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 January 2019 at 10.30 in Committee Room 1, Level 10, Ninewells Hospital, 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

		LEAD OFFICER	REPORT NO/ REQUIRED ACTION
1.	Welcome	R Peat	
2.	Apologies	R Peat	
3.	Declaration of Interests	R Peat	
4.	**FTF INTERNAL AUDIT**		
4.1	Internal Control Evaluation	T Gaskin	AUDIT01/2019 Attached – for consideration
4.2	Internal Audit T22/18 – Workforce Benefits Realisation Nursing and Midwifery Supplementary Planning	C Sinclair	AUDIT02/2019 Attached – for consideration
5.	**EXTERNAL AUDIT**		
5.1	NHS Tayside Annual Audit Plan 2018/19	F Mitchell-Knight	AUDIT03/2019 Attached – for consideration
5.2	Payments Relating to the Departure of the Former Chief Executive	F Mitchell-Knight	AUDIT04/2019 Attached – for consideration
6.	Code of Corporate Governance – Scheme of Delegation	R MacKinnon	Verbal Update
7.	Standing Committee Annual Report Template	M Dunning	AUDIT05/2019 Attached – for consideration
8.	**DATE OF NEXT MEETING**		
	Thursday 14 March 2019 at 10:30am in the Board Room Kings Cross	All	For information

AUDIT COMMITTEE DEVELOPMENT SESSION – PRIVATE MEETING

9.	Year End Assurances	F Gibson	To follow
10.	**AUDIT COMMITTEE HANDBOOK**		
10.1	Review of Role and Remit of Audit Committee	F Gibson	To follow
10.2	Risk Management Arrangement	F Gibson	To follow
11.	Internal Audit Planning Process 2019/20 – Briefing Note	T Gaskin	Paper attached

Dr Robert Peat
Chair
January 2019

Distribution

MEMBERS

Mrs J Alexander
Mrs T McLeay
Cllr B Myles
Dr R Peat
Dr N Pratt
Mrs E J Wells

REGULAR ATTENDEES

Mr B Crosbie
Ms M Dunning
Mr T Gaskin
Mrs F Gibson
Mr A Gray
Mr B Hudson
Dr A Ingram
Mrs J Lyall
Ms A Machan
Mr R MacKinnon
Mr R Marshall
Ms F Mitchell-Knight
Mrs H Walker

FOR INFORMATION

Mr G Archibald
Mr J Brown, CBE
Miss D Howey
Communications Team

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

ITEM NUMBER 4.1

AUDIT01/2019
AUDIT COMMITTEE
24 JANUARY 2019

INTERNAL CONTROL EVALUATION

1. SITUATION AND BACKGROUND

As Accountable Officers, Chief Executives are responsible for maintaining a sound system of internal control and managing and controlling all the available resources used in his/her organisation. This review aims to provide early warning of any significant issues that may affect the Governance Statement.

The Internal Control Evaluation audit work is informed by detailed review of formal evidence sources including Board, Standing Committee, Executive Leadership Team (ELT) and other papers. Our opinions are also informed by regular meetings with Directors, senior officers and through fieldwork undertaken for specific audits during the year.

The draft report was considered by the Executive Leadership Team on 10 January 2019 and Responsible Directors have agreed time bound actions to address internal audit findings. We recommend that, at the earliest opportunity, the report is formally considered by the Standing Committees of the Board to ensure members are fully cognisant of the actions required by year end, in order that Standing Committees can provide conclusions on assurances. Standing Committee Annual reports are an essential part of the internal control process and the conclusions on assurance are considered in June each year by the Audit Committee as part of the Annual Accounts process. The Annual Reports also provide assurance to the Accountable Officer regarding the Governance Statement.

2. ASSESSMENT

We note the considerable efforts made by management and staff since our last report, particularly actions taken to enhance governance, accelerate transformation and improve management structures. We are also aware that there are a number of major initiatives in progress which may lead to significant improvement by year-end. However, at the time of our audit these actions had not yet manifested in significant improvements to outcomes and these developments were not yet at a stage where we would be able to provide positive assurance on their likely impact within the required timescales.

3. RECOMMENDATIONS

The Audit Committee is asked to:

- Note the attached Internal Control Evaluation report and the required actions;
- Agree that the Internal Control Evaluation report be distributed to Standing Committees for consideration, noting that some aspects may be relevant in the production of Standing Committee annual reports and assurance statements.

4. REPORT SIGN OFF

Responsible Executive Director and contact for further information

If you require any further information in advance of the Audit Committee meeting please contact:

Contact for further information
Tony Gaskin
Chief Internal Auditor
tony.gaskin@nhs.net

Date 16 January 2019

Additional supporting information

Internal Control Evaluation report attached.

Internal Control Evaluation 2018/19

Report No. T08/19

Issued To: G Archibald, Chief Executive
A Gray, Director of Finance

NHS Tayside Directors
Tayside IJB Chief Officers

Follow-Up Co-ordinator

Audit & Assurance Committee
External Audit

Contents

Draft Report Issued	14 December 2018
Management Response Received	10 January 2019
Target Audit Committee Date	24 January 2019
Final Report Issued	17 January 2019

Section 1 Executive Summary

EXECUTIVE SUMMARY

1. As Accountable Officers, Chief Executives are responsible for maintaining a sound system of internal control and managing and controlling all the available resources used in his/her organisation. This review aims to provide early warning of any significant issues that may affect the Governance Statement.
2. Our Internal Control Evaluation audit work is informed by detailed review of formal evidence sources including Board, Standing Committee, Executive Leadership Team (ELT) and other papers. Our opinions are also informed by regular meetings with Directors, senior officers and through fieldwork undertaken for specific audits during the year.
3. The Assurance & Advisory Group report was issued after our fieldwork was complete. We therefore have not incorporated its detailed findings into our report narrative, but have checked to ensure that there are no elements which were inconsistent with our findings.
4. We note the considerable efforts made by management and staff since our last report, particularly actions taken to enhance governance, accelerate transformation and improve management structures. We are also aware that there are a number of major initiatives in progress which may lead to significant improvement by year-end. However, at the time of our audit these actions had not yet manifested in significant improvements to outcomes and these developments were not yet at a stage where we would be able to provide positive assurance on their likely impact within the required timescales.
5. Key findings from this Internal Control Evaluation include:
    - There have been improvements in risk management, governance and reporting. Further work is required with integration governance arrangements still not concluded;
    - Although financial planning has improved considerably, NHS Tayside will not be financially and operationally sustainable without significant transformational change;
    - Whilst there has been some progress, there is still no clear timeframe for delivery of the Integrated Clinical Strategy (ICS) and other key components of transformation. Arrangements for reporting to the Board and its Committees on progress around the strategy and transformation have not yet been finalised. Management have informed Internal Audit that the ICS will be presented to Board in February 2019;
    - Enabling strategies, particularly development of an overarching Digital Strategy and a Workforce Plan, to support transformation cannot be fully completed until the ICS is agreed;
    - The Board has not yet received assurance on capacity and capability as previously agreed. Whilst improvements have been made, there is still a risk that capacity and capability are not sufficient to drive transformation, deliver the required savings in the interim, and deliver business as usual;
    - There are significant risks in relation to eHealth and Information Governance, both of which have been subject to recent external reviews. These risks will be directly monitored by the Audit Committee.
6. Whilst some action has been taken to implement agreed actions, themes identified in the previous Interim and Annual reports, many of which are directly relevant to the

findings above, are still of concern. Particularly in relation to capacity and capability, prioritisation, transformation, integration, information assurance, eHealth and performance.

7. Internal audits planned for the remainder of the year include reviews of Transformation, Improvement, Innovation and Operational Planning, Performance Reporting, Performance Management, eHealth and Information Governance, all of which will be critical to our opinion at year end.

OBJECTIVE

8. The principal objective of this review is to provide assurance to the Chief Executive, as Accountable Officer, that there is a sound system of internal control that supports the achievement of the Board's objectives.

RISK

9. The following risk could prevent the achievement of the above objective and has been identified as within scope for this audit. The strategic risk relevant to this review is Risk 621 – Board Governance (Amber), described as *'A failure to implement new governance arrangements in line with the new Blueprint for Governance and other changes as directed by the Scottish Government will result in an inability to effectively deliver the five key functions of the Board'.*

AUDIT OPINION

10. The key issues arising from the report with detailed findings are included in Section 2.

ACTION

11. The following action plan has been agreed with management to address the identified weaknesses. Where recommendations do not relate to the most important issues that require the attention of senior management and may also give rise to material financial loss or error, they have been provided to the Director of Governance, Risk and Compliance or other appropriate Director in a separate memo.

12. A follow-up of implementation of the agreed actions will be undertaken by Internal Audit in accordance with the audit reporting protocol.

ACKNOWLEDGEMENT

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

A Gaskin
Chief Internal Auditor

Corporate Governance

Key arrangements in place:

Corporate Governance

- The NHS Scotland Corporate Governance Blueprint published on 5 October 2018 was presented to the November 2018 Board Development Event. The event also covered a Strategic Overview, three year financial plan and Transforming Tayside. A further development event to include Transformation is scheduled for 31 January and 1 February 2019. Tayside NHS Board will undertake a self-assessment of Board Effectiveness before the end of the financial year. The assessment will be based on the NHS Scotland Governance Blueprint.
- The Corporate Governance updates presented to the October and December 2018 Board meetings set out Next Steps for improvement and identified the development of a credible strategic plan as one of the biggest challenges. The paper specifically recognised the importance of improving engagement with stakeholders.
- Transformation is planned to be delivered through a combination of the long-term strategy; Transforming Tayside; a three-year Quality Improvement Programme and a series of actions to deliver immediate efficiencies in 2018/19.
- In response to an AAG recommendation to maximise opportunities for induction and development of Non-Executive Members to ensure robust and effective governance and scrutiny of the executive function of the Board, a Non-Executive Induction Plan has been provided to all new Non-Executives and an induction workshop was held on 20 November 2018. In addition, Non-Executives have or will be attending other external training, such as the Essential Governance Training for Board Members and Effective Audit and Assurance Committee training. The Vice Chair has established regular informal meetings for members starting 5 February 2019.
- NHS Tayside has a revised Internal Audit Charter compliant with the Public Sector Internal Audit Standards.
- The Institute of Internal Auditors review of the FTF Audit and Management Services was presented to the December 2018 Audit Committee and progress to address the recommendations will be presented to the Audit Committee through the External Reports – Recommendations Tracker document.

Planned and ongoing developments, including responses to previous significant internal audit reports:

- The Code of Corporate Governance (CoCG) was updated in February 2018 with the next update scheduled for February 2019. However, due to the commissioning of the independent review of corporate governance, the Governance Review Group, which manages these updates, has not met.
- The output of the Chairman's review of the allocation of role and responsibilities of Board members was scheduled to be presented to the December 2018 Board meeting but, to allow time for three new Board members to consider their future roles, this report will be presented to the February 2019 meeting. The intention is that once the recruitment of new Members has been completed the existing skills matrix for the Board will be reviewed and mapped against the Board's future requirements. This will inform

the completion of individual development plans for Board Members as part of an appraisal exercise to be undertaken by 31 March 2019.

- Internal audit T12/19 – Policies and Procedures concluded that whilst NHS Tayside policies are generally well managed, there needs to be a more rigorous system to ensure more robust monitoring and reporting of the currency of policies. Management have agreed that Executive Leads and managers will be reminded of their responsibilities in relation to ensuring the timely update, approval and publishing of policies. The ongoing review of the 'Policy Development, Review and Control Policy' will include an update on the realistic time period for reviews. The HR policies database presented to the Workforce and Governance Forum on 12 December 2018 included the 'Once for Scotland' timetable.
- The Director of Governance, Risk and Compliance is leading a review of the risk management system to ensure that all appropriate risks are identified, assessed and actions taken to mitigate the likelihood of them occurring and the impact on service delivery should they materialise. At the request of the Chief Executive, the Strategic Risk Management Group (SRMG) fully reviewed and updated the strategic risk profile in September 2018; there are currently 22 strategic risks with 6 rated as very high. 6 new strategic risks were agreed at this meeting, not all have yet been set up in Datix and scored. A further 2 risks were agreed for inclusion in the strategic risk profile in November 2018 based on horizon scanning.
- The strategic risk management system is currently being reviewed to be aligned with strategic planning and performance management arrangements. A revised risk assurance report template was approved by the SRMG in September 2018. An updated strategic risk register and refreshed Board Assurance Framework is planned for the February 2019 Board meeting. Internal audit have agreed to contribute to the planned review of risk appetite and to a Risk Management Development Event in early 2019. Internal audit T11A/19 will review overall risk management arrangements.
- The risk profile remains very high overall both in the number of Strategic Risks and their scores. Enhancements to the Risk Management system will not be sufficient to reduce this risk profile in isolation, the ability of management to mitigate these risks effectively will be the key factor. Whilst the Board should retain ownership of strategic risks, given the scale of the strategic risk profile, we would recommend that strategic risks continue to be aligned to Standing Committees and they receive detailed assurance reports on each risk.
- NHS Tayside's formal review of Best Value will not be completed for 2018/19, instead the focus will be on the Board Effectiveness self-assessment, which includes many aspects of Best Value. Internal Audit agree with this approach.
- Refinement of the performance framework and performance reporting continues. Quarterly meetings between the Head of Performance and internal audit are held to test new concepts and approaches. Internal Audit was pleased to note the improvements in the format of performance reports to date. The Key Metrics Report, presented to each meeting of Tayside NHS Board and P&RC, provides a clear summary of performance and explains variance and remedial action to address performance issues, thereby addressing a number of previous internal audit recommendations. Additional assurance is now provided through updates against previously agreed actions.
- In common with other Scottish Health Boards, the majority of targets are not being

achieved. As reported to the October 2018 Board meeting, eight actions to improve reporting had been identified and the December 2018 Board paper provides an update on progress. Actions include the development of two action trackers; one for acute service performance review and one for NHS Tayside Board performance metrics. Internal audit will review this in detail in internal audit T17/19 – Organisation Performance Reporting.

- Internal Audit welcome the systematic and holistic review of reporting processes which has led to the identification of two errors; local reporting of Treatment Time Guarantee (TTG) ongoing waits and the waiting times reported for key diagnostic tests within radiology, both of which were reported to the November 2018 P&RC.
- NHS bodies are required to follow the Scottish Public Finance Manual (SPFM) including the Audit and Assurance Committee Handbook which was revised in March 2018, albeit NHS Boards were not formally notified of this by the SGHSCD. The key change was an increased emphasis on understanding the sources of assurance and consideration of formal assurance mapping. A paper to the December 2018 Audit Committee highlighted the key changes, their implications and the way forward.
- During 2019/2020 the Director of Governance, Risk and Compliance will undertake a comprehensive governance assurance mapping process, working with Internal Audit, to ensure a robust process is in place for the scrutiny of the assurance provided by the organisation, and that key operational risks can be surfaced to the Standing Committee and where appropriate the Board.
- In December 2017 the Audit Committee agreed that two models of integration governance should operate in Tayside; one between Tayside NHS Board and Dundee and Angus Integration Joint Boards and one between Tayside NHS Board and Perth and Kinross Integration Joint Board (IJB). The underlying principles to these two models were agreed, and responsible Directors were to update the NHS Tayside governance arrangements to allow these to be put in place by April 2018. Whilst the previous Chief Executive appointed on 6 April 2018 took forward a number of initiatives to improve joint working, the update scheduled for August 2018 did not happen and there has been no subsequent reporting to the Audit Committee on progress.
- 'Working Together in Tayside' is a forum for Chairs, Council Leaders, Chief Executives and Chief Officers from the NHS Board, the Local Authorities and the Community Planning Partnerships to develop a more integrated and inclusive approach to delivering public services across Tayside. A meeting took place in October 2018.
- The December 2018 Board meeting considered a report highlighting the need to strengthen its contribution to community planning and joint working, and recommending that the Board receive reports and presentations on each of the Local Outcome Improvement Plans and Annual Performance Reports.
- In June 2018 the Board approved the North of Scotland Framework for Governance, to facilitate single system working. This was one of the key priorities from the Regional Delivery Plan and was intended to be a starting point for North of Scotland Chief Executives to move joint working forward. Internal audit would highlight that whilst Regional Planning is important to the Board, it is unlikely that it will contribute significant savings, although it may mitigate potential operational difficulties in certain specialties.
- Work to develop an Integrated Clinical Strategy (ICS) first commenced in June 2014 but,

whilst some progress has been made, there has been no evidence of significant progress in that four-year period.

- The first stage of the three-year plan for acute service redesign has been completed.
- The direction of travel for NHS Tayside's Site Review in relation to Kings Cross Hospital, Perth Royal Infirmary and Stracathro Hospital was supported by the November 2018 P&RC, noting the need to fit within an overall strategy and to incorporate Ninewells Hospital;
- It is of concern that the 'plan for a plan' to produce an ICS, new governance arrangements for Transforming Tayside, the update on the acute service redesign and the site review, which were due to be presented to the December 2018 Board meeting, have all been delayed. These are now scheduled for presentation to the Board meeting on 28 February 2019 following discussion at the Board Development Event on 31 January and 1 February 2019.
- Transformation is taking longer than originally envisaged. A realistic assessment of the timeframe for delivery of the long-term integrated strategy is required, taking into account organisational capacity and including sufficient time for consultation in line with national guidance, which will, almost inevitably, be prolonged and complex.
- Sustained improvement and financial sustainability cannot be achieved without strategic and structural change. The 3-year financial plan will be presented to the February 2019 Board meeting. This area will be reviewed in detail in T15/19 – Three Year Transformation Plan.
- The organisation-wide Safe Affordable Workforce (SAW) review of staff numbers, experience, grades and skills process has taken longer than expected. An update was provided to the P&RC on 18 December 2018 and a further update will be provided in January 2019. This will be an aspect of Transforming Tayside, rather than a standalone piece.
- The AAG produced a report in December 2018 which concluded that while an extensive programme of work has been undertaken and strong foundations have been put in place, both the challenges facing the Board with the associated level of risk remain significant. A sustainable future for NHS Tayside will rest on its ability to redesign clinical models for care and make real inroads into delivering the types of service reform that are set out in the Health and Social Care Delivery Plan.
- Tayside NHS Board has a membership of 20, consisting of nine Non-Executive Members, five Executive Members and six Stakeholder Members. Since 1 April 2018, 14 Members have left, and 13 new Members have joined the Board. The remaining vacancy will be filled in January 2019. Board membership will also be increased to include an additional two Non-Executive Members, with financial management experience being one of the desired competencies. In the short term, arrangements are in hand to co-opt two experienced Non-Executive Members (Audit Committee Chairs) from other NHS Scotland Boards.
- A new permanent Chief Executive commenced on 1 January 2019. A new clinically led leadership structure for the Acute Service Division was implemented in November 2018. Budgets have been delegated to the Clinical Care Divisions and their departments so that individual areas can have more influence, control and responsibility for how money is spent.

- The Nurse Director will retire in early 2019/20, as will the Perth IJB Chief Officer.
- There have been a number of developments aimed at strengthening capacity in performance management, governance and key operational areas.
- Despite these improvements, the Board has still not been given positive assurance that NHS Tayside has the capacity and capability to drive transformational change, whilst maintaining business as usual and delivering short-term savings.
- While Internal Audit commend the strengthening of the Non-Executive, Executive and Senior Management structures we would highlight that, overall, NHS Tayside has a long history of control weaknesses, culminating in the conclusion in 2017/18 that internal controls were not adequate and effective. There is a risk that the significant changes in Board members could result in a loss of organisational memory. This is of importance given the need to recognise the recurrence of themes or issues which have occurred repeatedly over recent years.
- The 'Transforming Tayside: NHS Tayside Collective Leadership & Culture Strategic framework 2018-2023' was adopted by the Board on 25 October 2018. The framework sets out the outcomes for year one and progress to the Board will be monitored by the Staff Governance Committee.
- The first AAG report highlighted that leadership and continuous scrutiny of a very high order will be required for all aspects of strategic planning, to deliver sustainable transformation over the next five years, and rigorous scrutiny and governance to ensure effective and timely delivery.
- The latest Tayside response to the AAG report highlighted developments since the last update and particularly the plans in relation to the Transforming Tayside programme, including the Integrated Clinical Strategy although, as noted above, these have already been delayed.

Detailed Finding and Action Point Reference

Finding 1:

There are a number of findings within this report in relation to governance, risk and compliance.

