DUMFRIES and GALLOWAY NHS BOARD

AUDIT and RISK COMMITTEE

18th June 2018

Annual Internal Audit Report 2017/18

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RECOMMENDATION

Audit and Risk Committee is asked to note the contents of this report which summarises the work undertaken by Internal Audit during 2017/18 and provides an opinion on the internal control environment within the Board.

CONTEXT

Strategy/Policy:

The Chief Internal Auditor's Annual Statement of Assurance, as required for the Governance Statement, is attached in **Appendix 4**.

Organisational Context/Why is this paper important/Key messages:

This Annual Report presented to Audit and Risk Committee provides an overview of the outcomes of the 2017/18 Internal Audit Plan and highlights the Chief Internal Auditor's opinion on the adequacy and effectiveness of the Board's internal control framework, risk management and governance processes.

GLOSSARY OF TERMS

Datix	-	Board's Risk Management system
EQA	-	External Quality Assessment
SFI's	-	Standing Financial Instructions

MONITORING FORM

Policy / Strategy Implications	This paper is part of the overall Internal Audit reporting framework where assurance is provided to the Board through Audit and Risk Committee.
Staffing Implications	None
Financial Implications	None
Consultation / Consideration	None
Risk Assessment	Internal Audit work is undertaken within a risk-based auditing framework. Internal Audit risks are assessed and contained within the Internal Audit Risk register on Datix.
Risk Appetite	Low [X] Medium [ ] High [ ] In the absence of an appetite statement in relation to governance ad compliance with board policy this is deemed to be low in that this is a key part of the boards control framework and essential to the workings of Audit and Risk Committee.
Sustainability	Sustainability is considered within the Audit Planning process.
Compliance with Corporate Objectives	The Internal Audit plan is informed by all NHS Dumfries and Galloway's corporate objectives and considers the risks that may impact on their achievement.
Local Outcome Improvement Plan (LOIP)	Whilst considered, not directly relevant to this paper
Best Value	All Best Value themes are considered through the annual audit plan, however this paper gives specific consideration to: • Vision and Leadership, • Governance and Accountability, • Performance Management, and • Sustainability
Impact Assessment Whilst a full impact assessment has not been undertaken, Equality and Diversity issues are fully considered during the audit planning process.	

CONTENTS

1. INTRODUCTION

1.1 Introduction

This Annual Report presented to Audit and Risk Committee provides a formal overview of delivery against the 2017/18 Internal Audit Plan and details other work undertaken within the Audit department during the course of the year. This report also provides the Chief Internal Auditor's opinion on the adequacy and effectiveness of the Board's internal control framework, risk management and governance processes for the financial year 2017/18.

This report has been structured to:

- Summarise assurances gained from the 2017/18 audit plan,
- Draw attention to areas of particular relevance through audit opinions and assurances gained,
- Summarise Internal Audit activity for 2017/18 and include performance indicators, and
- Provide the Chief Internal Auditor's Annual Statement of Assurance – **Appendix 4**.

1.2 Background

Internal Audit is an independent, objective assurance and consulting activity designed to add value and improve the Board's operations. It helps the Board to accomplish its objectives by bringing a systematic, disciplined approach to evaluating and improving the effectiveness of risk management, control and governance processes.

The range of Internal Audit activity covers the whole network of the Board's systems and the internal controls established to:

- Achieve the Board's objectives
- Ensure the economical and efficient use of resources
- Ensure compliance with established policies, procedure, laws and regulations
- Safeguard the Board's assets and interests from losses of all kinds including those arising from fraud, irregularity or corruption
- Ensure the integrity and reliability of information and data.

Executive Directors and Senior Management are responsible for ensuring that internal control arrangements are sufficient to address the risks facing their service areas and Internal Audit assesses the adequacy of, and provides assurance on, these arrangements.

The Chief Internal Auditor is responsible for the production of a risk based Annual Audit Plan, which is structured to ensure that the highest risk areas of the Board are audited within acceptable timescales, by audit resources appropriate to enable adequate assurances to be provided to Audit and Risk Committee.

1.3 Role of Internal Audit

The purpose, authority and responsibilities of the Internal Audit function within NHS Dumfries and Galloway are set out in the Internal Audit Charter and the Board's Standing Financial Instructions.

The Audit Charter was revised and presented to Audit and Risk Committee in March 2017 along with the 2017/18 Audit Plan. The Charter included minor revisions made to ensure that it reflects all current audit guidance and gives due consideration to the Public Sector Internal

Audit Standards. The Board's Standing Financial Instructions were also reviewed during the course of the year with no changes required to the Internal Audit or Fraud sections.

The Statement of Assurance provides an overview of the work undertaken during the course of the year and the assurances that can be taken from our audit work by the Chief Executive as Accountable Officer and our External Auditors.

2. ASSURANCE REPORT

2.1 Audit Plan 2017/18

The Internal Audit Plan for 2017/18 was approved at Audit and Risk Committee in March 2017.

The plan was structured to cover key areas and processes to provide assurance on what were assessed to be the highest priority areas of risk within the Board and to support the assurances required at the year-end for the Governance Statement.

The format of the plan is largely similar to that of the previous year which was intended to provide assurance on processes, with testing being undertaken across larger samples within the Board. This is felt to be a more effective use of audit days with more meaningful information coming through in the audit reporting.

During 2017/18, Internal Audit have completed 15 planned audits to reporting stage. One audit in relation to Lab Services has been removed from the plan for this year. This was at the request of management due to an external review in this area from UKAS the main accrediting body for Laboratories.

All of the audits completed have been used to inform the Chief Internal Auditor's Statement of Assurance and are summarised in the table in **Appendix 1**.

2.2 Assurances gained from Audit work

The assurances from the various audits are summarised in the table below.

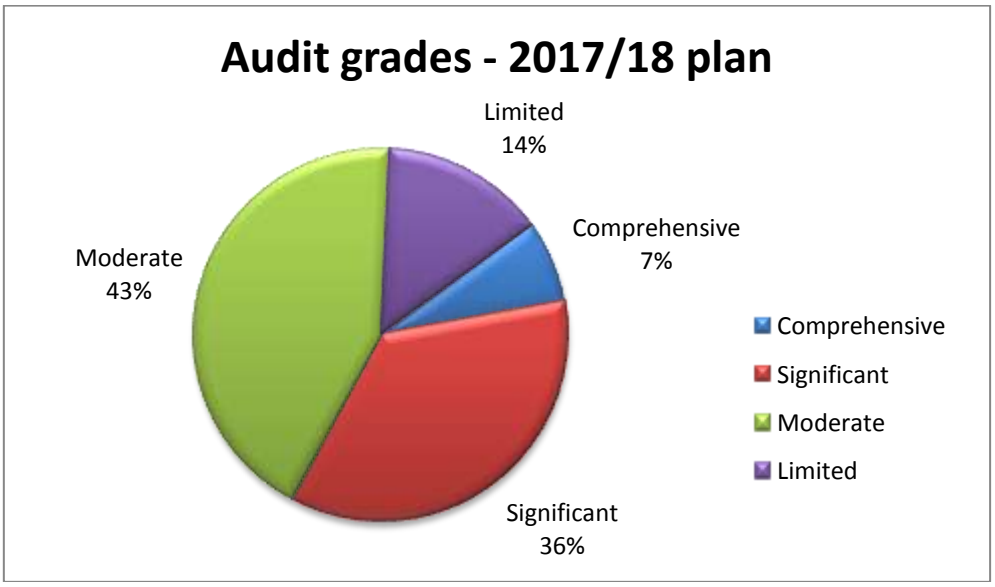
Table 1

Audit title	Assurance level			
	Limited	Moderate	Significant	Comprehensive
Board Governance and Decision Making Structures				
Health and Safety Policy and Procedures				
Nurse Revalidation (incl. Midwifery and AHPs)				
Info. Gov. & Security Improvement Measures				
New Hospital - Migration and Commissioning				
Capacity Management				
Out of Hours Service				
Child Protection				
Commissioning				
Property Transaction Monitoring				
Losses and Compensation				
Budgetary Control - Ring Fenced Funding				
Ledger Controls and Reconciliations				
Cash Control & Banking				

Assurances given are based on a number of different elements to form an opinion on the assurance level, but ultimately any assurance given is evidence based. Where a test cannot be carried out or where evidence cannot be provided then formal assurance cannot be given that satisfactory controls or processes are in place to support the achievement of objectives within a given area.

