.

1. Wrong site surgery

A surgical intervention performed on the wrong patient or wrong site (for example wrong knee, wrong eye, wrong limb, wrong tooth or wrong organ); the incident is detected at any time after the start of the procedure.

Includes wrong level spinal surgery and interventions that are considered surgical but may be done outside of a surgical environment e.g. wrong site block (unless being undertaken as a pain control procedure), biopsy, interventional radiology procedures, cardiology procedures, drain insertion and line insertion e.g. PICC/ Hickman lines.

Excludes interventions where the wrong site is selected because of unknown/unexpected abnormalities in the patient's anatomy. This should be documented in the patient's notes.

Excludes incidents where the wrong site surgery is due to incorrect laboratory reports/ results or incorrect referral letters.

2. Wrong implant/prosthesis

Surgical placement of the wrong implant or prosthesis where the implant/prosthesis placed in the patient is other than that specified in the surgical plan either prior to or during the procedure and the incident is detected at any time after the implant/prosthesis is placed in the patient.

Excludes where the implant/prosthesis placed in the patient is intentionally different from the surgical plan, where this is based on clinical judgement at the time of the procedure.

Excludes where the implant/prosthesis placed in the patient is intentionally planned and placed but later found to be suboptimal.

3. Retained foreign object post-procedure

Retention of a foreign object in a patient after a surgical/invasive procedure.

'Surgical/invasive procedure' includes interventional radiology, cardiology, interventions related to vaginal birth and interventions performed outside of the surgical environment e.g. central line placement in ward areas.

'Foreign object' includes any items that should be subject to a formal counting /checking process at the commencement of the procedure and a counting /checking process before the procedure is completed (such as swabs, needles, instruments and guide wires) **except where:**

Items are inserted any time before the procedure that are not subject to the formal counting/checking process, with the intention of removing them during the procedure and they are not removed

Items are inserted during the procedure that are subject to the counting/ checking process, but are intentionally retained after completion of the procedure, with removal planned for a later time or date and clearly recorded in the patients notes.

Items are known to be missing prior to the completion of the procedure and may be within the patient (e.g. screw fragments, drill bits) but where further action to locate and/or retrieve would be impossible or be more damaging than retention.

4. Mis – selection of a strong potassium containing solution

Mis - selection refers to:

When a patient intravenously receives a strong[1] potassium solution rather than an intended different medication.

[1] ≥10% potassium w/v (e.g. ≥ 0.1g/ml potassium chloride, 1.3mmol/ml potassium chloride)

5. Wrong route administration of medication

The patient receives one of the following:

Intravenous chemotherapy administered via the intrathecal route.

Oral/enteral medication or feed/flush administered by any parenteral route.

Intravenous administration of a medicine intended to be administered via the epidural route.

6. Overdose of Insulin due to abbreviations or incorrect device

Overdose refers to:

When a patient receives a tenfold or greater overdose of insulin because a prescriber abbreviates the words ‘unit’ or ‘international units’ , despite the care setting having an electronic prescribing system in place.

When a health care professional fails to use a specific insulin administration device i.e. does not use an insulin syringe or insulin pen to measure insulin.

7. Overdose of methotrexate for non-cancer treatment

Overdose refers to

When a patient receives methotrexate, via any route, for non-cancer treatment which results in more than the intended weekly dose being taken, despite the care setting having an electronic prescribing and administration system, or in primary care an electronic prescribing and dispensing system, in place.

8. Mis – selection of high strength midazolam during conscious sedation

Mis - selection refers to

When a patient receives an overdose due to the selection of a high strength midazolam preparation (5mg/ml or 2mg/ml) rather than the 1mg/ml preparation, in a clinical area performing conscious sedation.

Excludes clinical areas where the use of high strength midazolam is appropriate. These are generally only in general anaesthesia, intensive care, palliative care, or where its use has been formally risk assessed within an organisation.

9. Failure to install functional collapsible shower or curtain rails

Involves either;

failure of collapsible curtain or shower rails to collapse when an inpatient suicide is attempted/ successful.

failure to install collapsible rails and an inpatient suicide is attempted/successful using these non-collapsible rails.

10. All inpatient suicides

All suicides by an inpatient in an Acute/Mental Health setting

11. Falls from poorly restricted windows

A patient falling from poorly restricted window.

Applies to windows “within reach” of patients. This means windows (including the window sill) that are within reach of someone standing at floor level and that can be exited/fallen from without needing to move furniture or use tools to assist in climbing out of the window.

Includes windows located in facilities/areas where healthcare is provided and where patients can and do access.

Includes where patients deliberately or accidentally fall from a window where a restrictor has been fitted but previously damaged or disabled, but does not include events where a patient deliberately disables a restrictor or breaks the window immediately before the fall.

Includes where patients are able to deliberately overcome a window restrictor by hand or using commonly available flat bladed instruments as well as the ‘key’ provided.

12. Chest or neck entrapment in bedrails

Entrapment of a patient’s chest or neck within bedrails, or between bedrails, bed frame or mattress, where the bedrail dimensions or the combined bedrail, bed frame and mattress dimensions do not comply with Medicines and Healthcare products

Regulatory Agency (MHRA) guidance.

13. Transfusion or transplantation of ABO-incompatible blood components or organs

Unintentional transfusion of ABO-incompatible blood components.

Excludes where ABO-incompatible blood components are deliberately transfused with appropriate management.

Unintentional ABO mismatched solid organ transplantation.

Excluded are scenarios in which clinically appropriate ABO incompatible solid organs are transplanted deliberately

In this context, 'incompatible' antibodies must be clinically significant. If the recipient has donor specific anti-ABO antibodies and is therefore, likely to have an immune reaction to a specific ABO compatible organ then it would be a never event to transplant that organ inadvertently and without appropriate management.

14. Misplaced naso- or oro-gastric tubes

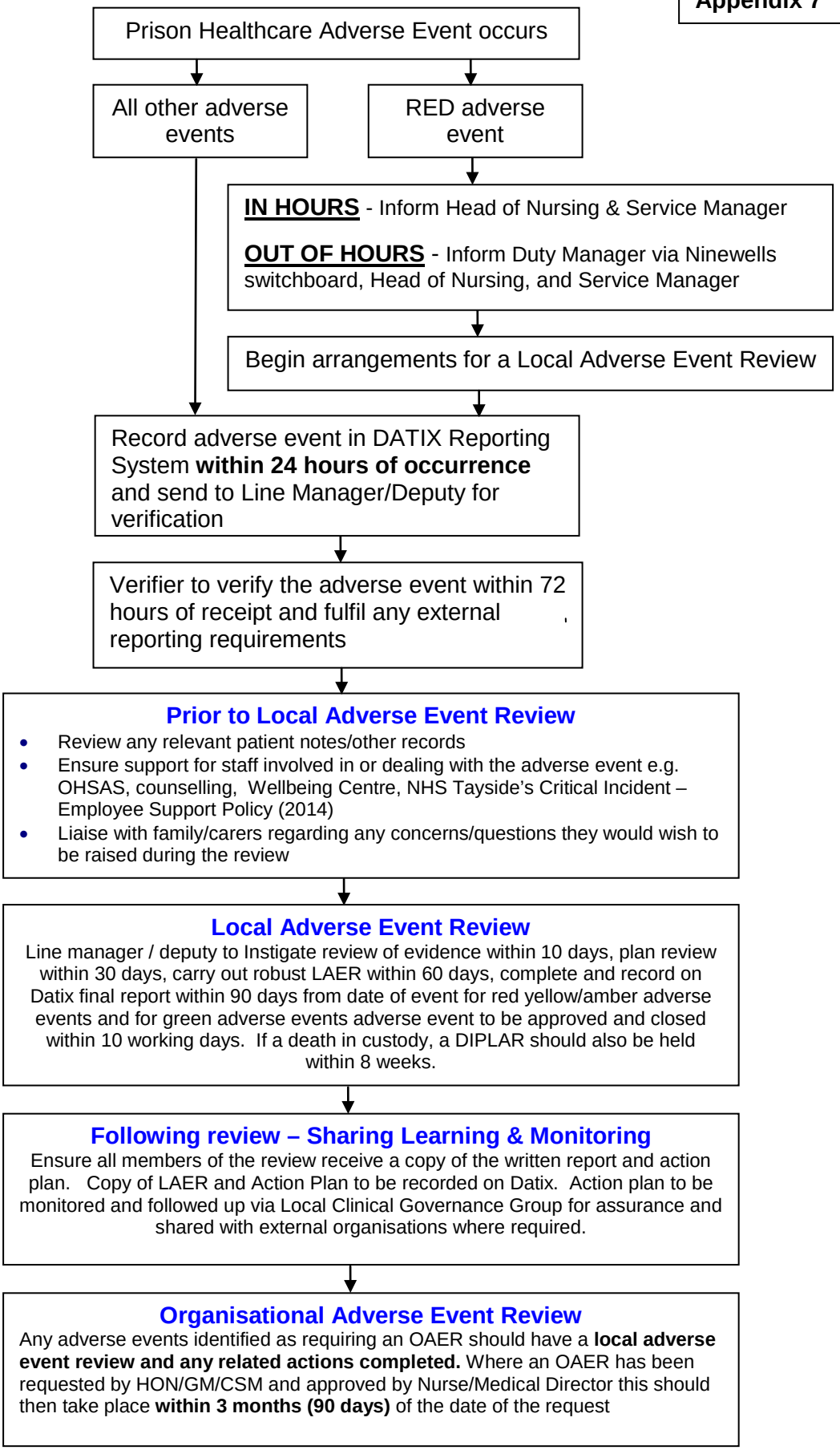
Misplacement and use of a naso- or oro-gastric tube in the pleura or respiratory tract where the misplacement of the tube is not detected prior to commencement of feeding, flush or medication administration.

15. Scalding of patients

Patient being scalded by water used for washing/bathing

Excludes scalds from water being used for purposes other than washing/bathing (e.g. from kettles).

Appendix 7


Prison Healthcare Adverse Event occurs
All other adverse events
RED adverse event
IN HOURS - Inform Head of Nursing & Service Manager
OUT OF HOURS - Inform Duty Manager via Ninewells switchboard, Head of Nursing, and Service Manager
Begin arrangements for a Local Adverse Event Review
Record adverse event in DATIX Reporting System within 24 hours of occurrence and send to Line Manager/Deputy for verification
Verifier to verify the adverse event within 72 hours of receipt and fulfil any external reporting requirements
Prior to Local Adverse Event Review
Review any relevant patient notes/other records
Ensure support for staff involved in or dealing with the adverse event e.g. OHSAS, counselling, Wellbeing Centre, NHS Tayside's Critical Incident – Employee Support Policy (2014)
Liaise with family/carers regarding any concerns/questions they would wish to be raised during the review
Local Adverse Event Review
Line manager / deputy to Instigate review of evidence within 10 days, plan review within 30 days, carry out robust LAER within 60 days, complete and record on Datix final report within 90 days from date of event for red yellow/amber adverse events and for green adverse events adverse event to be approved and closed within 10 working days. If a death in custody, a DIPLAR should also be held within 8 weeks.
Following review – Sharing Learning & Monitoring
Ensure all members of the review receive a copy of the written report and action plan. Copy of LAER and Action Plan to be recorded on Datix. Action plan to be monitored and followed up via Local Clinical Governance Group for assurance and shared with external organisations where required.
Organisational Adverse Event Review
Any adverse events identified as requiring an OAER should have a local adverse event review and any related actions completed. Where an OAER has been requested by HON/GM/CSM and approved by Nurse/Medical Director this should then take place within 3 months (90 days) of the date of the request

Any requests for information in relation to Adverse Event Management should be directed to the Clinical Governance and Risk Management Department who will liaise with the Chief Executive as Accountable Officer, Board Nurse and/or Medical Director, Information Governance and Health and Safety Teams		
Requesting persons/organisations	**Process**	**Further information**
Staff members who participate in Adverse Event Reviews	Staff members who participate in Adverse Event Reviews will be provided with a draft copy of the report to review and confirm for factual accuracy. Following receipt of all comments the report will be updated and all individuals will then be provided with a copy of the final version. All LAER reports must be written in a redacted format to safeguard patient, family and staff confidentiality.	Link to HIS redaction guidance click here
Individuals who are the subject of Adverse Event	Copies of Adverse Event Report Forms and Local Adverse Event Review Reports will be provided if requested. All LAER reports must be written in a redacted format to safeguard patient, family and staff confidentiality. Any Local Adverse Event reports written prior to December 2014 can be requested via a data protection subject access request. However, the individual will only be provided with personal information relating to them. All personal information relating to other individuals (i.e. verifiers, witnesses etc) within the documentation must be removed before the report is shared with the individual.	Sharing LAER guidance click here Data protection subject access request information click here
An individual's legal representative	Those holding, for example, Power of Attorney or Parental Responsibility can apply on behalf of the individuals and will be provided with information via a data protection subject access request.	
Solicitors and Other Third Parties	Can apply for access with express permission of the data subject; however requests will require a signed mandate.	Mandate Form click here
External Partner Organisations	Requests received from the external partners below will be honoured as we have a duty to provide them with the requested information. • Health and Safety Executive • Police (Section 29) – Sharing Information with the Police Policy click here for more information	Notifying the Commission guidance click here Reporting suicide guidance click here Reporting Deaths to Procurator Fiscal guidance click here

	• Procurator Fiscal • Scottish Public Services Ombudsman • Mental Welfare Commissions or • Healthcare Improvement Scotland (in respect of suicides)	
Freedom of Information Requests	FOISA provides a right of access to information but not a right of access to copies of specific documents. Disclosure of information in response to a valid request made under FOISA is in effect a disclosure into the public domain. NHS Tayside has a duty under FOISA Section 15 to provide advice and assistance to applicants, so far as it is reasonable to expect it to do so. However, as a significant amount of the information held in adverse event report forms and Local Adverse Event Review Reports is of a sensitive and personal nature, exemptions may apply in relation to withholding information. Advice and support should be sought from colleagues in the Information Governance Team.	Freedom of Information – Getting it Right First Time guidance click here For further Briefings and Guidance click here

Appendix 9

Adverse Events - Flowchart

Adverse Event Occurs

Make person/area safe and attend to any medical requirements. Implement any immediate operational actions to reduce risk of recurrence e.g. removal or trip hazard or faulty equipment.

Identify the grading of the adverse event

Determine the severity of the adverse event. Has harm occurred or was this a near miss.
Grade the adverse event accordingly as red, amber or green based upon the consequence and likelihood to re-occur.

Within 1 working day

Reporting the adverse event

All staff have a responsibility to report adverse events and near misses which, either caused, or could have caused, injury to individuals or damage or loss to NHS Tayside property.
Responsibility lies with the first person/s to recognise/become involved in the adverse event irrespective of their domain, department or position within the organisation or areas where the adverse event occurs.

This should be within 24 hours of the adverse event occurring and must be sent in the first instance to the immediate line manager

Within 72 hours

Verification of the Adverse Event

The line manager will verify all adverse events within 72 hours of receipt and manage and report the adverse event in accordance with the grade and type of adverse event / near miss. Discussion with colleagues may be required to confirm the type, grade and impact.

Between 10 working days and 3 months

Local Adverse Event Review

Line manager/deputy to instigate review of evidence within 10 days, plan review within 30 days, carry out robust LAER within 60 days, complete and record on Datix final report within 90 days from date of event for red, yellow/amber adverse events and for green adverse events, adverse event to be approved and closed within 10 working days.

