Agenda

A MEETING OF THE NHS FIFE AUDIT & RISK COMMITTEE WILL BE HELD ON 19 NOVEMBER 2020 AT 2PM via MS Teams

There will be a pre meeting of Non-Executive Members at 1.30pm

MARTIN BLACK
Chair

1.		Apologies for Absence	
2.		Declaration of Members' Interests	
3.		Minutes of Previous Meeting held on 17 September 2020 ***(MB)***	(enc)
4.		Matters Arising	
		ANNUAL ACCOUNTS PROCESS	
5.	5.1	Patients Private Funds – Annual Accounts 2019/20 Cover Paper ***(MM)***	(enc)
		Appendix 1 Fife Health Board Patients Funds Accounts 2019/20	(enc)
		Appendix 2 Patients' Private Funds Audit Completion Memorandum	(enc)
		Appendix 3 Patients Funds - Letter of Representation ***(AM)***	(enc)
6.	6.1	Endowment Fund Annual Accounts & Report 201920 Cover Paper ***(MM)***	(enc)
		Appendix 1 Endowment Fund Annual Accounts & Report 201920	(enc)
		Appendix 2 Endowment Funds Letter of Representation	(enc)
7.	7.1	Service Auditor Reports on Third Party Services Cover Paper ***(MM)***	(enc)
		Appendix 1 NSS P&CFS Service Auditor Report	(enc)
		Appendix 2 NSS IT Services Service Auditor Report	(enc)
		Appendix 3 NHS A&A Financial Ledger Service Auditor Report	(enc)
8.	8.1	Internal Audit Annual Report 2019/20 Cover Paper ***(TG)***	(enc)
		Appendix 1 Internal Audit Annual Report 2019/20	(enc)
9.	9.1	Audit & Risk Committee Annual Statement of Assurance Cover Paper ***(MB)***	(enc)
		Appendix 1 Audit & Risk Committee Annual Statement of Assurance 2019/20	(enc)
10.		Draft Annual Accounts for the Year Ended 31 March 2020	
		Under the terms of the Public Finance & Accountability (Scotland) Act 2000, the Board is not permitted to make the Accounts publicly available prior to the Audited Accounts being formally laid before Parliament. These papers are therefore not included in this pack.	
	10.1	Annual Accounts for the Year Ended 31 March 2020 Cover Paper	
	10.2	Annual Accounts for the Year Ended 31 March 2020	
	10.3	Annual Audit ISA 260 Report for the Board of NHS Fife and Auditor General for Scotland	
	10.4	Draft Letter of Representation (ISA560)	
	10.5	Annual Assurance Statement to the NHS Board	
		OTHER	
11.		Issues for escalation to NHS Board ***(MB)***	(verbal)
12.		Any Other Competent Business	

Date of Next Meeting: 19 January 2021 at 10am within The Boardroom, Staff Club, Victoria Hospital (location TBC)

MINUTE OF THE AUDIT & RISK COMMITTEE MEETING HELD ON 17 SEPTEMBER 2020 AT 10AM VIA MS TEAMS

Present:

Mr M Black, Chair
Ms S Braiden, Non-Executive Member
Ms J Owens, Non-Executive Member
Ms K Miller, Non-Executive Member

In Attendance:

Mrs C Potter, Chief Executive
Mrs H Buchanan, Director of Nursing
Mrs M McGurk, Director of Finance
Mr T Gaskin, Chief Internal Auditor
Mr B Hudson, Regional Audit Manager
Dr G MacIntosh, Head of Corporate Governance & Board Secretary
Mr R Mackinnon, Associate Director of Finance
Ms P Fraser, Audit Scotland
Mr B Howarth, Audit Scotland
Ms A Clyne, Audit Scotland

1. Welcome / Apologies for Absence

The Chair welcomed Alison Clyne, Trish Fraser and Brain Howarth from Audit Scotland, who were attending the meeting.

Apologies were received from Cllr David Graham.

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minute of the last Meeting held on 13 July 2020

The minute of the last meeting was **agreed** as an accurate record.

4. Action List

In reference to the outstanding action on Internal Audit Follow-Up Reporting, Mrs McGurk noted that EDG now considers the progress on outstanding internal audit actions on a quarterly basis. Directors have been reminded of the need to ensure good progress is made in clearing outstanding issues. Additionally, in reference to outstanding actions from last year's Annual Accounts Audit Recommendations, Mrs

McGurk reported that good progress is being made in relation to the outstanding actions, with all due to be complete by the end of October 2020.

The Audit & Risk Committee **noted** the update.

5. MATTERS ARISING

5.1. Clinical Governance update on Adverse Events Internal Audit report

Dr MacIntosh reported that this had been an outstanding action on the Audit & Risk Committee's rolling action list. This specific internal audit report was seen in full by the Committee in March, where the Committee had raised concern about the rating of limited assurance given therein. The Committee then agreed that they wanted further consideration of the issues by the Clinical Governance Committee. The Clinical Governance Committee reviewed the internal audit report at their meeting in July and a follow-up summary had been submitted to their meeting held last week, which outlined the detailed action points that were required by the report and progress made to address these thus far.

The Audit & Risk Committee **noted** the update and took assurance from the progress made to address the recommendations of the internal audit report.

5.2. Sharing Intelligence for Health & Care Group – Feedback letter on NHS Fife

Mrs Potter noted that the Sharing Intelligence for Health & Care Group is overseen by Healthcare Improvement Scotland and is a forum where a number of organisations come together to share information and intelligence on different aspects of the business of healthcare.

The feedback letter on NHS Fife was enclosed for the Committee's information. There were two main issues highlighted therein: the quality of the estate / buildings used to deliver care in a Mental Health setting; and the ongoing financial and governance challenges in the operation of the Health & Social Care Partnership / IJB. Positive progress was also highlighted in the letter, namely in the enhancement of medical education and training; the Board's engagement in quality improvement work; and strong partnership working in children's and young people's services. The Board's response and leadership in the context of the Covid-19 pandemic was also recognised at the recent feedback meeting. Members welcomed the useful summary.

In response to a question raised by Mr Gaskin around future reports containing information on how the actions have been taken forward, Mrs Potter advised that the report did not contain anything new, in that the Group considered data already in the public domain. In response to the original reports, all the actions are already being fully addressed through a number of individual workstreams and action plans, such as those around mental health via that stand-alone strategy.

The Audit & Risk Committee **noted** the update and the helpful feedback received from the Group.

6. ANNUAL ACCOUNTS

6.1. Annual Accounts Update

Mrs McGurk reminded the Committee that there had been significant workforce changes and capacity issues within the senior financial team, which, combined, had resulted in not achieving the 1 July completion date for the financial statements being submitted to Audit Scotland. There are ongoing regular communications with the Audit Scotland team, who have supported the Finance Department and have recognised the capacity issues.

As at the end of July, a package of data was agreed for submission the first week in August, but again delivery of the complete information could not be met. Audit Scotland therefore advised that their planned resources had to be moved to service another audit. Mrs McGurk confirmed that the full set of accounts was delivered to Audit Scotland on 17 August and their audit has now commenced. It is unlikely that the review will be finished until the end of November, with a possibility that this could be the beginning of December, which could cause a significant issue in terms of the NHS Scotland-wide consolidation of accounts. The Scottish Government have been kept up to date, along with the Chair of the Audit & Risk Committee, the Chair of the Board and Chief Executive. She added that NHS Fife has secured specialist support from finance staff in NHS Lothian, along with support from NHS Grampian, who have all been extremely helpful.

Mrs McGurk informed the Committee that good progress had been made with the audit of patients' funds accounts and, subject to a few transaction queries, these should receive a clean audit opinion. The Endowment accounts audit had also been recently completed.