The table in **Appendix 1** at the end of the report expands on this by mapping the audits against the Best Value characteristics and the four main strands of Governance to enable this information to be used to inform the Statement of Assurance and to provide information on where independent assurance has been gained across these areas.

Figure 1



Overall, the 2017/18 audit plan has delivered mixed levels of assurances. One audit has given Comprehensive Assurance (1 in 2016/17), five audits have given a Significant level of assurance (8 in 2016/17), six audits have given Moderate Assurance (6 in 2016/17) and two audit have given a Limited level of assurance.

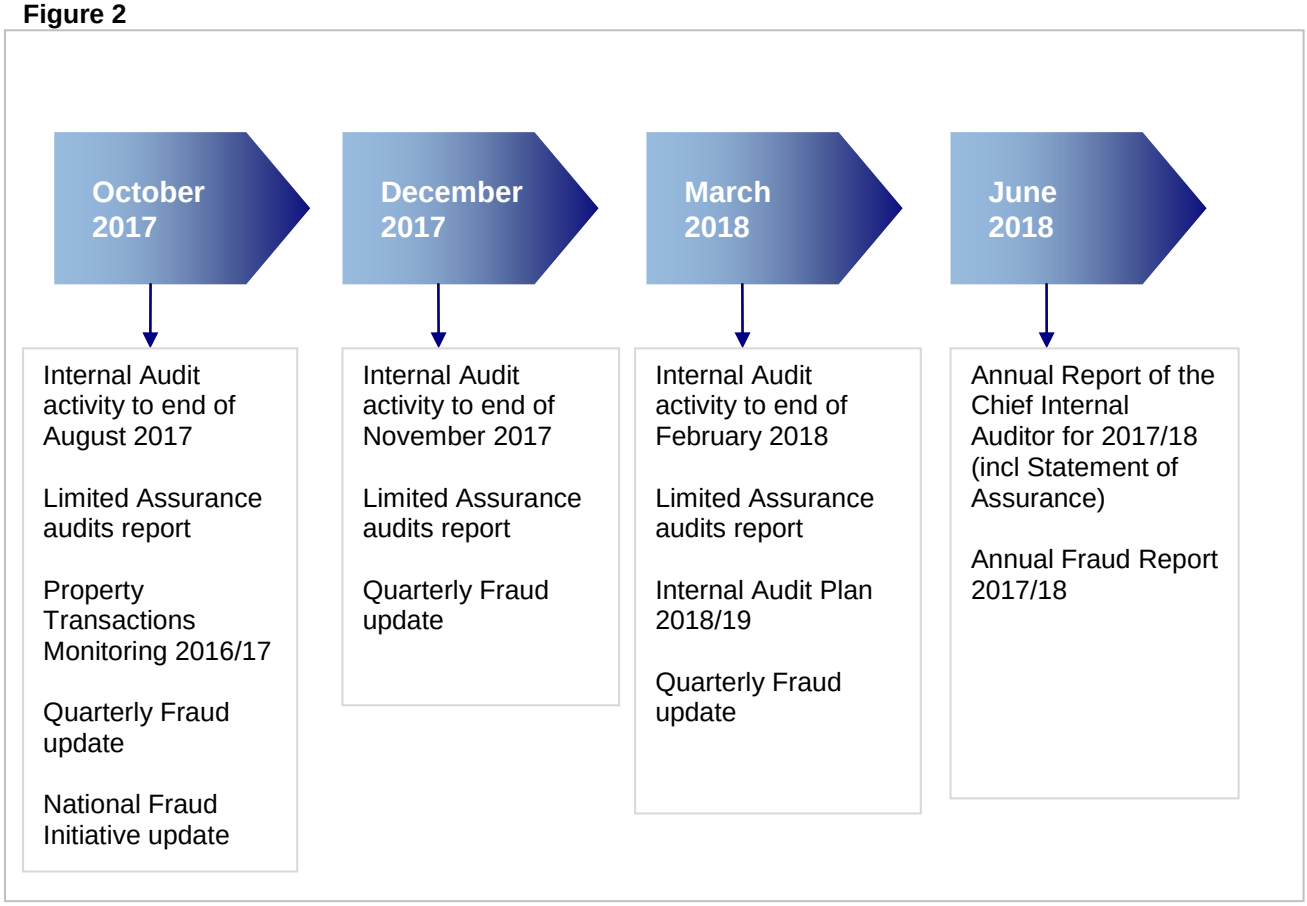
The two Limited Assurance audits relate to Information Governance and Security Framework and Health and Safety Policy and Procedures.

2.3 Reporting to Audit and Risk Committee

In addition to Audit and Fraud reporting, Intelligence Alerts from Counter Fraud Services are also brought to each Audit and Risk Committee as they are issued. These are detailed in the Annual Fraud report.

During 2017/18 the following reports were brought to Audit and Risk Committee by the Chief Internal Auditor.

Figure 2



Specific Limited Assurance audit reports are brought to Audit and Risk Committee as they are issued so that committee are made aware of specific weaknesses in the area that has been reviewed.

Limited Assurance audits now remain a standing item on the Audit and Risk Committee agenda to ensure that the continued focus on the closure of audit actions will not allow these audits to lose visibility and to ensure that committee members have the opportunity to receive updates on progress against these audits.

3. PERFORMANCE REPORT

3.1 Performance Management

Internal Audit have a range of key performance indicators within the section. These indicators are intended to measure internal performance and also measure those external factors that may impact on our delivery of the audit plan. The balanced scorecard approach which has been adopted provides a rounded set of measures that provide information to track performance throughout the year.

These performance indicators are subject to ongoing review and are used to inform the function's quality assurance and improvement processes. This information was of use when the audit function undertook the External Quality Assessment (EQA) during the year. One of the actions was to enhance the KPI's with the involvement of Audit and Risk Committee. This followed on from the Chief Internal Auditors objective setting process to ensure that a top down approach was adopted.

3.2 Audit Activity

The audit team continue to use AutoAudit, an audit software system, which was introduced during 2012/13. The functionality of the system has been built up to dovetail with existing audit processes. This development is ongoing and as audit practices evolve the system is reviewed to ensure that it supports these.

At key stages in each audit we have taken the opportunity to move from paper based to software hosted processes. This has been tested as we have gone along to ensure that the functionality of the system is operating as intended.

The audit plan for 2017/18 carried 308 audit days.

During the year 327.01 audit days were undertaken by the audit team. This is broken down as follows

- 301.83 days against the 2017/18 plan (including time delivering on the IJB audit)
- 25.23 days closing off audits from the 2016/17 plan (including 2016/17 IJB audit)

The Integration audit work has been undertaken from within the existing NHS resource. The assurances provided from all audit work undertaken are considered both within an NHS Board and IJB context. This decision has been endorsed by the Director of Finance and Chief Executive with assurances from all audit work to be shared with both IJB and NHS Audit and Risk Committees.

The focus of the section in the last two months of the audit year has been completion of the audit plan which has left very little capacity for any additional elements other than the continued follow-up work required to close off audit actions. 15 audits from the 2017/18 audit plan having been completed to reporting stage.

The two main elements of non-audit time are Audit Development & Administration (59.03 days) and Corporate Support (21.17 days) with Follow up recording 18.47 days.

Time recorded against Audit Development & Administration includes, for example, ongoing maintenance of our audit system, review of working documents and maintenance of our Internal Audit intranet page. This is therefore time spent by the audit team on non-audit specific tasks. Administration time has increased this year due to a change in administrative

support. Auditors had to pick up this work whilst there was a vacancy in this role and used this as an opportunity to overhaul the teams' admin processes.

One of the main elements of time has been recorded against Audit Development is the time spent within the team completing actions relating to the External Quality Assessment. This time commitment has been necessary to implement the changes as recommended.