Organisational Adverse Event Analysis

Any adverse events identified as requiring an OAER should have a **local adverse event review and any related actions completed.** Where an OAER has been requested by HON/GM/CSM and approved by Nurse/Medical Director this should then take place **within 3 months (90 days)** of the date of request

Within 90 days

Prior to Review

- Review any relevant patient notes/other records
- Ensure support for staff involved in or dealing with the adverse event e.g. OHSAS, counselling, Wellbeing Centre, NHS Tayside's Critical Incident – Employee Support Policy (2014)
- Liaise with family/carers regarding any concerns/questions they would wish to be raised during the review

Undertake Review Using Appropriate Investigative Tool(s)

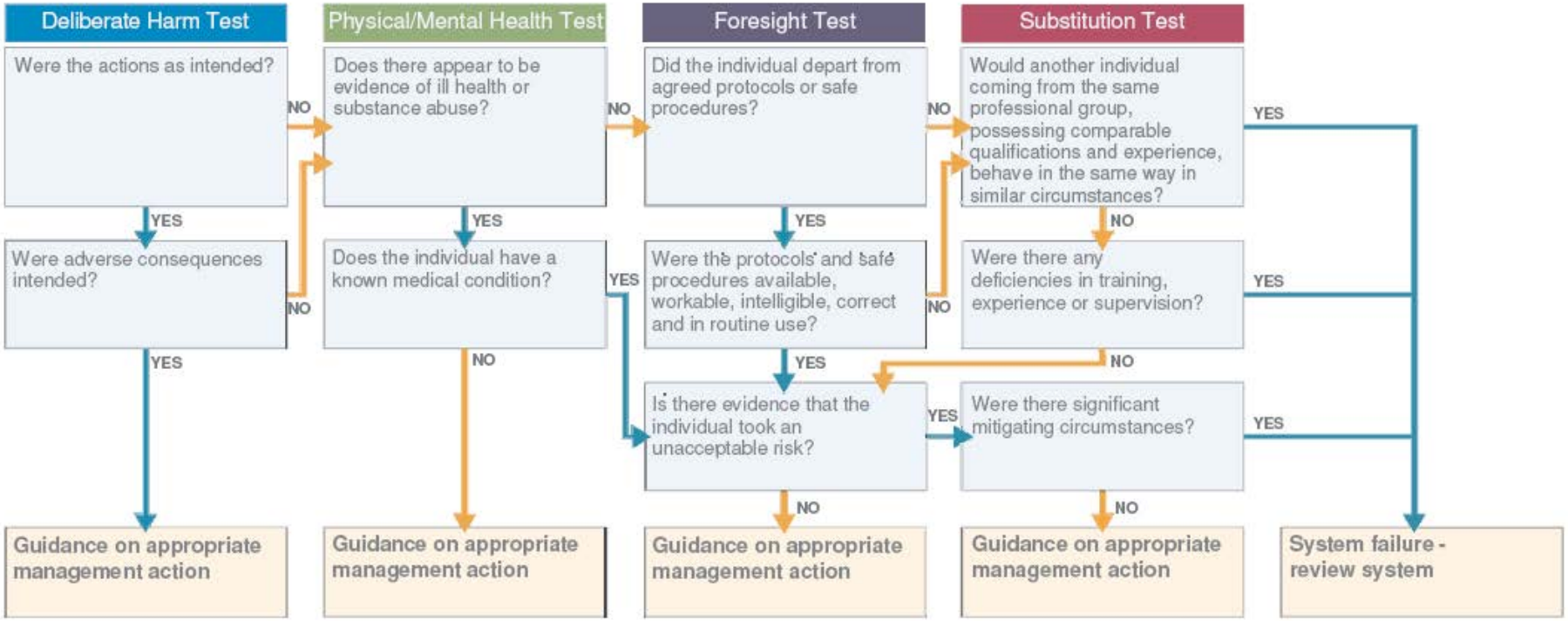
Identify what happened, why did it happen, contributing factors, actions for improvement, action plan with responsible persons and timescales for completion– prepare written report using LAER template and Learning Summary

Following review – Sharing Learning & Monitoring - Ensure all members of the review receive a copy of the written report and action plan. Copy of LAER and Action Plan to be recorded on Datix. Action Plan to be monitored and followed up via Local Clinical Governance Group for assurance.

Note: Please ensure the patient/family have been informed when an adverse event occurs during an episode of care

Incident Decision Tree

National Patient Safety Agency



15. REFERENCES AND BIBLIOGRAPHY

Healthcare Improvement Scotland, April 2015 (2nd Edition). Learning from Adverse Events through Reporting and Review, A national framework for Scotland. www.healthcareimprovementscotland.org (accessed May 2015)

Department of Health, 2000. *An Organisation With a Memory.* Crown Copyright: London

Department of Health, 2001. *Doing Less Harm.* Crown Copyright: London

Department of Health, 2001. *Building a Safer NHS.* Crown Copyright: London

Department of Health, 2006. *Safety First: A Report for Patients, Clinicians and Healthcare Managers.* Crown Copyright: London

Dineen M, 2002. *Six Steps to Root Cause Analysis*. Consequence: Oxford http://www.consequence.org.uk (accessed September 2011).

Health and Safety Executive, 2008. *A guide to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (L73)*. HSE Books: Suffolk

Harvard Hospitals 2006. *When Things Go Wrong – Responding to Adverse Events*. Massachusetts Coalition: MA. Available at http://www.ihi.org (accessed September 2011)

Institute for Healthcare Improvement, 2010. Respectful Management of Serious Clinical Adverse Events http://www.ihi.org (accessed September 2011)

National Patient Safety Agency 2003. *Seven Steps to Patient Safety* http://www.npsa.nhs.uk (accessed September 2011).

National Patient Safety Agency 2003. *Root Cause Analysis Toolkit*. http://www.npsa.nhs.uk (accessed September 2011).

National Patient Safety Agency 2005[1]. *Being open. Communicating patient safety adverse events with patients and their carers*. http://www.npsa.nhs.uk (accessed September 2011).

National Patient Safety Agency 2005[2]. Adverse event Decision Tree: http://www.npsa.nhs.uk (accessed September 2011)

NHS Healthcare Improvement Scotland 2013. *Learning from adverse events through reporting and review: A national framework for NHSScotland.* Available online http://www.nhshealthquality.org (accessed April 2014)

NHS Quality Improvement Scotland 2005. *Clinical Governance and Risk Management national Standards - Clinical Governance and Risk Management: Achieving Safer, effective, patient-focused care and services*. Available online http://www.nhshealthquality.org, (accessed December 2009)

NHS Quality Improvement Scotland (2006*) Safer Today – Safer tomorrow Patient Safety Review of Adverse event and Near Miss Reporting.* NHS Quality Improvement Scotland. http:// www.nhshealthquality.org (accessed September 2011)

Scottish Government (2008) - *Better Health, Better Care Action plan: What it Means for you.* February, ISBN: 978-0-7559-5666.

Standards Australia International Limited and Standards New Zealand. 2004. *Risk Management*. Sydney: Standards Australia International Limited and Standards New Zealand. AS/NZS 4360:2004

Standards Australia International Limited and Standards New Zealand, 2001. *Guidelines for managing risk in the Healthcare sector*. Sydney: Standards Australia International Limited and Standards New Zealand HB228:2001

Learning from Experience: How to Improve Safety for Patients in Scotland" (Scottish Executive, 2004

Never Events are serious, largely **preventable** patient safety events that should not occur if the available preventative measures have been implemented. (NPSA, 2015)

Guidance on Data Redaction and Standardised Adverse Event Review Reports.pdf (HIS 2015)

SPS "*Death in Prison Learning, Audit & Review (DIPLAR) Process Guidance*"

16. GLOSSARY OF TERMS

AEM	Adverse Event Management
CHI	Community Health Index
CSM	Clinical Service Manager
DIPLAR	Death in Prison Learning Audit and Review
DoH	Department of Health
FAI	Fatal Accident Inquiry
FOISA	Freedom of Information (Scotland) Act 2002
GM	General Manager
GP	General Practitioner
HAI	Hospital Acquired Infection
HIS	Healthcare Improvement Scotland
HON	Head of Nursing
HSE	Health and Safety Executive
IHI	Institute of Healthcare Improvement
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
IRIC	Incident Reporting and Investigation Centre
IT	Information Technology
IV	Intravenous
LAER	Local Adverse Event Review
MHRA	Medicines and Healthcare Products Regulatory Agency
MP	Member of Parliament
MSP	Member of Scottish Parliament
NHS	National Health Service
NPS	New Psychoactive Substances
NPSA	National Patient Safety Agency
OAER	Organisational Adverse Event Review
OHSAS	Occupational Health and Safety Advisory Service
QIS	Quality Improvement Scotland (now Healthcare Improvement Scotland (HIS))
PIRC	Police Independent Review Commissioner
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995
SBAR	Situation Background Assessment Recommendation
SCEA	Significant Clinical Event Analysis
SCR	Significant Case Review
SMART	Specific Measurable Assignable Realistic Time-Related
SOP	Standard Operating Procedure
TDDG	Tayside Drug Deaths Group

NHS TAYSIDE – POLICY APPROVAL CHECKLIST

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

POLICY AREA: Risk Management
POLICY TITLE: Adverse Event Management Policy
POLICY MANAGER: Arlene Napier, Head of Clinical Governance and Risk Management

<table>
<tr><td colspan="2">Why has this policy been developed?</td><td colspan="2">To advise staff on the arrangements within the organisation for adverse event management.</td></tr>
<tr><td colspan="2">Has the policy been developed in accordance with or related to legislation? – Please give details of applicable legislation.</td><td colspan="2">No – but developed to conform with Scottish Executive Recommendations & NHS HIS National Framework for Management of Adverse Events</td></tr>
<tr><td colspan="2">Has a risk control plan been developed and who is the owner of the risk? If not, why not?</td><td colspan="2">Yes. Owner is Head of Clinical Governance and Risk. Manager is Risk Manager.</td></tr>
<tr><td colspan="2">Who has been involved/consulted in the development of the policy?</td><td colspan="2">Wide consultation including: Clinical Quality Forum; Clinical and Care Governance Committee; Area Partnership Forum; Information Governance Department and Nurse and Medical Director.</td></tr>
<tr><td colspan="2">Has the policy been Equality Impact Assessed in relation to:-</td><td colspan="2">Has the policy been Equality Impact Assessed not to disadvantage the following groups:-</td></tr>
<tr><td>Age
Disability
Gender Reassignment
Pregnancy/Maternity
Race/Ethnicity
Religion/Belief
Sex (men and women)
Sexual Orientation</td><td>Please indicate Yes/No for the following:

Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes</td><td>People with Mental Health Problems
Homeless People
People involved in the Criminal Justice System
Staff
Socio Economic Deprivation Groups
Carers
Literacy
Rural
Language/Social Origins</td><td>Please indicate Yes/No for the following:

Yes

Yes
Yes

Yes
Yes

Yes
Yes
Yes
Yes</td></tr>
<tr><td colspan="2">Does the policy contain evidence of the Equality Impact Assessment Process?</td><td colspan="2">Yes</td></tr>
<tr><td colspan="2">Is there an implementation plan?</td><td colspan="2">No</td></tr>
<tr><td colspan="2">Which officers are responsible for implementation?</td><td colspan="2">Local Managers with support from Clinical Governance and Risk Department</td></tr>
<tr><td colspan="2">When will the policy take effect?</td><td colspan="2">Immediately – This is an review of the Adverse Event Management</td></tr>
<tr><td colspan="2">Who must comply with the policy/strategy?</td><td colspan="2">All staff</td></tr>
<tr><td colspan="2">How will they be informed of their responsibilities?</td><td colspan="2">Policy Tracker and also via Vital Signs.</td></tr>
</table>

Is any training required?	Training is available if requested and we also offer an ongoing continuous training programme.
If yes, attach a training plan	NA
Are there any cost implications?	No
If yes, please detail costs and note source of funding	NA
Who is responsible for auditing the implementation of the policy?	Clinical Governance and Risk Department
What is the audit interval?	Ongoing
Who will receive the audit reports?	Directorate Clinical Governance and Risk Management Groups/Performance Review/CQF
When will the policy be reviewed and provide details of policy review period (up to 5 years)	One year September 2018

POLICY MANAGER: Hilary Walker DATE: July 2017

APPROVAL COMMITTEE TO CONFIRM: Chief Executive & Directors

ADOPTION COMMITTEE TO CONFIRM: Audit Committee

Equality Impact Assessment

Name of Policy, Service Improvement, Redesign or Strategy:

Adverse Event Management (AEM) Policy

Lead Director or Manager:

Chief Operating Officer, Nurse & Medical Directors and Risk Manager

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

To advise staff on the arrangements within the organisation for Adverse Event Management.

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

The Adverse Event Management Policy seeks to establish a balance of proactive and reactive risk management processes to enable early identification of potential problems therefore creating prevention cycles to enhance patient and staff safety and share learning. The policy is intended to improve reporting systems, practice and care by providing guidance on the identification and management of adverse events.

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

The Policy will support staff in all areas of the organisation in the identification and management of adverse event reporting. Its purpose is to reduce harm and improve systems so that the likelihood of being exposed or experiencing similar adverse events is reduced and learning is shared.

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

The Clinical Governance and Risk Management department.

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

Item	Considerations of impact	Explain the answer and if applicable detail the Impact	Document any Evidence/ Research/Data to support the consideration of impact	Further Actions required
1.1	Will it impact on the whole population? Yes or No. If yes will it have a differential impact on any of the groups identified in 1.2. If no go to 1.2 to identify which groups	Yes – The national approach is intended to cover all care provided throughout Scotland. The scope includes all events that could have caused, or did result in, harm to people or groups of people including patients and service users.	Learning from adverse events through reporting and review: A national framework for Scotland (2nd edition) (NHS HIS, April 2015)	

Item	Considerations of impact	Explain the answer and if applicable detail the Impact	Document any Evidence/Research/Data to support the consideration of impact	Further Actions required
1.2	Which of the protected characteristic(s) or groups will be affected? • Minority ethnic population (including refugees, asylum seekers & gypsies/travellers) • Women and men • People in religious/faith groups • Disabled people • Older people, children and young people • Lesbian, gay, bisexual and transgender people • People with mental health problems • Homeless people • People involved in criminal justice system • Staff • Socio-economically deprived groups	All – see response in section 1.1 above.		

Item	Considerations of impact	Explain the answer and if applicable detail the Impact	Document any Evidence/Research/Data to support the consideration of impact	Further Actions required
1.3	Will the development of the policy, strategy or service improvement/redesign lead to • Discrimination • Unequal opportunities • Poor relations between equality groups and other groups • Other	No – please refer to section 1.1.		

Conclusion Sheet for Equality Impact Assessment	
Positive Impacts (Note the groups affected) All groups will experience a positive impact: Risk Taking behaviour will be positively affected. By analysing risks and adverse events looking at potential risk exposure ratings and the Adverse Event Review process, learning from experience can take place and shared throughout NHS Tayside. This will in-turn will have a positive impact on the safety of patients and staff. The Adverse Event Review process is designed to be a positive experience for all concerned, thereby reducing anxieties which may be perceived in relation to AEM Reporting of adverse events, adverse event review and learning from experience will promote a safer physical environment for staff and patients.	Negative Impacts (Note the groups affected) None identified. AEM Policy provides all groups with guidance on adverse event reporting.
What if any additional information and evidence is required None	
From the outcome of the Equality Impact Assessment what are your recommendations? (refer to questions 5 - 10) 1) Policy to be endorsed by Chief Executive and Directors 2) Policy to be signed off by Audit Committee 3) Policy to be published on NHS Tayside intranet and made applicable to all staff	

This conclusion sheet should be attached to the relevant committee report.

MUST BE COMPLETED IN ALL CASES

Manager's Signature: Hilary Walker Date: 01/07/2017

Item Number 8.2

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

AUDIT67/2017
Audit Committee
24 August 2017

PROMOTING SAFE MANUAL HANDLING POLICY

1. SITUATION AND BACKGROUND

The Promoting Safe Manual Handling Policy has been subject to minor changes/technical reviews since the implementation of version control in 2011. Therefore, the manual handling advisor adopted a whole policy review as part of this review cycle.

2. ASSESSMENT

NHS Tayside Board is a fully participative Board in the application of the Scottish Manual Handling Passport Standards (CEL 15) 2014. The previous version of this policy was entirely commensurate with best practice standards, which are embedded across the organisation.

A short-life working group with representation across both clinical and non-clinical specialities was established to undertake the review but no staff side representation could attend. The group reviewed the document through a series of meetings and remotely before agreeing the final version. The policy was then sent out for circulation and comment to the executive directors.

The improvements and changes made to the policy document can be summarised as follows:

- To reflect the organisational management structure and roles including working with the Health & Social Care Partnerships and Third Party agencies;
- The appendix section was rationalised to include only those directly related to the implementation of this policy. All other related appendices/procedural documents, which have also been updated, are now located within the manual handling section of Staffnet.

3. RECOMMENDATIONS

The Audit Committee is asked to consider this policy for adoption.