Mr Howarth from Audit Scotland advised that resources within their service had all been heavily impacted by Covid; productive time is down by 16% and audits are taking longer than normal as they are relying on key staff within organisations to gather and present evidence remotely, which has led to some difficult decisions to accommodate audits within the wider timetable. NHS Fife is one of the more significant of those in terms of timing and this is having a wider effect.

Ms Fraser advised that since 17 August Audit Scotland have been working on the NHS Boards audits and in the last few week have been focusing particularly on NHS Fife. She was hopeful that good progress can be made over the next few weeks and a larger team will be made available to work on the accounts. It was however anticipated that the accounts would not be ready for Audit & Risk scrutiny any sooner that the beginning of December, and meetings would require to be arranged to fit within that overall timetable.

The Audit & Risk Committee **noted** the update on the Annual Accounts

7. GOVERNANCE – GENERAL

7.1. Update on Board Action Plan for the implementation of the NHS Scotland 'Blueprint for Good Governance'

Dr MacIntosh gave an update on progress with implementing the recommendations of the NHS Scotland 'Blueprint for Good Governance'. Whilst the Board has adopted a number of the various workstreams, such as the Model Standing Orders and agenda paper template, she advised that the national work on the remaining areas had been heavily impacted by the focus on Covid. It is expected that the next national survey of Board members will not be held until at least early 2021. The action plan provided outlines all of the actions that had been previously agreed with the NHS Fife Board and the paper gives a summary on progress with meeting these.

The Audit & Risk Committee **noted** the update and **recommended** that the report be submitted to the next NHS Fife Board meeting for assurance purposes.

7.2. Annual Review of Code of Corporate Governance

Dr MacIntosh advised that, as previously mentioned, in April 2020 the Board adopted the Model Standing Orders for NHS Boards in Scotland. Additionally, all the Board Committees have recently reviewed their remits, as part of the year-end process, and the revised Code of Corporate Governance reflects these textual changes. The update to the Code also consolidates any other minor changes, to areas such as job titles, which are reflected within to ensure the Code remains current. It was noted that Mr MacKinnon has also reviewed the Standing Financial Instructions section and has made some clarifying recommendations, which are tracked within. Mr MacKinnon summarised the changes made and rationale for those amendments, with reference to each.

In reference to the proposed addition to clause 8.3 (p.54) of the SFIs ('The Chief Executive shall establish a system of delegated budgetary authority within which budget holders shall be responsible for the engagement of staff within the limits of their approved budget *unless following successful grading appeals*'), it was agreed that the addition could be helpfully clarified with the addition of further text to ensure budgets were adhered to. The Committee agreed that, under delegated authority, the production of revised wording be remitted to the Chief Executive and Director of Finance, to produce a revised clause for final consideration by the Board.

Mrs Braiden referred to Section 6.2(e) of the Standing Orders, which mentions the Annual Operational Plan, and queried if the plan still exists or has been replaced by mobilisation plans re Covid. Mrs Potter reported that NHS Fife are required to submit an Annual Operational Plan to the Scottish Government for next year, and guidance is coming out in the next month or so. That terminology still remains relevant.

The Committee **recommended approval** of the revised Code to the NHS Fife Board, with the caveat that the wording within clause 8.3 of the SFIs be revised prior to final submission to the Board.

7.3. Corporate Calendar / Committee Meeting Dates to 2021/22

Dr MacIntosh reported that the proposed meeting dates to March 2022 have been provided, with clarity still awaited around the possibility of an annual accounts meeting in December, followed by an additional meeting of the Committee in January to catch up on business normally considered at a routine December meeting. Members will be advised of the new dates as soon as they are available and their patience is appreciated.

The Audit & Risk Committee **noted** the proposed 2021/22 Committee meeting dates.

8. GOVERNANCE – INTERNAL AUDIT

8.1 B25/21 – Post Transaction Monitoring

Mr Hudson advised that, under the Property Transaction Handbook (PTH) regulations, the Audit & Risk Committee is charged with oversight of the monitoring of the process of property transactions. The monitoring process is a cyclical exercise and Internal Audit were requested to review all three transactions completed in 2019/20 to ensure the requirements of the PTH were followed.

The audit report assessed each transaction at grade A, i.e. transaction is properly completed, with three recommendations each risk assessed as 'merits attention', which management have accepted (two of which have now been addressed). A clean property transaction return in respect of 2019/20 can therefore be submitted to the SGHSCD by the 30 October 2020 deadline.

The Audit & Risk Committee **noted** that the requirements of the PTH have been complied with, that arrangements are in place to issue the Board's Annual Property Transactions Return to SGHSCD by the deadline of 30 October 2020, and that the return be submitted with no significant issues identified.

8.2 Draft Internal Audit Annual Report 2019/20

Mr Gaskin introduced the report, noting that there were some very important issues to be brought to the attention of the Committee. The report is currently in draft, and thus the recommendations do not have a management response at present. That allows the Committee to have the opportunity to feed into the response.

Overall, the rating of the report is that there are effective internal controls within NHS Fife. The key message of the report is that NHS Scotland as a whole is facing major issues in maintaining and planning for sustainability. Audit Scotland colleagues have produced some excellent reports on the national situation around an ageing workforce, financial sustainability and pressures on the health service as a whole, and Fife is no exception to this. In terms of recurring savings NHS Fife has not met this target in full for a number of years. As with all NHS Boards, service transformation will be an important factor in addressing this. With Covid-19 related pressures, the gradual slide in performance across Scotland has been vastly accelerated and pressures on the system have greatly increased.

It was noted that NHS Fife responded really well to the pandemic emergency and achieved in a matter of days significant areas of service transformation. Tremendous work has been delivered during this time, including improvements with the relationship with the IJB, with all parties working at pace for the population of Fife. Mr Gaskin noted further positive examples of progress with service change including the Orthopaedic Elective Centre and developing the Mental Health Strategy, and NHS Fife has shown that it can achieve transformation on a planned basis.

Mr Gaskin noted that progressing improvements in relation to Information Governance arrangements has been an issue in the Board for some time and requires continuing focus from the Clinical Governance Committee. The Information Governance programme of improvement is a priority for NHS Fife, it should be noted that without continuing progress this has the potential to be a disclosure in future years. Mr Gaskin noted he would like to thank the Chief Executive, Director of Finance and Board Secretary for their input in preparing this draft report and also to the internal audit staff who have been delivering a lot of work in difficult circumstances.

In relation to Mr Gaskin's comments on delivery of recurring efficiency savings, Mrs McGurk highlighted that the recurring gap had reduced through 2016/17-2018/19, though this had not been the case in 2019/20. In terms of achieving savings on a recurring basis, this is a major issue across all Health Boards. NHS Fife set out initial plans (pre-COVID 19) to address the delivery of efficiency savings, which linked that directly to service transformation over a realistic period of time. Mrs McGurk referenced the Board Development Session in January 2020 and February 2020 and the Finance, Performance & Resources Committee in March 2020, where a three-year medium-term financial strategy linked to the transformation was discussed. The Executive Team are focused on delivering against that medium-term strategy; however, it is unlikely that detailed planning and therefore delivery can commence this financial year given the impact of the pandemic.

Mrs Potter agreed that the planning and delivery of the Orthopaedic Elective Centre was a good example of delivering transformation. That project has been successful in getting to the current stage because the organisation understood how to put that transformation programme together, including effective clinical engagement. Mrs Potter also noted that the Mental Health Strategy has been developed and in the last month there has been the first meeting of the Mental Health Strategy Programme Board. These projects are being taken seriously by NHS Fife and there is real evidence of things beginning to progress.