Table 2

	Planned (days)	Actual (days)	Diff (days)
Public Holiday	16	16.00	
Annual Leave	58	58.00	
Contingency	**18**		
Sick Leave	0	2.00	
Study/Other Leave	0	0	
Governance	0	2.47	
Travel	0	1.13	
Consultancy	0	0.00	
Unplanned Work	0	0.00	
Other	0	2.10	
Total		**7.70**	**-10.30**
Corporate Support	20	21.17	1.17
Training and Development	20	7.83	-12.17
Audit Development & Admin	36	59.03	23.03
Fraud	14	0	-14
Follow Up Processes	30	18.47	-11.53
Total	**212.00**	**188.20**	**-23.80**

There has been a continued focus this year in getting responses to outstanding actions on Issue Track. This requires review of every response that comes through on the system and verification that the evidence provided has met the requirements of the initial recommendation. Follow up time has reduced from that of last year, although audit have been asked to review management responses in a number of spreadsheets that have been brought back to Audit and Risk Committee. This time has been recorded against Corporate Support as this has been limited to a review of updated information with no evidence provided and therefore no opportunity to close the actions off.

Corporate Support currently stands at 21.17 days this year. Time allocated against this includes attending meetings such as Information Assurance Committee, fire officer duties, support to staff on completing their actions within Issue Track and dealing with ad hoc requests for support.

Internal Audit's full KPIs are detailed in **Appendix 2**.

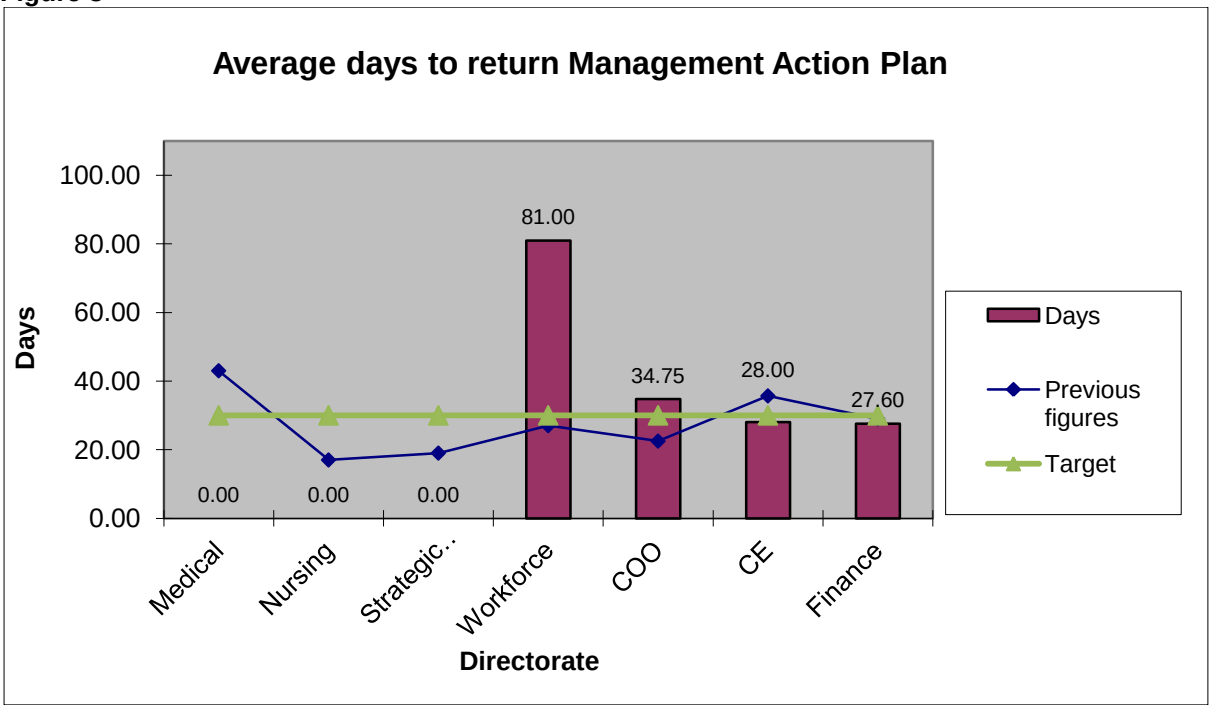
3.3 Reporting to Management

The outcomes of all audits are reported to relevant local managers, Audit and Risk Committee, the Chief Executive (Accountable Officer) and External Audit. A series of recommendations to remedy any control weaknesses or risks are identified in the Management Action Plan at the end of the audit report, to which a response is given by management in the form of an agreed action to meet the requirements of the recommendation.

For every recommendation that is made there has been a risk or control weakness identified which, until remedied by management remains an outstanding risk to the Board or may open up the system which has been audited to abuse or manipulation. It is therefore a crucial element of the audit process that timely responses to all recommendations made are identified and passed back to Internal Audit so that the audit report can be finalised and issued to the Accountable Officer and our External Auditors.

The following table shows the average days taken by management to respond to our audit reports against a target of 30 days.

Figure 3



There have been a couple of instances where circumstances have prevented a timely response, for example to take the report to a committee or team meeting and we have accommodated requests for extensions with management, however the responses are generally being returned around the 30 day timescale.

Internal Audit also have an internal measure for issue of the final report on receipt of the management action plan. The target is to review the responses and to issue the final report within 14 days. The current average is 6 days (7 days 2016/17).

3.4 Audit Follow-Up Processes

As previously mentioned, all recommendations are input into the AutoAudit software system as reports are issued. As audits are undertaken the risks, controls, findings, actions and subsequent management update are recorded on the system.

By using AutoAudit and the webhosted section Issue Track, we can facilitate the management update of any outstanding issues and subsequent internal audit verification of the implementation of agreed action points.

These processes do not detract from the assurances gained from the confirmation provided by management to the Chief Executive updating on the implementation of agreed

recommendations. This is a valuable part of the assurance process whereby managers are informing the Chief Executive as Accountable Officer directly of their progress on recommendations.

The monitoring of the implementation of audit recommendations is an area that is under continuing review to ensure that the processes for collation of, and the mechanism for reporting on progress against, recommendations is as efficient as possible. Auditors currently monitor progress against each recommendation and identify whether the action is complete or whether there is a requirement for further testing.

Information within the system can be accessed at any time which allows for real time monitoring of progress against identified risks. The most recent position as at 1st June 2018 is detailed below.

Table 3

Director	Total	Overdue	Open	Pending Review	Closed
Katy Lewis	128	45	4	0	79
Julie White	113	34	15	2	62
Eddie Docherty	44	15	0	0	29
Jeff Ace	93	19	0	1	71
Caroline Sharp	41	16	10	2	13
Dr. Ken Donaldson	6	2	0	0	4
Michele McCoy	3	0	0	0	3
Vicky Freeman	1	0	0	0	1
Grand Total	**429**	**131**	**31**	**5**	**262**

Overdue actions by grading - The 131 overdue actions can be broken down into the grading level of the initial recommendation as follows:

- A (Low Risk) – 8 actions
- B (Medium Risk) – 67 actions
- C (High Risk) – 56 actions

Overdue actions by due date - Further analysis shows that a number of these actions are considerably overdue. The age of the 131 actions are detailed as follows:

- 0 – 3 months – 26 actions
- 3 – 6 months – 8 actions
- 6 – 12 months – 27 actions
- Over 12 months – 70 actions

The profile of overdue actions at the last three year-ends is detailed below as a comparison.