4. REPORT SIGN OFF

Alix Mitchell
Head of Manual Handling

Lindsay Bedford
Director of Finance

Lorna Wiggin
Chief Operation Officert

August 2017

Risk Health and Safety

Promoting Safe Manual Handling Policy

Policy Manager	Policy Group
Alix Mitchell	Audit Committee

Policy Established	Last Updated	Policy Review Period/Expiry
	June 2017	June 2020

This policy does apply to Medical/Dental Staff

UNCONTROLLED WHEN PRINTED

Version Control

Version Number	Purpose/Change	Author	Date
1.0	**Please note earlier versions of this policy are available prior to version control being implemented in July 2011. These documents are available in the electronic document store.	Alix Mitchell	
1.1	Minor changes made following a review of the principle policy areas.	Alix Mitchell	January 2013
1.2	Technical review minor changes made to ensure policy is commensurate with CEL 15 (2014)	Alix Mitchell	January 2015
2.0	Whole policy review	Alix Mitchell	June 2017

Promoting Safe Manual Handling Policy

CONTENTS

1. PURPOSE AND SCOPE

NHS Tayside Board attaches the highest importance to the health, safety and welfare of its staff and in particular recognises the significance of risks associated with manual handling activities. NHS Tayside also recognises both its legal responsibilities of employment and the common law 'duty of care' it owes to all staff, patients and visitors.

This policy supports NHS Tayside's vision and outcomes and will be underpinned by the following standards:

Competence – Individuals undertaking manual handling are competent to do so. Employers have suitable and sufficient education programmes and systems to identify specific learning needs of employees, ensure employees complete modules contained within the Scottish Manual Handling Passport Scheme (SMHPS), ensure that employees are up to date with their knowledge and ensure that training activity is recorded and completed in line with SMHPS requirements.

Person-Centred – People are supported to maximise their aspirations and potential and in doing so optimise their independence and life choices.

Safety – Eliminate avoidable injury or harm to people and staff when undertaking manual handling. Employers have appropriate manual handling documentation that meets the minimum criteria identified in the SMHPS.

Quality – Quality Standards and the SMHPS are adhered to; systems are in place to audit, monitor and review manual handling arrangements; the way we do things is continuously improving; customer satisfaction levels are high.

Effective - Documented management arrangements are in place to adequately control the risks from manual handling activities and there is management commitment and support to implement the manual handling policy and strategy.

The purpose of this policy is to ensure a consistent approach to manual handling risk management that is commensurate with national standards. This document outlines the manner in which NHS Tayside will manage the risks arising from manual handling activities. It is a subsidiary document of the Management of Health and Safety Policy and should be read in conjunction with it.

This policy applies to ALL NHS Tayside staff including students and contractors.

2. STATEMENT OF POLICY

NHS Tayside Board has a responsibility to comply with the legal requirements of the Manual Handling Operations Regulations 1992 (as amended 2002) and to eliminate the risks to staff, so far as reasonably practicable, from hazardous manual handling in all but exceptional and life-threatening situations. Where this is impractical, NHS Tayside will promote a safety culture, which minimises the risks from manual handling.

NHS Tayside Board will:

- Ensure that all manual handling education is delivered to the nationally consistent level (SMHPS 2014).
- Ensure the allocation of sufficient resources to develop and implement the manual handling policy.
- Ensure there is a comprehensive system of written manual handling risk assessments in place to develop safe working procedures for both patient and load-handling tasks.

- Identify areas of significant risk as a result of risk assessments.
- Support the Manual Handling Trainer/Competency Based Assessor (link) role to carry out training/competency based assessment.
- Achieve conformity across the staff groupings for manual handling education across NHS Tayside to ensure that all staff at risk from manual handling operations receive appropriate information, instruction, training and supervision commensurate with their role.
- Eliminate the practice of unsafe lifting, i.e., 'controversial handling'.
- Provide suitable and sufficient manual handling equipment, including equipment required for emergency evacuation and for the manual handling of bariatric patients.
- Undertake manual handling equipment maintenance across NHS Tayside, complying with the Lifting Operations and Lifting Equipment Regulations 1998 and the Provision and Use of Work Equipment Regulations 1998.
- Monitor the incidence pattern and trend of reported manual handling accidents, incidents, sickness and absence due to musculoskeletal injuries.
- Work in partnership with Health and Social Care Partnerships and third party agencies.

3. DEFINITIONS

The term **"manual handling"** is used in this policy document to describe operations involving the transporting or supporting of a load, including the lifting, lowering, pushing, pulling, carrying, supporting or moving of an object by hand or bodily force.

Therapeutic Handling: may involve the taking of calculated risks. This is appropriate and essential if patients are to achieve their full potential. The management of risks in therapeutic handling is not addressed within this policy.

Any manual handling involved in physiotherapy treatment programmes constitutes therapeutic handling. Thus, any treatment where force is applied through any part of the therapist's body, such as facilitating, manipulating or providing resistance to any part of the patient constitutes therapeutic manual handling.

The Scottish Manual Handling Passport Scheme 2014 (SMHPS) covers all manual handling activities in Health Boards and Local Authorities. It clarifies the minimum requirements for manual handling education arrangements across these sectors and by doing so, promotes national consistency. It provides a platform for achieving our integration strategy goals for adult health and social care.

4. ROLES & RESPONSIBILITIES

4.1 NHS Tayside

NHS Tayside Board is responsible for complying with Health & Safety legislation and ensuring that a robust governance and assurance framework is in place for Health & Safety, including the management of manual handling. NHS Tayside Board encourages and expects the co-operation and involvement of all staff in managing the risks from manual handling.

4.2 The Standing Committees of the Board

In accordance with the NHS Tayside Code of Corporate Governance, the Standing Committees of the Board will address each area of risk as appropriate. The Manual Handling Policy is an affiliated Health & Safety Policy and is therefore governed by the Audit Committee, which has a duty to review the organisation's manual handling risk management arrangements, systems and processes.

4.3 The Chief Executive (CE)

- Has overall responsibility for the health, safety and welfare of staff and any others who may be affected by manual handling activities throughout NHS Tayside Board.
- The CE, however, will delegate responsibility and seek advice from suitably experienced and qualified specialists when required.

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

- Are accountable to the CE for the implementation of this policy, the objectives set for manual handling and for monitoring performance of their parts of the organisation.

4.5 Clinical Service Managers, Service Leads or Equivalent

Responsible for the implementation of local manual handling risk management within their area(s) of responsibility and are accountable to Directors, Chief Operating Officers, Chief Officers, General Managers, Heads of Service or Equivalent.

Clinical Service Managers, Service Leads or Equivalent must:

- Ensure that their line managers understand their roles and responsibilities for manual handling risk management within their areas.
- Ensure that line managers or other suitably trained assessors undertake manual handling risk assessments and that where appropriate these are acted upon to remove or reduce risks from hazardous manual handling.
- Escalate any concerns about unresolved manual handling issues to their line manager.

4.6 Senior Charge Nurses (SCNs), Supervisors and Departmental Managers

Managers are accountable to their respective Service Managers and are responsible for the day to day implementation and oversight of manual handling risk management within their area. The safety of patients and staff in day to day work is therefore one of their primary concerns.

Managers must:

- Ensure that work is undertaken safely in their area of authority; provide a safe place of work, as far as is reasonably practicable and provide safe and suitable equipment within the terms of the Manual Handling Operations Regulations 1992 (as amended 2002).
- Ensure that procedures and working conditions are risk-managed to minimise the manual handling risks to their patients and staff.
- On recruitment, establish whether previous manual handling education is to SMHPS standard, complete the Manual Handling Self Assessment Form (Appendix II) and enrol individuals in foundation training, as appropriate and detailed in the Manual Handling on Induction Process (Appendix I).
- Ensure that new employees, who have not attended foundation level training, **do not** undertake any handling activities posing significant risk until appropriate training is provided.
- Ensure that local manual handling induction is provided through completion of the Local Manual Handling Induction Checklist (Appendix III) with all staff when they commence work within their ward/department.

- Ensure that all members of staff complete the mandatory e-learning (or equivalent) manual handling modules.
- Ensure that all members of staff have attended refresher manual handling training and that staff adhere to and practise what is taught as best practice in the course of their duties.
- Ensure that manual handling competence is integral to the knowledge and skills (KSF) framework.
- Ensure that training records are maintained.
- Ensure that designated time and support is given to the identified local manual handling trainers, competency based assessors and risk assessors.
- Ensure that all manual handling incidents or near misses are reported using the incident reporting procedure (DATIX).
- Ensure that manual handling risk assessments are carried out and updated and that recommendations are implemented.
- Ensure that all patients requiring manual handling interventions have risk assessments completed and reviewed appropriately.
- Ensure that staff reporting musculoskeletal symptoms whilst at work or returning to work have their tasks assessed to identify any likely modifications to their working environment or duties.
- Consider the need to refer staff experiencing musculoskeletal issues, to the Occupational Health Department, in order to obtain advice on task modification, fitness to work or phased return to work, as applicable.

NB: Manual Handling risk assessment documentation, a policy implementation tool and guidance is posted on Staffnet.

4.7 **All members of staff** have a duty of care and are responsible for their own safety. They must ensure the implementation of this policy in their area of practice or work. Staff must inform their manager if there is any manual handling operation that they believe to be unsafe or if there is any reason why they may not be able to carry out the task safely.

Staff must:

- Comply with NHS Tayside Board's Promoting Safe Manual Handling Policy.
- Follow appropriate systems of work and make full and proper use of equipment provided for their safety.
- Ensure that they have completed the mandatory e-learning modules or equivalent, have had their competency assessed or attended practical manual handling training commensurate with their role.
- Practise and provide manual handling care to the standards taught in the course of their duties.
- Inform their manager if they are unable to take part in any practical elements of training, either due to their physical ability or religious beliefs. Further advice can be sought from the Occupational Health Department or Human Resources Directorate. Any training need should be raised with their manager.
- Familiarise themselves with local manual handling risk assessments and follow the safe systems of work, as specified.
- Escalate any manual handling concerns, either around observed poor practice, training needs or hazardous manual handling, to their line manager.
- Report and record on DATIX, any manual handling incidents or near misses.

4.8 **Health and Safety Representatives** can assist and support staff with the process and implementation of this policy.

4.9 Manual Handling Specific Roles

NHS Tayside endorses a cascade methodology to provide manual handling updates. The Manual Handling Department will facilitate the development of individuals with relevant skills, expertise and an interest in health and safety to undertake additional link roles in manual handling coaching. While continuing to work in their existing role, these individuals will receive additional training to provide advice and support to their managers and assist them in the implementation of this policy.

4.9.1 **Manual Handling Trainers/Competency Based Assessors.**
Ward(s)/Department(s) will have at least one Manual Handling Trainer, who will act on behalf of their manager to ensure that members of staff in their ward/department are trained, supervised or have their competency assessed in safe manual handling practice. In liaison with the Manual Handling Department and their managers, they cascade information to staff and provide guidance and supervision to newly appointed staff on the use of mechanical aids and safe manual handling practice within their area.

4.9.2 **Specialist Advice** e.g. bariatric patient advice, is available to all managers and staff within NHS Tayside and is provided by the Head of Manual Handling/Specialist Ergonomic Advisor, supported by the Manual Handling Practitioners and Department Administrator. (See Section 7, Key Contacts)

4.9.3 **Learning & Development Advisors** provide foundation manual handling training to those new recruits who are required to attend this training. Members of staff who have provided evidence of previous foundation training to SMHPS standard or competency/skills' acquisition need not attend. This will be determined by the recruiting manager, using the appropriate Manual Handling Self Assessment Form, i.e., Clinical or Non-Clinical (Appendix II).

5 ARRANGEMENTS

5.1 Risk Assessment

Line managers are responsible for the following:

- Identifying manual handling risks within their department. This can be delegated to the departmental risk assessor, who has received the appropriate training.
- Initiate safe systems of work/action plans to address risks that cannot be fully mitigated.
- Monitoring the process.

All staff must:

- Be conversant with risk assessments for manual handling tasks undertaken by them and ensure that they apply these when undertaking specified tasks.
- Escalate any manual handling hazards identified in the course of their duties.

Unless a client is completely independent and requires no intervention, then a Client-Handling Manual Handling Risk Assessment must be carried out, as part of a plan of care for each individual client.

For load risk assessments, a Manual Handling Risk Assessment is completed by the Manual Handling Trainer and returned to the manager for recommended action(s).

Generic risk assessments are posted on Staffnet, which cover the client-handling manoeuvres taught and reflect the foundation course elements.

5.2 Maintenance of Equipment

NHS Tayside, under the terms of the Health and Safety at Work Act 1974, is required to provide a safe place of work, so far as is reasonably practicable and to provide safe and suitable equipment. In order to meet these terms, the organisation also has a duty to ensure compliance with the Provision and Use of Work Equipment Regulations 1998 (PUWER) and the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). The meaning of these terms will be detailed in the NHS Tayside Equipment Management Policy.

5.3 Co-operation with other Organisations

When working in conjunction with external organisations, e.g., Scottish Ambulance Service, NHS staff will take the lead in transferring a patient when the patient is within NHS Tayside premises.

5.4 Vulnerable groups

New and expectant mothers and young persons, i.e., less than 18 years old, may be at a greater risk in some manual handling activities. Managers are required to ensure that vulnerable staff can continue to work safely by minimising these risks. Risk assessments must be carried out and **significant** risks identified. Staff and managers can access advice from the Occupational Health Department.

5.5 Records of Accidents and Ill-Health

Well-kept records of accidents and ill-health can play a useful part in the assessment process. They should identify accidents associated with manual handling. Careful analysis may show evidence of links between manual handling and ill-health. Managers should access the adverse incident management system (DATIX) to monitor the incident pattern and trend of reported manual handling incidents and monitor sickness absence due to musculoskeletal injury.

5.6 Unsafe Client-Handling

There are some lifts and handling techniques that are recognised as dangerous. Dangerous lifts cause injuries to nurses and patients. These lifts are unsafe even if the weight of the patient is within the numerical guidelines, which are given in the Manual Handling Operations Regulations 1992 (as amended 2002).

There are 5 main lifts in this group and all staff involved in the manual handling of patients must be aware of them, as they have been considered unacceptable for many years. These are as follows:

1. The drag lift
2. The orthodox lift
3. Lifting with the patient's arm around the neck
4. Australian lift
5. Lifting from the front with the patient's arm around the neck

(The Guide to the Handling of Patients, Revised 5th Edition)

These "controversial lifts" should not be used in any circumstances. Staff should neither participate in such unsafe practices nor condone them, by failing to report unsafe practice to their line manager.

6 TRAINING

6.1 Manual Handling Induction (Foundation) Training

This training is for all new starts who handle patients, who have not previously attended induction/foundation training from another organisation participating in the SMHPS (1 day). Non clinical staff will be inducted locally. The email address for bookings is as follows: coursebookings.tayside@nhs.net.

Members of staff who are not expected to carry loads regularly do not need practical manual handling training but are expected to complete the manual handling e-learning modules currently hosted on learnPro or equivalent, which are accessible through Staffnet.

Local orientation/induction programmes should also occur and be recorded on the appropriate Local Manual Handling Induction Checklist, i.e., Clinical or Non-Clinical (Appendix III).

6.2 Refresher training: Continuing education will be required in a number of circumstances, including the following:

- The employee and/or the employer has identified a learning need
- The employee is not working competently or adhering to current best practice
- There is a change in legislation or professional guidance
- There is a change in working procedures or equipment
- A need is indicated following an incident

Continuing education can include classroom-based training, coaching or advice, competency based assessment or e-learning modules.

The frequency of continuing education should be:

- Commensurate with the level of manual handling activities undertaken by staff groups.
- Informed by risk assessment outcomes, including competency based assessment outcomes, injury, incident and sickness absence data.

All staff should complete the mandatory manual handling e-learning modules or equivalent prior to attending either their practical update session or competency based assessment.

Generally, nursing and allied health professionals should receive an update every 12 - 18 months. Frequency of updates for non-clinical staff will vary from 18 months to 3 years. This can either be achieved through competency based assessment or a classroom-based update.

6.3 Manual Handling Trainers will complete an intensive 5-day course for client-handling and 3-day course for non-clinical handling, to reflect their specialist role and to develop their skills and knowledge in principles associated with manual handling and risk assessment. This training is based on current best practice SMHPS standards. They will be assessed on their ability to deliver a course and meet agreed objectives. Trainers will be supervised until they are confident and competent to carry out this role. Trainers will then cascade the training locally to a written standard, against which they will be monitored (randomised methodology), to ensure that standards are maintained.

All Manual Handling Trainers must attend refresher training sessions annually (18 months maximum expiry) to continue in this role.

All training documentation and records are posted on Staffnet for ease of access.