More generally Mrs Potter noted that in July 2019 a workshop was held across Heath & Social Care involving NHS Board Members, IJB and members from Fife Council, which featured items from all of the strands of redesign that were happening across Fife. The workshop prioritised programmes of work, and an Integrated Transformation Board was established, with Non-Executive representation and elected members from Fife Council. The Board also appointed a Programme Director to drive this forward. The most recent meeting was held in February 2020 and we consciously paused this area of work as the pandemic hit. Until February of this year, progress was being made, a supporting infrastructure was in place and the Board were supportive of the previous Chief Executive's approach with a PMO. We are now refreshing priorities and held a workshop recently to take stock of priorities going forward within NHS Fife and

the H&SCP, and to make changes to reflect the additional demands arising as a result of Covid. The roles of key directors, such as the Nurse Director, Medical Director and the Director of Finance in particular, have never been so important, also recognising the role of the Director of Public Health and the Public Health function. It was recognised that structures we have had in the past for transformation may not be fit for purpose now, but redesign will necessarily take some time, particularly if the Covid pandemic experiences a second peak.

Ms Braiden recognised that some of these issues have been apparent for some time. Her view was that this is a difficult situation; people are tired and are now preparing for a second wave of Covid. It is important to identify what have been the main blocks in the past for transformation and what can we actually do to move things forward in a realistic way.

Mr Gaskin noted that he had used the phrase 'green shoots' in reference to the work around the Orthopaedic Elective Centre and the Mental Health Strategy. These tell you the organisation does have capacity to achieve results. What it does not tell you is whether it has the capacity and capability to do the full range of things that are needed now. Internal Audit expect to see that information captured in one place. As a Board, members would also have to accept that there will be a focus on key issues and certain things may need to have less of a priority. Officers will need to be supported on that. Internal Audit is currently undertaking an audit around the remobilisation work and this will come to a meeting early in 2021.

Mr Black noted that, as a Board member, he had seen good examples of transformation work that was effective in Fife. The complexities in the relationship with the IJB and its construct remained a real challenge, which Mr Gaskin agreed was a difficult balance.

Mrs Potter highlighted to the Committee that, as Accountable Officer, she had received a letter dated last Friday confirming that the Cabinet Secretary will maintain the NHS on an emergency measures basis until 31 March 2021. As a result, the Board is being explicitly directed from the Scottish Government on what our immediate priorities are. These are Test & Trace work, the Flu Vaccination programme and preparing for Winter. In relation to the remobilisation plan, we will be linking with Scottish Government on a monthly basis, so will have input on how we respond to that.

Mr Black thanked all members and attendees for the helpful and robust discussion. The Audit & Risk Committee **considered** the draft Internal Audit annual report and noted that a final version, with formal management responses, will be considered at their next meeting.

9. RISK

9.1. Risk Management Annual Report 2020/21

Mrs Buchanan reported that the annual report provides a summary of all the developments over the last year highlighting the information provided in terms of the Risk Management Framework, Assurance Mapping, Board Assurance Framework,

Key Performance Indicators, Adverse Events Management, Duty of Candour and the Datix system.

The Audit & Risk Committee **noted** the annual report

9.2. Risk Management Framework Update

Mrs Buchanan reported that Risk Management Framework had been a work in progress for some time. The Framework has been updated to incorporate the approach to risk management within the organisation and the responsibilities for managing risks and processes for effective risk management. The Board's approach to risk appetite / tolerance is outlined, as are the appropriate structures to manage risk and also the governance structures that are in place to ensure that the relevant committees are aware of the risks that are in our system.

The Audit & Risk Committee **noted** the update and recommended the revised framework to the Board for approval.

9.3 Risk Management Key Performance Indicator Report

Mrs Buchanan gave a brief update, noting that Appendix 1 of the report highlights timescales of risks within the risk register and the length of time they have been there. It also looks at the Board Assurance Framework format.

The Audit & Risk Committee **noted** the report and that the development of the KPIs would be part of the implementation of the Framework as above.

9.4 Update on Risk Management Workplan

Mrs Buchanan reported that, as detailed in the paper, the 2019/20 workplan was complete as detailed within. She highlighted that 2020/21 workplan outlines the different areas that will be completed over that period by the risk management team.

In a response to a question raised by Ms Braiden, Mrs Buchanan advised that there were sufficient resources in place to fulfil the scope of the risk management work, noting however the continuing pressures of day-to-day business (such as adverse events management) on that service was significant. Tony Gaskin noted the benefits of allowing the Risk Manager to concentrate on strategic risk management initiatives, where at all possible.

The Audit & Risk Committee **noted** the proposed workplan.

10. ANNUAL ASSURANCES

10.1. Annual Assurance Statements for 2020/21

- **Clinical Governance Committee**
- **Finance, Performance & Resources Committee**
- **Remuneration Committee**
- **Staff Governance Committee**
- **Fife Integration Joint Board**

Dr MacIntosh advised that each of the individual committees had reviewed their statements as part of their meetings held in July and all had improved the content of the annual assurance statements. An assurance statement from the IJB's Chief Internal Auditor was also included within the pack.

The Audit & Risk Committee **noted** for assurance purposes the Annual Assurance Statements for 2020/21.

10.2 Draft Audit & Risk Committee Annual Statement of Assurance

Dr MacIntosh advised that this was a draft version of the Audit & Risk Committee Annual Statement of Assurance and was here for members' comments, before coming back to the Committee in final form at their next meeting. The report reflects the scope of business that the Committee has reviewed over the year, along with detailing the various training events that members have participated in.

Noting the content, the Audit & Risk Committee **approved** the draft Audit & Risk Committee Annual Statement of Assurance.

10.3 Significant Issues of Wider Interest / Draft Governance Statement

Mr Mackinnon advised that the paper provided the annual assurance letter that the Audit & Risk Committee is asked to submit to the Scottish Government. The report sets out key issues which could be of wider interest beyond NHS Fife; this year there were areas identified in the Directors' letter from Scottish Government Health and Social Care Directorate, as set out in the appendix, which the Board has responded to. The draft letter is provided within the document for consideration, which has been approved thus far by the Chair. The draft governance statement is also set out within the appendix.

The Audit & Risk Committee **approved** the Significant Issues of Wider Interest and draft Governance Statement as provided within.

OTHER

11. Issues for escalation to NHS Board

There were no issues of escalation to be highlighted from the current meeting.

12. ANY OTHER BUSINESS

In reference to the request under Item 8.2 that the draft Internal Audit Annual report be issued to the other standing committees, Mr Gaskin noted this would be good practice. A final version might be more appropriate, however, as this would contain management comments and action deadlines. Mr Black agreed to discuss initially with the Chair of Clinical Governance, as the findings related largely to that Committee's area of remit.

In reference to Item 10.2, Mr Howarth highlighted that, given the recommendations and findings of the Internal Audit annual report, whether the Committee would wish to see these reflected in the Committee's assurance statement to the Board. Mrs McGurk suggested that, since the Audit & Risk Committee had already approved the Annual Assurance Statement under the discussion on that agenda item, when the annual accounts are presented to the Board for final approval the Audit & Risk Committee usually provide at statement in support. That would be an opportunity to reflect to the Board anything that the Audit & Risk Committee would want to escalate from either the internal or external audit annual reports (the latter still to be considered). This was agreed by the Committee as an appropriate way forward.

13. POST-MEETING TRAINING SESSION

After the Committee's meeting, members attended a training session, led by Audit Scotland, on scrutiny of the annual financial accounts.

Date of Next Meeting: 19 November 2020, location TBC.

NHS FIFE

Meeting:	**Audit & Risk Committee**
Meeting date:	**19 November 2020**
Title:	**Patients' Private Funds – Receipts and Payments Accounts 2019/20**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Margo McGurk, Director of Finance**

1 Purpose

This is presented to the Committee for:

- **Assurance**
- **Discussion**
- **Decision**

This report relates to a:

- Legal requirement

This aligns to the following NHSScotland quality ambition(s):

- Effective

2 Report summary

2.1 Situation

The Audit & Risk Committee, as part of its remit, is required to review the Receipts and Payments Accounts for Patients' Private Funds and to recommend their approval by the Board.