Audit Recommendation:

Our findings in relation to governance risk and compliance should be considered by the Director of Governance, Risk and Compliance and an action plan presented to the Audit & Assurance Committee containing the actions outlined in the management response to address the issues raised, including in particular:

- A refresh of the Governance Review Group to ensure that the CoCG is updated as scheduled and adequately reflects the changes in governance and management;
- Overt consideration, within the ongoing review of risk management, of the number of risks and the extremely high risk profile as well as direct linkage to the assurance mapping process so that there is greater clarity on how assurance will be provided on these risk, and the likely success of the actions being taken to mitigate them.;

- Arrangements for progressing integration governance
- Consideration of the potential risks and opportunities relating to changes during the year at Board and Executive level.

Priority: 2

Management Response/Action

Agreement to undertake self assessment based on the NHS Scotland Governance Blueprint by 31 March 2019;

Bespoke governance training for Non Executive Members by 31 May 2019;

Corporate Governance Review Group will meet to consider updates to the Code of Corporate Governance prior to their submission to the Board on 28 February 2019;

Non Executive appraisal to be completed by 31 March 2019;

The actions from Internal Audit Report T12/19 –Policies and Procedures will be monitored through the Strategic Risk Management Group;

The Audit Committee's remit is being reviewed in line with the revised Audit and Assurance Committee Handbook. This will strengthen the Audit Committee's role in relation to risk management. A revised remit will be presented to the Audit Committee in March 2019.The new role of the Audit and Assurance Committee will allow overt consideration of the number of strategic risks, their rating and the actions being taken to mitigate them. The relationship between the Strategic Risk Management Group and the Audit Committee will be strengthened;

Work to develop a comprehensive governance assurance map will be taken forward by the Director of Governance, Risk and Compliance working with Internal Audit during 2019/20;

Discussions regarding integration governance should be progressed under the leadership of the Working Together in Tayside Forum during 2019/20;

Consideration will be given to whether the potential loss of organisational memory in NHS Tayside should be recorded as a risk;

Mitigating actions will include ensuring robust action plans and controls are in place.

Action by / Date:

Director of Governance, Risk and Compliance

31 May 2019

Ongoing for integration.

Detailed Finding and Action Point Reference

Finding 2:

There are a number of findings within this report in relation to transformation.

Audit Recommendation:

Our findings in relation to transformation should be considered and an action plan presented to the P&RC containing an action plan to address the issues raised, including in particular:

- The need for a clear, realistic timetable for delivery of the long-term integrated strategy, taking into account organisational capacity and including sufficient time for consultation in line with national guidance, which will, almost inevitably, be prolonged and complex;
- Transparency around progress and explanation of delays and remedial action to the Board;
- Provision of overt positive assurance to the Board that NHS Tayside has the capacity and capability (both in terms of planning and operations) to drive transformational change, whilst maintaining business as usual and delivering short-term savings.
- The need for assurances on how financial balance will be achieved until the ICS is in place and transformation is achieved.
- Consideration of portfolio management to ensure the organisation's priorities are clearly aligned to required strategic change.

Priority: 2

Management Response/Action

A refresh of the Transforming Tayside programme is in hand and will be presented to Board in February 2019, following which clear priorities and a revised structure for delivery will be developed. The ELT will oversee the programme. This will be ongoing, although there will be clarity by 28 March 2019.

Action by / Date:

Deputy CEO

28 March 2019

Clinical Governance

Key arrangements in place:

- A one-page user friendly summary of the Clinical Governance Strategy 2017-19 has been produced and was welcomed. The strategy is being reviewed, taking into account feedback received, signposting of relevant documentation and the Clinical & Care Governance framework for HSCPs.
- Several of the risks aligned to the Care Governance Committee (CGC) have been reviewed in depth, including those for Person-Centred and Older People. The strategic risk for Children, Young People and Families has now been archived during 2018/19. A new strategic risk on Child and Adolescent Mental Health Services (CAMHS) has been aligned to the CGC, with the first verbal report provided to Clinical Quality Forum (CQF) in November 2018.
- Reports on announced visits to three psychiatry of old age sites in Tayside during 2018 were positive.
- The CGC reviewed their remit on 11 October 2018 and agreed that the addition of audit data and clinical outcome data should be considered at the Quality and Performance Review Meetings and reported at the CQF.
- Agreed recommendations from T16/17 - Adverse Events Management have been completed and the Annual Internal Audit Report 2017/18 was presented to the October 2018 CGC meeting.

Planned and ongoing developments, including responses to previous significant internal audit reports:

- The draft Health Improvement Scotland (HIS) CAMHS report makes a number of recommendations which will be addressed by an action plan to be monitored by the P&RC. As a consequence, internal audit T18/19 – Review of CAMHS will now be rolled forward to the second quarter of 2019/20.
- An updated Adverse Events Management Policy, which includes Duty of Candour, is out for consultation and scheduled for approval by the March 2019 Audit Committee. Updates on implementation of the Duty of Candour have been provided to the CQF and CGC.
- The Duty of Candour Communication and Engagement Plan continues to be monitored through the Clinical Risk Management Group and a Duty of Candour Quick Guide is under development. Audits are being carried out by management to determine whether the duty has been applied appropriately and to gauge effectiveness of the training sessions.
- The Director of Medical Education Report 2018 and the General Medical Council (GMC) National Trainee Survey 2014-2018 presented to the CQF in November 2018 included reference to the two specialties currently under enhanced monitoring by the GMS (General Surgery, Ninewells Hospital and General Adult Psychiatry Board-wide), and set out the links to service redesign and non-compliant rotas.
- The Medical Director and the Strategic Director of Workforce are working together to strengthen Educational Governance. A Medical and Dental Education Governance Group

has been established as a formal sub group of the Staff Governance Committee (SGC) and a strategic risk on medical education will be established.

- An update on the Independent Inquiry into mental health services in Tayside was provided to the December 2018 Board and stated that there is evidence both of good practice and areas for improvement, including access to services, in-patient welfare, incident reviews and complaints handling.
- The October 2018 CGC received an update on the Mental Health risk, including the Deanery Review of the General Adult Psychiatry Training Programme. An action plan has been developed to address concerns over the NHS Tayside General Adult Psychiatry Training Scheme.
- Reports across a range of individual Mental Health risks and improvement are provided to the Board, CGC and CQF. There is also a Strategic Mental Health risk which has had the highest possible score of 25 since November 2017. The risk is extremely complex and diffuse and, whilst assurances are provided in various reports, it would be difficult for Board, CGC and CQF members to draw together these disparate stands of assurance into a cohesive understanding of the risk at any given time. It may be that this risk would be a suitable candidate for piloting the assurance mapping process.
- An Early Stage Improvement Plan for the Adult Mental Health Service was presented to the Board Development Event on 29 May 2018. A review of the 'Care and Professional Governance and Performance Review' process within Mental Health and Learning Disability Services was reported to the October 2018 CGC, after which it was noted that revised arrangements would be agreed with P&K Integration Joint Board (IJB) by the end December 2018. However, no update against the associated improvement plan has been provided to the CGC.
- An unannounced Health Improvement Scotland (HIS) inspection of Care for Older People in PRI was undertaken in June 2018. Assurance was provided that a Post Inspection Improvement Action plan had been completed. The HIS report was published in August 2018 and has not yet been reported through NHS Tayside's governance channels. A report on the Prison Healthcare inspection in May/June 2018 was provided to the CQF in November 2018 showing the full improvement plan approved by Perth & Kinross IJB Clinical Care & Professional Governance Forum. Healthcare Improvement Scotland (HIS) returned for 3 days on the 26 November 2018 for an interim inspection and noted improvements made since the initial inspection. A further report will be published following this visit. A full re-inspection will take place in approximately 12 months. A new strategic risk on Prisoner Healthcare was agreed by the SRMG in September 2018.
- There is regular reporting on external reports to both the CQF and the CGC, including reference to action plans and improvement plans which in turn are monitored outwith the governance meetings at an operational level. However, there is no routine reporting of whether associated actions have been completed on time and little evidence of consideration of why these issues had not been identified through internal clinical and care governance systems.
- Internal Audit has previously reported that further work was required to develop Clinical, Care & Professional Governance for HSCPs. Agreement was reached that an assurance template should be produced for each HSCP to populate. This will contain data and narrative in relation to complaints, adverse events and inspections. The development of a revised framework has been agreed for consideration by the Clinical

Risk Management Group (CRM) and CQF before coming to the CGC by the end of the 2018/19 Committee year.

- A meeting took place in October 2018 with the Chairman, Committee Members, Chief Officers, the Chief Internal Auditor and the Clinical Governance and Risk Management Team Lead to discuss clinical governance arrangements with IJBs. At a workshop held in June 2018 agreement was reached for an assurance template to be produced that each Health & Social Care Partnership will populate. This will contain data and narrative in relation to complaints, adverse events and inspections. The revised framework is to be considered by the Clinical Risk Management Group (CRM) and the CQF before being presented to the CGC by the end of the 2018/19 Committee year.
- From September 2018, Performance Reviews have been structured around the nine new Clinical Divisions but, thus far, no outputs have been formally reported. This creates a gap in assurance while the system is being refreshed which will need to be resolved by year-end. The Mental Health performance review process is being reviewed to align with the performance review process with the HSCPs.
- Internal Audit welcome the increased prominence given to Public Health with the Board receiving the Public Health Annual Report 2017/18 in individual components to allow detailed consideration of each. However, these reports do not enable an analysis of achievement and performance against predefined SMART objectives and we note that no performance reviews for Public Health have been reported to CQF/CGC since March 2018.
- The HAI risk is currently being reviewed by the SRMG.
- The Proposed Governance Structure for Adult Protection including implementation groups and an improvement plan were reported to CQF in September 2018. A paper on developing a strategic approach to Public Protection arrangements within NHS Tayside was presented to the Board on 6 December 2018.
- T20/19 Medical Equipment & Devices will review the restructure of medical equipment groups and follow up previous internal audit recommendations.

Detailed Finding and Action Point Reference

Finding 3:

Our audit work on clinical governance identified that more robust, cohesive assurances on the complex clinical governance risks are required.

Audit Recommendation:

Our findings in relation to Clinical Governance should be considered by the Medical Director and Nurse Director and a paper presented to the Care Governance Committee containing an action plan to address the issues raised, including in particular:

- Consideration of Mental Health as a suitable candidate for piloting for assurance mapping process;
- Routine reporting of implementation of all actions from external reviews, as well as overt consideration of whether the issues had been identified through internal clinical

and care governance systems;

- Consideration of including prisoner healthcare in the Performance Review system;
- Inclusion of Public Health in the revised schedule of performance reviews.

Priority: 2

Management Response/Action

The Medical Director and Nurse Director will consider the audit recommendations and will report our response and the development of any proposed actions to the Clinical Care Governance Committee by the end of April 2019.

Action by / Date:

Medical Director and Nurse Director

April 2019

Staff Governance

Key arrangements in place:

- The Staff Governance Committee (SGC) Terms of Reference (ToR) are generally in line with the 4th Edition Staff Governance Standard. Chief Officers representing Health & Social Care Partnerships are ex-officio Members of the SGC.
- We were pleased to note that a new format Staff Governance Report to the SGC was introduced in October 2018 and includes Workforce Planning and Redesign, Operational HR, Learning and Development, Occupational Health, Organisational Development and Health & Safety.
- The SGC relationship with the Remuneration Committee and the Area Partnership Forum are clearly defined.
- T22/18 – Workforce Benefits Realisation Nursing & Midwifery Supplementary Planning will be presented to the January 2019 Audit Committee. The audit opinion was Category C and management have requested that Internal Audit undertake further reviews of specific topics in this area in 2019/20. Management have agreed that quarterly updates of progress against recommendations will be provided through the Nursing and Midwifery Workforce Risk paper to the SGC.
- The Internal Audit Interim Review 2017/18 recommended that the SGC again consider its remit and work plan, to ensure that it is appropriately sighted and assured on workforce planning issues, including demonstrating that workforce planning effectively supports the achievement of the Board's operational and strategic objectives. However, many of these issues are now being considered through the P&RC with the exception of the workforce plan (see below).
- The NHS Tayside Workforce Plan was not presented to Scottish Government by June 2018; the Strategic Director of Workforce informed the SGC that she wished to present an appropriate rather than a rushed plan. The Corporate Workforce Plan, presented to the SGC in October 2018, highlighted that the August 2018 timescale for publication of staffing projections had passed and given the lack of clarity on the emerging model, projections were not submitted to Scottish Government, but workforce numbers at the end March 2018 were published. It also stated that as NHS Tayside is taking forward a transformational change agenda, the workforce would be re-profiled in accordance with the strategic and locally developed workforce plans and that the SAW plans to be submitted for executive challenge in September 2018 would provide further clarity in the current year. The 11 December 2018 SGC has been rescheduled to 29 January 2019.
- The Staff Governance Monitoring Report 2017/18 was presented to the 12 June 2018 SGC prior to submission to Scottish Government. The feedback received from the SGHSCD was presented to the APF and will be presented to the SGC in January 2019.
- The October 2018 SGC received an update on action to meet the NHS Board delivery requirements of the Everyone Matters 2018-2020 Implementation Plan.
- We previously reported that the People Matter Strategic Framework 2016 action plan was twice deferred. It was due to be presented to the June 2018 SGC but was not. The Board approved the Collaborative Leadership and Culture Management Framework, in August 2018, which has superseded this. The Attraction & Recruitment Strategy was included a key control in the Workforce Optimisation strategic risk and was deferred

from the March 2018 to the June 2018 SGC. The revised Corporate Workforce Plan recognised the need to significantly reduce the workforce and this required a different approach. Management have informed us that although the intention was to reframe the previous Attraction and Recruitment Strategy to a Retention and Recruitment Strategy, this objective/piece of work has been set aside to allow restricted capacity to focus on other priorities and, in the meantime, when a vacancy occurs, the accountable budget holders are required to ensure that they are maximising the opportunities to consider how best to deliver the service. The SAW process and the Boards Talent Management approach, approved as part of the Collaborative Leadership Strategy, will inform future requirements.

- A Head of Health & Safety was appointed in March 2018 and since then comprehensive Health & Safety risk assurance reports are presented to each SGC meeting, but these have identified a number of risks for the organisation. Ongoing actions to mitigate risks include a full review of the Health & Safety governance structure, development of a Health & Safety workplan, risk profiling across the organisation, review of training provision and review of the current Health & Safety workbook. During early 2019, a revised approach to HSG 65 compliance will start a refresh of the Board's approach. This area will be reviewed in T13/19 – Staff and Patient Environment.
- A new Whistleblowing Champion was appointed in September 2018, following the resignation of the previous incumbent. As reported to the October 2018 Board, a Whistleblowing Plan was being developed to look at the number of cases, the policy and training required for designated officers.
- The TURAS Appraisal system (replacement system for eKSF) was introduced from April 2018 and is a Standing agenda item for the Workforce Advisory Group. It is anticipated that reporting tool will not be available until later in the year.
- As reported to the October 2018 SGC, between April and July 2018, sickness absence rose from 4.44% to 4.95%, below the national average but above the target. Detailed Absence Information Report is shared with services on a monthly basis.
- The Compassionate & Inclusive Leadership Strategy was endorsed by the SGC in June 2018. The Mental Wellbeing Strategy consultation paper was noted at the same meeting and the SGC agreed the development of an action plan.
- As reported to the November 2018 CQF, Nursing and Midwifery Council Revalidation monitoring is now embedded across NHS Tayside and the HSCPs. There is a governance process to support timeous registration. Renewal, revalidation and escalation arrangements are in place should registrants allow their registration to lapse.

Planned and ongoing developments, including responses to previous significant internal audit reports:

- The Safe Affordable Working (SAW) process was approved by ELT on 21 May 2018. Service-led workforce plans are currently being presented to Executive Challenge Panels and 18 Challenge Panels have taken place, with decisions on their findings to be made by the ELT in January 2019. Regular SAW reports are reported to the P&RC. A verbal update was provided to the 18 December 2018 P&RC, with a more detailed Report expected in January 2019. t is unlikely that the SAW programme will deliver substantial savings of the order required without major service redesign.
- An implementation plan has been developed for the Leadership Programme and

includes the outcomes required and the measures to be used to determine success. The Staff Governance Committee will provide scrutiny of the Collective Leadership Programme and report progress to the Board at regular intervals.

- As reported in the Corporate Workforce Plan 2018/19, the three Tayside Health and Social Care Partnerships and the Tayside Local Medical Committee have jointly developed a single shared Tayside Primary Care Improvement Plan which will support the introduction of the new General Medical Services Contract. This plan will include a Workforce Plan describing the changes to the workforce profile over the next 3-year period.
- The Remuneration Committee met on 26 June 2018 and 15 November 2018 and a further ad-hoc meeting was held on 6 December 2018 to agree the arrangements for the Chief Executive position of NHS Tayside and the transition to Director General and Chief Executive at NHS Scotland.
- The minutes of the June 2018 Remuneration Committee reflect that there would continue to be a rebalancing of portfolios in the executive and management structures.
- The Section 22 Report received from Audit Scotland on the 2017/18 NHS Tayside financial position included narrative on the departure of the previous Chief Executive from NHS Tayside, concluding that the decision to reach a negotiated settlement with the former chief executive was reasonable, but identified weaknesses in the process.
- On 26 June 2018, the Remuneration Committee noted the requirement for the Board to confirm the organisation's Corporate Objectives, approved team objectives for Executives and approved the individual performance management approach for 2018/19. Objectives will include delivery of the health and social care delivery plan, partnership working, leadership and culture, the transformation agenda and service delivery, including finance. The June 2018 Remuneration Committee requested a report back to the next meeting on the Executive personal objectives, how the process had gone and how the objectives contributed to the organisation, but has received no further update on this.
- A new strategic risk on Medical Education was agreed at September 2018 SRMG. The Director of Medical Education Report 2018 and the GMC national Trainee survey 2014-2018 paper was presented to the October 2018 Board for the first time.
- In line with previous internal audit recommendations, a report on Secondary Care Appraisal and Revalidation was presented to the 30 August 2018 Board. The report set out NHS Tayside's poor compliance with the annual process and included a detailed action plan. 158 of 609 (26%) secondary care doctors had completed appraisal at 21 August 2018. The Board expressed concern that there was no forecast on when this situation was likely to improve, and this was an unacceptable situation. The report to the October 2018 Board stated that it was not envisaged that any doctors would be unable to revalidate, although it would be necessary to defer revalidation both this year and next year for a number of doctors, to enable them to provide sufficient evidence to allow the Responsible Officer to make a positive revalidation recommendation. The Acting Board Medical Director has written to all eligible clinicians who had not completed an appraisal since 31 March 2017 and this prompted a strong response from most clinicians who are now engaging.
- The 'Scotland Deanery Quality Management Visit Report doctors in training in General Adult Psychiatry Services across Tayside & Action Plan' was presented to the October 2018 Board.

Detailed Finding and Action Point Reference

Finding 4:

Our report identifies areas where the level of assurance provided to the SGC could be improved to ensure the business of the Committee is focussed on core activities to support relevant risks.

Audit Recommendation:

Our findings in relation to Staff Governance should be considered by the Deputy Chief Executive/Strategic Director of Workforce and an action plan presented to the Staff Governance Committee, including:

- A refresh of the Staff Governance Committee, including development of a strategic workplan that supports engagement of staff governance across the Board and is focussed on corporate objectives, workforce risks and contribution to the transformation agenda;
- A review of the workforce data presented to the SGC and P&RC to ensure there are no gaps in reporting, nor duplication;
- Presentation of SGHSCD feedback on the Staff Governance Monitoring Report 2017/18;
- Regular Reports on the Collaborative Leadership Strategy;
- Inclusion of assurances on Whistleblowing within the SGC year-end assurance report, including assurance that concerns raised by the previous incumbent have been addressed.

Priority: 2

Management Response/Action

The programme to revise the approach to staff governance, including a refresh of the strategic workplan, including the workforce data for the Staff Governance Committee will be addressed in the first quarter of 2019/20.

The SGHSCD feedback will be presented to SGC in January 2019. There will be regular reports on the progress of the Collaborative Leadership Strategy.

The Whistleblowing Champion will be invited to make a year-end Report.

Action by / Date:

Deputy Chief Executive/ Strategic Director of Workforce and Whistleblowing Champion.