Table 4

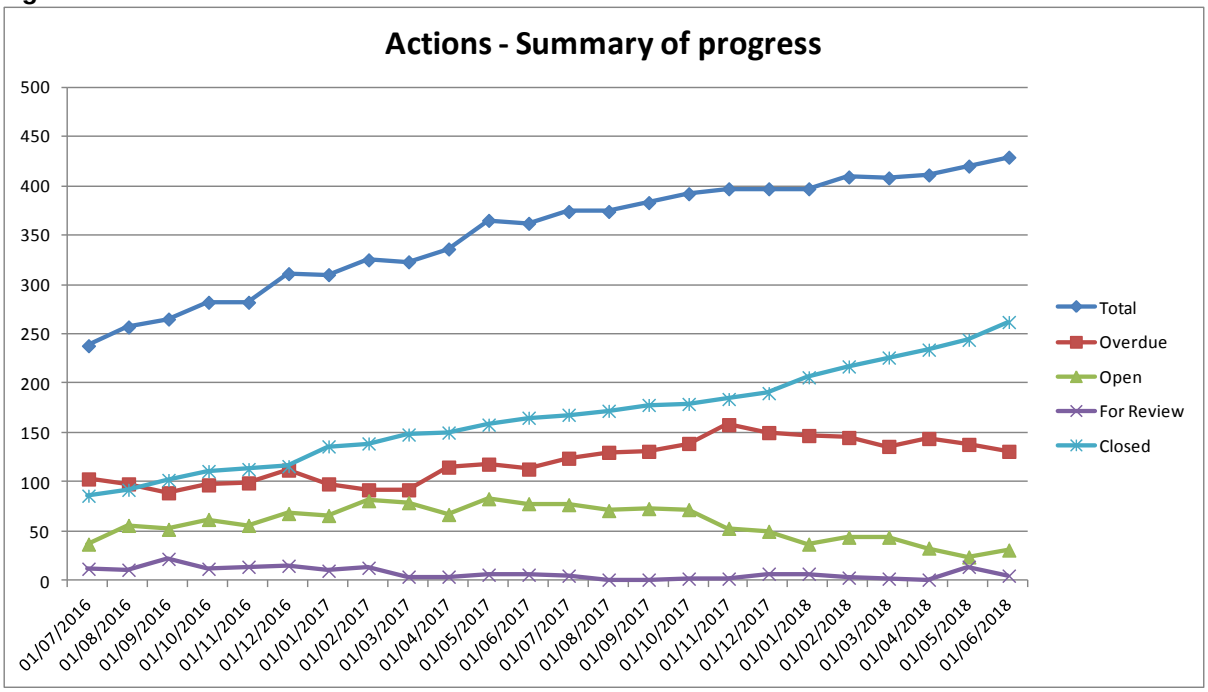
	Number of actions			
	1 June 2015	1 June 2016	1 June 2017	1 June 2018
0 – 3 months	23	35	30	26
3 – 6 months	22	13	14	8
6 – 12 months	41	17	12	27
Over 12 months	29	40	57	70
	115	**105**	**113**	**131**

Two updates on outstanding actions have been brought back to Audit and Risk Committee during the course of the year. One was on actions that were over 12 months overdue and the second on those that were graded as High Risk ('C' graded actions). A number of reported actions have been closed, although some actions require to be updated in IssueTrack by management.

The position as at 1 June 2018 is that we currently have 70 actions over 12 months overdue compared to 57 last year. This has been gradually increasing over the last four years.

The current exercise gives the opportunity for management to review their actions and to determine if these are still relevant and current. None have been closed due to being irrelevant or obsolete. Management continue to recognise that these should be actioned and have detailed their responses accordingly.

Figure 4



We can see that the number of overdue actions has been consistently sitting above 130 since April 2017. As detailed above information has been brought back to committee in the form of a management update and a continuing commitment was given to close off actions.

This information will continue to be reported to Audit and Risk Committee and Management Team to allow improvement measures to be put in place as required.

4. SUMMARY

Many improvements have been introduced within Internal Audit to ensure better working practices are adopted and to ensure that appropriate professional standards are adhered to. This requires consolidation to ensure that the assurances gained from audit work undertaken reflect the professionalism and effectiveness of the section.

The Statement of Assurance in **Appendix 4** provides more detailed information on audit assurances as they relate to the specific areas within the Governance Statement.

5. ACKNOWLEDGEMENTS

I would like to take this opportunity to thank all members of staff within the Board for the help and co-operation extended to Internal Audit and to thank the audit team and administrative support for their continuing commitment and effort during the course of the year.

Audit Plan 2017/18 – Progress and Outcomes

Best Value							Governance										
Vision and Leadership	Governance and Accountability	Use of Resources	Performance Management	Effective Partnerships	Equality	Sustainability	Financial	Staff	Clinical	Information			Status	Recommendations A	B	C	D	Total	Assurance
✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A/01/18	Board Governance and Decision Making - Structures	Prelim	2	2	2	-	6	Moderate
✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	A/02/18	Health and Safety Policy and Procedures	Prelim	-	2	9	-	11	Limited
	✓		✓					✓			A/03/18	Nurse Revalidation (incl. Midwifery and AHPs)	Prelim						Significant
✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	A/04/18	Information Governance & Security Improvement Measures - DL17(2015)	Final	-	1	5	-	6	Limited
		✓	✓	✓	✓	✓	✓	✓	✓	✓	A/05/18	New Hospital - Migration and Commissioning Plans	Final	1	2	1	-	4	Moderate
-	-	-	-	-	-	-	-	-	-	-	A/06/18	Laboratories	-	-	-	-	-	-	-
	✓	✓	✓	✓	✓	✓	✓			✓	A/07/18	Capacity Management	Final	-	4	-	-	4	Significant
	✓	✓	✓	✓		✓	✓		✓	✓	A/08/18	Out of Hours Service	Final	-	2	5	-	7	Moderate
✓	✓	✓		✓	✓				✓	✓	A/09/18	Child Protection	Prelim						Moderate
✓		✓	✓	✓	✓		✓		✓		A/10/18	Commissioning	Final	-	2	3	-	5	Significant
	✓	✓	✓	✓	✓	✓		✓	✓	✓	F/01/18	Property Transaction Monitoring	Final	-	-	-	-	0	Comprehensive
	✓	✓			✓	✓	✓		✓	✓	E/03/18	Losses and Compensation	Final	-	1	1	-	2	Moderate
	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	E/04/18	Budgetary Control - Ring Fenced Funding	Prelim						Moderate
	✓	✓	✓			✓	✓			✓	TS/06/18	Ledger Controls and Reconciliations	Final	-	2	1	-	3	Significant
	✓	✓	✓			✓	✓			✓	TS/12/18	Cash Control & Banking	Final	-	2	1	-	3	Significant
																		51	

Internal Audit Performance Measures – KPI's

Goals	Cost, Quality, Delivery	Measures	KPI	Performance to December 2017	Performance to March 2018	Performance to May 2018
Stakeholder perspective To assist the board through the enhancement of working practices and system/process controls.	Q	Recommendations accepted	95% of audit recommendations to be accepted	100% for 2017/18	100% for 2017/18	
	Q	Timely closure of audit issues		150 overdue (37.8%)	136 overdue (33.3%)	131 overdue (30.5%)
	Q	Audit feedback requested from management on issue of final reports detailing satisfaction measures and feedback.	To increase to at least 50% return rate	29% return rate	29% return rate	To follow
Internal Business perspective Operate an efficient and effective service through the timely provision of internal audit deliverables.	D	Percentage of audit plan complete	To be within 10% of budget	49.9% audit days used (95.5% of planned use)	74.5% audit days used (90.3% of planned use)	98% of 2017/18 audit plan completed
	D	Audit days – Budget v Actual *based on finalised audits	To be within 10% of budget	83.9 days against 78 planned (7.56% over)	117.1 days against 103 planned (13.69% over)	264 days against 228 planned (15% over)
Continuous Improvement perspective Maintain an appropriately qualified and experienced Internal Audit resource that meets relevant standards	Q	Conduct an annual self assessment of IA compliance against PSIAS	Completed during each audit year	-	-	Completed
	Q	Personal development reviews completed within timescales	100% completed within last 12 months	100% complete	100% complete	100% complete
Financial perspective To utilise resources in the most efficient and effective manner.	C	To deliver the audit plan for year within the budget allocated	To be within 10% of budget	-	-	Within budget

Audit Conclusions

Audit No. **Audit Title** **Assurance level**	**Conclusion**
A/01/18 Board Governance and Decision Making - Structures **Assurance – Moderate**	NHS Dumfries and Galloway's Code of Corporate Governance sets out the governance framework of the NHS Board and its standing committees. Guidance supporting an effective governance framework is not extensive but where applicable has been applied to ensure that remits have been defined and membership appropriately appointed to support a balanced and independent view through the appointment of non-executive board members. Audit findings focused on NHS Board and committee reporting and how the reporting template adopted by these groups including covering papers and monitoring forms can be used to inform the discharge of members' governance duties and the impact of decision-making on resource implications. To quantify this an analysis was undertaken of all 513 papers presented to the NHS Board and standing committee during the period 2016/17 and 2017/18 to January 2018. The following summarises audit findings with a view to enhancing governance processes; • NHS Board published documents should be of the most current version. • LDP Standard B7 – Diagnostic Waiting Times should be included in the IJB quarterly performance report where this remains relevant. • The role of annual reports as a source of assurance must be defined to enhance an overt scrutiny and approval route prior to presenting to the NHS Board or standing committee for noting. • A review of the NHS Board and standing committee reporting template should be undertaken to ensure it adds value to decision-making to include defined terminology for the recommendation to members and assigning authority to the standing committee chairs and secretariat to ensure the board standard is maintained. • Standing committee assurance statements must include only the approvals of the committees as reflected in their meeting minutes. • The Audit and Risk Committee must consider if they are fulfilling their terms of reference in relation to oversight of wider organisational risk management. In considering the impact of the IJB on decision-making there continues to be a need to review the committee structure and to align the business of the IJB and NHS committees to ensure a robust decision-making and assurance route has been established. Of the nine recommendations reported from the IJB Governance Arrangements audit in 2017, seven actions remain open and overdue in accordance with their target completion dates and of which three have been identified as high risk. Whilst the Board Governance and Decision-Making audit focused predominantly on the governance structures within the NHS, the impact of these arrangements in relation to the IJB must also be considered to ensure the required assurances are being received by all parties.