2.2 Background

The independent auditor (Thomson Cooper Accountants) provided an Audit Planning Memorandum which was previously noted by the Audit & Risk Committee.

2.3 Assessment

Thomson Cooper Accountants has concluded their audit of the financial statements of the Patients Private Funds.

2.4 Risk Assessment/Management

The auditors reported that there were no significant issues that adversely impacted the control environment or the integrity of the Abstract of Receipts and Payments.

2.5 Communication, involvement, engagement and consultation

The external auditor engaged both on-site and remotely via e-mail and telephone with cashiers, staff from Financial Services and the Associate Director of Finance in undertaking their work.

2.6 Route to the Meeting

A number of meetings have been held between the external auditor and NHS Fife staff prior to the audited abstract of accounts and Engagement Completion Memorandum being shared with the Director of Finance and Audit and Risk Committee.

2.7 Recommendation

The Audit & Risk Committee is asked to:

- **review** the Patients' Private Funds Accounts;
- **invite** Thomson Cooper Accountant's to report on their audit of the financial statements
- **recommend** that the Accounts be approved by the NHS Board.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 Abstract of Receipts and Payments for the Year Ended 31 March 2020.
- Appendix 2 Audit Completion Memorandum.
- Appendix 3 Letter of Representation.

FIFE HEALTH BOARD

PATIENTS' PRIVATE FUNDS

RECEIPTS AND PAYMENTS ACCOUNT

FOR

THE YEAR ENDED 31 MARCH 2020

FIFE HEALTH BOARD

PATIENTS' PRIVATE FUNDS

YEAR ENDED 31 MARCH 2020

STATEMENT OF HEALTH BOARD MEMBERS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

Under the National Health Service (Scotland) Act 1978, the Health Board is required to prepare accounts in accordance with the directions of Scottish Ministers which require that those accounts give a true and fair view of the state of affairs of the Patients' Private Funds as at 31 March 2020. In preparing these accounts, the Directors are required to:

- Apply on a consistent basis the accounting policies and standards approved for the NHS Scotland by Scottish Ministers;
- Make judgements and estimates that are reasonable and prudent;
- State where applicable accounting standards have not been followed where the effect of the departure is material.

The Health Board members are responsible for ensuring proper accounting records are maintained which disclose with reasonable accuracy at any time the financial position to ensure that the Accounts comply with the National Health Service (Scotland) Act 1978 and the requirements of the Scottish Government Health Directorates. They are also responsible for safeguarding the assets and hence taking reasonable steps for the prevention of fraud and other irregularities.

The NHS Board members confirm they have discharged the above responsibilities during the financial year and in preparing the accounts.

---------- Director of Finance

---------- Chief Executive

FIFE HEALTH BOARD
PATIENTS' PRIVATE FUNDS

INDEPENDENT AUDITORS' REPORT TO THE BOARD OF FIFE HEALTH BOARD

We have audited the financial statements of Fife Health Board Patients' Private Funds for the year ended 31 March 2020 set out on page 4. These financial statements have been prepared under the historical cost convention.

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

Respective Responsibilities of Board and Auditors

As described in the Statement of Board Members' Responsibilities you are responsible for the preparation of the financial statements in accordance with applicable law and United Kingdom Accounting Standards and for being satisfied that they give a true and fair view.

Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK). Those standards require us to comply with the Financial Reporting Councils' (FRC's) Ethical Standards for Auditors.

Scope of the audit of the financial statements

A description of the scope of an audit of financial statements is provided on the FRC's web-site at www.frc.org.uk/auditscopeukprivate.

Opinion

In our opinion, the financial statements give a true and fair view of the state of the Funds' Receipts and Payments Account for the year ended 31 March 2020.

Thomson Cooper
Registered Auditor
3 Castle Court
Carnegie Campus
Dunfermline
KY11 8PB

Date:

FIFE HEALTH BOARD
PATIENTS' PRIVATE FUNDS

RECEIPTS AND PAYMENTS ACCOUNT
FOR THE YEAR ENDED 31 MARCH 2020

2018/19 £		£	2019/20 £
	RECEIPTS		
	Opening Balances:		
387,701	Cash in Bank	492,018	
10,353	Cash on Hand	11,507	
371	Other Funds	885	504,410
398,425			
415,847	From or on behalf of Patients		312,231
-	Interest on Patients Funds Accounts		-
814,272	**TOTAL RECEIPTS**		**816,641**
	PAYMENTS		
309,862	To or on behalf of Patients		353,452
	Closing Balances:		
492,018	Cash in Bank	449,953	
11,507	Cash on Hand	12,075	
885	Other Funds	1,161	463,189
504,410			
814,272	**TOTAL PAYMENTS**		**816,641**
	Closing balances accounted for as:		
	Patient Personal Accounts		
504,544	Credit Balances		463,274
134	Less Debit Balances		85
504,410	**TOTAL CLOSING BALANCE**		**463,189**

I certify that the above abstract of Receipts and Payments is correct and in accordance with the Books of Account and that that the Register of Valuables has been inspected and checked with property held.

Director Finance ..... Date .....

The above abstract of Receipts and Payments was submitted at the NHS Board Meeting on XX and duly approved.

Chief Executive ..... Date .....

Fife Health Board Patients' Private Funds
Audit Completion Memorandum

To the Board

Audit of Accounts

Year Ended 31 March 2020

Contents

Introduction

International Standard on Auditing 260 requires auditors to communicate by effective means, matters concerning an entity's audit to those charged with the governance of that organisation.

The first part of this process involved issuing the Board with an Audit Planning Memorandum prior to the commencement of the audit. The purpose of that report was to provide the Board (as those charged with the governance of Fife Health Board Patients' Private Funds) with information regarding:

- the planned audit approach;
- the proposed means and modes of communication throughout the audit assignment; and,
- to provide the Board with the opportunity to discuss the assignment and the audit approach prior to the commencement of audit field work.

The final part of this process is covered by issuing an Audit Completion Memorandum, and ensures that the communication process has been followed before, during, and at the end of the audit. This report sets out the following:

- the progress of the audit to date, including any issues identified during the fieldwork and any information that has been requested but not provided;
- a summary of key financial information relating to the Fund based upon the draft financial statements; and
- conclusions of the audit risks identified during the planning stage, and included within the Audit Planning Memorandum.

This report only covers items that have been identified during our audit testing and therefore does not include every possible issue relating to the Fund. In addition, we will only include those issues that we feel could have a material impact upon the Fund or our audit procedures. Items deemed as immaterial are therefore not included.

This report is addressed to the Board of Fife Health Board Patients' Private Funds and is intended for internal use only for the purpose of reviewing and finalising the audit of the financial statements for the year ended 31 March 2020. This report may not be reproduced in whole or in part without the prior, written consent of Thomson Cooper.

Audit Status

Fieldwork Progress

Our audit fieldwork was undertaken by Billy Leith and Kara Coalter between Monday 22 and Wednesday 24 June 2020. All of the planned work was completed within this time frame, with no further fieldwork being required. Therefore, the fieldwork section of the audit is considered to be complete.

Issues Identified

The following is a summary of the key audit issues identified during the completion of our audit fieldwork:

Expenditure – Cheque Payment Requests (PF7)

As noted in previous years, from the sample selected for testing we noted that those relating to Cameron and Glenrothes Hospital did not note the patients' number on the PF7 forms. This means that reliance is placed on the patient's name and therefore there is the potential for the request to be allocated to the wrong patient account.

From the sample of forms selected for testing we noted three instances relating to Stratheden and one instance relating to Cameron where the "authorisation" box had not been signed on the form.

Expenditure – Monies Issued of <£50 (PF6)

From the sample of forms selected for testing we noted two instances relating to Queen Margaret and one relating to Lynebank where the "patient" box had not been signed on the form.