6.4 Training Records

Line managers are responsible for maintaining a record of training attended by their staff. The responsibility for collating this can be delegated to the trainer or an administrator. Protected time must be given in order to enable the trainer to manage this effectively. All training activity should be recorded on the NHS Tayside Training Database (NHS TTD) and a hard copy of the training record retained.

6.5 Monitoring, Audit and Review

NHS Tayside board is a participating board in the SMHPS 2014 Standard. Audit is required to demonstrate compliance with the principles and guidance contained within it.

The Manual Handling Department will undertake audits and submit reports, as required, on the implementation of this policy and the SMHPS.

The objectives set for manual handling will be detailed in the annual health and safety work plan and progress will be monitored through the NHS Tayside Health & Safety Management Group. This will be used to inform any subsequent review of the policy effectiveness and recommendations.

7 KEY CONTACTS

Manual Handling Department
Tel No: 01382 660111/424000 Ext. 36834
Email: mhtraining.tayside@nhs.net

Training & Development Department
Tel No: 01382 660111/424000 Ext. 71429
Email: coursebookings.tayside@nhs.net

The membership of the Policy Review Group:

Alix Mitchell	Head of Manual Handling
Lynne Armstrong	Occupational Therapy Team Leader
Avril Campbell	Training and Health/Safety Manager, Support Services
Alison Carnegie	Community Nurse Manager
Jennifer Hodge	Manual Handling Administrator
Susan Johnston	Learning & Development Advisor
Angela Milne	Food Safety Manager
Pauline Reid-Donald	Learning & Development Advisor
Teresa Simpson	Manual Handling Practitioner
Annette Watt	Manual Handling Practitioner
Hazel Wilson	Charge Nurse, Specialist Services (Renal)

References and OTHER RELEVANT READNG MATERIAL
LEGISLATION AND PROFESSIONAL GUIDANCE DOCUMENTS

HSE (1974) Health and Safety at Work etc. Act 1974 HMSO
http://www.legislation.gov.uk/legislation/hswa.htm

Management of Health & Safety at Work Regulations 1999 HSE (2000)
Management of Health and Safety at Work
Management of Health and Safety at Work Regulations 1999 Approved Code of Practice L21 revised 2000. HSE Books
http://www.hse.gov.uk/pubns/books/l21.htm

Managing for Health & Safety (formerly HSG65)
http://www.hse.gov.uk/managing/index.htm

Manual Handling Operations Regulations (as amended) 1992 (MHOR) HSE
(2004) Manual Handling
Manual Handling Operations Regulations 1992 (as amended) Guidance on Regulations L23
3rd edition 2004 HSE Books
http://www.hse.gov.uk/msd/backpain/employers/mhor.htm

Manual Handling Operations Regulations 1992 (as amended)
http://www.hse.gov.uk/msd/pushpull/regulations.htm
http://www.hse.gov.uk/foi/internalops/fod/oc/300-399/313_5.pdf

MSD Regulations
http://www.hse.gov.uk/msd/regulations.htm

Back Pain - Advice for employers
http://www.hse.gov.uk/msd/backpain/employers/mhor.htm

Seating at Work HSG57
http://www.hse.gov.uk/pubns/books/hsg57.htm

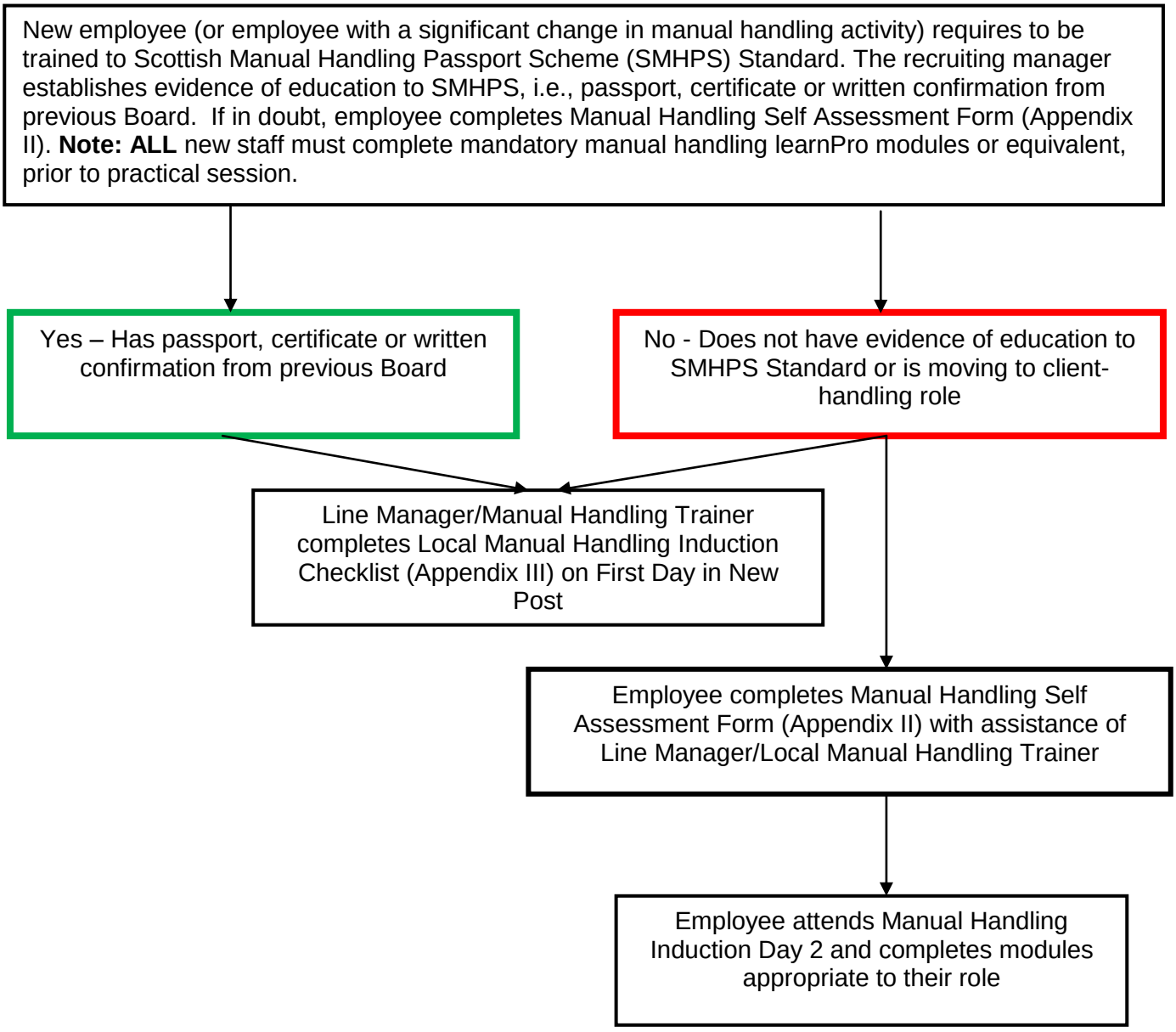
Upper limb disorders in the workplace HSG60
http://www.hse.gov.uk/pubns/books/hsg60.htm

The Law on VDUs: An easy guide: Making sure your office complies with
Health & Safe (Display Screen Equipment) Regulations 1992 (as amended
2002)
http://www.hse.gov.uk/pubns/books/hsg90.htm

Handling Home Care: Achieving safe, efficient and positive outcomes for
care workers and clients
http://www.hse.gov.uk/pubns/books/hsg225.htm

Scottish Manual Handling Passport Scheme

Manual Handling on Induction Process



Manual Handling Self Assessment Form

CLINICAL STAFF

Manual Handling Competencies:			
Place of Work:			
Speciality:			
Date:			
Name of Line Manager:		Signature:	

Details of Staff Member Assessed:	
Name	
Signature	
Do you have a Manual Handling Passport? Date:	
Date of Induction Training	
Date of Last Update Training	
Date of Last Manual Handling Competency Based Assessment	

To be completed by (new) staff member

As part of the NHS Tayside Induction Programme, please record your initials in the 'competent' or 'require an update' box to indicate any manual handling training you require.

Module A **Manual Handling Theory**	**Statutory for all NHS Tayside employees** All clinical staff must complete this module every 12 months and non-clinical staff every 2 years	**Date completed:**

Module B Inanimate Load Handling/ Practical Skills	Clinical Manual Handling Competencies	
	TO BE COMPLETED BY (New) Staff Member	
	COMPETENT	REQUIRE AN UPDATE
Principles of Safer Handling of Inanimate Loads (Including weight check prior to lifting)		
Risk Assessment of Inanimate Load		
Pushing and Pulling		
Lifting and Lowering from/to Floor or Low Level		
Carrying/Supporting a Load		
Assessment of DSE Workstation		

Module C Sitting, Standing and Walking/ Practical Skills	Clinical Manual Handling Competencies	
	TO BE COMPLETED BY (New) Staff Member	
	COMPETENT	REQUIRE AN UPDATE
Principles of Safer Handling of People		
High Risk/ Controversial Practices/Bariatrics		
RISK ASSESSMENT OF MOVING & HANDLING A PERSON		
Assisting a Person Forward in a Chair		
Assisting a Person Back in a Chair		
Sit → Stand from a Chair		
Stand → Sit in a Chair		
Seated/Standing Transfer, e.g., Chair → Chair		
Assisted Walking		

The Falling Person		
Raising the Fallen Person		
Assisting the Fallen Person from a Confined Space		

Module D **Bed Manoeuvres/** **Practical Skills**	**Clinical Manual Handling Competencies** **TO BE COMPLETED BY (New) Staff Member**	
	COMPETENT	**REQUIRE AN UPDATE**
High Risk/Controversial Practices/Bariatrics		
Functions/Moving/Maintenance of Beds		
Sitting to Standing from edge of Bed		
Standing to Sitting on edge of Bed		
Inserting and Removing Slide Sheets		
Turning in Bed using Slide Sheets		
Sliding the Supine Person Up/Down Bed using Slide Sheets		
Lying → Sitting and/or to edge of bed		
Assisting a Person to Lie from Sitting on edge of Bed		
Emergency Evacuation using Equipment		

Module E **Using Hoists and Slings/** **Practical Skills**	**Clinical Manual Handling Competencies** **TO BE COMPLETED BY (New) Staff Member**	
	COMPETENT	**REQUIRE AN UPDATE**
Principles/Main Points of LOLER		
Use of Standing Hoist		
Selection and Use of Slings		
Use of Full Body Hoist		

Fitting and Removing a Sling in Bed and on a Chair		
Hoisting from Chair to Bed/Bed to Chair		
Hoisting a Person from the Floor		
Hoisting a Person from the Floor using 'flat lifter'		
List below the types of slings and hoists used:		
•		
•		
•		

Module F **Lateral Transfers/ Practical Skills**	**Clinical Manual Handling Competencies** **TO BE COMPLETED BY (New) Staff Member**	
	COMPETENT	**REQUIRE AN UPDATE**
Lateral Supine Transfer from Surface to Surface		
•		

Area-Specific **Practical Activities**	**Clinical Manual Handling Competencies** **TO BE COMPLETED BY (New) Staff Member**	
	COMPETENT	**REQUIRE AN UPDATE**
•		
•		
•		

Manual Handling Self Assessment Form

NON-CLINICAL STAFF

Manual Handling Competencies:			
Place of Work:			
Speciality:			
Date:			
Name of Line Manager:		Signature:	

Details of Staff Member Assessed:	
Name	
Signature	
Do you have a Manual Handling Passport? Date:	
Date of Induction Training	
Date of Last Update Training	
Date of Last Manual Handling Competency Based Assessment	

To be completed by (new) staff member

As part of the NHS Tayside Induction Programme, please record your initials in the 'competent' or 'require an update' box to indicate any manual handling training you require.

Module A **Manual Handling Theory**	**Statutory for all NHS Tayside employees** All clinical staff must complete this module every 12 months and non-clinical staff every 2 years	**Date completed:**

Module B Inanimate Load Handling/ Practical Skills	Load Handling Competencies TO BE COMPLETED BY (New) Staff Member	
	COMPETENT	REQUIRE AN UPDATE
Principles of Safer Handling of Inanimate Loads (Including weight check prior to lifting)		
Risk Assessment of Inanimate Load		
Pushing and Pulling		
Lifting and Lowering from/to Floor or Low Level		
Carrying/Supporting a Load		
Assessment of DSE Workstation		

Module F Lateral Transfer/ Practical Skills	Load Handling Competencies TO BE COMPLETED BY (New) Staff Member	
	COMPETENT	REQUIRE AN UPDATE
Lateral Supine Transfer from Surface to Surface		
•		

Area-Specific Practical Activities	Load Handling Competencies TO BE COMPLETED BY (New) Staff Member	
	COMPETENT	REQUIRE AN UPDATE
•		
•		
•		

Local Manual Handling Induction Checklist
CLINICAL STAFF

The Employee has been:

Informed of the following:	Yes/No	Comments
• NHS Tayside's Promoting Safer Manual Handling Policy		
• Generic Client and Load-Handling Risk Assessments		
• Incident Reporting System - DATIX		
• Manual Handling information/resource including: DSE Self Assessment Checklist (posted on Staffnet)		
• LearnPro Clinical Theory Modules		

Shown the equipment required for role and tasks to be undertaken in the Department/Ward and must be supported and supervised until he/she feels confident in their use:			
Equipment:	**Discussed**	**Demonstrated**	**Comments**
•			
•			
•			
•			
•			
•			
•			
•			
•			
•			

Informed of the following:	Yes/No	Comments
• Department's Manual Handling Safe Systems of Work		
• Name of their mentor/buddy (if applicable)		
• Contact Details for Manual Handling Information/Advice:-		
➢ **Local Manual Handling Trainer or Competency Based Assessor:** ..... ➢ **NHS Tayside Manual Handling Department:** Email Address: mhtraining.tayside@nhs.net Tel No: 01382 660111 ext 36834		
• Emergency Evacuation Equipment and Emergency Evacuation Route		
• Procedures for Escorting a Patient		
•		
•		

Name of Manager: .....Signature..... Date.....
(or Nominated Deputy)

Name of Employee: .....Signature..... Date.....

Local Manual Handling Induction Checklist
NON-CLINICAL STAFF

The Employee has been:

Informed of the following:	Yes/No	Comments
• NHS Tayside Promoting Safe Manual Handling Policy		
• Generic Inanimate Load-Handling Risk Assessments		
• Incident Reporting System - DATIX		
• Manual Handling information/resource including: DSE Self Assessment Checklist (posted on Staffnet)		
• LearnPro Non-Clinical Theory Modules		

Shown the equipment required for role and tasks to be undertaken in the Department/Ward and must be supported and supervised until he/she feels confident in their use:			
Equipment:	**Discussed**	**Demonstrated**	**Comments**
•			
•			
•			
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•			

Informed of the following:	Yes/No	Comments
• Department's Manual Handling Safe Systems of Work		
• Name of their mentor/buddy (if applicable)		
• Contact Details for Manual Handling Information/Advice:-		
➢ **Local Manual Handling Trainer or Competency Based Assessor:** ..... ➢ **NHS Tayside Manual Handling Department:** Email Address: mhtraining.tayside@nhs.net Tel No: 01382 660111 ext 36834		

Name of Manager: .....Signature..... Date.....
(or Nominated Deputy)

Name of Employee: .....Signature..... Date.....

NHS TAYSIDE - POLICY/STRATEGY APPROVAL CHECKLIST

This checklist must be completed and forwarded with policy to the appropriate forum/committee for approval.