Audit No. Audit Title Assurance level	Conclusion
A/02/18 Health and Safety Policy and Procedures **Assurance – Limited**	In terms of staff health & safety, the relevant and most current version of government guidance and/or legislation has been identified and its principles and values have been incorporated into the appropriate governance documentation. There is a formal set of Policies and/or Operating Procedures that details how a range of standards should be applied, however instruction is not as clear in relation to Building Health and Safety. A corporate risk, 2398 Health and Wellbeing of our Staff, has been identified, within which health and safety is referred to as a control measure through Staff Governance Committee. However this corporate risk does not take into account Building Health and Safety nor are there any risks identified at directorate level that mirror the Scheme of Delegation responsibilities. At an operational level a range of risks associated with the process have been captured but are not linked through Datix and so it is difficult to determine how robustly these risks are being managed. A number of these risks have not been reviewed for some time and require review to confirm they are still relevant and appropriate. There is a perceived duplication of risk management on the building side where use of a national compliance monitoring system is reportedly mirroring the information within Datix. The robustness of this additional risk identification could not be verified during the audit due to Estates not providing the data requested. All Risk in relation to Health and Safety should be reviewed to clarify the position and ensure the focus is concentrated at the correct level of responsibility. In terms of adverse incidents there is a clear process of review where they have been reported through Datix and identified as being related to staff. This is not the case for incidents relating to building health and safety where incidents may not be raised through Datix at all. This is mainly due to the fact that the majority of these types of issues are logged as maintenance faults through Agility or via SERCO for DGRI and are not recognised or escalated through Datix. The lack of formal instruction to staff in these cases has the potential to cause harm to both patients and staff which has gone unrecognised. Cyclical monitoring processes are in place in relation to incidents reported through Datix, whereby regular review of quality and accuracy of reporting is assessed and then tied back to training provision to ensure themes and trends are addressed appropriately. This level of monitoring does not extend to include review of risk assessments to understand how well health and safety policy is being implemented. Once again this formal monitoring is undertaken for staff incidents and cannot be confirmed as taking place for the building health and safety as requests for data have gone unanswered at the time of writing this document. There are 3 groups/committees that are charged with monitoring health and safety at a corporate and local level. Whilst there are terms of reference for the local groups the same cannot be said for the Corporate Health and Safety Committee and so the formalities of monitoring activities are not structured with no expectation of cyclical assurance reporting from the local groups through the corporate group and on to a standing committee. There is no cohesiveness or clear linkage between them to provide a robust assurance pathway. Each of these monitoring groups is provided the same data in respect of incident management in the form of a report. The statistics presented to each committee are created using the figures from the board's incident management system Datix and only relate to reported

Audit No. Audit Title Assurance level	Conclusion
	staff incidents. The commentary used to support the statics is repeated from one report to the next with no tonal or content change to identify improvements or deterioration in performance. Whilst the reports refer to various programmes designed to reduce accidents and incidents there is little evidence in consecutive reports to show how these programmes have progressed. There is no formal reporting of building health and safety and although discussion in committee surrounding these topics takes place this is not supported by statistical information to demonstrate what activity occurs on an ongoing basis. This audit has revealed that the process of managing and monitoring Health and Safety is more transparent and verifiable where risk and adverse incidents relate to staff. The same cannot be said for the building side of health and safety whereby the discussions taking place are not supported by any level of statistical analysis and we cannot therefore demonstrate that we are meeting our legal obligations in this area. Refocus of the Corporate Health and Safety responsibility is required to ensure assurances capture all health and safety matters.
A/03/18 Nurse Revalidation (incl. Midwifery and AHPs) **Assurance – Significant**	Conclusion to follow
A/04/18 Information Governance and Security Improvement Measures – DL 17(2015) **Assurance - Limited**	In embarking on this audit clarity was sought from the Scottish Government on the ongoing validity of DL (2015) 17 as the timeframe for implementation has since lapsed. This concluded that whilst a review is pending during 2018 the principles of the ISPF are to remain unchanged. There is an intention nationally to conduct a survey of Board level compliance with the requirements of the DL prior to the review but the timescales for this were not shared. Given that there are to be no significant changes to the DL audit work was conducted in accordance with extant guidance. At the highest level the DL requires Boards to appoint a SIRO, develop an ISMS, implement security controls and bring Board eHealth Plans and information governance business plans in line with the wider ISPF. Compliance with security controls is a significant feature of the ISPF and whilst many of these controls may be operational there lacks a formal and overt demonstration of compliance and the identification of actions for ongoing monitoring. The ISMS is yet to be established, the role of the SIRO requires progressing and no evidence was provided of a local eHealth Delivery Plan to be brought in line with the ISPF and therefore no assurance could be provided on this specific requirement of the DL. Other audit improvement points to note include further developing the Information and Security Assurance Framework 2017-2020 acting as the local workplan to include action plans for key pieces of work, e.g. GDPR and PR(S)A, and to overtly prioritise actions with the available resources. This should be reported and monitored through IAC and captured by the committee meeting matrix to ensure progress is routinely on the agenda. NHS D&G has a low risk appetite for information governance however no evidence was available at the time of the audit in support of risk

Audit No. Audit Title Assurance level	Conclusion
	management beyond the corporate risk register. Specifically no risk has been identified by ICT around legal and regulatory compliance despite there being active workstreams or in relation to resource requirements and/or restrictions in service delivery. Ultimately the audit opinion was formed based on there being no active demonstration of compliance with the DL and the lack of assurance delivered through the governance route. Whilst governance arrangements have been defined in that the IAC reports to the Board through the NHS A&RC, upon review of the papers and minutes from both committees for the period June 2015 to-date, no assurance has been provided in relation to action in accordance with the requirements of the DL and there has been no follow-up to monitor the implementation of the DL by either committee. The role of the SIRO as an executive Board member must be utilised to raise awareness and appreciation for information risk and the potential exposures where regulations or guidance are not acted upon impacting delivery against the risk appetite. Whilst a route for assurance is in place the robustness of assurances in accordance with information governance obligations and regulations is contrary to the Board's risk appetite.
A/05/18 New Hospital – Migration and Commissioning Plans **Assurance – Moderate**	When auditing any planning process Internal Audit cannot provide absolute assurance given the variables of a project, particularly one of the size and nature of the new hospital. Master commissioning and migration plans have been developed and are subject to ongoing review and scrutiny with a view of making the transition to the new hospital as seamless as possible. To be effective the information flow into the plan is vital and to achieve this all departments and external contractors must provide accurate and timely information. The Project Team can only act upon what they know and therefore it is critical that a comprehensive flow of information is maintained. It had been anticipated at the outset of this audit that project documentation would have facilitated audit work however due to the completeness of some of the evidence provided observations at meetings became more important in demonstrating how the project was progressing and supporting governance arrangements. Internal Audit have identified four observations for management consideration with a view of providing a response to demonstrate a commitment to how these will be addressed. This will be followed-up as part of the post-migration audit work. At this time Internal Audit will also look to evidence outcomes and lessons learned from the project and for these to be overtly documented. A summary of observations is detailed as follows and is not inclusive of any arising issues in relation to the commissioning of the new hospital or migration, which should be progressed and overseen by management; The completeness and accessibility of project documentation should be reviewed upon completion of the project. Internal Audit is not aware of specific criteria for maintaining documentation for a project of this nature but it may be prudent to compile completed planning documents and associated paperwork and for these to be archived. Post Project Evaluation must remain firmly on the agenda as a mandatory requirement set by the Scottish Government for projects >£5m, and the time table set out in the FBC for PPE should be adhered to.