Expenditure – Recording of Monies Issued >£50 (PF5)

From the sample of forms selected for testing we noted two instances relating to Lynebank where the patients number had not been noted on the form. This means that reliance is placed on the patient's name and therefore there is the potential for the request to be allocated to the wrong patient account.

Audit Status (continued)

Ward Visits

This year we visited three wards at Stratheden and two at Cameron.

Disclaimer Notices

Disclaimer notices were displayed in all of the wards visited at Stratheden hospital.

At Cameron hospital one of the wards had the disclaimer displayed. Balcurvie did not have a notice on display however, staff informed that it is written in the patients notes.

Security Arrangements over records

All wards visited kept their records in the nurses' station, which was locked when not in use. All cash and valuables were kept either in safes or lockable cupboards, but not all records were kept locked away, with some being kept on open shelves within the locked room.

Custody of Property

PF11 forms were not used at any of the wards we visited, however each ward visited did keep a separate record of patient's belongings within each individual patient files. The correct NHS brown envelopes were used at all of the wards visited.

Recording of Income

All PF3 forms that were reviewed were completed correctly and sent to the cashier to ensure that the patient's accounts were updated.

Recording of Imprest

The cash on each ward at the time of our visit was counted and agreed back to the current PF6. All PF6 forms that were reviewed were completed correctly.

At the two wards visited in Cameron no PF6 forms were available for review as they are not used due to the nature of the wards.

Recording of Specific Expenditure

All PF5 forms for expenditure requests for amounts in excess of £50 that were reviewed were completed correctly.

Audit Status (continued)

Ward Visits (continued)

At the two wards visited in Cameron no PF5 forms were available for review as they are not used due to the nature of the wards.

Recording of Deaths and Discharges

All available PF2 forms that were reviewed were completed correctly.

Outstanding Information

There is no information that was requested during the fieldwork that remains outstanding.

Assistance during Fieldwork

We would like to take this opportunity to express our thanks for all of the help and assistance that was given to our staff during the audit fieldwork.

Key Financial Information

The accounts of the Fund are fairly straightforward. The Fund holds amounts in bank accounts being money held by the Board for or on behalf of patients.

At the beginning of the year the Fund held amounts on behalf of patients totaling £504,410.

During the year receipts from patients amounted to £312,231 (2019 - £415,847).

After deducting payments and other withdrawals in the year of £353,452 (2019 - £309,862) the Fund held amounts on behalf of patients totaling £463,188 at the end of the year.

Conclusion of Audit Risks Identified

Introduction

As set out in the Audit Planning Memorandum, our aim is to plan and perform sufficient audit work so as to ensure that detection risk is minimised and that the conclusion drawn regarding the truth and fairness of Fife Health Board Patients' Private Fund's financial statements is valid.

The risks below were identified at the planning stage and were based upon our initial discussions and a review of previous year's financial statements, prior to the commencement of the detailed planning work for the audit for the year ended 31 March 2020. Our response to these risks now that the audit fieldwork has been completed are summarised as follows.

Audit Risks Identified at Planning Stage

Security of Patients Funds

Due to the nature of the fund's assets i.e. cash, there is an increased susceptibility of the assets to loss through theft or misappropriation. A key focus of our audit will be the testing of the adequacy of the controls in place governing the security of patient funds on the wards.

Response

After reviewing the records for the year and after discussions with the Board we believe that there are adequate security and control arrangements in place.

Compliance with Agreed Operating Procedures

The Board has in place a series of control and authorisation procedures for patient funds which are documented in the Board's Financial Operating Procedure. This report details the various forms which should be used by staff in order to adequately record and control patient funds on the wards and is a key source of internal control. Our audit will include tests to assess the extent to which members of staff have adhered to the documented procedures, including visiting various hospital wards on a rotational basis.

We shall also consider any areas of potential non-compliance with procedures that were identified and communicated to the Board in the previous year's audit, and follow up with regard to how each item has been subsequently dealt with. In addition, where considered relevant, we will seek to re-visit any wards attended in the previous year where issues were identified to perform updated tests to re-assess the extent to which staff have been advised of the issues and have acted upon the recommendations.

Audit Risks Identified at Planning Stage (cont'd)

Compliance with Agreed Operating Procedures (cont'd)

Response

After reviewing the records for the year end from completing our ward visits, we can confirm that the Financial Operating Procedures are being adhered to and there were no significant instances of non-compliance, of which we are aware. Issues identified during our ward visits are detailed on Page 2 of this Audit Completion Memorandum.

Fraud

The auditor's responsibility to consider the audit risk of fraud is laid down in ISA 240 "The auditor's responsibility to consider fraud in an audit of financial statements".

In accordance with ISA 200, 'the auditor shall maintain professional scepticism throughout the audit, recognising the possibility that a material misstatement due to fraud could exist, notwithstanding the auditor's past experience of the honesty and integrity of the entity's management and those charged with governance'.

As part of the planning process, we are obliged to make enquiries of management and those charged with governance regarding:

a) Management's assessment of the risk that the financial statements may be materially misstated due to fraud, including the nature, extent and frequency of such assessments;
b) Management's process for identifying and responding to the risks of fraud in the entity, including any specific risks of fraud that management has identified or that have been brought to its attention, or classes of transactions, account balances, or disclosures for which a risk of fraud is likely to exist;
c) Management's communication, if any, to those charged with governance regarding its processes for identifying and responding to the risks of fraud in the entity; and
d) Management's communication, if any, to employees regarding its views on business practices and ethical behaviour.
e) Whether Management have knowledge of any actual, suspected or alleged fraud affecting the entity.

We can confirm that if we identify any fraud or obtain information that indicates that a fraud may exist, we will communicate this to the appropriate level of management as soon as practicable. If the fraud involves management, employees who have significant roles in internal control or where the fraud results in a material misstatement in the financial statements, we will communicate these matters to the Board as soon as practicable.

Audit Risks Identified at Planning Stage (cont'd)

Fraud (cont'd)

At the conclusion of our audit work, we will request written confirmation in our letter of representation that the Board acknowledge their responsibility for the design and implementation of internal control to prevent and detect fraud and that it has disclosed to ourselves the results of its risk assessment and disclosed any instances or allegations of fraud which have arisen.

Response

After reviewing the records for the year we can confirm that no instances of fraud were identified during the audit. Confirmation will be sought from the Board to ensure that there are no instances of fraud of which we are unaware.

Audit Risks Identified During Fieldwork

We are pleased to report that during our audit fieldwork there were no additional audit risks identified as being required to be brought to the attention of the Board.

Report to Management

General Report

Introduction

We have completed our audit of the financial statements for the year ended 31 March 2020 and set out below a summary of the matters which we believe should be brought to your attention. There are no significant matters to report and accordingly a separate management letter and report is not necessary.

Scope of our Report

The specific objective of our audit was to confirm whether the financial statements showed a true and fair view of the state of affairs of the Fund. We have prepared this report solely for use by the Board.

Our work cannot be expected to identify all weaknesses in your systems and procedures which a special investigation directed at the systems and procedures might reveal.

Principal Findings

We are pleased to report that in general, our audit testing revealed internal controls to be adequate, well designed and operating effectively.

The key issues that have been identified are brought to your attention on page 2 of this Audit Completion Memorandum.

Audit Adjustments

Introduction

Audit adjustments can be summarised under 3 main categories:

1. Provided to us during audit fieldwork

These adjustments are items that you identified in between providing the final period end figures upon which the audit has been planned and the completion of the audit fieldwork.

Examples include provisions for late invoices received and material post year end transactions that were not apparent before the commencement of the audit.

2. Provided by Thomson Cooper during or after audit fieldwork

These adjustments are items identified by the Thomson Cooper staff during the preparation of the draft statutory financial statements which are required to be provided in order for the financial statements to show a true and fair view of the results for the period.

Examples include amendments to accruals and prepayments and reallocation of expenses.

3. Unadjusted or additional proposed items after audit fieldwork

Unadjusted items would typically include adjustments that could have been made, however are deemed not material enough to justify their inclusion.