30 June 2019

Financial Governance

Key arrangements in place:

- T23/19 – Financial Planning highlighted significant improvement in financial planning processes, which, once codified and integrated into the business cycle should provide a sound base for future. Other key findings were:
  - *Clinical, Capital and eHealth strategies and the transformation programme are not yet at a point where they can meaningfully inform the financial plan. This situation is likely to also impact on the production of the 2019/20 budget; although we have noted encouraging signs in the operation of the newly established Asset Management Group (AMG) and the move towards clinical ownership of budgets through the new corporate structure;*
  - *Whilst the timescales for this year were necessarily curtailed, timelines for development of the 2019/20 financial plan should be formalised as soon as possible to ensure a financial plan is signed off before the start of the new financial year;*
  - *SFIs and other supporting documents should now be updated to reflect the new process;*
  - *Budgets should be formally accepted by nominated officers whose objectives should reflect the importance of achieving the agreed budget;*
  - *There is an opportunity to enhance the process further by obtaining feedback from and working with officers and partners including the 3 Tayside IJBs.*
- Tayside NHS Board approved its 2018/19 Budget and Finance Plan on 28 June 2018. The plan reported a gap between available funding and anticipated costs of £18.7M; this was agreed with SGHSCD as indicative brokerage for the year. This figure excluded a number of additional one-off issues and risk factors such as the repayment of endowment monies £3.6M, lack of financial gains from Pregabalin, and changes to the depreciation allocation.
- NHS Tayside has significantly reduced its reliance on deferred expenditure to £14m. Following a detailed review by finance staff, and in consultation with external audit and the Scottish Government, all funds held from community/primary care funds have been transferred to the IJBs.
- Following the requirement of brokerage over a number of years, NHS Tayside has agreed with SG to return to financial balance over 3 years from 2018/19. In the absence of progress on strategy and transformation, interim plans need to be established. T22/19 – Savings, currently in draft, recommends that the Board should receive a report, explicitly setting out the impact of the delay in producing and implementing the Clinical Strategy, Transforming Tayside on NHS Tayside's efficiency on achievement of recurrent savings and setting out the mitigating actions required to make good the shortfall.
- There was improved and increased reporting and scrutiny of the financial position to both the P&RC and Board. P&RC minutes showed evidence of detailed scrutiny, including requests for additional reports on key aspects of financial performance, demonstrating that the Committee is linking operational and financial performance. Financial reporting will be reviewed in detail as part of T24/19 Financial Management.
- The initial annual savings plan identified savings of £29.4m, including the IJBs' savings

and financial flexibility items of £16.2m. To the end of October 2018, £13.4m of savings has been achieved (including £6.1m for IJBs/Corporate), which is £1.7m behind plan. Recurrent savings make up 44% of identified savings.

- Previous internal audit recommendations on production of guidance on the budget setting process, production of a finance workforce plan and the refresh and update of financial risks have been addressed or superseded by internal audits T22&23/19. The May and September 2018 Audit Committees received updates on the Grant Thornton LLP recommendations.
- The previous Capital Scrutiny Group has been reconstituted as the AMG.
- An update against the actions arising from the 2017-2022 PAMS was received by the P&RC in August 2018 and reported that work is focussed on collection of accurate information to inform future planning. This should link to the work undertaken under the three sites review to date and the future Ninewells Hospital review.
- Conclusions from the three sites review were reported to the November P&RC and the report noted that 'Proposals are based on "no change" to clinical service capacity on site. i.e. they do not include ICS outputs.' As above, the scheduled report to the December 2018 Board meeting was deferred to February 2019.
- A review of the Infrastructure strategic risk recommended the establishment of a Capital funding strategic risk. It has been identified that the replacement of PCs and laptops with an estimated £6m impact is not currently provided for in the capital plan.

Planned and ongoing developments, including responses to previous significant internal audit reports:

- There is a risk that the year-end position will be significantly worse than the £18.7m agreed at the start of the year. The potential deficit of £21m was confirmed verbally at the December Board meeting.
- Following the implementation of the new corporate structure for the acute services division, work is required to update the budgetary control framework including delegation of authority. T24/19 Financial Management will conclude on this area.
- T20B/2018 – Effective Prescribing and T22/18 – Workforce Benefits Realisation Nursing & Midwifery Supplementary Planning both found no evidence to date of substantial savings arising from these programmes at that time. We do however note a reduction in agency spend in the first two quarters of 2018/19. Overall, both noted a lack of cohesion across the number of individual schemes in place, as well as a lack of oversight and recommended improvements in coordination and monitoring. As reported to the 10 January 2019 ELT, the Deputy Chief Executive and Nurse Director have confirmed that all recommendations from this report have now been effectively actioned.
- The Director of Finance will present a 3-year Financial Plan to the February 2019 Board meeting setting out the overall financial position, the trajectories for improved financial performance and the key actions that will be implemented in 2019/20 to deliver the out-turn agreed with Scottish Government.

Detailed Finding and Action Point Reference
Finding 5: Detailed recommendations are already included within finance internal audits T22&23/19 and recommendations on financial reporting will be included in T24/19. Recommendations are also included in as T20B/2018 – Effective Prescribing and T22/18 – Workforce Benefits Realisation Nursing & Midwifery Supplementary Planning. **Audit Recommendation:** N/A **Priority: 2** **Management Response/Action** All actions are tracked and reported at each Audit Committee. **Action by / Date:** **Implemented**

Information Governance

Key arrangements in place:

- The Information Governance Committee (IGC) has an agreed Terms of Reference (ToR) and approved its annual work plan on 9 May 2018. The ToR was updated at the November 2018 and the IGC will now report directly to the Audit Committee.
- The Director of Governance, Risk and Compliance has been the Senior Information Risk Owner (SIRO) throughout 2018/19 and Chairs the IGC.
- The IG Strategic Risk was considered by the Audit Committee on 13 December 2018 and the P&RC on 18 December 2018. The Audit Committee will be responsible for this risk (which is scored High) and reflects:
  - risks surrounding cyber security and the Network and Information Systems Regulations 2018 (NIS);
  - risks around the loss and/or denial of access with cross infection across the Quarantine Virtual Local Area Network (QVLAN) and other VLANs;
  - non compliance with Data Protection Act 2018/General Data Protection Regulation (GDPR);
  - ongoing work around the Level 2 Freedom of Information Intervention due to NHS Tayside's failure to comply with statutory timescales.
- Revised FOISA procedures have been developed and agreed with NHS Tayside Executive Leadership Team and a revised Freedom of Information Policy is in place.
- A Data Quality Policy was approved by the P&RC in September 2018.

Planned and ongoing developments, including responses to previous significant internal audit reports:

- The risk assurance paper to the P&RC on 18 December 2018, stated that 'as the SIRO for NHS Tayside and the owner for Strategic Risk 38 IG Risk, I am still unable at this stage to give assurance within our area of information/cyber security that appropriate resource and efforts are being targeted at ensuring that we can have appropriate plans and arrangements in place to enable the Board to continue to operate within the regulatory and legal framework'.
- Work is being progressed in conjunction with an external consultant from CyRisc to consider the risks relating to information security and cyber security, with a view to enhancing and improving risk and governance arrangements in this area. The remit includes compliance with the public sector cyber security action plan, DL (2015) 17 –IG and Security Improvement Measures, and measures to enable NHS Tayside to comply with ISO 27001/2 – Information Security Management. Internal Audit will consider the outcomes and recommendations from this work within T34/19 – Information Assurance/Information Security Framework.
- The Information Security Policy Maturity Assessment is being reassessed by and, where actions are complete, evidence will be updated to provide assurance to the IG Committee that the full control is addressed.
- A management review of the Information Security Policy Framework Improvement and

Action Plan is being undertaken to ensure it includes more specific actions and timescales are included.

- NIS Regulations came into force on 10 May 2018 and place security and reporting requirements on operators of essential services. Compliance against the security duties of the NIS Regulations will be monitored through audit and inspection. DL2015 (17) directed Boards to adhere to the NHSS Information Security Policy Framework and NIS security duties will be incorporated into this framework to avoid any duplication and ensure ease of compliance across the different standards.
- The Area Business Information Management & Technology (IM&T) group was disbanded during 2017/18. The update to the then Finance & Resources Committee in March 2018 stated that 'the focus for 2018-19 was the re-development of the eHealth Delivery plan. There were a number of national programmes to be implemented and plans for regional working, all of which are required to be reflected on in the development of the new eHealth Delivery Plan'. The 2017/18 Annual Internal Audit Report recommended that Area Business IM&T monitoring responsibilities should be assigned to another group or standing committee until the new governance framework was developed. This has not happened and there has been no formal oversight of this area.
- Previous internal audits have highlighted the importance of eHealth in supporting transformation. The commissioning of an independent structured review of the eHealth Directorate has concluded and was presented to ELT on 15 November 2018. The review focused on readiness to produce a digital strategy to support transformation and on operational delivery of eHealth system and solutions, including operational structures and management arrangements. Key recommendations included strategic leadership; development of a Digital Strategy for Board approval; investment in technical capability within the eHealth team; visibility of the eHealth Directorate work plan required by the Executive Team to support wider buy in and corporate awareness. We will consider the implementation of recommendations from this report in T35/19 – eHealth Strategic Planning and Governance.
- Various eHealth related risks are recorded within DATIX, but there is no overarching eHealth Strategic Risk. With the eHealth Delivery Plan needing to be updated and the outputs from the external reviews to be actioned/progressed, consideration of developing and overarching eHealth risk and appropriate reporting and monitoring arrangements should be considered.
- We previously reported that lessons should be learnt from the implementation of Trakcare and we will review this area within T36/19 eHealth Project Management.

Detailed Finding and Action Point Reference

Finding 6:

There are a number of findings within this report in relation to Information Governance.

Audit Recommendation:

Our findings in relation to information governance should be considered by the Director of Governance, Risk and Compliance and an action plan presented to the Audit Committee containing an action plan to address the issues raised, including in particular:

- The need for a committee/group to have oversight of eHealth strategic and operational delivery as previously provided by the Area Business IM&T Group, with appropriate governance monitoring by a Standing Committee;
- Reporting and monitoring of actions in response to recommendations from the IG and eHealth external reviews by a Standing Committee;
- Consideration of development of an overarching eHealth risk, with links to delivery of transformation, and appropriate governance monitoring and reporting, balancing the significance of this area against the already large number of existing strategic risks.

Priority: 2

Management Response/Action

The Director of Governance, Risk and Compliance will undertake to:

1. Review and redesign the eHealth governance structures providing a fit for purpose governance regime to support service provision and Transforming Tayside including:
   - co-ordinating a workshop between all stakeholders to identify appropriate governance requirements and capabilities;
   - Work with eHealth managers to establish the new governance structure and produce and update Terms of Reference in line with outcomes of the workshop;
   - Report on outcomes to the Audit and Assurance Committee
2. Produce a report for the Audit and Assurance Committee on progress in addressing issues highlighted by the e-Health and Cyber Security external reviews that have been undertaken.
3. Facilitate the articulation of risks arising in eHealth linked to the IT infrastructure, support and monitoring of technology and medical equipment in NHS Tayside and those risks arsing as a result of transformation

Action by / Date:

Director of Governance, Risk and Compliance

31 July 2019

Section 3 Recommendation Priorities

Recommendation Priorities

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

Recommendations	Definition	Total
Priority 1	**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	**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	**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	**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.	

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

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

ITEM NUMBER 4.2

AUDIT02/2019
AUDIT COMMITTEE
24 JANUARY 2019

INTERNAL AUDIT T20B/18 - WORKFORCE BENEFITS REALISATION NURSING & MIDWIFERY SUPPLEMENTARY PLANNING

1. SITUATION AND BACKGROUND

Internal Audit T20B/18 - Workforce Benefits Realisation Nursing & Midwifery Supplementary Planning was completed as part of the 2017/18 Internal Audit Plan and was finalised on 13 September 2018.

NHS Tayside's historical pattern of supplementary spend relied on internal nursing and midwifery bank and premium rate agency, resulting in the nursing supplementary unit cost being significantly higher than other Boards who access supplementary nursing staff through lower cost options such as bank and NHS Scotland contract agency. We have concluded that there was no realistic expectation that planned savings relating to supplementary staffing costs could have been be realised in 2017/18.

This internal audit report was considered by the Executive Leadership Team (ELT) on 10 September 2018 and the ELT and the then Chair of the Audit Committee requested that this report be presented to the Audit Committee.

2. ASSESSMENT

The audit opinion is **Category C** – Adequate – Business objectives are likely to be achieved. However, improvements are required to enhance the adequacy/ effectiveness of risk management, control and governance.

During 2019/20, we will follow up the status of the recommendations from T20B/18 as part of our normal follow-up process. Management have requested that internal audit undertake further reviews of specific topics in this area in 2019/20 and this will be considered as part of the revised Internal Audit Planning process.

The Associate Nurse Director will attend the Audit Committee to discuss the report and provide assurance on action to address the recommendations.

September 2018

At the time of audit fieldwork, a significant amount of work was ongoing to reduce supplementary staffing costs but there was no overarching comprehensive system to co-ordinate, prioritise, monitor and measure this work. The approach was fragmented and we recommended that the bringing together and co-ordination of this work in a single, measurable action plan with defined outcomes and robust governance and monitoring arrangements will be key in achieving continued improvement and in reducing the risk to the organisation.

January 2019

The Deputy Chief Executive and Nurse Director have now met and considered the issues highlighted in relation to eRostering and the nurse bank, together with the recommendations in the report action plan. A joint Management response has been provided as follows:

'The requirement for supplementary staff use and related spend will always be disparate as it is based on individual service needs. This is however coordinated through the escalation plans, discussed at 4 x daily site safety huddles, led by Associate Directors; central coordination and ordering of staff is through the nurse bank, that includes governance arrangements, oversight and monitoring. There is liaison with finance colleagues.

In addition, the supplementary staff spend is reported through the Workforce Strategic Risk governance report to the Staff Governance Committee and the Performance and Resources committee at each meeting.

The nurse bank review is complete and the eRostering will be complete by March 2019 and is due to be reported to the Staff Governance Committee on 29 January 2019.

In our view all of the actions required within this audit have been addressed and we can assure the committee that there a frameworks in place for oversight and review of supplementary spend. Reductions in spend are directly related, however, to patient acuity and patient and service need.'

The Associate Nurse Director has also confirmed that:

'Following publication of the report in September 2018 agreement has been reached with the Executive Nurse Director to provide a quarterly update of progress against recommendations through the Nursing and Midwifery Workforce Risk paper which reports through the Staff Governance Committee on a monthly basis. Examples of progress being made include:

E-Rostering

- *A progress update and timeline for completion of the initial roll out of e-rostering has been provided to the Executive Nurse Director outlining completion of implementation to the 121 adult inpatient areas as agreed by the end of March 2019;*
- *Meetings are being scheduled to enable the transition from implementation to business as usual, the report recommendations will provide focus as part of a work plan for ongoing reviews and implementation of e-Rostering to other staff groups;*
- *Roster scrutiny and compliance with policy continues with senior representation from Partnership, Human Resources and the Nursing and Midwifery Directorate. The approach taken will now include direct links with Lead Nurses and will inform scheduled performance reviews;*
- *A programme of five subject specific Masterclasses has been developed, designed to support Charge nurses, Senior Charge Nurses and Managers to effectively roster staff in accordance with the principles of Safe Affordable Staffing, in line with use of the mandated Nursing and Midwifery Workload and Workforce Planning Tools; using the e-Rostering programme to its full potential.*

Nurse Bank

- *The implementation of a reviewed and redesigned structure is progressing with recent substantive appointments of a 1 WTE Bank Administration (Call Handler), 4 WTE Roster Creator positions have now been made substantive and the Band 6 Charge Nurse position with responsibility for education, training, recruitment and staff concerns and wellbeing is now in post. The full extent of the nurse bank structure will be progressed by early 2019 with the outstanding appointments of a Senior Charge Nurse Bank and a Professional Lead for Bank and Rostering required completing the structure.*
- *Key Performance Indicators for the nurse bank are still to be fully developed. These will be focussed on the different service delivery elements including recruitment and staff retention, effective call handling and staff booking and education and training.'*

3. RECOMMENDATIONS

The Audit Committee is being asked to:

- Note the attached report.

4. REPORT SIGN OFF

Responsible Executive Director and contact for further information

If you require any further information in advance of the Audit Committee meeting please contact:

Contact for further information
Tony Gaskin
Chief Internal Auditor
Tony.gaskin@nhs.net

7 January 2019

FINAL REPORT

NHS TAYSIDE
INTERNAL AUDIT SERVICE

WORKFORCE BENEFITS REALISATION – NURSING & MIDWIFERY SUPPLEMENTARY STAFFING

REPORT NO. T22/18

Issued To:
M Wright, Chief Executive
A Ingram, Assistant Chief Executive/Strategic Director of Workforce
A Gray, Director of Finance

G Costello, Nurse Director
C Sinclair, Associate Nurse Director

L Wiggin, Director of Acute Services
G Doherty, Director for Organisational Development

IJB Chief Officers
Associate Directors for Hospital Services

M Dunning, Board Secretary

H Walker, Risk Manager

L Green, Audit Committee Members' Library Copy
NHS Tayside Audit Follow-Up

Audit Committee
External Audit

Date Issued: 13 September 2018

INTRODUCTION & SCOPE

1. NHS Tayside's historical pattern of supplementary spend reliance on internal nursing and midwifery bank and premium rate agency. This has resulted in the nursing supplementary unit cost being significantly higher than other Boards, who access supplementary nursing staff through lower cost options such as bank and NHS Scotland contract agency.

2. This review covered nursing and midwifery staff resource in the acute, mental health and community settings and, to assist NHS Tayside in reducing reliance on use of agency personnel, we reviewed:

   - The process to measure, monitor and report benefits realised from the actions taken to reduce agency spend;
   - Compliance with safe, efficient and effective rostering practices in a sample of ward areas, as well as review of NHS Tayside's methodology for conducting 'Deep Dives' into roster compliance;
   - Utilisation and operation of the Nurse Bank.

OBJECTIVES & BACKGROUND

3. Our audit work was designed to evaluate whether appropriate systems were in place and operating effectively to mitigate risks to the achievement of the objectives identified below:

   Assurance & Advisory Group recommendation 4 stated that *'NHS Tayside should undertake an early and comprehensive review of staffing levels across all services and sites, including those delegated to or utilised by HSCPs [Health and Social Care Partnerships]. This review should aim to clarify key drivers of NHS Tayside's workforce levels compared to peer Boards and to identify safe options for bringing redesigned services and sites within available resources'.*

4. The Transformation Support Team (TST) status of this recommendation in September 2017 was 'Red' and the status was assessed as 'Amber' in January 2018. The TST January 2018 report noted that it was less evident that workforce data was being used, as effectively as it could be, to identify safe options for bringing redesigned services and sites within available resources. In addition, workforce data, and those planning assumptions, would be a key element of the modelling and scenario planning needed to take forward the development of the Integrated Clinical Strategy and the budget planning process for 2018/19 and beyond.

5. On 21 May 2018, the Executive Leadership Team (ELT) approved principles, processes and key dates for this process and members were asked to cascade this information to their teams. In June 2018, the Strategic Director of Workforce / Assistant Chief Executive produced an SBAR paper for NHS Tayside Directors 'Achieving a Safe, Affordable Workforce'. The paper proposed implementation of a system with Executive oversight and scrutiny to help change the shape of services, drive efficiency and deliver a different workforce model. The introduction of the process will require service reviews to ensure that workforce costs are as lean as possible, whilst maintaining safe and effective care provision. Implementation is scheduled for the end of October 2018 and a Vital Signs communication has been issued to inform all staff.

6. Whilst not strictly within the scope of this audit, we recommend that the governance arrangements for this process should include reporting and monitoring against the planned timescales to the ELT and both the Staff Governance and Performance and Resources Committees. Reporting and monitoring arrangements should clearly set out linkages to the planned Integrated Clinical Strategy, the corporate financial plan and the Transformation Programme.

7. A revision of the structure for the Nurse Bank and Rostering Teams started in October 2017 and is nearing conclusion. The general alignment of teams has been agreed and the available budget is being finalised. It is intended that the new structure will be in place from October 2018.

8. Supplementary Staffing costs for 2017/18 were up by £0.957 million (5%) from the previous year and whilst the objective of reducing agency costs was met, overall staff costs went up considerably. Nursing agency costs rose in the 12 month period by £0.555 million (14%) from the previous financial year, with the balance of the overall reduction in agency costs of £0.362 million from within other job families. There was however more extensive use of the Nurse Bank, with the aim of reducing premium costs associated with agency and overtime.

9. As reported to the August 2018 Performance & Resources Committee, supplementary costs for the first three months of 2018/19 were:

	Cumulative April - June		
	2017/18	**2018/19**	**(Inc)/Dec**
	£m	**£m**	**£m**
Excess Part Time Hours	0.793	0.800	(0.007)
Overtime	0.923	0.820	0.103
Bank	1.563	2.012	(0.449)
Agency Costs	2.112	1.731	0.381
Total	**5.391**	**5.363**	**0.028**

10. In overall terms, supplementary costs for the period to June 2018 reduced by £0.027 million for the same period from the previous year. Total agency costs were down by £0.381 million (18%), including a decrease in nursing agency costs of £0.374 million (30%) as a result of the increased use of the Nurse Bank. As with the annual figures, agency savings were outweighed by an increase in bank costs.