POLICY/STRATEGY AREA: Risk Health and Safety
POLICY/STRATEGY TITLE: Promoting Safe Manual Handling Policy
LEAD OFFICER: Lorna Wiggin

Why has this policy/strategy been developed?		**To ensure NHS Tayside meets national standards in manual handling and their legal requirements.**	
Has the policy/strategy been developed in accordance with or related to legislation? – Please give details of applicable legislation.		**Health and Safety at Work Act 1974 Management of Health and Safety Regulations 1999 Manual Handling Operations Regulations 1992 as amended 2002**	
Has a risk control plan been developed? Who is the owner of the risk?		**Yes – Lorna Wiggin**	
Who has been involved or consulted in the development of the policy/strategy?		**Is a revised policy**	
Has the policy/strategy been assessed for Equality and Diversity in relation to:-		**Has the policy/strategy been assessed For Equality and Diversity not to disadvantage the following groups:-**	
	Please indicate Yes/No for the following:		**Please indicate Yes/No for the following:**
Race/Ethnicity	Yes	**Minority Ethnic Communities (includes Gypsy/Travellers, Refugees & Asylum Seekers)**	Yes
Gender	Yes	**Women and Men**	Yes
Age	Yes	**Religious & Faith Groups**	Yes
Religion/Faith	Yes	**Disabled People**	Yes
Disability	Yes	**Children and Young People**	Yes
Sexual Orientation	Yes	**Lesbian, Gay, Bisexual & Transgender Community**	Yes
Does the policy/strategy contain evidence of the Equality & Diversity Impact Assessment Process?		**Yes**	
Is there an implementation plan?		**Yes (Health & Safety Annual Workplan)**	
Which officers are responsible for implementation?		**Heads Of Nursing/Team Leads, Clinical Service Managers/General Managers or equivalent**	
When will the policy/strategy take effect?		**Has been in effect since January 1999**	
Who must comply with the policy/strategy?		**All Employees, NHS Tayside**	
How will they be informed of their responsibilities?		**Specified within the Policy, Local Health and Safety meetings**	
Is any training required?		**No**	
If yes, has any been arranged?		**N/A**	
Are there any cost implications?		**No - from within existing budgets**	
If yes, please detail costs and note source of funding		**N/A**	
Who is responsible for auditing the implementation of the policy/strategy?		**Manual Handling Department**	
What is the audit interval?		**3 yearly**	
Who will receive the audit reports?		**Health and Safety Management Committee**	
When will the policy/strategy be reviewed and by whom? (please give designation)		**2020 - Alix Mitchell, Head of Manual Handling**	

Name: Alix Mitchell **Date: 30 June 2017**

EQUALITY AND DIVERSITY IMPACT ASSESSMENT

Name of Service Improvement/Redesign, Policy or Strategy

Promoting Safe Manual Handling Policy

Location Area of Service Improvement/Redesign, Policy or Strategy

Risk Health & Safety

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

The purpose of this policy is to ensure a consistent approach in manual handling risk management. This document outlines the manner in which NHS Tayside board will manage the risks arising from manual handling activities. It is a subsidiary document to the Management of Health and Safety Policy and should be read in conjunction with it.

What are the intended outcomes from the proposed Service Improvement/Redesign, Policy or Strategy?

This policy supports NHS Tayside's vision and outcomes and will be underpinned by the following standards:

Competence – Individuals undertaking manual handling are competent to do so. Employers have suitable and sufficient education programmes and systems to identify specific learning needs of employees, ensure employees complete modules contained within the Scottish Manual Handling Passport Scheme (SMHPS), ensure that employees are up to date with their knowledge and ensure that training activity is recorded and completed in line with SMHPS requirements.

Person-Centred – People are supported to maximise their aspirations and potential and in doing so optimise their independence and life choices.

Safety – Eliminate avoidable injury or harm to people and staff when undertaking manual handling. Employers have appropriate manual handling documentation that meets the minimum criteria identified in the SMHPS.

Quality – Quality Standards and the SMHPS are adhered to; systems are in place to audit, monitor and review manual handling arrangements; the way we do things is continuously improving; customer satisfaction levels are high.

Effective - Documented management arrangements are in place to adequately control the risks from manual handling activities and there is management commitment and support to implement the manual handling policy and strategy.

Review Team – Who is assessing or considering the assessment?

This will be used to inform any subsequent review of the policy effectiveness and recommendations.

Names and Titles of Team Members:

Alix Mitchell, Head of Manual Handling Lynne Armstrong, Occupational Therapy Team Leader Avril Campbell, Training and Health/Safety Manager, Support Services Susan Johnston, Learning & Development Advisor Annette Watt, Manual Handling Practitioner

When completed, please attach to the policy prior to endorsement/approval at the relevant committee.

MUST BE COMPLETED IN ALL CASES

Item No	Considerations	Detail Impact and Identify Groups Affected	Document the Evidence Which Supports This	What Further Actions Require to be Taken?
1.	**Which groups of the population will be affected by the policy/strategy/service redesign**	All Staff Groups		
1.1	Will it impact on the whole population?	Yes - All Staff Groups		
1.2	If not which groups of the population do you think will be affected by this function/policy? • Minority ethnic population (including refugees, asylum seekers & gypsies/travellers) • Women and men • People in religious/faith groups • Disabled people • Older people, children and young people • Lesbian, gay, bisexual and transgender people • People with mental health problems • Homeless people • People involved in criminal justice system • staff	Some Ethnic groups may not wish to be handled by staff of the opposite sex. Staff with health problems might not be able to complete physical elements of Manual Handling training and some tasks associated with their posts. In some cases patients may refuse mechanical assistance due to the nature of their disability. Community staff will not be able to remove shoes on entering a patient's home, which may not be in keeping with their religious beliefs.	Race Relations Act 1076, 2000 and amended Regulations (2003). Immigration, Asylum & Nationality Acts 1994, &2006. Human Rights Act and religious beliefs. Equalities Act (awaiting guidance), Disability Discrimination Act 1995 (2005). Disability Discrimination Act and Human Rights Act, test cases, e.g., East Sussex.	This will be documented in individual client assessments and addressed where practicable Managers can refer staff to the Occupational Health Department to assess abilities to perform tasks associated with post. Modifications can be recommended and implemented where practicable. Balanced decision-making must be evidenced in patient risk assessments

Item No	Considerations	Detail Impact and Identify Groups Affected	Document the Evidence/Research	Actions Taken/To be Taken
2.	**What impact will the policy/strategy/service redesign have on lifestyles?** For example will the changes affect: • Diet & nutrition • Exercise & physical activity • Substance use: tobacco, alcohol or drugs • Risk taking behaviour • Education & learning or skills • Other	Nil		
Item No	**Considerations**	**Detail Impact and Identify Groups Affected**	**Document the Evidence/Research**	**Actions Taken/To be Taken**
3.	**Does your function/policy consider the impact on the communities?** Things that might be affected include: • Social status • Employment (paid/unpaid) • Social/family support • Stress • Income	Nil		

Item No	Considerations	Detail Impact and Identify Groups Affected	Document the Evidence/Research	Actions Taken/To be Taken
4.	**Will the proposal have any impact on:** • Discrimination • Equality of opportunity • Relations between groups • Other	Nil		
5.	**Will the function/policy have an impact on the physical environment?** For example will there be impacts on: • Living conditions • Working conditions • Pollution or climate change • Accidental injuries/public safety • Transmission of infectious diseases • Other	Nil		
Item No	**Considerations**	**Detail Impact and Identify Groups Affected**	**Document the Evidence/Research**	**Actions Taken/To be Taken**
6.	**Will the function/policy affect access to and experience of services?** For example:	Nil		

	• Healthcare • Social services • Education • Transport • Housing			
7.	**Consultation** 1) What existing consultation data do we have? • Existing consultation sources • Original consultations • Key learning 2) What consultation, if any, do you need to undertake?	Nil		
Item No	**Considerations**	**Detail Impact and Identify Groups Affected**	**Document the Evidence/Research**	**Actions Taken/To be Taken**
8.	**In relation to the groups identified** • What are the potential impacts on health? • Will the function/policy impact on access to health care? If yes - in what way? • Will the function/policy impact on the experience of health care? If yes – in what way?	Ethnic Groups - nil impact on their health. Clinical areas might have to compromise care if they are not able to achieve the right skill mix of male/female staff. Patients refusing mechanical assistance will increase their risks of injury and our ability to provide them with national standards of manual handling		This will be documented in individual client assessments and where practicable addressed Balanced decision-making must be evidenced in patient risk assessments

		risk assessment and intervention. Under H&S legislation community staffs are not expected to remove their shoes for religious beliefs of clients they are providing care for.		
Item No	**Considerations**	**Detail Impact and Identify Groups Affected**	**Document the Evidence/Research**	**Actions Taken/To be Taken**
9.	**Have any potential negative impacts been identified?** • If so, what action has been proposed to counteract the negative impacts? (if yes state how) For example: • Is there any unlawful discrimination? • Could any community get an adverse outcome? • Could any group be excluded from the benefits of the function/policy? (consider groups outlined in item 3) • Does it reinforce negative stereotypes? (For example, are any of the groups identified at item 3 being disadvantaged due to perception	No		

	rather than factual information?)			
Item No	**Considerations**	**Detail Impact and Identify Groups Affected**	**Document the Evidence/Research**	**Actions Taken/To be Taken**
10.	**Data & Research** • Is there need to gather further evidence/data? • Are there any apparent gaps in knowledge/skills?	No		
11.	**Monitoring** • How will the outcomes be monitored? • Who will monitor? • What criteria will you use to measure progress towards the outcomes?	Outcomes will be monitored by the Manual Handling Department. Local managers need to monitor local implementation. National Guidance and Manual Handling Standards. Scottish Manual Handling Passport Scheme. The manual Handling policy is governed by the Audit Committee which has a duty to review the organisations manual handling risk management arrangements.	The Head of Manual Handling will submit reports as required on the implementation of this policy or audit outcomes. The objectives set for manual handling will be detailed in the annual health and safety work plan and progress will be monitored through the NHS Tayside Health & Safety Management group. This will be used to inform any subsequent review of the policy it's effectiveness and recommendations.	
12.	**Recommendations** State your conclusion of your Impact Assessment			

Item No	Considerations	Detail Impact and Identify Groups Affected	Document the Evidence/Research	Actions Taken/To be Taken
13.	Is a more detailed assessment needed? • If so, for what reason?	No		No further action needed.
14.	Completed function/policy • Who will sign this off? • When?	Audit Committee, August 2017		
15.	Publication			

Conclusion Sheet for Equality Impact Assessment	
Positive Impacts (Note the groups affected) Positive impact for all staff groups as this policy provides the framework for compliance with national standards in manual handling risk management**.** Undertaking safe manual handling is a positive experience for both staff and patients and will reduce musculoskeletal injuries and incidents associated with manual handling tasks,	Negative Impacts (Note the groups affected) None identified.
Additional Information and Evidence Required	
From the outcome of the Equality Impact Assessment what are your recommendations? (Refer to questions 10 -13) Where patients either refuse to be handled using mechanical aids or due to religious beliefs patients request not to be handled by male staff then this will be documented in individual client assessments and where practicable addressed. Balanced decision-making must be evidenced in patient risk assessments. Where staff identify that they are unable to undertake either some of their work tasks or the practical elements of manual handling then managers can refer staff to the Occupational Health Department to assess abilities to perform tasks associated with post. Modifications can be recommended and implemented where practicable.	

This conclusion sheet should be attached to the relevant committee report.

MUST BE COMPLETED IN ALL CASES

Manager's Signature:  **Date: 30 June 2017**

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

Item Number 9

AUDIT68/2017
Audit Committee
24 August 2017

PROPERTY TRANSACTION MONITORING

1. SITUATION AND BACKGROUND

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

The purpose of the report is to advise the Committee of the Internal Audit of the property transactions completed in 2016/17, which provides assurance that the required procedures have been followed.

2. ASSESSMENT

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

There were six completed property transactions during 2016/17 that were previously advised to the Committee at their meeting on 11 May, 2017. FTF Internal Audit were requested to review three transactions, being Murray Royal Hospital, Sunnyside Hospital and Dundonnachie House, to ensure that the requirements of the PTH were followed.

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

A clean property transactions return in respect of 2016/17 can, therefore, be submitted to SGHSCD by the deadline of 30 October, 2017.

3. RECOMMENDATIONS

The Committee is requested to note that:-

i. the requirements of the PTH have been complied with;
ii. the internal audit report is attached at Appendix 1,
iii. arrangements are in place to issue the Board's Annual Property Transactions Return to SGHSCD by the deadline of 30 October, 2017, and that the return be submitted with no significant issues identified.

Louise Lyall
Capital Finance Manager

Lindsay Bedford
Director of Finance

August 2017

FINAL REPORT

NHS TAYSIDE
INTERNAL AUDIT SERVICE

POST TRANSACTION MONITORING

REPORT NO. T25/18

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

L Wiggin, Chief Operating Officer
M Anderson, Head of Property
M Valentine, Property Asset Manager
G McIntyre, Property and Asset Manager
L Lyall, Capital Finance Manager

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

Audit Committee
External Audit

Date: 14 August 2017

INTRODUCTION

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

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

OBJECTIVES

3. To establish whether NHS Tayside complies with the procedures set out in the NHS Property Transactions Handbook.

4. We reviewed a sample of three disposals by sale of NHS Tayside property during the financial year 2016/17. The 11 May 2017 Audit Committee agreed that both Sunnyside Hospital and Murray Royal Hospital plus one other of the six completed transactions for 2016/17 would be reviewed as follows:

Sales	**Sale Proceeds £**
Murray Royal Hospital (MRH)	£550,000
Sunnyside Hospital (SH)	£300,000 & 10 Annual Payments of £77,900
1 Dundonnachie, Bank Street, Aberfeldy	£99,667

5. Transaction files were examined to ensure that:

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

AUDIT OPINION AND FINDINGS

6. In accordance with the requirements of Part A Section 6.9 of the Handbook each transaction must be categorised as:

   A Transaction has been properly conducted, or

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

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

7. The audit opinion for the sample of transactions concluded in 2016/17 is:
   - ◊ Sale of Murray Royal Hospital (MRH) **Category A**
   - ◊ Sale of Sunnyside Hospital (SH) **Category A**
   - ◊ Sale of 1 Dundonnachie, Bank Street, Aberfeldy **Category A**

8. The transactions for both MRH and SH have been both complex, specifically in relation to the size and type of buildings and land at each site. These transactions have taken a considerable time to conclude and issues have been reported and considered by Tayside NHS Board over the last few years. The scope of this review focuses on the requirements of the PTM Handbook around NHS Tayside's procedures and responsibilities.

9. Our review of the procedures followed to complete the above 2016/17 transactions confirmed that they were concluded in accordance with the Handbook. We examined evidence which confirms that appropriate advice and guidance was sought and received from the Central Legal Office (CLO) and the appointed external Property Advisers during each transaction.

10. As required by the Handbook, the relevant trawl procedures were carried out as part of the consideration process for the disposal of each of the properties. The properties were advertised on the Scottish Government website for surplus public sector property. There was no interest from any other public body and the properties were subsequently advertised and sold on the open market.

11. The Mandatory Requirements section of the Handbook requires a Monitoring Pro forma be completed to provide sufficient documentation for audit purposes. This form has been completed for each of the property transactions sampled.

12. Although not affecting our conclusion that all transactions were concluded in accordance with the Handbook, the procedures for opening tenders were not fully in accordance with those outlined within the Procedures section of the Handbook. For MRH the offer was opened by NHS Tayside officers without property advisors being present. The Handbook states that "tenders should be opened in line with the Standing Financial Instructions (SFIs)." The Handbook also notes that the Property Adviser's representative should be present when offers are opened. The requirement and process, in particular who should be present for opening capital disposals offers is not clear in the SFIs which are incorporated within the Code of Corporate Governance for NHS Tayside.

ACTION

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

ACKNOWLEDGEMENT

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

Barry Hudson BAcc (Hons) CA
Regional Audit Manager

Action Plan

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
1.	The procedures for opening tenders were not fully in accordance with those outlined within the Procedures section of the Handbook. For MRH the tenders were opened by NHS Tayside without the presence of the property advisor.	Offers should be opened in accordance with the Handbook in future ensuring that all necessary parties are present. We recommend that the Code of Corporate Governance is updated to reflect this requirement.	**3**	Noted. Tenders are normally opened on the closing date for submitted offers and the availability of the Property Adviser is not always guaranteed, however, all tender openings are carried out in accordance with NHS Tayside Standing Financial Instructions. Consideration will be given to updating the SFI's to include the requirement for the Property Adviser to be present at tender openings for capital asset disposals.	Property Asset Manager December 2017

DEFINITION OF RECOMMENDATION PRIORITIES

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 10

AUDIT69/2017
Audit Committee
17 August 2017

PAYMENT VERIFICATION: FAMILY HEALTH SERVICE (FHS) CONTRACTORS

Payment Verification Annual Process Update

1. PURPOSE OF THE REPORT

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

a) Updates to the guidance on payment verification procedures and arrangements for payment verification for 2017/18 for FHS Contractors, i.e. General Dental; Ophthalmic; Pharmaceutical; and Medical Services (DL (2017) 11 Appendix 1);

and

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

2. RECOMMENDATIONS

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

3. EXECUTIVE SUMMARY

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

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

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

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

4 REPORT DETAIL

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

The main areas investigated are:

4.1 General Dental Services:

- Earnings summary
- Cost per case
- General earnings
- Assistants and Trainee earnings
- Earning and list size
- Full cost per case
- Ortho earnings
- Ortho Assistants & Trainees
- Salaries earnings

4.2 General Ophthalmic Services:

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

4.3 Pharmaceutical Services:

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

4.4 General Medical Services:

- Global Sum
- Core Standard Payment
- Temporary Patient Adjustment
- Additional Services
- Payments for a Specific Purpose
- Section 17c Contracts
- Seniority
- Enhanced Services
- Clinical Inspection of Medical Records
- GP Practice Security

As previously reported, a new Scottish General Medical Services contract is currently being negotiated. Further details should be published by the end of this year for progression from April 2018. The scope and processes in relation to payment verification of the new contract are yet to be confirmed and an update will be come to Committee when arrangements are finalised.