Audit No. Audit Title Assurance level	Conclusion
	The procedures to be followed around the transfer of patients with infection, of differing severity and risk, must be clearly understood at all levels to avoid unnecessary delays during the migration period. The review of the Commissioning and Migration risk register must be overtly demonstrated reflecting changes in the risk environment and preparation of risk mitigation plans. Updates should be explicit and escalated as required, specifically those with a risk grading of high or above. The impact that Internal Audit can have at this stage in the project is more limited given the timescales to migration and with commissioning having commenced. Observations however aim to avoid any unnecessary complications during migration and to ensure that post-migration key pieces of work continue to be driven forward. At this time there are plans in place for the commissioning of the new hospital and for the migration of patients, these are plans and will be subject to ongoing change. This is unavoidable and no amount of planning can account for a set of circumstances faced on any given day to disrupt these plans but what is important is the reaction to risk and the ability of the Project Team, and through the Command and Control Structure, to react and put in place mitigating measures to ensure a successful outcome.
A/07/18 Capacity Management **Assurance – Significant**	Capacity management impacts on all inpatient episodes with a view to achieving continuous patient flow from admission to discharge or transfer. This process is supported by a team of Capacity Managers. This is not achieved in isolation and requires co-operation across all specialities and from the Acute and Diagnostic Management Team when capacity pressures result in escalation. It was apparent from audit work that there was a high demand for medical beds, potentially contributed to by an aging population and that staffing presents a risk to capacity in the ability to resource beds within the agreed ward templates impacted by unplanned absences. It is not anticipated that these risks will change moving to the new hospital and should continue to be managed. Audit findings have identified areas for enhancement including; • Incorporating business-as-usual activities into the Capacity Management Procedure. • Review of capacity reporting methods namely daily reporting and the approach to accessing emergency admission predictions. • Reviewing the use of systems to prevent potential service disruption. Having migrated to the new hospital the principles of capacity management remain unchanged, daily site huddles will continue and Capacity Manager's will undertake their daily walk-rounds ensuring each patient has a bed and that beds are adequately staffed. Changes to the working environment including new ward names and the larger scale CAU will take time to bed-in and become routine working practice but the work undertaken prior to the move should support this transition.

Audit No. Audit Title Assurance level	Conclusion
A/08/18 Out of Hours Service **Assurance – Moderate**	The completion of the audit took some time to get under way due to service commitments restricting the amount of time staff could spend with us. However, once we were able to meet with staff we received all the information we required and were provided with unlimited access to documentary support to facilitate our review. Resource is concentrated on the day-to-day activities and staff work tirelessly to ensure an Out of Hours Service is provided. Effort is particularly heightened when there are gaps in the operational staff rota through staff availability or sickness. We have observed the significant amount of time one issue can take to resolve which supported anecdotal evidence provided through discussion. This level of reactive effort is not a rare occurrence and can almost be daily and is difficult to substantiate and is therefore not always appreciated when assessing performance. Whilst gaps in the rota have been somewhat alleviated by the various clinical improvements that have been introduced over the past 12 months this has prevented improvements or streamlining of the administrative side of the process, which underpins the service. Further improvements are being recognised almost continually; however until the national review of the Out of Hours Service has concluded it is difficult to define how this will affect the local strategy for the service and therefore remain on hold. There is not yet a structured and consistent approach to measuring the success or failure of the Out of Hours service. Fixed criteria of measurement are not in place and computer systems do not assist in the process by providing any meaningful information to enable any appropriate level of monitoring. The staff complement has completely changed at all levels within the past 18 months with the new incumbents having to become instantly familiar with the service processes. At the time of writing this report the OOH resource had further changed with the current Service Manager and Project Officer leaving. Recruits to the vacant posts will require their own adjustment period to gain experience and be fully operational. Therefore senior management must consider how this impacts on the remaining staff to ensure business continuity and staff moral are not impacted. Our assurance level for this audit may have been Limited, due to failure to recognise the risk to sustainability of service delivery at a higher level. We have considered the soundness of the processes in place and the ability of core staff to react to service demands and the recruitment process in place. The longer the Service Manager role is vacant, the further behind the development of the service will fall as core staff are stretched. We have given this audit a Moderate assurance level, based on the above, however may escalate this to a Limited Assurance level at year end should essential roles not be filled.
A/09/18 Child Protection **Assurance – Moderate**	Conclusion to follow

Audit No. Audit Title Assurance level	Conclusion
A/10/18 Commissioning **Assurance – Significant**	The relevant and most current version of government guidance and/or legislation has been identified and its principles and values have been incorporated into the appropriate governance documentation locally. There is a formal set of Policies and/or Operating Procedures that details how relevant standards should be applied across the Board; however we feel that the range of information needs drawing together to provide a clear picture of how the process works and confirm gaps in information do not exist. We have reported separately that risk management within the IJB is still being developed and has not yet transferred to a computer management system. This is still the case and whilst this is being resolved Strategic Planning risks have introduced their own version of control locally. Risk for the process has been identified and is being managed departmentally and supports one of the corporate risks for the IJB, although it is not always evident how a fluctuation in risk is being highlighted. In addition to the IJB risk, there continues to be a corporate risk for the NHS Board in relation to Strategic Planning. The main operational risk within this process is where suppliers can back out of their commitments, either by giving no notice or their agreed term. Whilst continuity procedures have been considered, management may wish to escalate the level of risk attached to this scenario to understand how or even if this can be mitigated. The way that care is delivered continues to be driven by historical methods including how funding is sourced and the fact that existing contracts may continue for some years ahead. However, where opportunities exist, advantage is taken to explore how service provision can be improved. The way that service review is completed can take years to effect once staff and public engagement is taken into account and so commissioners almost need to start the next review as soon as the previous one has occurred. This continues to be developed.
F/01/18 Property Transactions Monitoring **Assurance – Comprehensive** This is a mandatory audit that is undertaken every year	
E/03/18 Losses and Compensation	Since our previous audits of this process in 2014 and 2011 the theory and practical application has largely remained unchanged. Day-to-day management and financial accounting appears appropriate and supported using tried and tested processes.

Audit No. Audit Title Assurance level	Conclusion
Assurance – Moderate	The biggest area of concern relates to the lack of clarity in what should be reported through the Scottish Financial Returns and remains the subject of two unresolved actions from our previous audits. This issue should be reviewed as a matter of priority and clear pathways mapping guidance to the local position drawn up that can be confirmed at year-end reporting
E/04/18 Budgetary Control – Ring Fenced Funding **Assurance - Moderate**	Conclusion to follow
TS/06/18 Ledger Controls and Reconciliations **Assurance – Significant**	Our work has confirmed that the relevant and most current version of national guidance and/or legislation has been identified and its principles and values have been incorporated into the appropriate governance documentation. There is a formal set of Policies and/or Operating Procedures that detail how relevant Standards should be applied across the Board, however this would benefit from an additional procedural document that captures all month end and year-end activities for this process. This will provide a consistent approach to these tasks and capture all duties for continuity purposes. Risk in relation to the whole process have been identified and documented but have not been reviewed in accordance with the Board's Risk Management Strategy. Risk was highlighted as a whole in the CE-02-17 Standing Financial Instructions audit in September 2016 where a recommendation was agreed to be resolved by March 2018. This has not occurred and therefore remains open. There is a national platform that dictates a formalised account coding structure within the financial ledger that follows standard accounting conventions that is matched in all other linked systems. Access to the accounting system is restricted to current departmental employees at the required user level, who are fully trained on all relevant operation and security protocols. However there is a potential gap in that assurance on access protocols is not consolidated for all feeder systems. Data is held securely and accessible when required to authorised personnel; however there is an opportunity to improve the management of off-site access as the levels of current approved personnel could not be provided at the time of the audit. The segregation of duties within the processing of Journals through eFinancials is not used as financial value does not necessarily capture the riskiest elements. Instead a mitigating review process has been in effect since our previous audit; however now requires overhauling, which was recognised by External Auditors in their annual reports in 2015/16 and 2016/17. We concur that a more robust level of management review should be introduced. All housekeeping duties had been performed in preparedness for month end testing sample and there were no outstanding transactions that would affect the closedown of the ledger. The clear pre-set cut off times and dates for processing of all relevant data leading up to the closure of each period end as being met.