11. Overall workforce savings for 2018/19 have been identified as £1.471m and savings of £0.411m were made to end of June 2018, a surplus of £0.043m.

AUDIT OPINION

12. The audit opinion is **Category C** – Adequate – Business objectives are likely to be achieved. However, improvements are required to enhance the adequacy/ effectiveness of risk management, control and governance. A description of all audit opinion categories is given in the final section of this report.

13. The following chart shows where the grade lies within the C band:

A	B	C	D	E	F
		X			

EXECUTIVE SUMMARY

14. Nursing staffing costs were the largest component of the overall NHS Tayside pay overspend (£1.718m of £2.070m) at end of June 2018. In our view, because of the lead time associated with the actions to address this issue, there was no realistic expectation that savings relating to supplementary staffing costs would be realised in 2017/18. We would however expect to see some improvement in 2018/19.

15. A significant amount of work is ongoing to reduce supplementary staffing costs (Exhibit 1). While the Associate Nurse Director provides professional leadership for the numerous strands of work currently being progressed and there is some reporting to the P&RC and Staff Governance Committee at governance level, there is currently no overarching comprehensive system to co-ordinate, prioritise, monitor and measure work to address AAG recommendation 4.

16. The several disparate activities to reduce supplementary spend are not being undertaken within a coherent framework, resulting in a fragmented approach. However, supplementary staff (bank and agency) use is reported through NHS Tayside Board and Performance & Resources meetings. Work progressed is reported through the Nursing and Midwifery Workforce Risk Assurance paper to the Staff Governance Committee, with appropriate escalation to NHS Tayside Board.

17. In response to the AAG report, NHS Tayside identified a number of actions to plan for the step down of agency staff. During 2017/18, progress reports were presented to the Transformation Board and the weekly Transformation Executive Team. However, a collated overall report on progress has not been reported through governance structures. Our summary of progress against each of these actions is detailed at Appendix 1 to this report. In our opinion the current status of these actions is:

    - 1 Red
    - 6 Amber
    - 3 Green

18. **Key findings:**

    - With the exception of the Nursing & Midwifery Workforce Risk Assurance reporting to the Staff Governance Committee which provides an update on progress on individual actions to manage the risk, the financial benefits of these disparate actions designed to step down agency spend have not been individually quantified and reported although overall figures are reported through finance papers submitted to the NHS Tayside Board.

- A number of different projects are being progressed in parallel to address the AAG report recommendations. There are many distinct ongoing activities including the Safe Affordable Workforce Review, the work to reduce supplementary staffing and improve rostering compliance and the management accountant and service manager review of staff costs in July 2018.
- The organisation should take stock of all these distinct pieces of work to ensure they effectively contribute to the common goal and to avoid overlap;
- There needs to be a cohesive, prioritised approach to the numerous pieces of ongoing work, linked to and focused on achievement of savings. This work needs to be co-ordinated in a single, measurable action plan with defined outcomes and robust monitoring arrangements;
- Targets to measure improvement affected by each component should be introduced and data should be produced to demonstrate the results;
- The ongoing restructure of the rostering and bank structures should be concluded to ensure that appropriate staff are in place to progress actions and to deliver rostering and bank support;
- While business processes within the nurse bank have been reviewed and enhanced, further improvements to the efficiency and effectiveness of the nurse bank are required;
- The draft Transformation Programme 2017/18 Annual Report includes a workforce section, although it does not contain financial data. The report has not been finalised nor presented to the Board or Performance & Resources Committee (P&RC);
- The conclusion of the Standardised Shifts project has not been reported to an appropriate committee and lessons learned disseminated, although it was reported to the Executive Leads for AAG recommendation 4, the Chair of the former Transformation Board and relevant Non-Executives.

Exhibit 1– Examples of current initiatives

- A programme of ward level 'deep dives' to review and update staffing establishment and budget for each ward / area, with amendments formally approved by a senior staff, multidisciplinary panel;
- A refreshed programme to timetable the running of the NHS Scotland Nursing & Midwifery Planning tools, triangulated with other patient data;
- Ongoing development of a four step nursing and midwifery annual workforce planning governance cycle to assess future nursing and midwifery workforce needs, produce service level workforce plans, develop directorate / HSCP workforce plans and feed in to the NHS Tayside corporate workforce plan;
- Strengthening of the NHS Tayside Rostering Policy with robust application of requirements. Key changes include:
  - annual leave requests that exceed the documented acceptable level will not be approved;
  - specific requirement to ensure that approval of requests for annual leave does not lead to a need for supplementary staffing;
  - Flexible working requires adjustments to be formally agreed and reviewed;
  - Clarification that requests should be for specific days off and requests for specific shifts to be considered only in exceptional circumstances.
- A Vital Signs communication issued in August 2018 to inform staff of the key points and main changes within the updated Rostering Policy;
- An ongoing programme of mandatory Rostering Masterclasses to ensure staff have the skills to roster effectively;
- Ongoing development of the Workforce Resourcing Toolkit. The guidance aims to provide Nursing and Midwifery Teams with a range of knowledge and tools to support teams to produce, maintain and predict effective workforce plans;
- Ongoing programme of rostering compliance checks carried out by the Roster Compliance Assurance Group;
- Rostering review, support and advice provided by the Healthroster Implementation Team;
- Planned appointment of a Professional Lead for Rostering and Supplementary Staff, with a role to include scrutiny of compliance with the Rostering Policy and holding officers to account for non-compliance;
- Ongoing Safety & Flow huddles at acute sites and local processes within community and mental health;
- Enhanced escalation processes for use of Agency staff, detailed in flowcharts;
- Actions to improve recruitment and retention.

20. The risk assurance report to the August 2018 Staff Governance Committee assessed the risk as 'High – 20' with a planned risk score of 'High – 16'. Risk assurance reports provide updates on controls over: application of the NHS Scotland Nursing and Midwifery Planning Tools; Effective Roster Practice and Controls; Supplementary staffing; Review and update of NHS Tayside Rostering Policy for Nursing and Midwifery; Nurse Bank and Review; Recruitment and Retention; Nursing and Midwifery Annual Workforce Planning Governance Cycle and the proposed staffing structure for rostering and bank staff.

21. Our review of the Nursing & Midwifery Workforce risk recorded on Datix confirmed that the controls stated were appropriate and reflected the current systems, processes and development work. An annual report on the use of the Nursing & Midwifery Workforce Planning tools is included within the 'assurances' section. This report is still to be produced. No gaps in assurance are identified in the risk record but we recommend that the controls and assurances around the disparate pieces of ongoing work are formalised and the risk record updated accordingly to reflect action taken to address recommendations from this report.

22. The Associate Nurse director has informed internal audit that while work has been led with Partnership, Human Resources and Nursing Colleagues, there is limited opportunity to see the true impact on the use of supplementary staffing until the current vacancy factor is addressed (Newly Qualified Practitioner recruitment will start to influence this as new registrants join NHS Tayside from September 2018) and future service models are agreed and implemented. Issues relating to recruitment of Newly Qualified Practitioners and their relationship with cost mitigation was highlighted in the Nurse Workforce Risk report submitted to 14 August 2018 Staff Governance Committee.

23. Detailed key areas of improvement to improve risk monitoring and reporting arrangements are detailed below:

Key areas for improvement:

- The eRostering Programme Board last met on 8 February 2018. At this meeting the revised Nurse Bank and Roster Team structure was presented and approved to progress to implementation. Ring fenced funding will be transferred to the Nursing and Midwifery Directorate to enable this to take place and the transition from implementation to business as usual. Whilst many of the recommended key areas for improvement are in place, there is no other overarching framework to bring together the ongoing strands of work. Creation of a formal Governance Assurance Group for management of supplementary staffing is recommended, to pull together the ongoing work on Nursing & Midwifery workforce planning and the running of the workforce tools. The Deep Dives to ensure the ward establishment and budget is correct, the work on assessing roster compliance, the work of the HealthRoster Implementation Team in providing review of rosters and support in rostering practice, and the ongoing improvement work on the Nurse Bank should be led by the Roster Compliance Assurance Group;
- A flowchart or diagram detailing the inputs to the process would be useful;
- Terms of Reference should be reviewed to encourage inclusion of:
  - Membership including operational staff across the rostering and bank teams, relevant stakeholders and user representation;
  - A focus on ensuring improved systems and processes that translate to achievement of savings whilst maintaining a safe environment;
  - Monitoring of targets to measure and demonstrate improvement;
  - Development and monitoring of a single, measurable action plan with defined outcomes and robust monitoring arrangements;
  - Arrangements for escalation and sharing of findings from all parties contributing to review and update of rosters;
  - Agreement of a timetable to ensure that the 'deep dives' to review the establishment and budgets of all wards are completed and outcomes are actioned for all rostering areas. This should include co-ordination of all strands of ongoing work to ensure there is no duplication and that there is full coverage, and that learning is shared. In addition, all decisions and amendments as a result of the Deep Dives should be recorded. Improvements should be quantified, monitored and reported;
  - Review and timetabling of application of the workforce tools and review of outcomes to ensure good quality triangulated data is recorded and feeds in to the organisation wide workforce plans;
  - Development and regular review and reporting of KPIs to measure and benchmark compliance with the Rostering Policy, including compliance with Time Out allowances, use of bank and agency staffing and efficiency of nurse bank;
  - Review of workforce planning governance cycle process.
- The ongoing restructure of the rostering and bank structures should be concluded to ensure that appropriate staff are in place to progress actions and to deliver business as usual for rostering and bank support;
- Review of the full functionality of SafeCare for workforce planning to ensure optimum use of triangulation and contribution to the Safety & Flow Planning Huddles [appendix 2, action 8 Issues for consideration].

25. Ensuring accuracy of budgets and establishments is the first step to effective and efficient rostering and the review to ensure accuracy of baseline data through a series of 'Deep Dives' is an important aspect of the overall process. Deep Dives review the service demand and establishment in each ward and the bed complement, staff in post, Whole Time Equivalents (WTE) as per the workforce models, the current budget and any variances are recorded, as well as Time Out information and explanatory comments. The outcomes of this review process for each ward or department are discussed with Heads of Nursing, Clinical Services Managers, Senior Charge Nurses and the Senior Nurse for Workforce Planning, with the aim of ensuring ownership of workforce tools at ward level.

26. When the spreadsheet is agreed for an area, the outcomes are provided to the relevant Associate Director. Proposed changes to the establishment and budgets are reviewed by a panel led by the Associate Nurse Director, the Director of Acute Services and the Deputy Director of Finance. Deep Dives have been completed for all acute in-patient areas. It is intended that this review will be carried out NHS Tayside wide and, as above, we recommend a timetable is put in place. In the paper submitted to the Executive Leadership Team in June 2018, 'NHS Tayside Achieving a Safe Affordable Workforce ' the internal process was originally intended to be completed by the end of August, followed by Challenge Meetings in September and Executive Review Panels in September/October; for Implementation by the end of October 2018.

27. To ensure quality of the data informing the Deep Dive process, HealthRoster should be regularly updated to reflect hours worked. Healthroster data should be the single data source for all rostering review work.

28. The Roster Compliance Assurance Group established review processes and has senior representation from the Nursing and Midwifery Directorate, Human Resource department and Staff Partnership. This group meets weekly with a brief to review the efficiency of shift patterns and explore rostering practice and compliance. The Roster Compliance Assurance Group has developed a flowchart for measuring compliance, communicating areas of concern and developing improvement action plans in association with the Senior Charge Nurse, Head of Nursing, communicated to the General Manager.

29. In June 2018, the Rostering Policy was updated and considerably strengthened to make clear that non-compliance with roster principles, particularly compliance with Time Out allowances, without reliance on supplementary staffing.

30. Discussions with staff confirmed wide spread understanding of the roster principles set out in the Rostering Policy, and of escalation processes. All staff consulted were clear on the circumstances where it was appropriate to utilise the bank and all staff consulted viewed use of agency as a last resort.

31. Key areas for improvement to enhance the steps already taken to improve roster compliance are detailed below:

Key areas for improvement:

- Organisation wide communication of the programme of Roster Master classes and the expectation that all relevant staff will attend, as well as delivery of masterclasses in venues outside the acute hospital sites *[appendix 2, action 3 Issues for consideration]*;
- Senior, independent overview of authorised non-compliant rosters;
- Development of a process to check that the compliance audit tool at appendix 1 of the Roster Policy is always completed and formal review of the outcomes of the audit tool by the recommended overarching governance and assurance group;
- Ongoing scrutiny of compliance with Time Out requirements with overall monitoring through the recommended governance and assurance group;
- Consideration of inclusion of roster compliance KPIs in Directorate Performance Reviews;
- Establishment of clearly delineated governance arrangements;
- In line with the planned refresh, formal Terms of Reference for the Roster Compliance Assurance Group should be agreed and should include:
  - Development of a work plan and timetable to ensure coverage of all areas across the organisation;
  - More formal recording of discussions, actions and meetings at wards areas;
  - Clear feedback processes to ensure findings are communicated to and are fully discussed with Senior Charge Nurses and Heads of Nursing / Clinical Services Managers;
  - Use of the formal escalation route for the group to ensure concerns and learning are shared and dealt with;
  - Formal reporting from the group to monitor progress of review of all wards areas and to highlight strengths and weaknesses in rostering compliance.
- Clear communication to staff that information in Healthroster is the tool for managing workforce and must reflect the roster actually worked. This information should be mirrored in SSTS for payroll purposes, but HealthRoster is the prime system for recording workforce data.

Detailed ward based testing

32. To inform our assessment we visited:
    - Clova / Isla ward, Whitehills (Community)
    - Ward 42, Ninewells (Infectious Diseases)
    - Ward 3, PRI (Medicine)
    - Ward 1, Kingsway (Mental Health)

33. In conjunction with the HealthRoster Implementation Team we also reviewed the Ward 2, Carseview roster for three periods. We did not however visit this ward as the Implementation Team is currently working closely with the ward to progress agreed action points to improve rostering practice.

34. For the five wards detailed above, we carried out a review of the HealthRoster Analyser to obtain a snapshot of the Budget, Unavailability, Safety, Effectiveness, Annual Leave and Fairness performance indicators over three roster periods. This analysis showed issues with Unavailability, Effectiveness and Annual Leave on all the wards reviewed. From discussion with Senior Charge Nurses and Heads of Nursing we were informed that the main reasons for these issues included:

    - barriers to compliant rostering such as historical restrictions which may or may not be contractual;
    - delays in updating HealthRoster when changes to the ward establishment / skill mix have been agreed;
    - challenges in managing vacancies, sickness absence and pre-arranged annual leave for new staff.

35. We found that the HealthRoster Notes section was useful in explaining the reasons for non-compliance, although the quality of the Notes varied. We reviewed use of notes for 100 roster periods over 10 wards, over a nine month period. One ward did not use notes at all and the remainder used this function with a varying degree of frequency and quality (notes were used for 54 of the 100 roster periods). We would encourage use of Notes within the system to explain reasons for non-compliance.

36. We also reviewed time balances for a sample of five wards and identified several instances where staff members hours worked were significantly over or under contracted hours, either for the roster period or on a rolling basis. These time balances detail the hours an individual has worked over or under their contracted hours, both in the roster period and as a 'rolled forward' total. These balances should be subject to review to ensure staff do not regularly work significantly more or less than their contracted hours as large balances create a risk that:

    - staff are allocated 'additional hours' i.e. shifts are allocated to staff where there is no service requirement;
    - there are payroll implications where an employee moves wards or leaves NHS Tayside employment.

37. We identified some general operational improvements to assist in better rostering and these are summarised in a separate memo which will be provided to the Associate Nurse Director.

Effectiveness of the Nurse Bank

38. Considerable work has been undertaken to improve the operation of the Nurse Bank including:

    - development of an integrated team model and internal review of bank systems and processes;
    - improvements in the recruitment processes. However, at start of August 2018, there were 183 bank nurses in post and 242 bank staff applications in progress. We have been informed that the processing of applications can take between one and three months due to the requirement to put the staff member on to SSTS, obtain Child & Adult Protection checks, obtain Occupational Health approval and for applicants to attend Corporate Induction;

- implementation of Direct Booking to improve shift uptake;
- daily reporting of demand and fill rates for supplementary staffing over the last two months;
- development of KPIs, although these have not been implemented;
- ongoing development of Standard Operating Procedures for operation of the Nurse Bank;

39. While business processes within the Nurse Bank have been reviewed and enhanced, further improvements to the efficiency and effectiveness of the nurse bank are required and implementation of the reviewed staffing structure will be fundamental to this. Key areas for improvement are detailed below:

Key areas for improvement:

- While there has been significant amount of work to improve the Nurse Bank systems and processes, considerable risks remain in relation to progressing recruitment of bank staff to the point where they are available for work and in relation to developing Standard Operating Procedures. An operational risk reflecting key controls and assurances should be recorded within the Datix system;
- Assurance on Nurse Bank performance is not reported to any formal group and this aspect should be a critical part of the work of the recommended governance and assurance group.
- A suite of KPIs for this area have been developed but have not been implemented. Data gathering, reporting and monitoring of these KPIs should be progressed;
- Until end of June 2018 a full time staff member was extended to drive improvement and manage the nurse bank. The resource now available is one Nursing and Midwifery Directorate manager assigned to provide staff support and education to the Nurse Bank one day per week. Management have informed us that this role will become fulltime from October 2018. As part of the development of the Nurse Bank and Rostering Teams, management should consider whether the development activities required for the Nurse Bank are sufficiently progressed that the proposed structure is adequate to ensure an effective and efficient service;
- There are currently 242 bank staff applications in process. Management should consider whether the current resource is adequate to both manage the day to day operation of the bank and process the ongoing application process;
- There are plans to extend the nurse bank for other staff groups e.g. doctors, support staff and consideration should be given to future resource requirements;
- The existing Standard Operating Procedures for operation of the Nurse Bank are being reviewed to ensure consistent, reliable procedures are in place and these should ensure that:
    - assurances that all bank staff have completed mandatory training and induction can be provided;
    - there is a transparent route for escalation of professional issues;
    - any performance or conduct issues are dealt with in line with NHS Tayside policies and through the professional nursing route, with appropriate communication to ensure all incidents and risks can be closed off;
    - the system developed for dealing with non-attendance of bank staff is rigorously enforced;
    - bank workers comply with the European Working Time Regulations or an appropriate opt-out waiver is in place.
- Feedback from some staff consulted indicated that bank staff may not have all the required skills and training required. For example, there is an expectation that staff working within Mental Health / Psychiatry of Old Age will have completed Control of Violence training. A process should be put in place to ensure that staff assigned to areas with specific skill requirements are appropriately trained.

40. In November 2016, NHS Tayside Directors considered a paper assessing quality and safety issues, with particular reference to compliance with the Working Time Regulations, associated with longer shifts. As a result, a decision was made at the Transformation Programme Board to explore opportunities through consideration of a move to a standard shift length model. It was hoped that this work would lead to releasing staff in to the system. The internal audit interim report 2017/18 highlighted the principle that officers should be empowered to take informed, calculated risks to achieve delivery, and this will be supported by the Board. The report also highlighted the importance of clear expectations of acceptable progress and delivery, tempered with an understanding of risks and acknowledgement that risks may crystallise. We recognise the work on Standardised Shifts as a positive example of this. However, although a 'Standardised Shifts' report was prepared in March 2018, in response to a request from the Executive Leads for AAF recommendation 4, the report has not been formally presented to the ELT, or any other group or committee. It was not presented to the NHS Tayside Transformation Programme Board as it has not met since April 2018. HR colleagues have informed us that '*the report was submitted to the former Chair of the Transformation Board and cessation and redirection of the project aims (ie roster compliance) was then agreed by the former Board Chair and the report was separately provided to a Non Executive Director in his capacity as a member of the Transformation Board, both at the request of the Transformation Board and in light of his lead interest in this area*'.

41. NHS Tayside has decided not to proceed with the roll out of standardised shifts but we have found no evidence that this decision has been ratified by a governance or business committee. The Transformation Board and its Executive Group have now been disbanded and there has been no update to the Board or Standing Committee and a formal 'Lessons learned' report has not been produced and reviewed, focusing on whether barriers to success could have been identified earlier in the process. Therefore, the learning for future projects has not been disseminated.

42. We have been informed that the Standard Shifts roll out was stopped because of application of No Detriment Protection costs and staff feedback. The paper provides some information on the net gain of implementation of standardised shifts across eight wards, the average protection costs across the eight wards over a three month period and data on sickness absence, vacancies and bank and agency demand in the test of change wards.