Examples would include small differences identified in bank reconciliations, sales or purchase ledger control financial statements.

Additional proposed items would normally relate to potential adjustments that have been identified by our audit staff that because of their materiality could impact upon the truth and fairness of the financial statements.

Current Period Audit Adjustments

There were no audit adjustments made.

Audit Report

Conclusions

Based upon the information provided and the results of the audit fieldwork undertaken we anticipate issuing a clean audit report for the current financial period.

Anticipated Audit Report

The audit report that is anticipated to be included in the financial statements for the current financial period is contained within Appendix 2.

APPENDIX 1 – JOURNAL ADJUSTMENTS

Note – there were no adjustments provided to us during our audit fieldwork or any adjustments required as a result of our audit fieldwork.

APPENDIX 2 – ANTICIPATED AUDIT REPORT

A copy of the anticipated audit report, as referred to, is included on the following page. This is what is frequently referred to as a "clean" audit opinion and is in the format provided by the Financial Reporting Council.

FIFE HEALTH BOARD PATIENTS PRIVATE FUND

INDEPENDENT AUDITORS' REPORT TO THE BOARD
OF FIFE HEALTH BOARD

Opinion

We have audited the financial statements of Fife Health Board Patients' Private Funds for the year ended 31 March 2020 set out on page 4. These financial statements have been prepared under the historical cost convention.

In our opinion, the financial statements give a true and fair view of the state of the Funds' Receipts and Payments Account for the year ended 31 March 2020.

Basis of Opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Respective Responsibilities of Health Board and Auditors section of our report. We are independent of the fund in accordance with the ethical requirements that are relevant to our audit of the financial statements of the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Respective Responsibilities of Health Board and Auditors

As described in the Statement of Health Board Members' Responsibilities you are responsible for the preparation of the financial statements in accordance with applicable law and United Kingdom Accounting Standards and for being satisfied that they give a true and fair view.

Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK). Those standards require us to comply with the Financial Reporting Council's (FRC's) Ethical Standards for Auditors.

Use of Our Report

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

Thomson Cooper
Statutory Auditor
3 Castle Court
Carnegie Campus
Dunfermline
KY11 8PB

Date: XX September 2020

Thomson Cooper
Statutory Auditors
3 Castle Court
Carnegie Campus
Dunfermline
Fife
KY11 8PB

Dear Sirs,

This representation letter is provided in connection with your audit of the financial statements of Fife Health Board Patients' Private Funds for the year ended 31 March 2020 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view of the financial position of Fife Health Board Patients' Private Funds as of 31 March 2020 and of the results of its operations for the year then ended in accordance with United Kingdom Generally Accepted Accounting Practice.

We acknowledge our responsibility for the fair presentation of the accounts in accordance with United Kingdom Generally Accepted Accounting Practice.

We confirm to the best of our knowledge and belief, the following representations:

1. **General**

   We acknowledge as Board Members our responsibilities for preparing financial statements which give a true and fair view and for making accurate representations to you. All the accounting records have been made available to you for the purpose of your audit and all the transactions undertaken by the Fund have been properly reflected and recorded in the accounting records. All other records and related information, including Minutes of Board Meetings, have been made available to you.

2. **Going Concern**

   We believe that the Fund's financial statements should be prepared on a going concern basis. We have considered a period of twelve months from the date of the approval of the financial statements. We believe that no disclosure relating to the Fund's ability to continue as a going concern need be made in the financial statements.

3. **Loans and arrangements**

   The Fund has not had, or entered into, at any time during the period any arrangement, transaction or agreement to provide credit facilities (including loans, quasi loans or credit transactions) for Board Members or to guarantee or provide security for such matters.

4. **Transactions with related parties**

All transactions with related parties have been disclosed in the financial statements. We have made available to you all relevant information concerning such transactions and are not aware of any other matters, which require disclosure in order to comply with the requirement of the Financial Reporting Standard 102.

5. **Law and regulations**

We are not aware of any irregularities involving Board Members or employees of the Fund: nor are we aware of any breaches or possible breaches of statute, regulations, contracts or agreements which might prejudice the going concern status or that might result in the Fund suffering significant penalties or other loss. No allegations of such irregularities or such breaches have come to our notice.

6. **Fraud**

We acknowledge our responsibility for the design and implementation of internal controls and procedures to prevent and detect fraud. We have disclosed to you any actual or suspected fraud involving management, employees with significant roles in internal controls, and all instances where the fraud could have a material effect on the financial statements.

7. **Post-balance sheet events**

There have been no events since the balance sheet date which necessitate revision of the figures included in the financial statements or inclusion of a note thereto.

Yours faithfully

.....
Carol Potter
Chief Executive

.....
Margo McGurk
Director of Finance

Date: .....

NHS Fife

Meeting date:	**19 November 2020**
Title:	**Draft Annual Accounts and External Audit Report 2019/20**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Margo McGurk, Director of Finance**

1 Report summary

1.1 Situation

The Annual Accounts were submitted to the Registered Auditors, Thomson Cooper, who reviewed the accounts and confirmed an unqualified audit opinion.

1.2 Background

The Endowment Fund Sub-Committee reviewed the Annual Accounts of the Fife Health Board Endowment Fund on 2 October 2020 and recommended approval to the Board of Trustees who approved the accounts on 28 October 2020. To conclude the governance process the accounts are now submitted for noting by the Audit and Risk Committee.

1.3 Assessment

The unqualified audit opinion provided assurance to Trustees that they have properly fulfilled their financial governance responsibilities and that the published accounts are a true and fair view of the financial results of the charity.

An assessment on progress around findings contained in the external auditor's Audit Completion Memorandum will be undertaken in November, 2020 and reported via the Sub-Committee.

The auditors have provided assurance to Audit Scotland in respect of their responsibilities (as component auditors) with regard to the Endowment Fund in the context of the audit of the Board's group financial statements (ISA600).

1.4 Communication, involvement, engagement and consultation

The principal issue which impacted these accounts was the unprecedented investment market turbulence at the end of the financial year. This was addressed through engagement between the Investment Manager, the Director of Finance and Trustees which culminated in a meeting on 26 August 2020 when extensive discussion took

place and assurances around the performance of the investment portfolio were provided.

1.5 Route to the Meeting

The audited accounts were presented to the Endowment Sub Committee for review following which they were approved by the Board of Trustees.

1.6 Recommendation

The Committee is asked to note the approval of the Endowment Fund Accounts by the Board of Trustees.

2 List of appendices

The following appendices are included with this report:

- Appendix 1 Annual Accounts for the Year Ended 31 March 2020.
- Appendix 2 Letter of Representation




Endowment Fund Accounts

For the year ended 31 March 2020

Scottish Charity Number: SC011988

FIFE HEALTH BOARD
ENDOWMENT FUND

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 20

Contents	**Page**

FIFE HEALTH BOARD
ENDOWMENT FUND

REPORT OF THE TRUSTEES FOR THE YEAR ENDED 31 MARCH 2020

The Trustees present their Report, together with the accounts for the year ended 31 March 2020. The Trustees have adopted the provisions of the Statement of Recommended Practice (SORP) "Accounting and Reporting by Charities" (FRS 102) in preparing the annual report and financial statements of the charity.

The financial statements comply with the Charities and Trustee Investment (Scotland) Act 2005, the Charities Accounts (Scotland) Regulations 2006 (as amended), the Memorandum and Articles of Association, and Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) published on 16 July 2014.

Objectives and Activities

The Endowment Fund exists for the benefit of the patients in Fife, the staff of NHS Fife and the staff and students of the former Fife College of Nursing, now Dundee University School of Nursing and Midwifery. There are numerous funds within the overall Fund, some are for specific purposes and certain funds are held for individual wards and departments. There are no specific restrictions on the General Funds held by the Board other than the principle of providing for the benefit of patients and staff. All Executive and Non Executive Directors of the NHS Board are Trustees of the Endowment Fund, which is a charitable fund administered separately from NHS funding from the Scottish Government and Commercial income and used for improvements in patient care, research, and improvements in patient and staff welfare. There have been no changes in objectives since the last annual report.