Audit No. Audit Title Assurance level	Conclusion
TS/12/18 Cash Control and Banking **Assurance - Significant**	The majority of processes remain in place from our previous audit in 2013/14. They continue to be completed well by a small nucleus of long-standing staff to which the processes are familiar and applied with consistency. The relevant and most current version of national guidance and/or legislation has been identified and its principles and values have been incorporated into the appropriate policy documentation. Whilst there is a formal set of Policies and/or Operating Procedures within Financial Services that details how relevant Standards should be applied within the Finance Department, this does not extend to a more basic set of instructions across all of the localities with only two areas having any meaningful procedural guidance. Risk in relation to the whole process has been identified and documented but does not have sufficiently detailed commentary to support the specific hazards and control measures. Risk was highlighted as an action in the Standing Financial Instructions audit (CE-02-17) in September 2016 where a recommendation was agreed to be resolved by March 2017. This has not occurred and therefore remains open. The main concern revealed within this audit surrounds the completion of the quarterly self assessments which requires all responsible managers to confirm the value of their delegated change and/or petty cash floats. Our review found that no quarterly check has resulted in a complete return, failing to confirm all floats are in agreement with the central records and the auditor's use of the standing data found incorrect e-mail and managerial information that probably caused the delays and non-return of the information required. It is not clear that self assessment by itself is providing the level of assurance that was originally intended and it is possible that quarterly checks are too frequent. Whilst the auditor's independent check did not reveal any significant variances in the cash holdings, the unwieldy nature of the current quarterly check is masking the real benefit of unannounced spot checks, which is more of a preventative measure as well as an opportunity to maintain direct contact with locality staff. Management should review the frequency of the paper exercise, conduct random spot checks in the intervening months and revise the administrative duties that support this task.

Annual Statement of Assurance from the Chief Internal Auditor 2017/18

Chief Internal Auditor's opinion of the System of Internal Control 2017/18

This statement is provided for the use of NHS Dumfries and Galloway in support of the Governance Statement for the year ended 31 March 2018.

Based on our work throughout the year, Internal Audit have concluded that:

- There were adequate and effective internal controls in place throughout the year, and
- The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role.

In addition, we have not advised of any concerns around the following:

- The format and content of the Governance Statement in relation to the relevant guidance,
- The process adopted in reviewing the effectiveness of the system of internal control and how these are reflected,
- Consistency of the Governance Statement with the information that we are aware of from our work, or
- The disclosure of relevant issues

The 2017/18 Internal Audit plan has been delivered in line with the Public Sector Internal Audit Standards.

1. INTRODUCTION

This Annual Statement of Assurance has been compiled to document and communicate the Chief Internal Auditor's opinion on the adequacy and effectiveness of the Board's internal control framework for the financial year 2017/18.

This Statement should be read in conjunction with the other information received, as outlined in the Governance Statement guidance to support the Accountable Officer and Audit and Risk Committee's conclusions on the adequacy and effectiveness of internal controls.

2. BACKGROUND

The Chief Internal Auditor is required to give an annual opinion to the Board through the Audit and Risk Committee, on the adequacy and effectiveness of the internal control system within the Board and the extent to which it can be relied on.

As the Board's Accountable Officer, the Chief Executive is required to sign a Governance Statement for inclusion within the Annual Accounts.

The report of the Chief Internal Auditor is a key element of the independent assurance that is included in the overall framework of assurance and evidence of compliance that should be considered within the Governance Statement.

3. THE GOVERNANCE STATEMENT

The purpose of good governance within any organisation is to ensure that the level of direction and management of the affairs of the organisation is sufficient to align corporate behaviours with the expectations of the public and to be accountable to all stakeholders in the public interest. The process of governance involves the clear identification of responsibilities, accountabilities and adequate systems of supervision, control and communication.

As Accountable Officers, Chief Executives have a responsibility for maintaining a sound system of internal control and must prepare a Governance Statement that is accurate, complete and fairly reports the known facts.

Over a number of years there have been changes to the year-end governance reporting requirements which has seen a move from the original Statement of Financial Controls to the Statement on Internal Control and, most recently, the Governance Statement. This has been driven by a number of factors such as significant corporate collapses and major governance failings, which has led to the development of the UK Corporate Governance Code.

The issuing of guidance by the Scottish Government each year is seen as a cumulative process with Boards building on the strengths of the implementation of previous years' guidance and further developing processes to evidence compliance against the various aspects of governance. The most recent guidance within the online section of the Scottish Public Finance Manual (SPFM) referencing the 2017/18 FReM summarises a range of assurances necessary to support the statement to ensure they are from a wide range of sources within NHS Boards. Whilst not being prescriptive on the format of the Governance Statement, the guidance details essential features for inclusion within the statement and draws Accountable Officer attention to the four governance strands of Clinical, Staff, Financial and Information Governance.

Audit Scotland completed a piece of work around good practice in preparing Governance Statements in May 2016 to help boards improve the disclosures made within their governance statements and ensure that they comply with the requirements of the SPFM. This guidance has been used by the board to develop the quality of our statement moving forward.

The Board has produced a Governance Statement which does not identify any disclosures.

My evaluation of the Chief Executive's compliance with Accountable Officer requirements and of the Board's Governance Statement draws on:

- the results of individual audits conducted during the year,
- assurances from Board officers, and
- official, relevant Board documentation presented as part of the preparation process for the Governance Statement

The process for collation of information to support the Governance Statement for 2017/18 has been supported with the production of a portfolio of documentation which informs the Accountable Officer and the Audit and Risk Committee on the information that is used to

evidence the Governance Statement. This information is provided in hard copy to the non-executives and they will be able to raise any queries at an Annual Accounts workshop at which key officers will be able to respond to any queries around the content.

With the aim of providing a more focussed structure, Executive Directors were asked to consider a checklist covering key areas required to inform the Governance Statement in relation to their particular areas of responsibility. These returns have been completed with varying levels of content and the shorter returns show no evidence of background information relied upon for completion.

The robustness of this process is unclear where the returns do not capture supporting information. The returns that I have been able to consider against internal audit findings are those that capture an enhanced level of detail.

In previous years a template was used which maintained a consistency in the format and content of the returns as well as ensuring that all the key governance and accountability areas were covered. This could be reintroduced for future years to enhance the level of reporting.

During 2017/18 we completed an audit around the Governance and Control Framework within the board, specifically in relation to committee structures and reporting. This audit gave a Moderate level of assurance with 6 recommendations being made to improve NHS Board and IJB governance processes.

This audit makes a recommendation around the approval process for annual reports on which reliance is placed for yearend processes i.e. Risk Management and Information Assurance. These reports should be approved through their respective groups/committees before being passed for assurance purposes.

4. AUDIT ASSURANCES TO SUPPORT THE GOVERNANCE STATEMENT

The Chief Internal Auditor must prepare an Annual Statement of Assurance which provides an opinion on the adequacy and effectiveness of the Board's internal control framework, risk management and governance processes for the financial year 2017/18.

This Statement is prepared based on audit work undertaken and takes into account Director and Committee returns along with the Annual Risk Management and Information Governance reports.

The Chief Internal Auditor is satisfied that the level of audit coverage over the year has provided a breadth of assurances from which to inform her audit opinion.

As each audit is undertaken, the results are reviewed by the Chief Internal Auditor and the areas of Governance and Best Value that each audit can provide assurance on are noted. This is then mapped into the year-end report which is presented to Audit and Risk Committee.

Audit work which can be identified as evidence in the various governance strands is detailed below along with specific information which has been drawn from the Directors' returns and Committee Assurance statements.

The Committee Assurance Statements follow the same template and cover areas such as membership, quoracy, attendance and minute approval through Board. There is a comments

section which has been used in a range of ways by the respective committee chairs to capture information. The level of detail in these areas varies considerably with some much shorter than others.