43. We would suggest that any Lesson Learned exercise considers whether the data presented in the closure report was sufficient to demonstrate the longer terms benefits of this change and whether an exercise to extrapolate the payment protection costs across a larger sample of wards and for a longer period would have been helpful. We note that it was highlighted that the application of no detriment protection would incur a cost to the organisation throughout the process between 2016 and 2017.

ACTION

44. An action plan has been agreed with management to address the identified weaknesses and the Strategic Director of Workforce has agreed that this report will be presented to the Staff Governance Committee. A follow-up of implementation of the agreed actions will be undertaken in accordance with the audit reporting protocol.

ACKNOWLEDGEMENT

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

Jocelyn Lyall BAcc (Hons) CPFA
Regional Audit Manager

Action Plan

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
1.	While there are several disparate strands of ongoing work to reduce supplementary spend, the approach is fragmented and the bringing together and co-ordination of this work in a single, measurable action plan with defined outcomes and robust monitoring arrangements will be key in achieving continued improvement and in reducing the risk to the organisation.	The recommendations within this report and the accompanying appendix should be considered for inclusion in the overarching action plan to deliver improvement and cost savings.	**2**	Following discussion at ELT on 10 September it was agreed that the Strategic Director of Workforce, the Director of Acute Services and the Nurse Director will meet to agree responsibilities for the detailed actions within this report. An overarching action plan will be put in place.	Strategic Director of Workforce Meeting to be arranged and action by date confirmed.
		Appropriate governance arrangements should be put in place to monitor progress.	**2**	The Strategic Director of Workforce will have overall responsibility for monitoring progress and appropriate governance arrangements will be agreed.	

Action Plan

Ref.	Finding	Audit Recommendation	Priority	Management Response / Action	Action by/Date
2.	While the Associate Nurse Director has professional responsibility for the numerous strands of work currently being progressed, there is no overarching group with a remit to co-ordinate and monitor work to action AAG recommendation 4.	The Nursing & Midwifery Workforce Risk should be updated accordingly.	**2**	The Nursing and Midwifery Workforce Strategic Risk is reviewed and updated to enable a contemporary position to be reported at each Strategic Risk Management Group meeting and each Staff Governance Committee. Relevant points from this audit report will be incorporated in the next update.	Nurse Director October 2018

Action 1 - A review of staffing levels and establishments against the 2015/16 Nursing Workforce and Workload Tools across all Acute Wards

Progress / status / reporting RAG status - Amber

- A summary progress report on application of the national Nursing & Midwifery Workload and Workforce Planning tools was presented to the Staff Governance Committee on 14 April 2015. The report stated that tools had been applied in 93.4% of relevant areas;
- Application and outcomes of Nursing & Midwifery planning tool outcomes have not been formally reported to an appropriate standing committee since and an annual report on the application of the tools has still to be produced for 2017/18;
- Tools are generally run annually and in line with the national timetable. Tools are not 'stand alone' and triangulation with quality and patient safety data and professional judgement is used to determine establishment;
- Where tools are not appropriate for some areas e.g. Out Patients, ICU, HSCI multidisciplinary areas, professional judgement and occupancy and dependency criteria are applied along with other nationally recognised tools;
- Safer Staffing Legislation due to come into effect from April 2019 should help ensure the current Nursing & Midwifery Workload and Workforce Planning tools, currently mandatory, will be in statute. This will require Boards to evidence the running of the tools where applicable at the agreed frequency.
- There is no timetable for running tools across NHS Tayside to ensure 100% coverage, although creation of a timetable is scheduled for end 2018/19;
- Whilst a record of levels of completion for tool runs and outcomes for all areas are not centrally available, information is held within the Nursing and Midwifery Directorate and is shared with colleagues across Tayside. Tool runs should be recorded on SSTS by all areas at the point of a tool run. A system will be implemented to track progress as part of the schedule mentioned above;
- Outcomes from tools may not always have been communicated to service areas;
- Some initial benchmarking has been undertaken with other Boards;
- The Senior Workforce Planning Nurse is reviewing the use and outcomes of the workforce tools across the organisation, and has a role in troubleshooting, supporting and educating staff who either create or authorise rosters;
- Programme of Deep Dives continues;
- Current approach to workforce planning for nursing and midwifery is working one to one with individual services with a focus on the comparison of actual and budgeted establishment. The outcomes of this work do not result in a workforce plan, but aims to provide robust information to inform the workforce plans.

Issues for consideration:

- Development of a timetable to ensure that the tools are run for all appropriate areas and that tool runs are completed;
- Outcomes of the tools to:
  - be formally recorded as a key component of the work to ensure establishments and budgets are accurate (Deep Dives);
  - contribute to the organisation's wider workforce planning;
  - communicated to service areas;
  - benchmarked against other NHS Boards;
  - formally reported and monitored though the appropriate structures, with assurances provided through an annual report.

Action 2 - Implementation of the recommendations from the national team review of the Nurse Bank

Progress / status / reporting RAG status - Amber

- National Services Scotland review of the Nurse Bank was requested by the Director of Nursing and the report issued in October 2016 made 18 recommendations;
- The outcomes of the report and progress against the recommendations were reported to NHS Tayside Board as part of the Nursing and Midwifery Workforce Risk Assurance report However, nursing staff consulted during the review have informed us that the report was not widely shared with staff;
- A report on the RAG status of the 18 recommendations and a paper detailing themes from the review were produced in July 2017 and presented to the Staff Governance Committee and NHS Tayside Board. Whilst progress against all recommendations was 'Green', not all were complete at this point. It was proposed that themes would be tested and developed into an action plan with milestones, outcome measures and leads, to be progressed through collaborative leadership to engage internally (NHS Tayside & Health & Social Care Partnerships) and externally across Scotland. The 18 recommendations included recruitment to the bank, development of performance indicators, enhanced escalation procedures for use of supplementary staffing and adherence with professional standards. Internal audit review confirmed that all recommendations are currently either complete or in progress. Progress will be reported through the Nursing and Midwifery annual report to the Clinical Quality Forum;
- The Risk Assurance reports on Nursing & Midwifery Workforce provide updates on the Nurse Bank.

Issue for consideration:

- NHS Tayside should, through an appropriate forum, revisit the October 2016 Nurse Bank report to assure itself that all relevant recommendations have been appropriately progressed.

Action 3 - Meetings with all Heads of Nursing and Senior Charge Nurses to ensure a clear understanding and compliance with safe and effective rostering practices

Progress / status / reporting RAG status - Amber

- The Roster Compliance Assurance Group has developed a flowchart for measuring roster compliance, communicating any areas of concern and developing an improvement action plan in association with the Senior Charge Nurse and Head of Nursing, communicated to the General Manager;
- Roster Compliance Assurance Group has met with all Senior Charge Nurses and Heads of Nursing across the acute division;
- A rolling programme of Roster Master Classes is being delivered to support and develop skills to:
  - ensure a reliable and sustainable approach to ensuring the right staff are on duty to provide the care required;
  - support and facilitate a cohesive approach to effective rostering across the organisation;
  - ensure that use of the e-Rostering systems and processes meet the challenges in

maximising the available staffing resource in an effective and efficient manner;
- work within agreed budgeted establishments, including the use of supplementary staffing.

- The Healthroster Implementation Team is managing an ongoing timetable of ward compliance reviews.

Issues & Recommendations:

- A communication explaining the purpose of the Roster Master Classes should be issued, setting out the timetable of classes and making clear that all staff with rostering responsibilities are expected to attend;
- The programme of Master Classes should include venues outside of acute hospital sites;
- Heads of Nursing should be able to access appropriate 'business' training to ensure they understand the detail of their budgets and can identify the impact of payment of enhancements, supplementary staffing, impact of shift patterns and application of leave policies.

Action 4 - Implementation of a nurse workforce toolkit to support proactive planning and decision making.

Progress / status / reporting RAG status - Amber

- An NHS Tayside Nursing and Midwifery Annual Workforce Planning Governance Cycle has been developed and a draft was presented to the April 2018 Staff Governance Committee.
- The redraft of the Workforce Resourcing Toolkit is ongoing but has taken longer than anticipated because as the workforce planning cycle progresses, more areas for inclusion are becoming evident. As reported to the June 2018 Staff Governance Committee, the projected launch of the next working draft of the Workforce Resourcing Toolkit has been postponed in order to allow receipt of feedback on the Annual Workforce Planning Governance Cycle.

The current draft of the toolkit covers:

- Nursing and Midwifery Workforce Planning governance arrangements;
- Triangulated methodology;
- Recruitment & retention;
- Managed predicted absence;
- Health roster;
- Supplementary staffing;
- Workload / workforce planning;
- Writing and reporting the workforce planning exercise report;
- Training module, Local NHS workforce learning.

It is anticipated that the toolkit will also include sections on:

- The workforce planning cycle and governance arrangements;
- Risk management;
- Financial aspects;
- A section on Newly Qualified Practitioners.

Issues & Recommendations:

- The draft 'toolkit' should be approved through the appropriate formal governance

structures, including a period of consultation before final approval;
- The status of the toolkit as guidance or policy should be agreed and communicated to staff;
- A programme of training / LearnPro training on the toolkit should be organised.

Action 5 - Implementation of revised escalation procedures for authorisation of requests for supplementary staff

Progress / status / reporting RAG status – Amber

- Flowcharts for Agency Escalation within business hours and Out of Hours have been developed. The Safety and Flow huddles are key within the escalation processes with the Director of Acute Services (business hours) and the Duty Executive (out of hours) having final sign off to authorise agency staff;
- Anecdotal evidence indicates that this system is working well, however, we are not aware of any analysis of use of agency staff that would confirm the reasonableness of the decision making process.

Issues & Recommendations:

- The effectiveness of the escalation flowcharts should be assessed to ensure that they are being complied with and data on the reasons for agency use should be maintained and reviewed by an appropriate group to identify trends and common themes, as well as areas which need assistance to decrease the number of requests made.

Action 6 - Introduction of nursing staff pools and modification of nurse bank personnel contracts

Progress / status / reporting RAG status - Green

- Nurse bank pools were shifts that were put on the system aligned to a shift on a hospital site but not initially aligned to a ward. This was to test what additional flexibility this would provide in relation to being able to allocate staff where demand changed or there was a short notice need. Nurse directorate colleagues have informed us that there was poor uptake from bank workers. Agency staff did take these shifts when escalated, although this was not encouraged.

Issues & Recommendations:

- Feedback from Clinical Service Managers indicated that a 'pool' of bank nurses with specialist skills would be useful in some areas, for example, mental health and psychiatry of old age nursing staff with training in control of violence and aggression. Establishment of this 'pool' of specialist nurses should again be considered through the evolving nurse bank arrangements.

Action 7 - Four-times-a-day, seven-days-a-week safety and flow huddle framework which includes safe staffing review and staff redeployment

Progress / status / reporting RAG status - Green

- Safety & Flow Huddles have been implemented in all acute areas. Feedback from the Heads of Nursing consulted indicates that the huddles have been helpful in sharing information and making the staffing process more open and transparent, in identifying

hotspots and in encouraging a culture where staff are more likely to work across ward areas as required;

- While huddles were not considered necessary within the community and mental health areas visited, the Clinical Services Managers maintained documentation which is reviewed every night and looks ahead to staffing over the next 24 hours. We were informed that staff move across wards / areas as required and the skills are generally the same across areas;
- Guidance on staff deployment is contained as an appendix in the Nurse Bank Policy;
- Staff described the huddles as short, succinct and as an effective forum to consider a standard set of data. Staff felt that there has been considerable progress in ensuring that, where required, staff are moved to areas for which they have been inducted or in which they have the necessary skills and experience;
- A script covering relevant actions from the previous huddle, emerging safety risks to be aware of, exception reporting on staff, capacity & flow update and key actions is used as the basis for each Safety & Flow Planning meeting. An SBAR template is completed by the Huddle Chairs to summarise critical issues and to summarise capacity and flow actions / escalation / support required;

Issues & Recommendations:

- Heads of Nursing have informed us that an 8.30am (rather than an 8am) morning huddle would allow them to present a fuller picture of the position within their areas following shift handover and may be beneficial in gaining engagement from medical staff, which is currently poor. Staff felt that medical staff input would be particularly helpful in contributing to safety and flow discussions and that knowledge of elective admission plans would be a useful addition to the huddle;
- Steps should be taken to encourage wider clinician involvement in the huddles.

Action 8 - Implementation of Safe Care to prioritise staff deployment across areas of risk

Progress / status / reporting RAG status - Red

- SafeCare is available across all acute areas but is not widely utilised. The system is designed to complement the information from the workforce tools by providing 'live' information on actual dependency. It is planned that SafeCare data will be included as part of the quality measure for triangulation;
- SafeCare information is used to some extent to inform the Safety & Flow Huddles. However, SafeCare data is captured at 6.30am, 2.20pm and 8pm and data is therefore not available for the 1pm huddle;
- SafeCare has potential as a tool to identify hotspots, but this is dependent on the system being accurate and up to date;
- SafeCare cannot be accessed from outwith NHS premises and data is therefore not available for the 8pm huddle;
- There is no evidence of monitoring or reporting of SafeCare;
- We have been informed that SafeCare is not used in other Health Board areas.

Issues & Recommendations:

- Nurse directorate colleagues have informed us that when the electronic rostering system is sufficiently progressed and the organisation has moved to business as usual, use of SafeCare will be reviewed. The benefits of further implementation across NHS Tayside should be assessed, taking into account any lessons learned in other Board areas.

Action 9 - Successful recruitment of Newly Qualified Practitioners

Progress / status / reporting RAG status – Green

- The Nursing & Midwifery and the Human Resources & Organisational Development departments are working together to review processes for nursing and midwifery recruitment and develop a process map / pathway for recruitment, subject to financial parameters;
- A Standard Operating Procedure for recruitment will also be developed;
- Initial matching of Newly Qualified Practitioners has been undertaken with the potential to recruit 130 General Adult and 50 Mental Health Nurses;
- The Senior Workforce Planning Nurse, along with newly qualified practitioners (including Mental Health) and a newly appointed Senior Charge Nurse have attended the local University job fairs to recruit staff;
- Application packs have been updated and are provided to students to encourage recruitment;
- Work has been completed to identify 'hotspots' where recruitment is difficult e.g. Medical Unit, Medicine for the Elderly;
- Other ongoing activity includes:
  - Recruitment to the HNC in Healthcare programme which can be used as access to Nursing as the equivalent of year 1 of Nursing training;
  - Actions to improve vacancy management;
  - Encouraging staff to return to practice through the Return to Practice course run by NHS Tayside in partnership with the University of Dundee;
  - Consideration of the use of rotational contracts where staff work in a variety of wards within a directorate and their substantive post is identified at the end of their rotational contract;
  - Review of ways to retain staff. For example, review of outcomes of exit interviews when staff leave NHS Tayside employment.

Issues & Recommendations:

- NHS Tayside should continue to progress actions to ensure the workforce is sufficiently flexible to meet demand in the future and that career opportunities and flexible working conditions are available for staff to encourage nurses to seek and continue in employment in the organisation, in line with the ongoing work on 'Achieving a Safe, Affordable Workforce'.

Action 10 - Agreed escalation for highly specialised nursing workforce for critical care, theatres, Emergency Departments and Child and Adolescent Mental Health Services

Progress / status / reporting RAG status – Amber

- In addition to the standard escalation processes for the areas identified, it has been acknowledged that generally, the bank has few workers with the skills required for departments such as critical care, theatres, Emergency departments and CAMHS. We have been informed that escalation is through line management and essentially involves the local discussion of the recognised staffing gaps and agreement to request agency staff through line management structures for these areas. The process is the same as the standard escalation process but the scope to find staff with the requisite skills in-house is reduced when compared to e.g. adult inpatient areas, and escalation to premium rate Agency tends to be accelerated.

Issues & Recommendations:

- Efforts to recruit suitably skilled bank staff should continue, with a targeted approach to staff with specialist skills.

DEFINITION OF ASSURANCE CATEGORIES AND RECOMMENDATION PRIORITIES

Categories of Assurance:

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

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

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

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

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

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

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

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

ITEM NUMBER 5.1

AUDIT03/2019
AUDIT COMMITTEE
24 JANUARY 2019

NHS TAYSIDE ANNUAL AUDIT PLAN 2018/19

Fiona Mitchell-Knight
Audit Director, Audit Scotland

January 2019

NHS Tayside

Annual Audit Plan 2018/19

AUDIT SCOTLAND

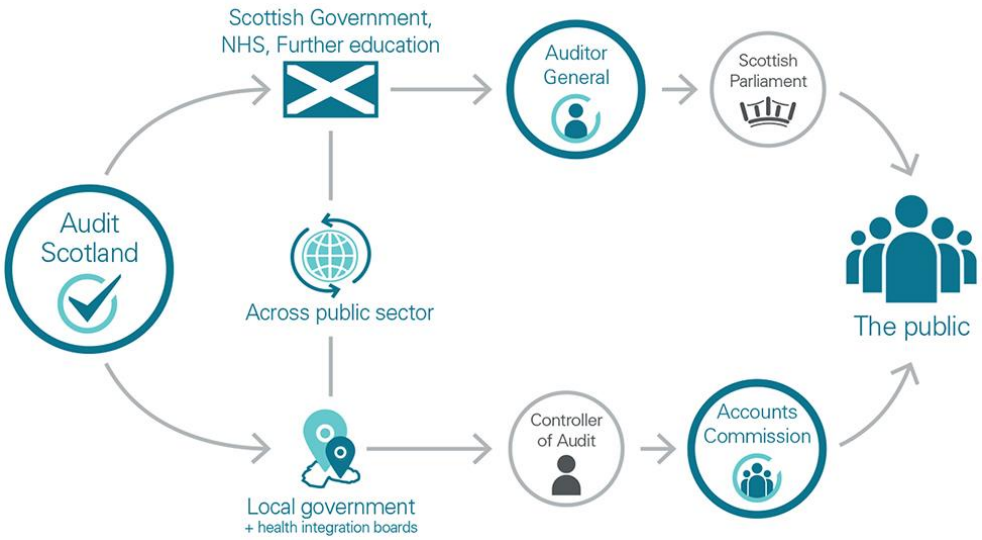
Prepared for NHS Tayside

January 2019

Who we are

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

- The Auditor General is an independent crown appointment, made on the recommendation of the Scottish Parliament, to audit the Scottish Government, NHS and other bodies and report to Parliament on their financial health and performance.
- The Accounts Commission is an independent public body appointed by Scottish ministers to hold local government to account. The Controller of Audit is an independent post established by statute, with powers to report directly to the Commission on the audit of local government.
- Audit Scotland is governed by a board, consisting of the Auditor General, the chair of the Accounts Commission, a non-executive board chair, and two non-executive members appointed by the Scottish Commission for Public Audit, a commission of the Scottish Parliament.



About us

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

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

- carrying out relevant and timely audits of the way the public sector manages and spends money
- reporting our findings and conclusions in public
- identifying risks, making clear and relevant recommendations.

Contents

Risks and planned work

1. This annual audit plan contains an overview of the planned scope and timing of our audit and is carried out in accordance with International Standards on Auditing (ISAs), the Code of Audit Practice, and any other relevant guidance. This plan sets out the work necessary to allow us to provide an independent auditor's report on the financial statements and meet the wider scope requirements of public sector audit.

2. The wider scope of public audit contributes to assessments and conclusions on financial management, financial sustainability, governance and transparency and value for money.

Adding value

3. We aim to add value to NHS Tayside through our external audit work by being constructive and forward looking, by identifying areas for improvement and by recommending and encouraging good practice. In so doing, we intend to help NHS Tayside promote improved standards of governance, better management and decision making and more effective use of resources.

Audit risks

4. Based on our discussions with staff, attendance at committee meetings and a review of supporting information we have identified the following main risk areas for NHS Tayside. We have categorised these risks into financial risks and wider dimension risks. The key audit risks, which require specific audit testing, are detailed in Exhibit 1.

Exhibit 1
2018/19 Key audit risks

⚠ Audit Risk	Source of assurance	Planned audit work
Financial statements issues and risks		
1 Risk of management override of controls ISA 240 requires that audit work is planned to consider the risk of fraud, which is presumed to be a significant risk in any audit. This includes consideration of the risk of management override of controls to change the position disclosed in the financial statements.	• Owing to the nature of this risk, assurances from management are not applicable in this instance.	• Detailed testing of journal entries. • Review of accounting estimates. • Focused testing of accruals and prepayments. • Evaluation of significant transactions that are outside the normal course of business. • Substantive testing of transactions after the year end to confirm expenditure and income has been accounted for in the correct financial year.