Achievements and Performance

Business Review and Plans for the Future

The overall purpose of the Board's Endowment Fund is the enhancement of healthcare and patient welfare in Fife. The Trustees adopt the NHS Fife Code of Corporate Governance including Standing Financial Instructions and Scheme of Delegation as the framework for financial governance of the charity. In addition the NHS Fife Financial Operating Procedures provide information on the overall management of the Endowment Funds and includes how they can be used. In line with the Constitution, expenditure on projects over £10 000 is considered by the Board of Trustees. Trustees actively encourage Fund Managers to utilise the Endowment Funds that they manage for the benefit of patients and staff appropriately. This was enhanced in 2019-20 with the introduction of the Small Grants 2020 programme, which will continue to be administered throughout 2020-21. The Board of Trustees is supported by an Endowment Sub Committee, with a range of delegated functions including the monitoring of income, expenditure and investment performance.

FIFE HEALTH BOARD
ENDOWMENT FUND

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2020

In 2019 a Charity Manager was employed to develop the business model and support Trustees in the governing of the Fund as well as to improve procedures and processes. During the year the Manager and Trustees have worked together to raise the profile of the charity, develop a monitoring process, create a risk register and improve processes as well as to launch and administer the Small Grants Programme 2020. Areas of further development include creating a disbursement strategy, rebranding the charity and creating a communications strategy as well as developing a business plan. Links have been established with other Scottish NHS charities which will help develop Fife's charity.

The Endowment Fund is subject to consolidation with NHS Fife Exchequer.

FIFE HEALTH BOARD
ENDOWMENT FUND

REPORT OF THE TRUSTEES FOR THE YEAR ENDED 31 MARCH 2020

Financial Review

Income:
During the year the value of donations, gifts and legacies totalled £564,000. Income from donations was £306,000 and income from legacies was £258,000. Investment income was £421,000 to provide a total income figure of £985,000.

Expenditure
A great many initiatives have benefitted from contributions from the Fife Health Board Endowment Fund in the last year.

A number of multiyear projects funded through the 2018 grant programme have been ongoing. These include: the Electra project which has developed an information technology and management structure based on the analysis of GP patients data which will provide datasets; the Going Beyond Gold initiative set up to develop a culture of kindness, the creation of a Therapeutic Environment within Theatre Recovery and the Mindfulness Practises based at GP's in the Levenmouth area.

New initiatives which Trustees have supported in 2019 – 20 include the Palliative Care within Respiratory Wards initiative, Shelters for the Queen Margaret Hospice garden and a Weight Management project to prevent or reverse Type 2 Diabetes levels within staff.

Some other funded projects to highlight are:

Noise reduction in Intensive Care
The Intensive Care Unit benefitted from the purchase of new technology totalling £11 400 known as Sound Ears which help to reduce noise in a room. The Ears work by visualising the level of noise in the ward so that staff are aware of how much noise is being created and potentially how much patients are being disturbed.

Evidence has shown that increased noise is related to poorer patient experience and is thought to be related to an increase in delirium. The purchase of the 10 sound ears has enabled staff to be more alert to the level of noise in the ward giving genuine reason for clinical awareness and adjustments to be made where possible.

Going beyond Gold
The overall aim of the Going for Gold project was to create a kinder, more mindful organisation where staff, patients and carers feel looked after and valued, thus improving the health and wellbeing within NHS Fife and the Fife community. Funding enabled the project to grow and reach across the whole organisation, extending out to patients and localities. It included the delivery of mindfuless training courses as well as Good Conversation training. It also supported the development of Good Conversation Champions.

The evaluation of the project concluded that the initiative had nurtured the growth of a very positive shift in the health and social care culture with responses to the training being extremely positive with participants feeling kinder, calmer and more resilient. The courses for many were transformative for their working practice and for their personal wellbeing. The wide range of staff groups involved felt valued, supported and provided with a wealth of practical strategies. These strategies helped them to be more mindful of their own wellbeing and they learnt to support each other and their patients more effectively with good conversations about the things that really matter to them as human beings.

Art Catalogue

In 2020 the NHS Fife Art Catalogue that details all the owned art across NHS Fife properties was finally completed. The collection includes some 2000 pieces of art and ranges from sculptures to stained glass windows to pieces painted by local artists. The collection is situated over 12 venues and can now be viewed in the online catalogue at https://nhsfifeart.com/. The cataloguing work was carried out by Art in Healthcare over the past couple of years. Recent acquisitions include a donated print by Flanet and commissioned pieces for ward 42 by Alison Cage which was purchased through donations from the family of a patient. This artwork has significantly brightened up sparse walls within the Victoria Hospital.

Playlist for life

The use of personalised music, using the approach of Playlist for Life, is a non-pharmacological strategy that is used to support the management of stress and distressed behaviour in patients with dementia in ward settings. Using music that is personal and full of meaning to a patient can stimulate fond memories and positive emotional reactions, and in turn reduces agitation.

The Alzheimer Scotland Dementia Nurse Consultant undertook a research study exploring the use of personalised music playlists to reduce agitation in people with moderate to severe dementia. This took place in wards at Stratheden Hospital. As a result of the positive effect of using personalised music as demonstrated in these research studies, NHS Fife has invested in accredited training for wards from the Playlist for Life charity.

Currently nine wards in NHS Fife have completed the Playlist for Life accredited training and are supporting the delivery of Playlist for Life to patients with dementia in community hospital wards and specialist mental health wards. Endowment funds are used to purchase music devices and headphones for patients. Feedback from one family carer as to the impact of Playlist for Life was:

"Those final weeks were filled with fun and laughter. Many a sing song was had in the ward, often with the rest of the ward joining in. Dementia is a harrowing condition for anyone to experience, so to have the power of music to influence my father's mood in such a positive manner was of great solace at his time of need."

Palliative and End of Life Care Staff Development programme

A staff development programme led by the Specialist Palliative Care service was awarded £88 000 to provide 8 nurses with opportunities to improve skills in palliative and end of life care across the health and care system in Fife. Following the application and interview process eight participants were appointed onto the programme, 4 from the acute sector, 3 from the community sector and 1 from the community hospital sector. The programme started in August 2018 and completed a year later.

Staff who participated in the programme reported that afterwards they felt confident in communicating with parents and families, were able to have conversations about end of life needs and were also able to recognise when someone was dying. A number of improvements were implemented within services as a result of the training including improved signposting, introduction of palliative care meetings and offering complementary therapies for patients at the end of life. All trainees became Palliative Care Champions within their own services. All Supervisors agreed that they would send another member of staff on the training were it to be offered again.

Small Grants Programme

The Small Grants Programme 2020 was launched near the end of the financial year to enable NHS Fife staff to apply for up to £5000 for projects that would benefit patients, their family and friends. Successful projects will be named in the following year.

Investments

Investments are included in the financial statements at market value. The value of the portfolio has decreased in the year. The fund had unrealised losses on the portfolio which amounted to £922,000 and realised gains on investments sold of £216,000.

The Trustees confirm that the assets are available and adequate to fulfil the objectives of the charity.

Principal Funding Sources

The principal funding sources continued to be a combination of charitable donations received and dividends and interest received from the investment portfolio.

Reserves Policy

The Trustees are conscious of the need to hold reserves in order to be able to generate sufficient investment income to meet grant commitments each year. The Trustees believe that the current level of reserves is sufficient for this purpose but not excessive.