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

5 CONTRIBUTION TO NHS TAYSIDE'S STRATEGIC AIMS

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

6. MEASURES FOR IMPROVEMENT

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

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

7. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

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

8. PATIENT EXPERIENCE

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

9. RESOURCE IMPLICATIONS

Financial

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

Workforce

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

10. RISK ASSESSMENT

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

11. LEGAL IMPLICATION

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

12. INFORMATION TECHNOLOGY IMPLICATIONS

Not applicable

13. HEALTH & SAFETY IMPLICATIONS

Not applicable

14. HEALTHCARE ASSOCIATED INFECTION (HAI)

Not applicable

15. DELEGATION LEVEL

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

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

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

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

16. TIMETABLE FOR IMPLEMENTATION

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

17. REPORT SIGN OFF

Jane Haskett
General Manager
Primary Care Services

Lindsay Bedford
Director of Finance

August 2017

18. SUPPORTING DOCUMENTS

DL (2017) 11 Appendix

The Scottish Government
Health Finance Directorate

Chief Executives and Directors of Finance
NHS Health Boards

The Scottish Government
Riaghaltas na h-Alba

Dear Colleague

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

The attached document updates and supersedes the guidance on payment verification procedures contained in DL (2016) 11 and outlines the arrangements for payment verification for 2016-17.

BACKGROUND

This revision includes the following main changes:

Dental

The revision for 2017-18 has introduced a flowchart demonstrating guidelines for payment verification reviews, and a paragraph relating to the recovery of overpayments.

Medical

The revision for 2017-18 reflects the continuing development of the GP contract. Sections relating to the Quality & Outcomes Framework and the Organisational Core Standard have been removed.

Ophthalmic

The revision for 2017-18 has resulted in the introduction of a paragraph relating to IT System Security.

DL (2017) 11

22 May 2017

Addresses

For action
Chief Executives and Directors of Finance, NHS Boards

Chief Executive, NHS National Services Scotland

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

Auditor General

NHSScotland Counter Fraud Services

Enquiries to:

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Basement Rear
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Edinburgh
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http://www.scotland.gov.uk

Pharmacy

The revision for 2017-18 has resulted in no changes to the protocol.

ACTION

Chief Executives are asked to:

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

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

FURTHER INFORMATION

Further information is available from David Knowles, Director, Practitioner & Counter Fraud Services, NHS National Services Scotland:

email: david.knowles@nhs.net
telephone: 0131 275 6462

Yours faithfully,

Christine McLaughlin
Director of Health Finance

Payment Verification Protocols

Payment Verification Programme for 2017-18

TABLE OF CONTENTS

Introduction

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

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

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

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

1.5 The verification process across all contractor streams relies, amongst other things, on the accuracy of CHI. Further details in relation to the verification of CHI data is detailed within Annex II, Medical Payments.

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

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

Contractor Checking

Ophthalmic, Pharmaceutical and Dental Payments

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

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

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

- the results of level 1 checks indicate that this would be beneficial;

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

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

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

GMS Payments

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

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

Inspection of Clinical Records

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

Risk Assessment

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

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

Reporting to NHS Boards

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

4.2 In order to support this, the Practitioner Services PV teams will produce quarterly reports for each of the contractor streams, providing information on the

level of checking carried out in each NHS Board area and highlighting any specific issues of interest.

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

Countering Fraud

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

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

Adjustment to Payments

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

Annex I – Dental Payments

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Introduction

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

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

Dental, unlike the other contractor streams within Practitioner Services, have a responsibility regarding Clinical Governance. And if they become aware of any significant clinical issues during the course of an investigation notification will be discussed with the relevant NHS Board at the earliest opportunity for agreement to be reached on whether a referral to the GDC is appropriate

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

Retention of Evidence

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

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

Capitation & Continuing Care

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

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

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

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

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

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

- patient letters
- sampling of patient records and associated documentation
- liaison with private capitation scheme providers to establish registration status

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

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries(as per Appendix B)

Items of Service

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

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

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

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

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

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

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

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

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

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Details of information used to verify service provision
- Any necessary recommendations, actions and recoveries(as per Appendix B)
- SDRS reports

Allowances

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

Level 1 will comprise 100% checking of:

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

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries(as per Appendix B)

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

1 Background

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

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

2 Selection of Patients

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

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

3 SDRS Reports

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

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

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

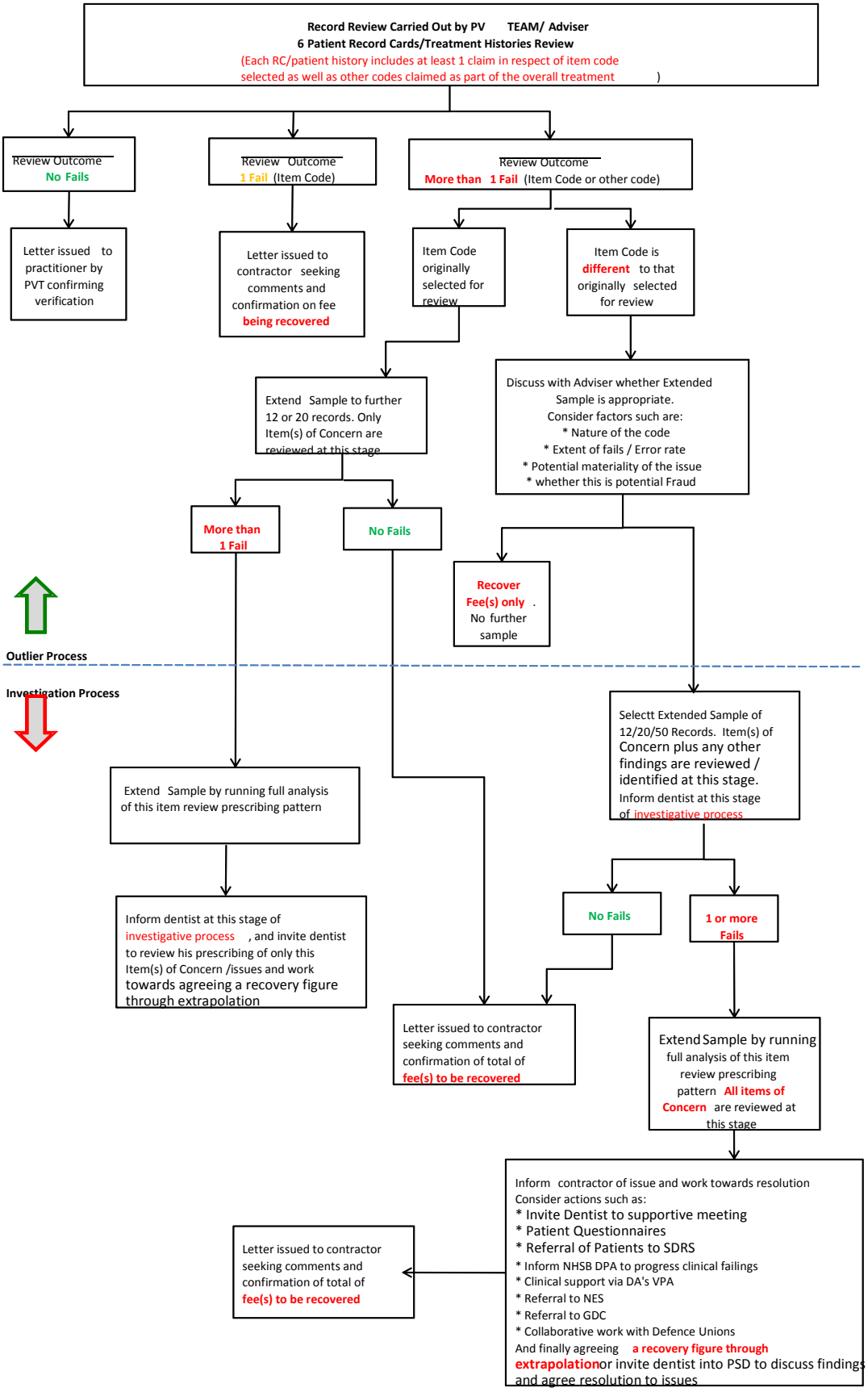
Administrative (i) c: possible clerical error e.g. mixing an upper and lower or left and right on the charting of a restoration

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

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

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

Appendix B - FLOWCHART DEMONSTRATING GUIDELINES FOR PAYMENT VERIFICATION REVIEWS



Recovery of Overpayments

Under Regulation 25(1) of the National Health Service (General Dental Services (Scotland) Regulations 2010, Practitioner Services (as the Agency) will draw to the attention of the dentist payments which they consider have been made in circumstances in which they are not due and therefore proceed to makes recoveries by any means possible.

Extrapolation to the entire population is used to make recoveries where a high number of systematic errors are identified from either the original or extended sample of record cards and item of service claims tested. This aims to keep the administrative burden to a minimum from both the practitioner and practitioner services.

Annex II – Medical Payments

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Introduction

The following sections detail the payment verification requirements for Primary Medical Services for the 2017/18 financial year.

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

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

Retention of Evidence

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

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

Data Protection

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

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

Premises and IT Costs

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

Payment Verification for Global Sum

METHOD

The Global Sum is the payment to GP Contractors for delivering essential and additional services.

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

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

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

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

System/Process Generated Controls

- All new patient registrations transferred electronically via PARTNERS to the Community Health Index (CHI) are subject to an auto-matching process against existing CHI records. If a patient cannot be auto-matched further information is requested from the GP Practice so that positive patient identification can be ensured.
- All patient addresses transferred by PARTNERS to CHI are subject to an auto-post coding process to ensure validity of address within the Health Board Area.
- All deceased patients are automatically deducted from the GP Practice on CHI using an interface file from NHS Central Register (information being derived from General Register of Scotland). Patients registering elsewhere in the UK are deducted from the GP Practice on CHI following matching by NHS Central Register.
- Patients are automatically deducted from GP Practice on registration with another GP Practice in Scotland.
- All patients confirmed as no longer residing at an address are removed on CHI and automatically deducted from GP Practice lists via PARTNERS.
- Quarterly archiving of GP Practice systems and generation of PARTNERS reports ensures that all patient transactions (acceptances and deductions) have been completed by the GP Practice.
- All patients whose address is an exact match with a Care Home address will automatically have a Care Home indicator inserted on CHI.
- Where new patient registrations are not transferred by PARTNERS manual scrutiny of registration forms is undertaken.
- Registration Teams check unmatched patients (without CHI number) to NHS Central Register database to ensure positive patient identification.

Random Checking

- Validation on patient data for a minimum of 10% of GP Practices annually via Patient Information Comparison Test (PICT) to ensure that patient data on CHI and on GP systems match. The following fields can be validated:

    1. Date of Birth and Sex differences
    2. Name differences
    3. Unmatched patients
    4. Patients on CHI but not on practice system
    5. Patients who have left the practice
    6. GP Reference differences
    7. Address differences
    8. Possible duplicates
    9. Missing CHI Postcodes
    10. Mileage differences

Targeted Checking

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

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

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

Payment Verification Practice Visit

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

Trend Analysis

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

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

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

OUTPUTS:

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

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

Payment Verification of Core Standard Payment

In 2016-17 the remaining 659 QOF points were merged with the clinical and organisational core standard payments to create a single Core Standard Payment.

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

There will be no specific payment verification arrangements aligned to the Core Standard Payment.

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

Payment Verification for Temporary Patient Adjustment (TPA)

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

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

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

OUTPUTS:

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

Payment Verification for Additional Services

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

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

OUTPUTS:

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

Payment Verification for Payments for a Specific Purpose

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

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

Immunisations

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

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

OUTPUTS:

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

Payment Verification for Section 17c Contract

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

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

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

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

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

OUTPUTS:

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

Payment Verification for Seniority

METHOD

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

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

OUTPUTS:

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

Payment Verification for Enhanced Services

INTRODUCTION

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

METHOD

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

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

OUTPUTS:

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

GP Practice System Security

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

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

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

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

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

OUTPUTS:

- Any necessary recommendations and actions.

Annex III – Ophthalmic Payments

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Introduction

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

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

Retention of Evidence

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

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

GOS 1 Primary Eye Examination Claim

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

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

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

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

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

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

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

Level 4 checking will be undertaken as follows:

- the carrying out of practice visits as per Appendix A

Outputs:

Quarterly PV report detailing:

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

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

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

GOS 1 Supplementary Eye Examinations

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

Level 1 will comprise 100% checking of:

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

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

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

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

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

Level 4 checking will be undertaken as follows:

- the carrying out of practice visits as per Appendix A

Outputs:

Quarterly PV report detailing:

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

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

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

GOS 1 Domiciliary Visits

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

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

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

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

- examination of record cards and associated documentation

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

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

Level 4 checking will be undertaken as follows:

- the carrying out of practice visits as per Appendix A

Outputs:

Quarterly PV report detailing:

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

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

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

GOS 3 Spectacle Vouchers

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

Level 1 will comprise 100% checking of:

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

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

- ratio of GOS3 claims to total eye examination claims

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

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

Level 4 checking will be undertaken as follows:

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

Outputs:

Quarterly PV report detailing:

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

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

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

GOS 4 Repair/Replacement Voucher

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

Level 1 will comprise 100% checking of:

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

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

- examination of record cards and associated documentation

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

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

Level 4 checking will be undertaken as follows:

- the carrying out of practice visits as per Appendix A

Outputs:

Quarterly PV report detailing:

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

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

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

IT System Security

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

Contractors are responsible for the purchase, maintenance, upgrade and running costs of integrated IM&T systems for their practices, as well as for telecommunications links within the NHS. Within each NHS Board area, assurances will be obtained as part of the premises inspection programme that appropriate measures are in place to ensure the integrity of the data held within each ophthalmic practice's clinical system.

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

- That the practice has current registration with the Information Commissioner's Office regarding Data Protection
- an established policy on System Security should exist that all employees have access to and have agreed to abide by;
- administrator access to the system should only be used when performing relevant duties;
- a comprehensive backup routine should exist and appropriate storage of backup media should occur; and
- all staff utilising the VPN connection comply with of the Acceptable User Policy in place in their Health Board

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

OUTPUTS:

- Any necessary recommendations and actions.

Appendix A – Inspection of Ophthalmic Records and Practice Visits

1. Background

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

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

2. Selection of Practices

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

2.2 Practitioner Services and NHS Boards will jointly agree the selection of practices. In the case of those visits carried out as part of random sampling, consideration will be given to avoiding the selection of any practices that have recently been in receipt of a Practice Inspection or routine record card check. It is for the NHS Board to determine the level of assurance it requires from the payment verification process.

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

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

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

3. Selection of Records

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

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

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

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

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

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

4. Visiting Team

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

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

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

5. Examining the Patient Record Cards

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

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

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

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

6. Concluding the Visit

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

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

- Which payments were verified, and which payments were not;

- Whether an extended sample of clinical records require to be examined/further investigation carried out;
- What actions the practice is required to take as a result of the visit;
- Whether recoveries require to be made as a result of the visit, and the terms according to which they will be made.

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

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

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

7. Practice Visit Report

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

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

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

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

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

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

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

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

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

Annex IV – Pharmaceutical Payments

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Introduction

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

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

Retention of Evidence

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

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

Minor Ailments Service

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

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

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

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

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

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

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

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

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

Chronic Medication Service

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

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

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

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

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

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

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

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

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

Gluten Free Food Service (GFF)

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

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

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

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

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

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

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

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

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

Acute Medication Service

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

Payment verification checking takes place on 4 levels as follows:

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

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

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

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

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

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

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

Public Health Service - Emergency Hormonal Contraception

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

Payment verification checking takes place on 4 levels as follows:

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

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

- Claim activity.