	Audit Risk	Source of assurance	Planned audit work
2	**Risk of fraud over income** NHS Tayside receives a significant amount of income from several sources other than Scottish Government funding. The extent and complexity of income means that, in accordance with ISA 240, there is an inherent risk of fraud.	• Budget monitoring by management. • Internal control processes built into systems utilised by the board. • Fraud reports are regularly monitored and information across Scotland is routinely shared. • There are a range of measures in place to prevent and detect fraud, including Standing Financial Instructions, Standing Orders and a Code of Conduct for Staff which incorporates both whistleblowing and fraud policies.	• Analytical procedures on income streams. • Detailed testing of revenue transactions focusing on the areas of greatest risk.
3	**Risk of fraud over expenditure** Most public-sector bodies are net expenditure bodies and therefore the risk of fraud is more likely to occur in expenditure. The Code of Audit Practice requires consideration of risk of fraud over expenditure (excluding payroll costs which are already a core part of all annual audits). NHS Tayside incurs significant expenditure, including expenditure on family health services, which require audit coverage.	• Budget monitoring by management. • Internal control processes built into systems utilised by the board. • Fraud reports are regularly monitored and information across Scotland is routinely shared. • There are a range of measures in place to prevent and detect fraud, including Standing Financial Instructions, Standing Orders and a Code of Conduct for Staff which incorporates both whistleblowing and fraud policies. • The board has a formal partnership agreement with NHS Scotland Counter Fraud Services and an agreed protocol covering a programme of regular payment verification checks on family health service contractor payments. • The board participates in the National Fraud Initiative.	• Walk-through of controls over family health service expenditure. • Detailed testing of revenue transactions focusing on the areas of greatest risk. • Audit work on the National Fraud Initiative matches. • Obtain assurances from the Counter Fraud Service reports.
4	**Estimation and judgements** There is a significant degree of subjectivity in the measurement and valuation of the material account areas of non-current assets and provisions. This subjectivity represents an increased risk of misstatement in the financial statements.	• Non-current asset base is reviewed on a rolling programme by the board's independent valuers. • Information is received from the Office of National Statistics, HM Treasury, the Scottish Public Pension Agency and the Central Legal	• Completion of 'review of the work of an expert' for the professional valuer. • Review of information provided by the Office of National Statistics, HM Treasury, the Scottish Public Pension Agency and the Central Legal Office.

⚠ Audit Risk		Source of assurance	Planned audit work
		Office which form the basis of the provisions calculations.	• Focused substantive testing of assets and provisions.
5	**Going concern** NHS Tayside continues to face significant financial challenges and has required brokerage from the Scottish Government since 2012/13. NHS Tayside's 2018/19 financial projections indicate it could need as much as £22.5 million brokerage in 2018/19. NHS Tayside's annual report and accounts are prepared on a going concern basis, based on Scottish Government's ongoing funding commitment to the board. There is a risk that NHS Tayside may be unable to contain its net expenditure going forward and that the Scottish Government will be unwilling to provide further brokerage. This creates uncertainty that the board will remain as a going concern.	• The Financial Plan for 2019/20 is currently under development and following further discussions with the Scottish Government will be presented to the NHS Tayside Board on 28 February 2019. This will form the first year of the NHS Tayside Three Year Financial Plan that will be discussed at the Board meeting in April 2019. • The board monitors its financial outturns with the aim of achieving its projections. The board is also in regular dialogue with the Scottish Government.	• Review the board's assurances to support a going concern assumption for the preparation of the annual report and accounts. • Review the funding assurances to the board from the Scottish Government.
6	**Submission of annual report and accounts for audit** Much of the annual report part of the 2017/18 draft annual report and accounts i.e. the Performance Report; Accountability Report; and Governance Statement, were not fully available by the agreed dates. In addition, IJB results were not available to NHS Tayside for consolidation into the Group Accounts until 1 June 2018. Consequently, the audit process was delayed. There is a risk that the 2018/19 annual report and accounts may not be audited by the statutory deadline of 30 June 2019.	• Senior leadership commitment to annual report and accounts preparation. • Board finance officers are liaising with their local government colleagues regarding the timetable for IJB draft accounts. • The board will provide annual report and accounts and relevant working papers by agreed timescales.	• Continue to meet with finance officers throughout the year to agree the timetable for receipt of the unaudited annual report and accounts and working papers to ensure statutory audit deadline is met.
7	**Governance statement** The Chief Executive reported in the 2017/18 Governance Statement that he was "not able to conclude, taking into account the governance framework and the assurances and evidence received from the Board's	• The Board will undertake a self-assessment of its governance arrangements against the NHS Scotland Governance Blueprint by 31 March 2019. • The board will provide assurance that the governance	• Review the outcome of the assessment against the NHS Scotland Governance Blueprint. • Review the 2018/19 Governance Statement, including the assurances provided to the Chief Executive and the

	Audit Risk	Source of assurance	Planned audit work
	committees, that corporate governance was operating effectively throughout the financial year ended 31 March 2018." There is a risk that the 2018/19 governance framework will not provide the assurances needed by the new Chief Executive to conclude positively on NHS Tayside's governance arrangements in place for 2018/19.	framework is operating effectively. • Internal audit has undertaken an independent review of the internal control framework. • The Assurance and Advisory Group has undertaken further reviews and reported on its findings in relation to the progress the Board has made during 2018/19.	supporting evidence for the Governance Statement. • Consider compliance with the Audit Scotland governance guidance note on openness and transparency. • Review internal audit report T06-19: annual internal audit. • Report progress with implementation of the requirements of the new Audit and Assurance Committee Handbook.
8	**Tayside Endowment Fund** In April 2018 the Board agreed to repay £3.6 million to NHS Tayside Endowment Fund (Health Fund). Officers advised the Board in December 2018 that the payment was to be made in December 2018 via a revenue grant, under existing legislative powers and that the Scottish Government had confirmed that it had no concerns with the payment to the Health Fund. This is an unusual transaction which leads to a risk that it is not properly accounted for.	• Scottish Government Health Finance advice was obtained which confirmed they have no concerns with the payment. • Independent VAT advice was obtained, which confirmed the payment will be out with the scope of VAT and will not carry a VAT liability. • The Board has been assured that the payment was made under existing legislative powers.	• Review the advice for the legislative basis for grant payment to the Health Fund. • Review the Scottish Government confirmation. • Review the VAT advice provided. • Consider the findings of The Office of the Scottish Charity Regulator (OSCR) formal inquiry into the use of funds by the Tayside NHS Board Endowment Fund. The OSCR inquiry was due to report at the end of November 2018. • Review the accounting treatment of the repayment.
9	**Former Chief Executive departure costs** During 2018/19 NHS Tayside signed a settlement agreement with its former Chief Executive who left the employment of NHS Tayside on 31 July 2018. Our Management Report on this issue is scheduled to be presented to the 24 January 2019 Audit Committee. In error, as part of the settlement £19,135 was paid to the Scottish Public Pensions Agency (SPPA). The board said that it intended to recover this amount in 2018/19, despite advice from the Central Legal Office (CLO) that this should not be reclaimed.	• The Audit Committee considered the findings of the review in December as part of the s22 report. • The remuneration committee formally approved the contractual settlement, including the change to the former Chief Executive's notice period on 15 November 2018. • The overpayment has been recovered as part of the normal reconciliation process of over and under payments of pension contributions made to the SPPA.	• Our management report on the departure costs will be presented to the Audit Committee. • Review any year-end adjustments with the SPPA. • Report on the recovery process.

⚠ Audit Risk	Source of assurance	Planned audit work
There is a risk that the board is unsuccessful in its claim.		
10 DBFM project – NHS Scotland pharmaceutical specials service hub During 2018/19 the construction phase of the NHS Scotland Pharmaceutical Specials Service HUB (DBFM) project is likely to be completed before the financial year end, resulting in the formal handover to NHS Tayside. HUB projects are accounted for in accordance with HM Treasury application of IFRIC 12, Service Concession Arrangements as detailed in the FReM. There is a risk that the accounting treatment is applied incorrectly which could have a material impact on the financial statements.	• The FReM will be reviewed to ensure the annual accounts reflects the accounting requirements. • Recognition of assets and liabilities in financial statements supported by service concession model breaking down payments into constituent parts.	• Review the accounting treatment and underlying models for the NHS Scotland Pharmaceutical Specials Service HUB (DBFM).
Wider dimension issues and risks		
11 Leadership and governance During 2018/19 there has been significant change in the executive, non-executive and senior leaders' cohorts at NHS Tayside. There have also been significant changes to committee membership, including the committee chairs. Alongside this, in response to the governance weaknesses reported in the 2017/18 Governance Statement, extensive new governance structures are being developed at the board. There is a risk that leadership and governance arrangements are not effective in the short to medium term as the new executive, non-executive and senior leaders' cohorts' roles and governance arrangements become established.	• A non-executive induction plan and induction workshops have or will be provided to all new non-executives. • Non-executives have or will be attending other external training, such as the essential governance training for Board members and effective audit and risk committee training. • The vice chair has established regular informal meetings for members starting 5 February 2019. • Bespoke governance training for non-executive members by 31 May 2019. • Non-executive appraisal to be completed by 31 March 2019. • Once the recruitment of new non-executives is completed, the Board's skill matrix will be reviewed and mapped against the Board's future requirements. • An implementation plan has been developed for the Leadership Programme which includes outcomes required and measures to be used to determine success. The Staff	• Continue to attend Board and committee meetings and consider the operation and scrutiny of the new committee arrangements. • Monitor implementation of collective leadership programme to the Staff Governance Committee, including consideration of how performance appraisals for executive officers are conducted. • Review the Remuneration Committee and the Staff Governance Committee annual assurance reports to the Board. • Review internal audit's report T08/19: internal control evaluation and T06/19: annual internal audit.

Audit Risk	Source of assurance	Planned audit work
	Governance Committee will provide scrutiny of the Collective Leadership Programme and report progress to the Board at regular intervals.	
12 Financial sustainability, transformation and integrated clinical strategy In December 2018, the Auditor General reported (for the fourth year in a row) to the Public Audit and Post-Legislative Committee on NHS Tayside's unsustainable and worsening financial position and deteriorating performance. The Board need to urgently set out how it intends to achieve service reform to deliver services in the future. Implementation of a clinical strategy is a key foundation for this. Of particular importance for our assessment of the sustainability of the board is its progress with workforce planning and management of prescribing costs.	• In 2017/18 the board's approach to transformation to meet its financial challenges was reviewed. The Board was due to discuss an update on progress, including the development of its clinical strategy in December, this was not achieved. • The latest version of the Transforming Tayside plan will be considered by the Board in February 2019 and reviewed again in April 2019. • Progress with the transformation programme is monitored by the Scottish Government appointed Assurance and Advisory Group. • The Financial Plan for 2019/20 is currently under development and following further discussions with the Scottish Government will be presented to the NHS Tayside Board on 28 February 2019. This will form the first year of the NHS Tayside Three Year Financial Plan that will be discussed at the Board meeting in April 2019. • Internal audit plan to undertake audit work on the transformation programme.	• Monitor the development of the Board's financial plan. • Review financial monitoring reports and the financial position. • Monitor transformation programme progress, including the Assurance and Advisory Group update reports. • Review progress in the development of: the integrated clinical strategy; the workforce plan; and management of prescribing costs. • Review internal audit's reports T08/19: review internal control evaluation and T15/19: three-year transformation plan.
13 Financial management The board is yet to finalise its 2019/20 financial plan and no medium term plans are in place. Without effective medium to long term planning, the board may not plan adequately to respond to the significant financial risks.	• The Financial Plan for 2019/20 is currently under development and following further discussions with the Scottish Government will be presented to the NHS Tayside Board on 28 February 2019. This will form the first year of the NHS Tayside Three Year Financial Plan that will be discussed at the Board meeting in April 2019. • Implications of EU withdrawal has been considered by the Executive Leadership Team. Steps will be taken to develop a contingency plan as soon as	• Review the Financial Plan 2019/20 to 2021/22 once available. • Review financial monitoring reports and the financial position for 2018/19.

	Audit Risk	Source of assurance	Planned audit work
		the Scottish Government's funding plans are clearer.	
14	**Financial capacity** In our 2016/17 and 2017/18 annual audit reports we reported issues related to the capacity and capability of the finance directorate. In addition, over the course of 2018 the finance directorate experienced significant change and upheaval at senior levels, including the appointment of a new Director of Finance, whose role is split between NHS Tayside and NHS Grampian. There is a risk that until the new finance directorate structure is operational the finance directorate is stretched in supporting the day to day financial activities, the transformation programme and the production and quality of the 2018/19 annual report and accounts.	• The Director of Finance has reported to the Audit Committee in September and December 2018 on progress to implement the new senior management structure, which will support the single integrated finance team (across NHS Tayside and NHS Grampian). A steering group has been established with respective Human Resource advisors and staff side representatives in both boards in line with the organisational change processes and respective policies. • The proposed structure has been developed and job descriptions prepared and graded by the National Evaluation Committee. • It is anticipated the interviews and appointments to the new roles will be completed in February 2019.	• Monitor developments with the finance directorate. • Continue to meet with finance officers throughout the year to ensure the statutory audit deadline is met.
15	**Risk management** Risk management arrangements were strengthened in 2018 but the December 2018 Audit Committee considered the Risk Management Mid-Year Review report, that acknowledges further work is required to focus on risk assurance through risk mitigation and robust effective actions. There is a risk that until the revised risk management arrangements are fully developed and embedded the arrangements are not effective.	• An updated strategic risk register and refreshed Board Assurance Framework is planned for the February 2019 Board meeting. • The Audit Committee's remit is being reviewed in line with the revised Audit and Assurance Committee Handbook. The relationship between the Strategic Risk Management Group and the Audit Committee will be strengthened. • Work to develop a comprehensive governance assurance map will be taken forward by the Director of Governance, Risk and Compliance working with internal audit during 2019/20. • Internal audit is undertaking a review of the overall risk management arrangements.	• Monitor progress with the development of the risk management arrangements, including the operation of the Strategic Risk Management Group. • Review the year end risk management report, including the year-end report from the Strategic Risk Management Group. • Review internal audit report T11/19: Risk management when available.
16	**Integrated Joint Boards (IJBs)** We have previously reported on 'inadequate" arrangements relevant to IJBs' governance	• Discussions regarding integration governance will be progressed under the leadership of the Working	• Review progress with the development of the health and social care integration risk

	Audit Risk	Source of assurance	Planned audit work
	arising from a lack of clarity of the impact of Health and Social Care Integration (HSCI) on the accountability structures in place and a number of elements of the Integration Schemes and risk management systems. Some progress has been made during 2018, however, fully clarified and understood governance arrangements, including those associated with risk management and risk ownership are required. Risks in relation to IJB related activities may not be fully understood and managed putting patient care at risk.	Together in Tayside Forum during 2019/20. • There are regular scheduled meetings between the NHS and Local Authority Chief Executives, including engagement with the Chief Officers. • There are regular scheduled meetings between the NHS Tayside Director and Deputy Director of Finance and the IJB Chief Finance Officers.	management arrangements. • Review internal audits report T19/19: HSCI. • Review the board's consideration of Audit Scotland's November 2018 national report on health and social care integration.
17	**Asset management** NHS Tayside does not have a comprehensive or complete understanding of its asset base including: masterplans of its four main sites; site usage; building quality; and infrastructure requirements. Consequently, it does not have comprehensive estimates of the costs to maintain or develop its asset base, aligned to a clinical strategy. Current estimates for backlog and infrastructure maintenance work are £160 million. There is a risk that NHS Tayside efforts to reduce its cost base and deliver effective transformation are undermined in the absence of a robust asset management plan which is suitably aligned to an integrated clinical strategy and the transformation programme.	• Officers reported to the Performance and Resources Committee in November 2018 that work had commenced to address this. • The previous Capital Scrutiny Group has been reconstituted as the Asset Management Group. The remit for this group includes actions taken in response to the Property and Asset Management Strategy (PAMS) and should in future help to strengthen the link between property and asset management and the financial planning process. • Update reports on asset management are scheduled for the February 2019 Board meeting. • The revised five year capital programme is to be presented for Board approval by 31 March 2019, following a comprehensive risk assessed prioritisation process to identify the key areas for investment. • Independent reviews of the four major sites have been commissioned to inform to support the planning for future service provision in line with the Transforming Tayside plan.	• Monitor progress with the development of the asset management plan.
18	**Information governance** Information governance remains a high risk on the board's corporate risk register and work	• The Information Governance Committee (IGC) has an agreed Terms of Reference which were updated. From December 2018 the IGC will	• Monitor progress with the management of risk in this area.

	Audit Risk	Source of assurance	Planned audit work
	in this area is ongoing. The Senior Information Risk Owner cannot, at this point in time, provide assurance that all possible controls are in place to control this risk and has noted that the board will be more informed of its exposure within this area once additional information/cyber security assessments are completed. Without an assurance that appropriate controls are in place there is a risk that systems could fail, leading to patient safety and quality of care issues and loss of personal data.	now report directly to the Audit Committee. • Work is being progressed in conjunction with an external consultant to consider the risk relation to information security.	• Monitor reporting to the Audit Committee. • Review internal audit's report T34/19: information assurance/ information security framework.
19	**eHealth** During 2018 NHS Tayside undertook an external review of its eHealth service. The findings from this review indicate that the service faces significant challenges, ranging from: needing to develop a more strategic approach; needing to support the transformation programme; insufficient staff in place in key roles (in part from key members of staff retiring and not being replaced); and insufficient revenue and capital funding. There is a risk that the board fails to deliver and support business critical services if the eHealth service is not able to address the issues identified in the 2018 external review.	• The Director of Governance, Risk and Compliance will be undertaking a review and redesign of the eHealth governance structures to provide a fit for purpose governance regime to support service provision and Transforming Tayside. The outcome of the review will be reported to the Audit and Assurance Committee.	• Monitor progress with developments in this area. • Review internal audits reports T35/19: eHealth strategic planning and governance and T36/19: eHealth project management, development, procurement, implementation and training.
20	**Best Value** NHS Board Accountable Officers have a specific responsibility detailed in the Scottish Public Finance Manual (SPFM). The board's 2017/18 governance statement noted that NHS Tayside had not met their SPFM responsibilities for the Accountable Officer to ensure that arrangements have been made to secure Best Value. NHS Tayside has yet to determine how it will deliver on	• The Board's self-assessment of Board Effectiveness, to be completed in 2018/19, will include some aspects of Best Value arrangements. • Internal audit update on best value arrangements. • The Board's commitment to moving to a sustainable financial balance includes ensuring that resources are being effectively and efficiently deployed.	• Monitor development in this area. • Review the 2018/19 governance statement and portfolio of evidence. • Review internal audit report T06/19: annual internal audit.

	Audit Risk	Source of assurance	Planned audit work
	the SPFM best value responsibility. There is a risk that the Accountable Officer is unable to discharge their best value SPFM responsibility.		
21	**Public performance reporting** We have previously recommended that 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, recommending also the performance page should be well sign posted. Our view is that this recommendation has not been fully implemented. There is a risk that key stakeholders, including local residents do not have easy access to composite and easily understood performance information.	• As the board's performance management arrangements develop, reports will be made available and signposted on the NHS Tayside website. • The Board and Performance Resource Committee meetings at which performance is reviewed are open meetings and papers are available to the public.	• Monitor developments in public performance reporting.
22	**Audit recommendations – implementation** **External audit** During 2018/19 the board introduced an External Reports – Recommendations Tracker report which is now routinely presented to the Audit Committee. W**e** welcome this important feature of good governance. However, our assessment of the report is that it presents an overly optimistic view of progress, in particular the sections related to our 2017/18 annual audit report recommendations. For example, some actions are noted as implemented as management has begun to take steps to address the risk. In our view this should only be classified as implemented when the risk has been fully addressed and the actions to address it are complete.	• Management are continuing to review the process to provide appropriate assurances that actions are being implemented as intended. • Regular internal audit recommendation update reports are presented to the Audit Committee.	• Meet with management to discuss the recommendation tracker and clarify progress and status of recommendations. • Review future recommendation trackers reports including reviewing evidence demonstrating progress. • Meet with internal audit to ensure management are implementing agreed recommendations.

Audit Risk	Source of assurance	Planned audit work
Internal audit During 2018/19, the process for following up internal audit recommendations has changed, in response to evidence that agreed recommendations were not being implemented by agreed timescales. Internal audit has taken over responsibility for this area and are progressing and developing a new process and reporting mechanism to the Audit Committee. There is a risk that improvement actions are not fully addressed if agreed audit recommendations are not fully and timeously implemented.		