Board Governance Framework

- **Staff Governance**

  The Workforce Director's assurance return offers examples of arrangements or processes that have been put in place during the course of the year to enable her to discharge her responsibilities as Workforce Director and links these with the two corporate risks that she has lead responsibility for.

  Although not solely related to Staff Governance, Internal Audit are able to provide independent assurance in this area through the following audits undertaken this year:

  - Health and Safety Policy and Procedures – Limited Assurance
  - Nurse Revalidation (incl Midwifery and AHPs) – Significant Assurance
  - Capacity Management - Significant Assurance, and
  - Out of Hours Service – Moderate Assurance

  As the majority of our audits are focussed around processes and not departments or locations there have been a number of other audits such as the Board Governance and Decision Making and New Hospital Migration and Commissioning audits that have considered, and provided further assurances around, Staff Governance processes.

  Follow up work has been undertaken on a number of audits from previous years. There are currently 16 outstanding actions out of the 28 that are currently open within the Workforce Director's area. Whilst there has been some progress, the momentum should be maintained to ensure that these remaining actions are closed as a number have been outstanding for some time.

- **Financial Governance**

  The Director of Finance's return refers to board's statutory and financial duties and the delegated areas of responsibility in relation to the system of internal control.

  The return goes on to summarise the various processes around which financial assurances are given.

  Audit testing of the key financial systems and processes within NHS Dumfries and Galloway is a significant element of the information that is required to inform the Financial Governance strand within the Statement of Assurance. Audits that have been undertaken in the last year have included:

  - Losses and Compensation - Moderate Assurance
  - Ledger Controls and Reconciliations - Significant Assurance
  - Cash Controls and Banking - Significant Assurance
  - Budgetary Control – Ring Fenced Funding - Moderate Assurance

  Follow up has also concluded or is well progressed on a number of audits with a large number of actions being closed during the course of the year. There are

currently 45 outstanding actions against the 49 that are currently open within this area.

During 2017/18 we identified no significant weaknesses in the financial control systems we reviewed which would lead to those systems being open to significant abuse or error.

Through implementation of recommendations on previous audits, we are continuing to see more documented procedures and guidance to support the various roles and responsibilities covering financial processes.

- **Clinical Governance**

Clinical Governance is specifically covered within the Healthcare Governance Committee statement. The main focus of the work of the committee, when looking at the schedule of business for the year, is Patient Safety, Quality Improvement, feedback from various external performance reviews and learning from adverse incidents. This is consistent with previous years.

Assurance is also provided from the Nurse Directors statement which covers, amongst others, clinical governance, quality of care, risk management and patient safety. The Medical Director's statement confirms controls are in place but does not detail what evidence has been used to support this.

We have completed a number of audits this year which provide assurance over the wider theme of clinical governance. These are:

- New Hospital Migration and Commissioning Plans – Significant Assurance,
- Capacity Management – Significant Assurance,
- Out of Hours Service – Moderate Assurance, and
- Child Protection – Moderate Assurance

- **Information Governance**

Information to inform the Governance Statement in this area comes from the Information Assurance Committee (IAC) annual report.

The Information Assurance Committee (IAC) annual report details that there is a comprehensive governance structure in relation to assurances delivered around Information Governance. This report has not been taken to Information Assurance Committee for approval prior to submission and does not detail that there has been a Limited Assurance audit in this area (see below).

The Medical Director's role as Senior Information Risk Owner (SIRO) has not been recognised in the director's return.

During the course of the year we have undertaken one audit specific to Information Assurance:

- Information Governance and Security Improvement Measures – Limited Assurance

This audit aimed to provide assurance that we are implementing guidance in this area and that we have a strong and robust governance framework in place. We were unable to evidence this.

This Limited Assurance audit will be brought back to Audit and Risk Committee in full to discuss how gaps in this area can be resolved.

I can call upon testing from other audits during the past year which have considered information systems and security. Our audit approach is to look at whole processes and this has also looked to gain assurance from the IT systems being used and the levels of control that these offer. The following audits touch upon elements of Information Governance within the processes reviewed:

- Board Governance and Decision Making – Moderate Assurance,
- Capacity Management – Significant Assurance,
- Out of Hours Service – Moderate Assurance, and
- Child Protection – Moderate Assurance,

In the past five years we have also undertaken the following audits:

- Information Governance – Moderate Assurance,
- Records Management – Moderate Assurance, and
- Data Protection – Moderate Assurance.

Within the areas of Information Governance and Records Management there have been significant gaps in compliance and without the actioning of audit recommendations there are a number of very high risks that we are not evidencing that we are managing. This is therefore an area that requires focus to close off actions or to understand why these remain open.

- **Best Value**

How the board achieves Best Value is not detailed in the directors' or committee returns and therefore cannot be evidenced through this process.

As with the various governance strands, each audit undertaken is mapped against the principles of Best Value, therefore we build up a picture of where our work provides assurance on these principles. Therefore it can be demonstrated that Best Value is considered at the audit plan approval stage, during the course of each audit and at year-end with this Statement of Assurance.

- **Risk Management**

Three of the returns received from Directors refer to Risk Management in general terms and give various examples to evidence this. The return from the Workforce Director provides an overview of the corporate risks that she is responsible for and the return from the Nurse Director identifies that he has Executive responsibility for Risk.

There is a requirement for an Annual Risk Management report to be prepared. This should include a thorough description of how risk management has been embedded across the organisation. We can confirm that the Board has produced an Annual Risk Management report for this year.

Risk continues to be governed through the Risk Executive Group and Risk Steering Group with minutes coming to Audit and Risk Committee for information.

The Corporate Risk Register has been revised in year and this is being linked into a Board Assurance Map. The setting of a Board Risk Appetite has been completed although there is little evidence of this being embedded across the organisation. This is at early stages but understanding of what this is and how it can be used is not evidence below Board level.

Taking all the information contained within the portfolio of evidence into account I am satisfied with the consistency of the evidence which supports the Governance Statement with the information available from the work undertaken within Internal Audit.

5. BASIS OF ASSURANCE

Our opinion is limited to the work carried out by Internal Audit during the year based on the coverage of the Audit Plan. While all risks and areas of governance may not have been included in the 2017/18 Plan, we have undertaken sufficient work to provide reasonable assurance that there is an adequate control environment in place.

Our external auditors, Grant Thornton UK LLP, consider the work of internal audit as part of their audit process although they no longer require to place reliance on the work undertaken.

Audit and Risk Committee receive quarterly reports on the outcomes of audits undertaken and are able to request further information as required to enable them to form an opinion on assurances gained through the work of Internal Audit.

We have conducted our audits in accordance with the relevant mandatory Internal Audit Standards in place for NHSScotland during the course of the year. The relevant Standards for 2017/18 are the Public Sector Internal Audit Standards (PSIAS). These were adopted from 1st April 2013 to promote further improvement in the professionalism, quality and effectiveness of Internal Audit and reaffirm the importance of independent and objective internal audit arrangements to provide the Accountable Officer with key assurances needed to support the Governance Statement.

Guidance advises that minor deviations from the PSIAS should be reported to Audit and Risk Committee and more significant deviations should be considered for inclusion in the Governance Statement, with appropriate justification. Some issues which have previously been reported to Audit and Risk Committee have been addressed, such as the completion of an External Quality Assessment which supports the quality assurance and improvement processes within the function.

The external assessment carried out by KPMG and completed in November 2016 determined that the Internal Audit function conforms to PSIAS, and demonstrates several areas of good practice and effective corporate governance.

6. SUMMARY

Based on the work throughout the year, Internal Audit have concluded that:

- There were adequate and effective internal controls in place throughout the year;

- The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role;

In addition, we have not advised of any concerns around the following:

- The format and content of the Governance Statement in relation to the relevant guidance
- The process adopted in reviewing the effectiveness of the system of internal control and how these are reflected
- Consistency of the Governance Statement with the information that we are aware of from our work
- The disclosure of relevant issues

The 2017/18 Internal Audit plan has been delivered in line with the Public Sector Internal Audit Standards.

To conclude, we are satisfied with the consistency of the evidence which supports the Governance Statement with the information available from the work undertaken within Internal Audit.