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

- Sampling of patient medication records and associated documentation.

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

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

Public Health Service – Nicotine Replacement

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

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

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

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

- Claim activity.

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

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

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

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

Locally Negotiated Payments

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

Out of Pocket Expenses

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

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

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

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

- Claim activity.

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

- Targeted letters to contractors to request supporting documentation.

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

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

Stock Orders

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

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

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

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

- Claim activity.

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

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

Level 4 checking will be undertaken as follows:

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

Outputs:

Quarterly PV report detailing:

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

Other Contractor Types - Dispensing Doctors

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

Payment verification checking takes place on 4 levels as follows:

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

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

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

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

- Targeted letters to patients to confirm provision of service.

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

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

Other Contractor Types - Appliance/Stoma Suppliers

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

Payment verification checking takes place on 4 levels as follows:

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

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

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

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

- Targeted letters to patients to confirm provision of service.

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

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

Appendix A – Level 1 Checks

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

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

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

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

Appendix B – Random Sampling

1. Background

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

2. Selection of Pharmacies

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

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

3. Selection of Records

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

4. Examination of Patient Medication Records

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

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

Item Number 11

AUDIT70/2017
Audit Committee
17 August 2017

PAYMENT VERIFICATION: FAMILY HEALTH SERVICE (FHS) CONTRACTORS

1. PURPOSE OF THE REPORT

The purpose of this report is to give assurances to the Audit Committee in respect of the discharge of financial governance in accordance with the national payment verification procedures and arrangement for payment verification for FHS Contractors, i.e. General Dental: Ophthalmic; Pharmaceutical; and Medical Services DL(2017)11 included under cover of the Payment Verification Annual Process Update paper.

2. RECOMMENDATIONS

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

3. EXECUTIVE SUMMARY

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

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

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

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

4. REPORT DETAIL

4.1 General Dental Services

Quarter 4 (Jan 2017– Mar 2017)

Post Treatment Referral Analysis

Referral for appointments	300
Reports received	6
Failed appointments	8
Referrals cancelled	1
Outcomes awaited	285

Of the 300 referrals 9 % were non random (PV level 3 & 4).

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

Post Treatment Reports

	No of Dentists	No. of Patients
Code 1	28	32
Code 2	4	4
Code 3	0	0
Code 4	0	0

Pre Treatment Reports

	No. of Dentist	No of Patients
Code A	4	4
Code B	1	1
Code C	1	1
Code D	0	0

EXPLANATION OF DENTAL REFERENCE OFFICER CODES

Clinical Codes:

Code 1 or Code A
Defines that in the opinion of the Dental Reference Officer the treatment provided/ the treatment proposals are satisfactory.

Code 2
Defines that the Dental Reference Officer confirms that the treatment carried out was satisfactory at completion and something minor is a miss at the time of examination (i.e. a restoration has been lost) OR the dental officer believes the treatment was satisfactory at completion but requires further information to be sure (i.e. the practitioner has not submitted a final root treatment radiograph to confirm that the canal has been satisfactorily obdurated).

Code B
Defines that the Dental Reference Officer believes the treatment proposals are broadly satisfactory but is asking the practitioner to consider minor changes to the treatment proposals or a minor addendum.

Code 3 or Code C
Defines that the Dental Reference Officer has concerns related to the clinical care provided or proposed and is requesting that Practitioner Services carry out further investigations related to the findings.

Code 4 or Code D
Defines that the Dental Reference Officer has concerns related to the clinical care provided or proposed that are of such concern that the matter should be discussed with/ referred to the Health Board.

Code R
The Dental Reference Officer recommends the practitioner obtains a consultant's report.

Report on Investigation and Outliers – Update on Actions – Progress

No of active outliers 17

No of active investigations	3
New cases under investigation	4
Closed cases	0

Monies recovered to date £7,600.00

4.2 General Ophthalmic Services

Quarter 4 (Jan 2017 to Mar 2017)

i) Level 1: No further action required.

ii) Level 2: Random Sampling – No further action required.

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

iv) Level 3: The data in respect of ongoing level 3 investigations was reviewed. 35 cases were discussed, 13 of which have been closed with a recovery of £726.90 being made. Recovery mandates have been issued for a further 11, five cases are ongoing, records have been requested for a further four and two cases are scheduled for further review.

v) Level 4: No practice visits were undertaken in the 4th quarter as the programme for 2016/17 was complete.

4.3 Pharmaceutical Services:

Quarter 3 (October – December 2016)

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

ii) Level 2: Discussions continue on the new Tableau reports with the Board. The Board expressed some concerns that the new reports were not currently easy to use to identify outliers. The payment verification team assured the Board that they have a Payment Verification Implementation Group (PVIG) established which will look closely at the tableau dashboard and all of the comments to date from the Health Boards with a view to implementing iterative improvements.

As interim measure payment verification agreed to look into a number of additional areas for the Board:

- Minor Ailments Service:- establish which contractors are currently increasing the number of patients registered for the service and any contractors registering over 25 patients in one day
- Chronic Medication Service:- contractors registering over 25 patients in one day.
- Contractors who have not done any “Urgent Supply” (CPUS) in the last 6 month period

. Further investigation was requested in one specific area:

- Two contractors with a higher than average cost for Nicotine Replacement Therapy

iii) Level 3: All previously requested level 3 actions had been successfully completed and any appropriate recoveries made.

Gluten Free Foods- The investigation of high cost dispensing pharmacies identified an anomaly with the payments for Juvela mixed cases and subsequent recoveries have been made.

iv) Level 4: As requested payment verification obtained an appropriate explanation, and a copy of the controlled drugs register, following an omitted PMR entry for a methadone prescription. Payment verification looked into the treatment of an aspirin prescription item with ePharmacy and ascertained that it had been an unusual situation where the paper prescription had been received before the electronic message was received. This is not a regular occurrence.

4.4 General Medical Services

The Quarter 4 report was provided to the Audit Committee meeting of 11th May 2017. There is no further update at present. Two practices have been selected for random visits in 2017/18.

Details of the new contract and information in respect of future payment verification processes are still awaited.

5. CONTRIBUTION TO NHS TAYSIDE'S STRATEGIC AIMS

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

6. MEASUREMENT FOR IMPROVEMENT

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

The payment verification process and regular scrutiny of all claims across the FHS contractor groups provides a programme discouraging false or erroneous claims.

7. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

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

8. PATIENT EXPERIENCE

Not applicable

9. RESOURCE IMPLICATIONS

Financial

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

Workforce

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

10. RISK ASSESSMENT

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

11. LEGAL IMPLICATIONS

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

12. INFORMATION TECHNOLOGY IMPLICATIONS

Not applicable

13. HEALTH & SAFETY IMPLICATIONS

Not applicable

14. HEALTHCARE ASSOCIATED INFECTIONS

Not applicable

15. DELEGATION LEVEL

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

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

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

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

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

16. TIMETABLE FOR IMPLEMENTATION

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

17. REPORT SIGN OFF

Jane Haskett
General Manager,
Primary Care Services

Lindsay Bedford
Director of Finance

August 2017

CORPORATE GOVERNANCE REVIEW MEETING

Action note from above meeting held at 1030 am on Wednesday 17 May 2017 in Committee Room 1, Level 10, Ninewells Hospital

Present
Ms Valerie Aitken, Corporate Services/Business Support Manager, Perth & Kinross (teleconference at 1050)
Mrs Lisa Green, Committee Support Officer
Miss Donna Howey, Head of Committee Administration
Ms Margaret Dunning, Board Secretary (teleconference from 1045)
Mrs Alison Hodge, Committee Support Officer
Mrs Nicki Owen, Committee Support Officer

Mrs Hilary Walker, Risk Manager, NHS Tayside (teleconference)
Apologies
Ms Jackie Bayne, HR Manager
Mr Derek Colley, Financial Governance Accountant
Mrs Judith Golden, Employee Director
Mr Barry Hudson, Regional Audit Manager
Mrs Jocelyn Lyall, Principal Auditor
Ms Jackie Rogers, Committee Support Officer
Mrs Judith Triebs, Regional Audit Manager, FTF Audit Services

Miss D Howey in the Chair

ACTION

1. Apologies and Welcome

Donna welcomed all to the meeting and advised that there would be no representative from Internal Audit. Val Aitken and Margaret Dunning were to join the meeting via teleconference. The apologies were as noted above.

Action Note of Last Meeting

Action Note – 30 November 2016

The Action Note of the meeting held on 30 November 2016 was approved. The Action Note was forwarded to the Audit Committee in January 2017.

3. Action Points Update

The following was highlighted:-

Item 6 – 19 August 16 UK Bribery Action 2010 – Gifts Gratuities and Hospitality – a report was provided to SMT on 21 February 2017. This item is now complete.

Item 5 – Update Decisions Report Template and Guidance – Hilary Walker is continuing to work on the Assurance Report

Item 4 Section of Code of Corporate Governance – Meetings were being undertaken on 15 May 2017 around the IJBs. Further amendments would be make for the September 2017 update.

Item 5 – Draft Vital signs – Code of corporate Governance – This was published in December 2016 and is therefore complete.

The Action Points Update was noted.

4. Other Matters Arising

There were no other matters arising.

5. Internal Audit Report T20B/17 Standards of business Conduct

The following was discussed:-

- a letter had been received from Christine McLaughlin from the Scottish government in relation to the Bribery Act
- Internal Audit were asked to look at the process and requested that a text be added to the Code of Corporte Governance to detail line management within the text. This action would be taken forward for inclusion within the Code of Corporate Governance update in September 2017 **DH**
- A response to Christine McLaughlin would be produced with the Internal Audit action enclosed.

6. Update to Decision Making Report Template

Stephen Hay had requested that reports presented to Tayside NHS Board should indicate which Committees the report had been considered at prior to the Board. A section was to be added to the Board within the Executive Summary stating:- "this report has been considered at/..." **DH**

7. Updates to the Code of Corporate Governance

Introduction – Director of Finance – Executive Board Member:- the Director of Finance is now a reporting Executive Member

Section A – Updates to universities Strategic Liaison Committee Remit - the amendments to the Remit were accepted

Section C – Updates re Hospitality Form and Possibility of Flowchart – the form would be updated to include Line Management information with the addition of a Date of Discussion with Employee. Forth Valley shared their Flow Chart. Internal Audit advised it would be useful for NHS Tayside to implement a Flow Chart.

It was agreed a flow Chart would be implemented and included in the Vital Signs updating Staff on Hospitality Forms and put on the Hospitality Staffnet Page **DH**

Section E – Updates re Scottish Capital Investment Manual – this was not ready to be updated. Louise Lyall would would take this forward **LL**

Section F – Updates re Section 5 Annual Accounts and Possible Amendments re changes in Intermediate Tax Legislation – Frances Gibson would be making amendments to the Annual report and Accounts and this would be presented to the Audit Committee.
IR35 – Frances Gibson and Robert MacKinnon would provide an update. Donna would take this forward and circulate to the Group in due course **DH**

8. Board Guidance March 2017

Donna advised that the Guidance had been issued to Non Executives and Committee Support Officers.

It was noted that 3 Non Executives would be leaving in 2017 and 3 new stakeholders from the Council would be joining the Board.

9 Any Other Competent Business

Risk Assessment Reporting – Hilary advised there had to be a clear process of risk reporting for Standing Committees. A written risk report had to be provided to each Standing Committee meeting on the correctly formatted reporting template. Standing Committees have a Governance responsibility and need to be assured they are receiving the correct risk report.

Hilary Walker would provide a copy of the Associate Director of Nursling's risk report which should be used as an exemplar for all risk reports.

Advisory Assurance Group – Margaret Dunning highlighted that the 3 main areas the Advisory Assurance Group would be looking into were the Financial Plan, Service Plan and Governance.

Governance was being monitored through the Transformation Programme Board.

Ernst & Young had finished their assessment within the Organisation.

Hugo Macy Taylor would be talking to clinicians

The Advisory Assurance Group report would be published at the end of June 2017.

10 Date of Next Meeting

The date of the next meeting is Wednesday6 September 2017 at 1030am in Committee Room 1, Level 10, Ninewells.

Minute NHS Tayside

STRATEGIC RISK MANAGEMENT GROUP

Minute of the above meeting held at 2:00pm on Thursday 27 April 2017 in Committee Room 1, Ninewells Hospital.

Present

Members	
Ms Margaret Dunning	Board Secretary, NHS Tayside **(Chair)**
Mr Alan Gall	Interim Performance Director, NHS Tayside
Mrs Judith Golden	Employee Director, NHS Tayside
Ms Frances Rooney	Director of Pharmacy, NHS Tayside
In Attendance	
Mr Mark Anderson	Head of Property NHS Tayside (deputising for Ms Lorna Wiggin)
Ms Deborah Balshaw	Lead Nurse Early Years
Ms Alison Dailly	Information Governance Manager, NHS Tayside
Ms Alison Hodge	Committee Support Officer, NHS Tayside
Miss Donna Howey	Head of Committee Administration, NHS Tayside
Ms Elisabeth Leslie	Head of Resilience, NHS Tayside
Ms Gail McClure	Quality and Services Manager, Primary Care Services, NHS Tayside (deputising for Dr Michelle Watts)
Ms Jennifer Mudie	Associate Director of HR – Resourcing, NHS Tayside (deputising for Mr George Doherty)
Ms Tracey Passway	Clinical Governance and Risk Management Team Leader, NHS Tayside (deputising for Ms Arlene Napier)
Ms Hazel Scott	General Manager Public Health
Mr Charlie Sinclair	Associate Nurse Director, (deputising for Mrs Gillian Costello) to 3:30pm
Mr Finlay Stewart	Head of eHealth Strategic Delivery, NHS Tayside (deputising for Ms Jenny Bodie)
Mrs Hilary Walker	Risk Manager, NHS Tayside
Ms Kerry Wilson	General Manager, Perth Royal Infirmary, NHS Tayside
Apologies	
Ms Karen Anderson	Director of Allied Health Professions (AHPs), NHS Tayside
Mr Lindsay Bedford	Director of Finance, NHS Tayside
Mrs Gillian Costello	Nurse Director, NHS Tayside
Ms Jenny Bodie	Director of eHealth, NHS Tayside
Mr George Doherty	Director of Human Resources and OD, NHS Tayside
Ms Lesley McLay	Chief Executive, NHS Tayside
Ms Arlene Napier	Associate Director, Clinical Governance and Risk, NHS Tayside
Mr Bill Nicoll	Director of Strategic Change, NHS Tayside
Professor Andrew Russell	Medical Director, NHS Tayside
Dr Drew Walker	Director of Public Health, NHS Tayside
Dr Michelle Watts	Associate Medical Director, Primary Care, NHS Tayside
Ms Lorna Wiggin	Chief Operating Officer, NHS Tayside

Ms Margaret Dunning in the Chair

1	**Welcome and Introduction** Ms Dunning welcomed everyone to the meeting, in particular to those attending the meeting for first time.	**ACTION**

Ms Dunning welcomed the deputies attending the meeting on behalf Ms Wiggin, Mr Doherty, Ms Bodie, Dr Watts, Professor Russell and Mrs Costello.

2 Apologies

Apologies were noted as above.

3 Minute of the last meeting

3.1 Minute of the Strategic Risk Management Group 2 February 2017

The group noted the minute of the meeting held on 2 February 2017 and there were no comments.

As the meeting today was not quorate the group recommended approval of the minute of the meeting held on 2 February 2017.

Ms Dunning advised that the Risk Appetite statement was approved by the Audit Committee and the Tayside NHS Board.

She added at the Board would receive reports on the six very high category strategic risks which were currently outwith the risk appetite. These risks will be reported at every Board meeting until they fall below the Risk Appetite.

The SRMG:

- Agreed the Minute of the Strategic Risk Management Group 2 February 2017 was an accurate record of the meeting and recommended approval

3.2 Action Points Update Strategic Risk Management Group 2 February 2017

There were no comments relating to the action points update.

The SRMG:

- Noted the action points update

3.3 Matters Arising

There were no matters arising.

4 RISK MANAGEMENT

4.1 Application of the matrix for the risk appetite

Mrs Walker advised that the Risk Appetite Statement had been developed by a short life working group (SLWG) which had non executive and internal audit representation.

The Risk Appetite statement had been welcomed by the Audit Committee. This statement recommended that all strategic risks above the Risk Appetite were reported at every Tayside NHS Board meeting until they fall below the Risk Appetite.