Source: Audit Scotland

Clinical governance

5. Clinical governance is the system through which the NHS works to monitor and improve the quality of the care and services they deliver. Health Improvement Scotland works to ensure that NHS boards have a clear and consistent approach to clinical governance in healthcare across Scotland. Audit Scotland's audit role is restricted to reporting on whether the board has governance arrangements that are appropriate and operating effectively, which includes the clinical governance arrangements.

6. The Sharing Intelligence Group is a partnership involving Healthcare Improvement Scotland, NHS Education for Scotland, the Care Inspectorate, the Scottish Public Services Ombudsman, the Mental Welfare Commission for Scotland, Public Health and Intelligence and Audit Scotland. The group meets periodically to discuss emerging issues at individual health boards as identified by the group members. The discussions of this group have been considered in planning our audit approach described in this plan.

Reporting arrangements

7. Audit reporting is the visible output for the annual audit. All annual audit plans and the outputs as detailed in Exhibit 2, and any other outputs on matters of public interest will be published on our website: www.audit-scotland.gov.uk.

8. Matters arising from our audit will be reported on a timely basis and will include agreed action plans. Draft management reports will be issued to the relevant officer(s) to confirm factual accuracy.

9. We will provide an independent auditor's report to NHS Tayside, Scottish Parliament and the Auditor General for Scotland setting out our opinions on the annual report and accounts. We will provide the Accountable Officer and Auditor General for Scotland with an annual report on the audit containing observations and recommendations on significant matters which have arisen during the audit.

10. Under the Public Finance and Accountability (Scotland) Act 2000 there is a requirement for the resource account of the Scottish Government to be presented

to Parliament within nine months of the financial year end i.e. 31 December. Management are required to submit their audited financial statements by 30 June to meet the consolidation timetable.

Exhibit 2
2018/19 Audit outputs

Audit Output	Target date	Audit Committee / Board Date
Annual Audit Plan	17 January 2019	24 January 2019
Management Report	29 April 2019	9 May 2019
Proposed Annual Audit Report *	13 June 2019	20 June 2019
Independent Auditor's Report	27 June 2019	27 June 2019 (Board date)

* The final Annual Audit Report cannot be submitted until after the independent auditor's report is signed.

Source: Audit Scotland

Audit fee

11. The proposed audit fee for the 2018/19 audit of NHS Tayside is £208,104 (2017/18: £192,896). In determining the audit fee, we have taken account of the risk exposure of NHS Tayside, the planned management assurances in place and the level of reliance we plan to take from the work of internal audit. The fee level reflects the amount of audit input required to cover audit work on the following:

- audit of the payments made to the board's former Chief Executive who left the board on 31 July 2018, a Management Report was issued to the board in December 2018.
- the significant number of governance and wider scope audit risks in the board described in Exhibit 1.

12. Our audit approach assumes receipt of the unaudited annual report and accounts, with the agreed working papers package on 6 May 2019 in accordance with the final agreed timetable. Where our audit cannot proceed as planned through, for example, late receipt of unaudited annual report and accounts or slippage in the agreed timetable, a supplementary fee may be levied. An additional fee may also be required in relation to any work or other significant exercises out with our planned audit activity.

Responsibilities

Audit Committee and Accountable Officer

13. Audited bodies have the primary responsibility for ensuring the proper financial stewardship of public funds, compliance with relevant legislation and establishing effective arrangements for governance, propriety and regularity that enable them to successfully deliver their objectives.

14. The audit of the annual report and accounts does not relieve management or the Audit Committee as those charged with governance, of their responsibilities.

Appointed auditor

15. Our responsibilities as independent auditors are established by the Public Finance and Accountability (Scotland) Act 2000 and the Code of Audit Practice

(including supplementary guidance) and guided by the Financial Reporting Council's Ethical Standard.

16. Auditors in the public sector give an independent opinion on the financial statements and other information within the annual report and accounts. We also review and report on the arrangements within the audited body to manage its performance, regularity and use of resources. In doing this, we aim to support improvement and accountability.

17. Details of the current audit team in Appendix 1.

Audit scope and timing

Annual report and accounts

18. The annual report and accounts, which include the financial statements, will be the foundation and source for most of the audit work necessary to support our judgements and conclusions. We also consider the wider environment and challenges facing the public sector. Our audit approach includes:

- understanding the business of NHS Tayside and the associated risks which could impact on the financial statements
- assessing the key systems of internal control, and establishing how weaknesses in these systems could impact on the financial statements
- identifying major transaction streams, balances and areas of estimation and understanding how NHS Tayside will include these in the financial statements
- assessing the risks of material misstatement in the financial statements
- determining the nature, timing and extent of audit procedures necessary to provide us with sufficient audit evidence as to whether the financial statements are free of material misstatement.

19. We will give an opinion on whether the financial statements:

- give a true and fair view in accordance with the National Health Service (Scotland) Act 1978 and directions made thereunder by the Scottish Ministers of the state of affairs of the board and its group as at 31 March 2019 and of the net expenditure for the year then ended
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the 2018/19 Financial Reporting Manual (FReM)
- have been prepared in accordance with the requirements of the National Health Service (Scotland) Act 1978 and directions made thereunder by the Scottish Ministers.

Other information in the annual report and accounts

20. We also review and report on other information published within the annual report and accounts including the performance report, governance statement and the remuneration and staff report. We give an opinion on whether these have been compiled in accordance with the appropriate regulations and frameworks in our independent auditor's report.

21. We also read and consider any information in the annual report and accounts other than the financial statements and audited part of the remuneration and staff report and report any uncorrected material misstatements.

Materiality

22. We apply the concept of materiality in planning and performing the audit. It is used in evaluating the effect of identified misstatements on the audit, and of any

uncorrected misstatements, on the financial statements and in forming our opinions in the independent auditor's report.

23. We calculate materiality at different levels as described below. The calculated materiality values for NHS Tayside are set out in Exhibit 3.

Exhibit 3
Materiality values

Materiality	Amount
Planning materiality – This is the calculated figure we use in assessing the overall impact of audit adjustments on the financial statements. It has been set at 0.5% of gross expenditure for the year ended 31 March 2019 based on the latest audited accounts for 2018.	£5.34 million
Performance materiality – This acts as a trigger point. If the aggregate of errors identified during the financial statements audit exceeds performance materiality this would indicate that further audit procedures should be considered. Using our professional judgement, we have calculated performance materiality at 50% of planning materiality.	£2.67 million
Reporting threshold (i.e. clearly trivial) – We are required to report to those charged with governance on all unadjusted misstatements more than the 'reporting threshold' amount. This has been calculated at 1% of planning materiality.	£53,000
Cumulative errors and impact on financial targets – We are required to consider all monetary errors identified through the audit process (including those below the reporting threshold) and consider them against the board's financial targets. If the cumulative errors were to result in the board failing to achieve breakeven against its financial targets, this may result in a comment in the independent auditor's report.	n/a

Source: Audit Scotland

Timetable

24. To support the efficient use of resources it is critical that the annual report and accounts timetable is agreed with us to produce the unaudited accounts. We have included an agreed timetable at Exhibit 4.

Exhibit 4
Annual report and accounts timetable

Key stage	Date
Latest submission date of unaudited annual report and accounts (excluding group consolidation, performance report and accountability report) with complete working papers package	6 May 2019
Latest submission date of performance report and accountability report	15 May 2019
Latest submission date of consolidated unaudited annual report and accounts	20 May 2019
Latest date for final clearance meeting with Director of Finance	10 June 2019
Issue of Letter of Representation and proposed independent auditor's report	13 June 2019
Agreement of audited unsigned annual report and accounts	13 June 2019

Key stage	Date
Issue of proposed Annual Audit Report to those charged with governance	13 June 2019
Independent auditor's report signed	27 June 2019

Internal audit

25. FTF Audit and Management Services (FTF) provides internal audit services to a number of health boards, including NHS Tayside. As part of our planning process we carry out an annual assessment of the internal audit function to ensure that it operates in accordance with Public Sector Internal Audit Standards (PSIAS). We have concluded that internal audit, generally operates in accordance with PSIAS and has appropriate documentation standards and reporting procedures in place. PSIAS requires an external review of internal audit to be carried out once every five years, providing an independent assessment of the internal audit function against PSIAS.

26. In December 2018 the Audit Committee considered an independent review of internal audit services specific to NHS Tayside, carried out by the Institute of Internal Auditors (IIA). The report concludes that FTF generally conforms to the majority of the IIAs professional standard and notes that "this result places FTF in the mid-range of internal audit functions we have reviewed. It shows the basic requirements of the standards are in place but also that there is scope for improvement and development in terms of delivery."

27. An improvement action plan has been agreed for the ten (out of sixty-four) areas where FTF partially conforms with the IIA standards, covering the arrangements for quality assurance and improvement, managing internal audit activity and engagement planning. The Audit Committee will receive reports on progress with the plan.

28. We reported on some slippage in the delivery of the overall internal audit plan in 2017/18. Internal audit resources had been redirected towards a number of emerging risks and working with board staff to respond to them. This, together with staff shortages within internal audit and pressures on management and staff to engage with and respond to internal audit queries, delayed some internal audit work. Due to the extent of the risk areas to be covered by internal audit at the board there is a risk that they will not deliver their 2018/19 audit plan. Progress against the plan will be monitored by the Audit Committee.

Using the work of internal audit

29. Auditing standards require internal and external auditors to work closely together to make best use of available audit resources. We seek to rely on the work of internal audit wherever possible to avoid duplication. We plan to consider the findings of the work of internal audit as part of our planning process to minimise duplication of effort and to ensure the total resource is used efficiently or effectively.

30. From our initial review of internal audit plans, we do not plan to place formal reliance on FTF work to support our financial statements audit opinion this year, but we do plan to use the work of internal audit in selected areas in respect of our wider dimension audit responsibilities.

Audit dimensions

31. Our audit is based on four audit dimensions that frame the wider scope of public sector audit requirements as shown in Exhibit 5.

Exhibit 5
Audit dimensions

Source: Code of Audit Practice

Financial sustainability
32. As auditors we consider the appropriateness of the use of the going concern basis of accounting as part of the annual audit. We will also comment on the body's financial sustainability in the longer term. We define this as medium term (two to five years) and longer term (longer than five years) sustainability. We will carry out work and conclude on:

- the effectiveness of financial planning in identifying and addressing risks to financial sustainability in the short, medium and long term
- the appropriateness and effectiveness of arrangements in place to address any identified funding gaps.

Financial management
33. Financial management is concerned with financial capacity, sound budgetary processes and whether the control environment and internal controls are operating effectively. We will review, conclude and report on:

- whether NHS Tayside has arrangements in place to ensure systems of internal control are operating effectively
- whether NHS Tayside can demonstrate the effectiveness of budgetary control system in communicating accurate and timely financial performance
- how NHS Tayside has assured itself that its financial capacity and skills are appropriate
- whether NHS Tayside has established appropriate and effective arrangements for the prevention and detection of fraud and corruption.

Governance and transparency
34. Governance and transparency is concerned with the effectiveness of scrutiny and governance arrangements, leadership and decision – making and transparent reporting of financial and performance information. We will review, conclude and report on:

- whether NHS Tayside can demonstrate that the governance arrangements in place are appropriate and operating effectively (including services delivered by, or in partnership with, others)

- whether there is effective scrutiny, challenge and transparency on the decision-making and finance and performance reports

- the quality and timeliness of financial and performance reporting.

Value for money and best value

35. Value for money refers to using resources effectively and continually improving services. We will review, conclude and report on whether:

- NHS Tayside can provide evidence that it is demonstrating value for money in the use of its resources

- NHS Tayside can demonstrate that there is a clear link between money spent, output and outcomes delivered

- NHS Tayside can demonstrate that outcomes are improving

- there is sufficient focus on improvement and the pace of it.

36. The Chief Executive as Accountable Officer of the Board has a formal duty to ensure the achievement of Best Value in the delivery of services within Tayside. We will review the board's arrangements to ensure that there is evidence to demonstrate the extent to which this duty is being met.

37. In November 2018 Audit Scotland published Health and Social Care Integration: Update on Progress, which identified that, while some improvements have been made to the delivery of health and social care services, Integration Authorities, councils and NHS boards need to show a stronger commitment to collaborative working to achieve the real long term benefits of an integrated system. We will review and report on the board's response to this report. NHS Tayside should ensure that it has considered the findings of this report and takes appropriate action to address the recommendations that are relevant to the board.

Independence and objectivity

38. Auditors appointed by the Auditor General or Accounts Commission must comply with the Code of Audit Practice and relevant supporting guidance. When auditing the financial statements auditors must also comply with professional standards issued by the Financial Reporting Council and those of the professional accountancy bodies. These standards impose stringent rules to ensure the independence and objectivity of auditors. Audit Scotland has robust arrangements in place to ensure compliance with these standards including an annual "fit and proper" declaration for all members of staff. The arrangements are overseen by the Director of Audit Services, who serves as Audit Scotland's Ethics Partner.

39. The engagement lead (i.e. appointed auditor) for NHS Tayside is Fiona Mitchell-Knight, Audit Director. Auditing and ethical standards require the appointed auditor Fiona Mitchell-Knight to communicate any relationships that may affect the independence and objectivity of audit staff. We are not aware of any such relationships pertaining to the audit of NHS Tayside.

Quality control

40. International Standard on Quality Control (UK and Ireland) 1 (ISQC1) requires that a system of quality control is established, as part of financial audit procedures, to provide reasonable assurance that professional standards and regulatory and legal requirements are being complied with and that the independent auditor's report or opinion is appropriate in the circumstances.

41. The foundation of our quality framework is our Audit Guide, which incorporates the application of professional auditing, quality and ethical standards and the Code of Audit Practice (and supporting guidance) issued by Audit Scotland and approved by the Auditor General for Scotland. To ensure that we achieve the required quality

standards Audit Scotland conducts peer reviews and internal quality reviews. Additionally, the Institute of Chartered Accountants of Scotland (ICAS) have been commissioned to carry out external quality reviews.

42. As part of our commitment to quality and continuous improvement, Audit Scotland will periodically seek your views on the quality of our service provision. We welcome feedback at any time and this may be directed to the engagement lead.

Appendix 1: The audit team

The core audit team consists of the following staff and might be supported at peak times with additional resources to ensure key reporting deadlines are met:

Fiona Mitchell-Knight

Audit Director

fmitchell-knight@audit-scotland.gov.uk 0131 625 1937

I am the appointed independent auditor established under the Public Finance and Accountability (Scotland) Act 2000 and the Code of Audit Practice and guided by the auditing profession's ethical guidance.

Bruce Crosbie

Senior Audit Manager

bcrosbie@audit-scotland.gov.uk 0131 625 1794

Bruce will have overall control of the delivery and quality of the audit including audit engagement and ensuring the audit is properly planned, resourced and concluded within time.

Anne Marie Machan

Senior Auditor

amachan@audit-scotland.gov.uk 0131 625 1994

Anne Marie will lead the audit team and will be the main contact for the audit.

Euan Robertson

Auditor

erobertson@audit-scotland.gov.uk 0131 625 1807

Euan will lead on distinct areas of audit work supporting the delivery of the audit.

Amber Ogilvie

Auditor (Trainee)

aogilvie@audit-scotland.gov.uk 0131 625

Amber will work across a variety of core audit activities.

NHS Tayside
Annual Audit Plan 2018/19

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

ITEM NUMBER 5.2

AUDIT04/2019
AUDIT COMMITTEE
24 JANUARY 2019

PAYMENTS RELATING TO THE DEPARTURE OF THE FORMER CHIEF EXECUTIVE

Fiona Mitchell-Knight
Audit Director, Audit Scotland

January 2019

NHS Tayside

Management Report 2018/19

Payments Relating to the Departure of the Former Chief Executive

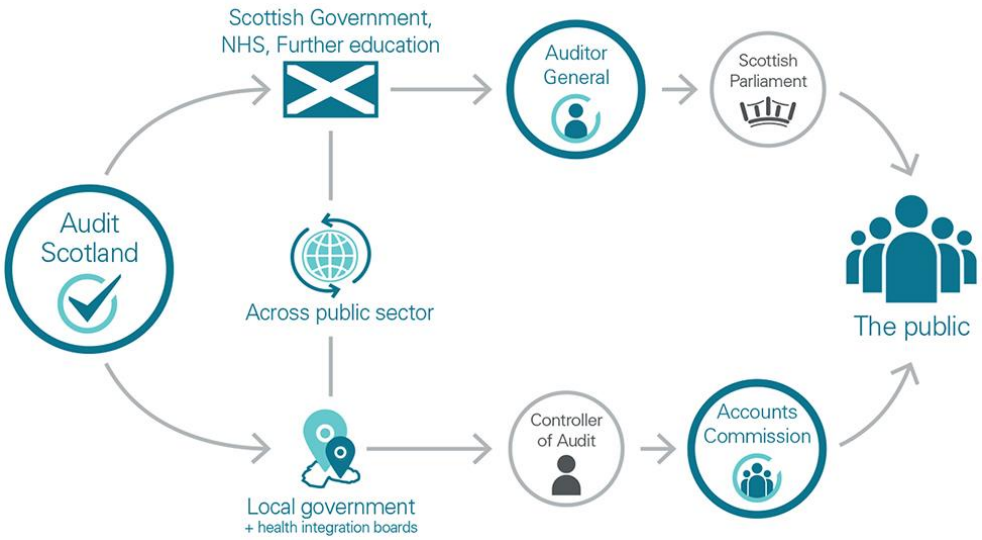
AUDIT SCOTLAND

Prepared for NHS Tayside
18 December 2018

Who we are

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

- The Auditor General is an independent crown appointment, made on the recommendation of the Scottish Parliament, to audit the Scottish Government, NHS and other bodies and report to Parliament on their financial health and performance.
- The Accounts Commission is an independent public body appointed by Scottish ministers to hold local government to account. The Controller of Audit is an independent post established by statute, with powers to report directly to the Commission on the audit of local government.
- Audit Scotland is governed by a board, consisting of the Auditor General, the chair of the Accounts Commission, a non – executive board chair, and two non – executive members appointed by the Scottish Commission for Public Audit, a commission of the Scottish Parliament.



About us

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

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

- carrying out relevant and timely audits of the way the public sector manages and spends money
- reporting our findings and conclusions in public
- identifying risks, making clear and relevant recommendations.

Audit Findings

Introduction

1. Our 2017/18 Annual Audit Report was published in June 2018, and our 2018/19 Annual Audit Plan is due to be reported in January 2019. In the period between these publications, the former Chief Executive left NHS Tayside.

2. We were asked to review the payments made relating to the departure of the former Chief Executive, for inclusion in the recent report prepared by the Auditor General for Scotland under section 22 of the Public Finance and Accountability (Scotland) Act 2000. This report was prepared for the Public Audit and Post-Legislative Scrutiny Committee. On 13 December the committee took evidence from the Auditor General for Scotland and members of the Audit Scotland audit team on the report. The committee has now invited the Chair, the Chief Executive and Assistant Chief Executive of NHS Tayside, the Scottish Government and the Central Legal Office to give oral evidence at a future committee meeting.

3. The Auditor General's section 22 report covers a range of issues which were included in our 2017/18 Annual Audit Report, and we will follow them up and report progress in our 2018/19 Annual Audit Report in June 2019. However, given their significance, it is appropriate that we report now the audit findings on the payments relating to the departure of the former Chief Executive for the board's consideration.

4. Prior to issuing this report our audit findings were discussed with NHS Tayside's Chairman, Chief Executive, Assistant Chief Executive and the Director of Finance.

Conclusion

5. The former Chief Executive's employment with NHS Tayside ended on 31 July 2018, with a negotiated settlement. The approach taken by the board to negotiate the settlement was reasonable, but errors were made in the process and the settlement business case submitted for approval by the Scottish Government did not contain all the pertinent information.

6. We now recommend that NHS Tayside's Audit Committee consider the audit findings and scrutinise the actions planned by officers in response to these findings.

Audit Findings

7. In April 2018, the Cabinet Secretary for Health and Sport moved NHS Tayside to the highest level of escalation. Following this, the Chair of the NHS Tayside Board stood down and the former Chief Executive was removed from her accountable officer status. She left NHS Tayside in July 2018.

8. The former Chief Executive's employment with NHS Tayside ended on 31 July 2018, with a negotiated settlement. The approach taken by the board to negotiate the settlement was reasonable, but errors were made in the process and the settlement business case submitted for approval by the Scottish Government did not contain all the pertinent information.

9. The payments made relating to the settlement were:

- payment of £64,211.52 to the former Chief Executive equating to six months' notice
- payment of £6,904.46 to the former Chief Executive in lieu of 20 days' annual leave entitlement due, but not taken
- a contribution of £19,135.08 to the NHS Scotland pension fund, intended to cover the notice period
- a contribution of £1,028.76 to the NHS Scotland pension fund, to cover annual leave not taken.

10. NHS Tayside's Assistant Chief Executive/ Strategic Director of Workforce was responsible for managing the departure and agreeing the settlement for the former Chief Executive. The current Chief Executive and the Chairman have both confirmed that they supported the actions taken to secure the settlement and each stage of the settlement was discussed with them. The Assistant Chief Executive/ Strategic Director of Workforce had support from the NHS Central Legal Office (CLO) and Scottish Government Health and Social Care Workforce Directorate throughout the settlement process.

11. The current Chief Executive and the Chairman agreed with the Scottish Government Health and Social Care Workforce Directorate that early resolution of the former Chief Executive's position was necessary. The board determined that any possible legal action which could have arisen from a proposed contract termination would have been expensive, time consuming and entail a reputational risk. The total costs of the negotiated settlement to the board were less than the Central Legal Office's estimated cost of defending an unsuccessful legal case.

12. The decision to reach a negotiated settlement with the former chief executive was reasonable, but there were several weaknesses in the settlement process and a lack of good governance.

13. The Scottish Executive Health Department's circular on Pay and Conditions for Executive Managers, NHS HDL (2006) 23, is mandatory and states a minimum notice period of between three to six months should be included in all executive manager contracts. The former Chief Executive's contract of employment, dated 17 December 2013, includes a notice period of three months. Following discussions between the Assistant Chief Executive/ Strategic Director of Workforce, the current Chief Executive, the Chairman, the Scottish Government's Director of Health Workforce and Strategic Change and the CLO this was increased to six months. The Assistant Chief Executive/ Strategic Director of Workforce and current Chief Executive believed this was required to bring parity with other Chief Executives across the public sector, but the board cannot provide evidence to substantiate this. This increased the payments made to the former Chief Executive by £32,105.

14. Since these discussions with the board, auditors have confirmed that the current chief executives of three territorial and four special boards have contractual notice periods of three months, with the others having contractual notice periods of six months. The board's assumption that the former Chief Executive's notice period needed to be changed to bring parity with all other boards was therefore not correct.

15. The Scottish Government's Director of Health Workforce and Strategic Change approved the settlement, in accordance with Scottish Public Finance Manual guidance. The Business Case for the Settlement, submitted for approval to the Scottish Government on 25 June 2018 by the Assistant Chief Executive/ Strategic Director of Workforce, records the contractual notice period as six months. It does not mention the three months' notice period included in the contract of employment. The CLO has subsequently confirmed that three months was the contractual position until the settlement was agreed on 26 July 2018, when the notice period was revised to six months. The Scottish Government's Director of Health Workforce and Strategic Change was aware of the change of notice period before the settlement was approved.

16. To comply with the Pay and Conditions for Executive Managers circular, NHS HDL (2006) 23, any extension of the Chief Executive's notice period to six months should have been explicitly approved by the Board's remuneration committee. The board was unaware that the Remuneration Committee were required to approve the change in the notice period until the auditor brought it to the boards attention. This was approved by the Remuneration Committee, retrospectively on 15 November 2018.

17. The business case excluded the pension contributions of £1,028.76 paid by the board (on 7 August 2018) to cover untaken holiday leave. This amount was also excluded from the settlement agreement.

18. The settlement agreement states that the termination payment includes £19,135.08 in employer pension contributions to cover the former Chief Executive's notice period. The board identified late in the negotiation process that payment in lieu of notice does not represent pensionable service and therefore pension contributions should not be made. At this late stage the former Chief Executive was not prepared to consider an updated settlement. The agreement was not changed, and the payments were made to the Scottish Public Pensions Agency (SPPA).

19. The board now aims to recover these contributions through year-end adjustments with the SPPA. However, the CLO have said that in their view this would be a breach of the agreement and they cannot advise the board to do this. The Assistant Chief Executive/ Strategic Director of Workforce's view is that these contributions do not provide any benefit to the former Chief Executive and that as result they will go ahead and seek repayment of £19,135.08 later in the year. We will follow this up as part of the audit of the 2018/19 accounts.

NHS Tayside

Management Report 2018/19

Payments Relating to the Departure of the Former Chief Executive

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

ITEM NUMBER 7

AUDIT05/2019
AUDIT COMMITTEE
24 JANUARY 2019

STANDING COMMITTEE ANNUAL REPORT TEMPLATE

1. SITUATION AND BACKGROUND

As part of the annual review of internal control and to complete the Governance Statement in the Annual Accounts, the standing committees are required to complete an annual report.

The standing committees' annual reports are submitted to the Audit Committee to provide this assurance and an annual report is submitted to the Board, to provide an overall assurance on internal control.

2. ASSESSMENT

The Standing Committees are required to prepare and submit an annual report as part of the governance processes of internal control.

A template Annual Report is attached for completion in 2018/19 by the Standing Committees.

Once approved the report will be circulated to Committee Chairs, Lead Officers and Committee Support Officers for completion and submission to Committees for approval before submission to the Audit Committee.

3. RECOMMENDATIONS

The Audit Committee is asked to consider the template Standing Committee Annual Report, recommend any changes and approve its use to inform the Governance Statement for 2018/19.

4. REPORT SIGN OFF

Responsible Executive Director and contact for further information

If you require any further information in advance of the meeting please contact:

Contact for further information
Miss Donna Howey
Acting Board Secretary
donna.howey@nhs.net

Responsible Executive Director
Ms Margaret Dunning
Director of Governance, Risk and Compliance
margaret.dunning@nhs.net

January 2019

Additional supporting information
Appendix 1 – NHS Tayside Annual Report Template

Appendix

TAYSIDE NHS BOARD

ANNUAL REPORT OF [*NAME OF COMMITTEE AND YEAR]*

1. PURPOSE

In order to assist the Board in conducting a regular review of the effectiveness of the systems of internal control, the Code of Corporate Governance requires that this Standing Committee submits an annual report to the Audit Committee. This report is submitted in fulfilment of this requirement.

2. NAME OF COMMITTEE

2.1 Composition

During the financial year ended 31 March 2019 membership of **[*NAME OF THE COMMITTEE]*** comprised:

- Chairperson

[LIST MEMBERSHIP]

Support to the Committee is provided by **…….**

2.2 Meetings

The Committee has met on [***NUMBER]*** occasions during the period from 1 April 2018 to 31 March 2019 on the undernoted dates:

[LIST DATES OF MEETINGS]

Attach as attendance schedule as appendix 1.

2.3 Business

[SHORT PARAGRAPH ABOUT BUSINESS CONSIDERED]

Details of the business items considered are attached at Appendix 2. Minutes of the meetings of the Committee have been timeously submitted to the **[*BOARD/STANDING COMMITTEE]*** for its information.

3. OUTCOMES

[PARAGRAPH ABOUT COMMITTEE'S ACHIEVMENTS AND WORK COMPLETED DURING THE FINANCIAL YEAR]

The ***[NAME OF COMMITTEE]*** has reviewed its remit and work plan during 2018/19 and what has been achieved during the year.

Consideration should be given to Internal Audit's report Internal Control Evaluation 2018/19.

Please include an update on any issues that were carried forward from last year and any that are to be carried forward to next year.

All business was conducted in open session/reserved session and include percentage held in open and reserved business.

4. RISK REPORTING

[NAME OF COMMITTEE] **receives reports on the following Strategic Risks :**

[*LIST STRATEGIC RISKS]*

These were considered by the *[NAME OF COMMITTEE]* on INSERT DATE

5. CONCLUSION

[PARAGRAPH COVERING THE COMMITTEE'S ABILITY TO SATISFY THE GOVERNANCE ARRANGEMENTS OF THE INTERNAL CONTROL FRAMEWORK]

As Chair of the **[NAME OF COMMITTEE]** during financial year 2017/18, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken, and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year, I can provide an assurance to the Audit Committee on the XXXXXX throughout NHS Tayside during the year.

I would again pay tribute to the dedication and commitment of fellow members of the Committee and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings of the Committee, and last, but certainly not least, express my sincere thanks to [*NAME OF SUPPORT OFFICER]* for their support of the Committee.

(signed)……..

CHAIRPERSON *(FINANCIAL YEAR)*
On behalf of *[NAME OF THE COMMITTEE]*

Record of Attendance

NHS Tayside

[NAME OF COMMITTEE] **FOR YEAR 1 APRIL 2018 TO 31 MARCH 2019**
ATTENDANCE RECORD

Name	Designation	Organisation	Meeting Date	Meeting Date	Meeting Date	Meeting Date	Meeting Date	Meeting Date
Members								
In Attendance								

Ref
Ref
Ref

NAME OF COMMITTEE

SCHEDULE OF BUSINESS CONSIDERED DURING YEAR 1 APRIL 2018TO 31 MARCH 2019

[DATE]

[*LIST BUSINESS CONSIDERED]*

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

ITEM NUMBER 11

AUDIT COMMITTEE DEVELOPMENT EVENT
24 JANUARY 2019

INTERNAL AUDIT PLANNING PROCESS 2019/20 – BRIEFING NOTE

1. SITUATION AND BACKGROUND

This report is intended to:

a) Advise Audit Committee members of the revised Internal Audit Planning process for 2019/20;
b) Seek initial views on key topics for inclusion in the 2019/20 operational Internal Audit Plan;
c) To advise that initial views on key topics will be sought from Non Executives who are not members of the Audit Committee;
d) Highlight the potential for improved co-ordination between Health Board and IJB Internal Audit Plans.

2. ASSESSMENT

Internal Audit Planning Process

For many years Internal Audit Strategic Plans were based on a detailed process which assigned risk and materiality scores to the individual elements of an audit universe structured around the 5 elements of governance: Corporate, Clinical, Staff, Financial and Information. These were then assigned materiality scores by management and risk assessed by Internal Audit based on NHS Tayside's risk register and our knowledge of each area. The scores were then combined and ranked and each component categorised as high, medium or low and audited accordingly in the 5 year cycle. The outcomes were then checked against the Strategic Risk Register and the resultant plan discussed with the Executive Leadership Team (ELT) before approval by the Audit Committee.

Whilst this approach was rigorous, systematic and comprehensive, it did not allow senior management, Audit Committee and other Non Executive members to influence the formation of the plan at an early stage and presenting a fully-fledged draft plan based on a complex spread-sheet did not necessarily leave sufficient space for members and senior officers to amend the final plan. Whilst the detailed backing papers did map the audit universe to the risk register, the recent IIA review highlighted the need for clearer linkage between strategic risks, the controls that mitigate risks and the focus of individual audits.

We have therefore decided to change to a two stage planning process. The first stage was a separate meeting with the ELT on 10 January 2019 to present the Internal Control Evaluation (ICE) and to ask them, having considered the ICE and the strategic risk register, recognising it is being reinvigorated, to suggest areas for inclusion in next year's plan. Following this planning discussion the Chief Executive and Director of Finance have agreed to collate responses.

This initial step will be repeated with the Audit Committee and with the Chairs of other Standing Committees.

Between January and March we will conduct detailed discussions with the Executive Directors responsible for the five areas of Governance including the Chief Executive, Director of Finance, Director of Workforce, Medical and Nurse Directors and Director of Governance, Risk and Compliance, following which suggestions will be collated and considered by the Chief Executive and Director of Finance, so Internal Audit receive a single, coherent response, aligned to the priorities of the organisation. We will then produce a Strategic Internal Audit plan structured around the Strategic Risk Register, incorporating as many suggested audits as possible, still using our audit universe to ensure that no key governance areas have been missed.

The resultant operational plan will clearly link to both the specific corporate risk and the associated key controls and will prioritise audits in line with the IIA recommendation.

The Internal Audit Strategic and Operational plans will then be taken back to the ELT for endorsement before discussion with External Audit and submission to the March 2019 Audit Committee for approval.

This approach is very much in line with both IIA guidance and the new Audit Committee Handbook. In particular, we will ensure that the plan takes account of other sources of assurance as outlined within the BAF for each Corporate Risk and throughout the year we will liaise with the Director of Governance, Risk and Compliance to ensure that the assurance maps produced by the client are used to ensure that audit coverage does not duplicate independent assurance provided by external bodies. However, in this year, we have asked the ELT to identify any areas where independent assurance is available from other sources, particularly if this is not readily apparent from the relevant BAF.

We have also highlighted the need for Health Board internal audit plans to be congruent with those of its IJB Partners. The NHS Tayside Internal Audit Plan includes 80 days for Internal Audit of the IJBs (supplemented by contributions from Local Authority Internal Audit teams), with IJB Plans agreed with the IJB CO and CFO and approved by the IJB Audit Committee.

IJB Chief Officers already have the opportunity to influence the Health Board Plan as member of the ELT and there is an output sharing protocol that allows for Health Board and Council Internal Audit Plans to be shared with the IJB and vice-versa. However, there is currently no direct process that allows the ELT to consider IJB Internal Audit plans and there is an opportunity to enhance co-ordination through discussion of IJB Internal Audit Plans at ELT, noting that final determination will be by the IJB CO and Audit Committee.

2019/20 Plan

The 2018/19 Internal Control Evaluation is presented as a separate paper. The Strategic Risk Register is shown as Appendix 1. Both documents highlight a number of areas for Internal Audit review. We will be considering all Strategic Risks in detail as part of the planning process in the next two months but at this stage we would highlight the following areas where we anticipate that Internal Audit input would add value.

Corporate Governance

Risk Management – the IIA review specifically recommended a review of Risk Management each year, with a range of suggested areas for inclusion.

Assurance mapping – this will be a fundamental component of future Internal Audit planning and is a key element of the new Audit Committee Handbook.

Transformation/Strategic Planning/Regional Planning.

Internal audit follow-up including detailed follow-up of Workforce and Prescribing benefits realisation audits.

Clinical Governance

Mental Health- taking account of independent assurance/external reviews and following up implementation of agreed actions.

CAMHS.

Staff Governance

Staff Governance Standard.

Workforce strategy/planning with consideration of the impact on the mitigation of specific workforce risks.

Financial Governance

Property Asset Management Strategy/capital planning.

Information Governance

Information assurance and security.

eHealth – both to include review of implementation of recommendations arising from external reviews.

3. REPORT SIGN OFF

Responsible Executive Director and contact for further information

If you require any further information in advance of the Board meeting please contact:

Contact for further information
Tony Gaskin
Chief Internal Auditor
tony.gaskin@nhs.net

Date 16 January 2019

Additional supporting information

Appendix 1 – Strategic Risk Register as at 8 January 2019

NHS TAYSIDE RISK RATINGS – STRATEGIC RISK PROFILE

	Datix Ref	Risk Title	Risk Owner	Risk Exposure – No Controls	1 April 2017 – 31 March 2018				1 April 2018 – 31 Mar 2019					Planned Risk Exposure	Current Risk Trend
					April 2017	August 2017	Nov 2017	Feb 2018	April 2018	June 2018	Sept 2018	Nov 2018	Jan 2019		
Audit Committee:															
1	621	Board Governance	Director of Governance, Risk and Compliance	25 (5x5) Very High	-	-	-	-	-	-	-	-	16 (4x4) High	12 (3x4) High	
Performance and Resources Committee:															
2	36	Strategic Financial Plan 2015/16 – 2019/20	Director of Finance	25 (5x5) Very High	25 (5x5) Very High	25 (5x5) Very High	25 (5x5) Very High	25 (5x5) Very High	25 (5x5) Very High	25 (5x5) Very High	25 (5x5) Very High	25 (5x5) Very High	25 (5x5) Very High	25 (5x5) Very High	→
3	37	Impact of Reduction in Capital Resources	Director of Finance	20 (5x4) Very High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	→
4	38	Information Governance Risk	Board Secretary	25 (5x5) Very High	12 (4x3) High	12 (4x3) High	12 (4x3) High	12 (4x3) High	12 (4x3) High	12 (4x3) High	12 (4x3) High	12 (4x3) High	12 (4x3) High	9 (3x3) Medium	→
5	26	Waiting Times and RTT Targets	Director of Acute Services	25 (5x5) Very High	15 (5x3) High	15 (5x3) High	15 (5x3) High	15 (5x3) High	15 (5x3) High	15 (5x3) High	15 (5x3) High	15 (5x3) High	15 (5x3) High	15 (5x3) High	→
6	494	Capacity and Flow	Medical Director – Operational Unit	25 (5x5) Very High	-	-	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	15 (5x3) High	→
7	312	NHS Tayside Estate Infrastructure Condition	Assistant Chief Executive	20 (5x4) Very High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	6 (2x3) Medium	→
8	615	Effective Prescribing	Medical Director	16 (4x4) High	-	-	-	-	-	-	-	-	12 (4x3) High	12 (4x3) High	

	Datix Ref	Risk Title	Lead Director/ Risk Owner	Risk Exposure – No Controls	1 April 2017 – 31 March 2018				1 April 2018 – 31 Mar 2019					Planned Risk Exposure	Current Risk Trend
					April 2017	August 2017	Nov 2017	Feb 2018	April 2018	June 2018	Sept 2018	Nov 2018	Jan 2019		
Staff Governance Committee:															
9	95	Medical Workforce	Assistant Chief Executive	25 (5x5) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	9 (3x3) Medium	→
10	58	Workforce Optimisation	Assistant Chief Executive	20 (4x5) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	9 (3x3) Medium	→
11	280	Nursing and Midwifery Workforce	Nurse Director/ Assistant Chief Executive	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	12 (3x4) High	→
12	28	Health and Safety	Assistant Chief Executive	25 (5x5) Very High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	12 (3x4) High	→
13	To be added to Datix	Brexit	Assistant Chief Executive		-	-	-	-	-	-	-	-	-		
14	To be added to Datix	Medical Education	Medical Director – Operational Unit		-	-	-	-	-	-	-	-	-		
Care Governance Committee:															
15	16	Clinical Governance	Medical and Nurse Directors	25 (5x5) Very High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	9 (3x3) Medium	→
16	121	Person Centeredness	Medical and Nurse Directors	20 (4x5) Very High	12 (3x4) High	9 (3x3) Medium	9 (3x3) Medium	9 (3x3) Medium	9 (3x3) Medium	9 (3x3) Medium	9 (3x3) Medium	9 (3x3) Medium	9 (3x3) Medium	6 (3x2) Medium	→
17	15	Delivering Care for Older People	Medical and Nurse Directors	20 (5x4) Very High	12 (3x4) High	12 (3x4) High	12 (3x4) High	12 (3x4) High	12 (3x4) High	9 (3x3) Medium	9 (3x3) Medium	9 (3x3) Medium	9 (3x3) Medium	8 (2x4) Medium	→
18	395	Mental Health Services – Sustainability of Safe and Effective Services	Chief Officer, P&K HSCP	20 (4x5) Very High	20 (5x4) Very High	20 (5x4) Very High	25 (5x5) Very High	25 (5x5) Very High	25 (5x5) Very High	25 (5x5) Very High	25 (5x5) Very High	25 (5x5) Very High	25 (5x5) Very High	12 (4x3) High	→

	Datix Ref	Risk Title	Lead Director/ Risk Owner	Risk Exposure – No Controls	1 April 2017 – 31 March 2018				1 April 2018 – 31 Mar 2019					Planned Risk Exposure	Current Risk Trend
					April 2017	August 2017	Nov 2017	Feb 2018	April 2018	June 2018	Sept 2018	Nov 2018	Jan 2019		
Care Governance Committee continued:															
19	14	Infection Prevention and Control	Medical and Nurse Directors	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	20 (5x4) Very High	→
20	To be added to Datix	Child and Adolescent Mental Health Services (CAMHS)	Medical Director – Operational Unit		-	-	-	-	-	-	-	-	-		
21	To be added to Datix	General Adult Psychiatry – Enhanced Monitoring	Medical Director – Operational Unit		-	-	-	-	-	-	-	-	-		
Angus Integrated Joint Board:															
22	353	Sustainable Primary Care Services	Chief Officer, Angus HSCP	20 (5x4) Very High	9 (3x3) Medium	9 (3x3) Medium	9 (3x3) Medium	9 (3x3) Medium	9 (3x3) Medium	9 (3x3) Medium	9 (3x3) Medium	9 (3x3) Medium	9 (3x3) Medium	9 (3x3) Medium	→
Dundee Integrated Joint Board:															
23	To be added to Datix	Drug Utilisation (Deaths)	Chief Officer, Dundee HSCP /Director of Public Health		-	-	-	-	-	-	-	-	-	-	
Perth and Kinross Integrated Joint Board:															
24	To be added to Datix	Prisoner Healthcare	Chief Officer, Perth & Kinross HSCP		-	-	-	-	-	-	-	-	-	-	

Information correct as at time of compilation and extract from Datix system (08/01/2019)