The SRMG:

- Noted the verbal update

4.2 Risk Management Annual Report

Mrs Walker advised that previously a mid year and an annual report had been submitted to the Audit Committee. There had been a test of change and the report was presented in a different format. Following the test of change the reporting format and process had reverted back to the original format and submission frequency. The mid year report (April – Sept 2016) was welcomed by the Audit Committee.

Following the SRMG meeting today the Risk Management Annual Report will go to the Audit Committee in May 2017 for approval.

The SRMG:

- Reviewed and approved the Risk Management Annual Report
- Noted that the Risk Management Annual Report would now go to the Audit Committee on 11 May 2017

4.3 Risk Management Workplan 2017/18

Mrs Walker advised that the Risk Management Workplan 2017/18 was considered an element of good practice in providing assurance to the Audit Committee. The Workplan was not a mandatory or statutory requirement. The group had no comments in relation to the Risk Management Workplan 2017/18.

The SRMG:

- Reviewed and agreed the Risk Management Workplan 2017/18
- Noted the progress and work undertaken during 2016/17
- Noted the Risk Management Workplan 2017/18 will now go to the Audit Committee on 11 May 2017

4.4 CIPFA Self Assessment and Audit Tool

Ms Walker advised that this document was produced by the Chartered Institute of Public Finance and Accountancy (CIPFA) and culd be applied to the Health Board.

Mrs Walker explained that NHS Tayside completed the CIPFA self assessment annually, and that moving forward this would be underpinned by Annex F of the NHS Tayside Audit Committee handbook.

Mrs Walker highlighted the section 'Projects and Partnerships', page 27 commenting that this had been largely completed in respect of Capital Projects with the exception of 5 key questions which had resulted in the overall compliancy score for this section being reduced to take cognisance of the ongoing work in relation to governance for the Health Board, Councils and the Integrated Joint Boards .

There was short discussion on the level of confidence in relation to compliance. Ms Walker advised that there was evidence and an audit trail available should this be required.

Mrs Golden highlighted the ninth question on page 6 and requested that this be updated to reflect the situation in relation to representation from staff side. Mrs Walker acknowledged the request and agreed to update the report and forward to Ms Golden to review. H Walker

Ms Dunning advised that there would be a meeting with the Chief Officers, Board Chairman, Chief Executive and Internal Audit to explore how strategic risks would be managed in the future.

There are currently two different models:

- Fully delegated model - Angus HSCP and Dundee HSCP
- Commissioning model – Perth and Kinross HSCP

In a fully delegated model strategic risks should move to Health and Social care Partnerships

The Group noted that the current Datix system was Tayside wide and would not be replaced.

There were no comments in relation to the CIPFA Self Assessment and Audit Tool.

The SRMG:

- Noted the progress against the CIPFA Self Assessment and Audit Tool

Ms Gail McClure and Dr Cesar Rodriguez joined the meeting at 2:30pm.

5 STRATEGIC RISKS

Ms Dunning explained the reporting process at the SRMG for those attending the meeting for the first time.

There was short discussion on

- The frequency of risk reporting to groups and Committees.
- The potential overlap of some strategic risks with others which may lead to duplicate reporting or a different interpretation of the risks

Mr Mark Anderson joined the meeting at 2:45pm

The Chair requested that the risk owners/ managers provide a brief exception report on their strategic risk(s)

Strategic Risks aligned with the Tayside NHS Board

14 Infection Management

Owner – G Costello, A Russell
Manager – D Weir

Ms Dunning advised that Ms Costello had provided a written update to the Chair. The new owner of this risk will be Ms Lynn Smith following the retiral of Ms Dawn Weir.

There were no issues to highlight to the group.

The group recommended that this risk should remain as a strategic risk.

26 Waiting Times and RTT Targets

Owner – L Wiggin
Manager – S Lowry
This risk was not discussed.

The group recommended that this risk should remain as a strategic risk.

201 Health Equity

Owner – D Walker
Manager – H Scott

Ms Hazel Scott was in attendance for this update. She provided background on the risk commenting that the Health Equity Strategy had been published in 2010 and the Public Health Directorate had a responsibility to monitor the implementation throughout NHS Tayside

Following discussion the group recommended that this risk was archived acknowledging that it could be reactivated at a later date if required. There would still be visibility and health equity would continue to be relevant throughout the organisation.

The group recommended that this risk should be archived.

Ms D Balshaw joined the meeting at 3:00pm

312 NHS Tayside Estates Infrastructure Condition

Owner – L Wiggin
Manager – M Anderson

Mr Mark Anderson was in attendance and provided an update.

Mr Anderson reported:

- The last meeting with the Capital Investment Group was very positive and there would continue to be investment in the electrical infrastructure.
- The estate asset management system had been updated and accurate
- The risk was managed through available resources
- All projects required to connect to a resilient electrical infrastructure

Mr Anderson confirmed that the risk should remain a strategic risk.

The group recommended that this risk should remain as a strategic risk.

Mr Anderson left the meeting.

313 Capacity and Flow (Winter Plan)

Owner – L McLay
Manager – L Wiggin

Ms Kerry Wilson was in attendance for this report.
The group noted that there would be proposal to the Tayside NHS Board meeting on 4 May 2017 for risk Risk 313, Capacity and Flow to be merged/ amalgamated with the Risk 302, PRI / Patient Flow.

It was noted that the risk scores were the same and this would provide assurance on the whole system.

The group recommended that this risk should remain as a strategic risk.

353 Sustainable Primary Care Services

Owner – V Irons
Manager – J Galloway

This risk was not discussed.

The group recommended that this risk should remain as a strategic risk.

Strategic Risks aligned with the Finance and Resources Committee

36 Strategic Financial Plan 2015/16 - 2019/20

Owner – L McLay
Manager – L Bedford

This risk was not discussed.

The group recommended that this risk should remain as a strategic risk.

37 Impact of Reduction in Capital Resources

Owner – L McLay
Manager – L Bedford

This risk was not discussed**.**

The group recommended that this risk should remain as a strategic risk.

38 Information Governance Risk

Owner – M Dunning
Manager – A Dailly

Ms Alison Dailly was in attendance and provided an update. The group noted that DL17 had been implemented and a GAP analysis had been completed. Good governance arrangements are in place and report would go to the Finance and Resources Committee with a recommendation to archive this risk.

There were no issues to highlight to the group.

The group recommended that this risk should be archived.

415 Implementation of TrakCare

Owner – J Bodie
Manager – A Graham

Mr Finlay Stewart was in attendance. He advised that the risk score would be unlikely to change before the TrakCare go-live date on 26 June 2017.

The group noted that the implementation date had changed. Mr Stewart advised that due to the change there had been an opportunity to gather more information and learning opportunities from NHS Fife who have recently gone live with TrakCare.

The group noted that this risk would likely be archived following implementation of TrakCare.

There were no issues to highlight to the group.

The group recommended that this risk should remain as a strategic risk.

Strategic Risks aligned with the Staff Governance Committee

58 Workforce Optimisation

Owner – G Doherty
Manager – J Mudie

95 Medical Workforce

Owner – G Doherty
Manager – J Mudie

Ms Jennifer Mudie was in attendance and provided a verbal update. She advised that both risks would be reviewed to ensure that the current position was reflected.

There were no issues to highlight to the group.

The group recommended that both risks should remain as strategic risks.

280 Nursing and Midwifery Workforce

Owner – G Costello
Manager – C Sinclair

Mr Charlie Sinclair, Associate Nurse Director provided an update on this risk. He advised that the risk remained high and that there were currently several hotspots within NHS Tayside. In respect of Perth Royal Infirmary (PRI) the group noted that mitigating actions were still in place.

Mr Sinclair discussed:

- Staff rosters
- Number of beds/ staff /quality of care
- Supplementary staff
- Recruitment and retention

Mr Sinclair reported:

- There would be increased attendance at recruitment fairs
- In March 2017 400 former Registered Nurses were contacted to explore with them their reasons for leaving NHS Tayside and to invite their feedback on the possible return to NHS Tayside
- As part of focussed work on focussed work on recruitment there would be a specific advert for Bank nursing staff for PRI
- Shortlisting will take place for 120 student nurses who will qualify this year.

The group recommended that this risk should remain as a strategic risk.

28 Health and Safety

Owner – L Wiggin
Manager – S Muir (interim)

This risk was not discussed.

The group recommended that this risk should remain as a strategic risk.

Strategic Risks aligned with the Clinical and Care Governance Committee

15 Delivering Care for Older People

Owner – G Costello, A Russell
Manager – C Rodriguez

Dr Cesar Rodriguez was in attendance and provided an update on this risk. There were no major changes to highlight to the group. As previously reported to the SRMG, Dr Rodriguez advised that the risk was updated after each meeting of the Older People Clinical Board.

The group noted that there was an unannounced HIS Inspection Care of Older People in Acute Care Hospitals to Stracathro Hospital 21-22 February 2017. The report from this inspection is embargoed until 10 May 2017.

Dr Rodriguez advised that Ms Sarah Dickie, Associate Nurse Director was now the co chair of the Older People Clinical Board and would be the joint manager of this risk.

There were no issues to highlight to the group.

The group recommended that this risk should remain as a strategic risk.

16 Clinical Governance

Owner – G Costello, A Russell
Manager – A Napier

Ms Tracey Passway was in attendance and provided an update on this risk.

This risk is regularly refreshed and reported at the Clinical Quality Forum (CQF) and the Clinical and Care Governance Committee (CCGC). The risk was last updated on 27 April 2017. The group noted that the current risk score reflected the need to extend controls to all aspects of healthcare including primary care and health and social care. The arrangements set out in the IJBs need to be more assured.

There were no issues to highlight to the group.

The group recommended that this risk should remain as a strategic risk.

22 Health Protection of Children and Young People

Owner – G Costello
Manager – J Wilson

Ms Debbie Balshaw was in attendance and provided an update on this risk. She advised that an in depth review of the risk had taken place supported by the Clinical Governance and Risk Team. The risk title has been updated to Children, Young People and Families. The manager of the risk is now Ms Joan Wilson, Associate Nurse Diretcor, Children, Young People, Families, Primary Care and Protection following the retirement of Ms Kay Fowlie.

There were no issues to highlight to the group.

The group recommended that this risk should remain as a strategic risk.

121 Person Centredness

Owner – G Costello, A Russell
Manager – G Munro, C Sinclair

Mr Charlie Sinclair was in attendance and provided an update on this risk. He advised that the manager in the Datix system would be Ms Gillian Munro but the risk would be jointly owned by Gillian Munro and Charlie Sinclair.

The group noted that 'What Matters to You?' day would be on 6 June 2017.

There were no issues to highlight to the group.

The group recommended that this risk should remain as a strategic risk.

144 Maternity Services

Owner – G Costello, A Russell
Manager – J Craig (under review)

Mrs Walker advised that the risk would be reviewed and refocused around the maternity infrastructure. This may result in the risk becoming an operational risk underpinning the Estates Infrastructure strategic risk. Ms Walker advised that she would be attending a meeting in June 2017 to progress this. Following discussions and agreement the owner of this risk would be Ms Lorna Wiggin and the manager would be Ms Carol Goodman. Any remaining clinical issues relating to this risk would be owned by Ms Gillian Costello and Ms Justine Craig.

The group recommended that this risk should remain a strategic risk pending the outcome from the meetings as discussed.

302 PRI/Patient Flow

Owner – A Cook
Manager – K Wilson

Ms Wilson advised that there would be proposal to the Tayside NHS Board meeting on 4 May 2017 for this risk to be merged/ amalgamated with the Strategic Risk 313, Capacity and Flow.

The group recommended that this risk should remain a strategic risk pending the outcome from the Tayside NHS Board meeting on 4 May 2017.

395 Mental Health Services – Sustainability of Safe and Effective Services

Owner – A Russell
Manager – R Packham

Ms Dunning advised that a written update had been provided by Mr Rob Packham. Ms Walker advised that, going forward, there would be an event to review all current risks and ensure that those to be archived are updated appropriately and that those that remain have correct owners and managers. This process will ensure that there are robust governance arrangements and assurance processes in place.

There were no issues to highlight to the group.

The group recommended that this risk should remain a strategic risk.

414 Managed/ 2C Practices

Owner – A Russell
Manager – M Watts

Ms Gail McClure was in attendance and provided an update. The group noted that the situation was becoming unstable after a period of stability. Ms McClure highlighted a change in HRMC tax arrangements which has seen a decrease in availability of locums. It was anticipated that this would not be a long term issue.

There were no issues to highlight to the group.

The group recommended that this risk should remain a strategic risk.

The SRMG:

- Thanked everyone for their updates and contribution to the discussions
- Acknowledged that there had been a number of valuable comments

5.2 Risk Horizon Scanning and Emerging Risks

Ms Walker highlighted the Duty of Candour legislation and advised that this was included within the Clinical Governance Risk.

6 HEALTH AND SAFETY

6.1 NHS Tayside Health and Safety Support

There were no comments in relation to this report.

The SRMG:

- Noted the NHS Tayside Health and Safety Support report

7 RESILIENCE PLANNING

7.1 Resilience Planning Quarterly Update

There were no comments in relation to this report.

The SRMG:

- Noted the Resilience Planning Quarterly Update

8 POLICY MANAGEMENT

8.1 Policy Management Quarterly Report

There were no comments in relation to this report.

The SRMG:

- Noted the Policy Management Quarterly Report

9 GOVERNANCE

9.1 Strategic Risk Management Group Annual Report 2016/17

The SRMG:

- Recommended approval of the Strategic Risk Management Group Annual

Report 2016/17

9.2 Strategic Risk Management Group Terms of Reference 2017/18

The SRMG:

- Recommended approval of the Strategic Risk Management Group Terms of Reference 2017/18

9.3 Strategic Risk Management Group Workplan 2017/178

The SRMG:

- Recommended approval of the Strategic Risk Management Group Workplan 2017/18

10. ITEMS FOR INFORMATION

10.1 Datix Implementation Group 21 February 2017

The SRMG:

- Noted the Datix Implementation Group minute 21 February 2017

10.2 Sharps Management Committee 20 December 2016

The SRMG:

- Noted the Sharps Management Committee minute 20 December 2016

10.3 Record of attendance

The SRMG:

- Noted the record of attendance

11. ANY OTHER COMPETENT BUSINESS

There was no other competent business.

12. DATE OF THE NEXT MEETING

Thursday 1 September 2017, 13:30-12 noon in Committee Room 1, Ninewells Hospital.

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	Apologies			
Mrs L Dunion	Non Executive Member	NHS Tayside	Present	Present			
Mrs J Golden	Non Executive Member & Employee Director	NHS Tayside	Present	Present			
Mr S Hay	Non Executive Member (Chair)	NHS Tayside	Present	Present			
Mr M Hussain	Non Executive Member	NHS Tayside	Present	Present			
In Attendance							
Mr L Bedford	Director of Finance	NHS Tayside	Present	Present			
Ms M Dunning	Board Secretary	NHS Tayside	Present	Present			
Mr T Gaskin	Chief Internal Auditor	FTF Audit & Management Services	Present	Apologies			
Regular Attendees							
Mr D Colley	Financial Governance Accountant	NHS Tayside	-	Present			-
Mr B Crosbie	Senior Audit Manager	Audit Scotland	Present	Present			
Mr G Doherty	Director of Human Resources	NHS Tayside	Present	Present			-
Mrs F Gibson	Head of Financial Servicew	NHS Tayside	Present	Present			
Mr B Hudson	Regional Audit Manager	FTF Audit & Management Services	-	Present			
Mrs J Lyall	Principal Auditor	FTF Audit & Management Services	Present	Present			
Mr R MacKinnon	Associate Director of Finance, Financial Svs & Governance/FLO	NHS Tayside	Present	Present			
Ms F Mitchell-Knight	Asst Director, Audit Services	Audit Scotland	-	Present			-

Mrs H Walker	Risk Manager	NHS Tayside	Present	Apologies			
Mr R Marshall	Representative Area Partnership Forum	NHS Tayside	Present	Apologies			
For Information							
Prof J Connell FMedSci FRSE	Chair, Tayside NHS Board	NHS Tayside	Present	Present			
Mrs G Costello	Nurse Director	NHS Tayside	-	-			
Dr A Cowie	Non Executive Member	NHS Tayside	-	Present			
Mrs L Green	Committee Support Officer	NHS Tayside	Present	Present			
Miss D Howey	Head of Committee Administration	NHS Tayside	Present	Present			
Ms L McLay	Chief Executive	NHS Tayside	Present	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	-	-			