Structure, Governance and Management

Governing Document

The Inland Revenue recognised the Endowment Fund as a “charity” for the purpose of Section 505, Income and Corporation Taxes Act 1988. The Endowment Funds are held on trust under Section 82 of the National Health Service (Scotland) Act 1978. In accordance with the terms of the Charities and Trustee Investment (Scotland) Act 2005 the Fund is entitled to describe itself as a “Scottish Charity”. The Scottish Charity number is SC011988.

FIFE HEALTH BOARD
ENDOWMENT FUND

REPORT OF THE TRUSTEES FOR THE YEAR ENDED 31 MARCH 2020

Recruitment and Appointment of Trustees

All appointed Board Members are automatically appointed as the Trustees for the Endowment Fund. The Trustees exercise power over investment decisions and ensure the appropriate use of Endowment Funds through the Board of Trustees. The Board of Trustees is chaired by the Fife Health Board Chair and comprises all Fife Health Board Members. The Trustees express their grateful acknowledgement for the donations made by many individuals and organisations who, by gift, bequest or fundraising have contributed to these Funds.

Trustee Induction and Training

A Trustee Induction pack is issued to every new Trustee which includes information on the roles and responsibilities of a Trustee and others involved in the charity, the structures in place to distribute and manage funds as well as an introduction to charity governance. New Trustees meet with the Charity Manager and spend time learning about the Endowment Fund as well as receiving the pack.

Risk Management

A risk register has been created for the charity which includes potential risks and mitigating actions. It is regularly updated to ensure it remains current and is regularly highlighted to the Board of Trustees.

Significant external risks to funding have led to the appointment of professional advisers to oversee the management of the investments. Internal risks have been minimised by the introduction of financial controls on authorising of expenditure and strict budgetary control. All Trustees signed a mandate which states that they can act in an official capacity. In addition the Trustees have signed a “fit and proper persons” declaration to ensure that charity funds and tax reliefs are used only for charitable purposes.

Investment Policy

During 2019/20, the investment portfolio was transferred from Investec Ltd to Aberdeen Standard Capital. They provide regular reports to members of the Sub Committee providing professional advice and informing Trustees of current and future trends in the market. In managing the investments, Aberdeen Standard Capital reflected the Trustees’ long-standing policy to exclude investment in companies directly involved in the tobacco industry and to consider the appropriateness of investment in industries whose products have the potential to be detrimental to health, and the broader principle of Ethical Investment.

Trustees require an investment approach which seeks to achieve an optimal total return of capital growth and income over a period of time, based on a medium-high risk profile of investment across equities, bonds and cash. In respect of economic, social and governance factors, Trustees require investments to be limited to those acceptable under the Charities and Trustee Investment (Scotland) Act 2005.

FIFE HEALTH BOARD
ENDOWMENT FUND

REPORT OF THE TRUSTEES FOR THE YEAR ENDED 31 MARCH 2020

Trustees accept the need for environmental, social and governance (ESG) issues to be taken seriously and reflected in where the Charity's assets may be invested.

The following investment restrictions have been agreed by Trustees, as they feel these would be in direct conflict with the Charity's objectives:

- **Tobacco**: No direct investment in tobacco production (i.e. exclude the tobacco sector)
- **Alcohol**: No direct investment in a company that manufactures alcoholic products
- **Armaments**: No direct investment in armaments (i.e. exclude the aerospace & defence sector)
- **Predatory Lending**: No direct investment in a company providing any pay day loan services.
- **Exploitative Practices**: No direct investment in companies that have severe or very severe controversies related to child labour within its own operations or within the supply chain. No direct investment in companies that have moderate, severe or very severe controversies related to the impact of a firm's operations on human rights.

It will therefore be reasonable for Trustees to exclude investments:

- that are obviously directly contrary to the Board's objectives;
- where failing to exclude would mean a financial loss, e.g. through a fall in the level of legacies and donations; and
- as long as the remaining portfolio is sufficiently diverse and robust to achieve satisfactory performance.

Trustees must at all times act in the best interests of the Fund, and not pursue their own ethical beliefs.

The Trustees agreed to the establishment of a sub-committee to give detailed consideration of investment policy and performance.

FIFE HEALTH BOARD
ENDOWMENT FUND

REPORT OF THE TRUSTEES FOR THE YEAR ENDED 31 MARCH 2020

Reference and Administrative Information

The Trustees who served during the year were as follows: -

Chair	Mrs T Marwick	
Trustees:	Mrs C Potter	
	Mrs W Brown	
	Mr P Hawkins	Until 27 January 2020
	Ms M McGurk	From 3 February 2020
	Ms J Owens	
	Dr L Bissett	
	Ms R Laing	
	Ms K Miller	From 1 February 2020
	Mr M Black	
	Mrs C Cooper	
	Mr A Morris	
	Mrs H Buchanan	
	Mr E Clarke	
	Mrs M Wells	
	Cllr D Graham	
	Ms S Braiden	
	Dr C McKenna	
	Ms D Milne	
Auditors	Thomson Cooper 3 Castle Court Carnegie Campus Dunfermline Fife, KY11 8PB	
Bankers	Bank of Scotland 9 Falkland Gate Glenrothes Fife, KY7 5LW	
Investment Managers	Aberdeen Standard Capital 1 George Street Edinburgh EH2 2LL	
Registered Office	Hayfield House Hayfield Road Kirkcaldy Fife, KY2 5AH	
Charity Registration Number	SC011988	
Tax Reference	CR41403	

FIFE HEALTH BOARD
ENDOWMENT FUND

REPORT OF THE TRUSTEES FOR THE YEAR ENDED 31 MARCH 2020

Statement of Trustees Responsibilities

The Trustees are responsible for preparing the Trustees' Report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

The law applicable to charities in Scotland requires the Trustees to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources for that year. In preparing these financial statements, the Trustees are required to:

- select suitable accounting policies and then apply them consistently;
- observe the methods and principles in the Charities SORP 2015 (FRS 102)
- make judgements and estimates that are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements;
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in operation.

The trustees are responsible for keeping accounting records that disclose with reasonable accuracy at any time the financial position of the charity and enable them to ensure that the financial statements comply with the Charities and Trustee Investment (Scotland) Act 2005, the Charities Accounts (Scotland) Regulations 2006 (as amended) and the provisions of the charity's constitution. They are also responsible for safeguarding the assets of the charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Statement of Disclosure to the Auditor

In so far as the Trustees are aware:

- there is no relevant audit information of which the charity's auditors is unaware; and
- the Trustees have taken all steps that they ought to have taken to make themselves aware of any relevant audit information and to establish that the auditor is aware of that information.

Approved by the Board of Trustees and signed on its behalf by:

Tricia Marwick
Chair

Margo McGurk
Trustee

FIFE HEALTH BOARD
ENDOWMENT FUND

INDEPENDENT AUDITORS' REPORT TO THE TRUSTEES
OF FIFE HEALTH BOARD ENDOWMENT FUND

Opinion

We have audited the financial statements of Fife Health Board Endowment Fund (the 'charity') for the year ended 31 March 2020 which comprise the Statement of Financial Activities, the Balance Sheet, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102, the Financial Reporting Standard applicable in the UK and Republic of Ireland (United Kingdom Generally Accepted Accounting Practice).

In our opinion the financial statements:

- give a true and fair view of the state of the charity's affairs as at 31 March 2020, and of its incoming resources and application of resources, including its income and expenditure, for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Charities and Trustee Investment (Scotland) Act 2005, and regulation 8 of the Charities Accounts (Scotland) Regulations 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the charity in accordance with the ethical requirements that are relevant to our audit of the financial statements of the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the trustees' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the trustees have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the charity's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Independent Auditors' Report to the Trustees of Fife Health Board Endowment Fund

Other information

The other information comprises the information included in the trustees' annual report, other than the financial statements and our auditor's report thereon. The trustees are responsible for the other information. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinions on other matters prescribed by the Companies Act 2006

In our opinion, based on the work undertaken in the course of the audit:

- the information given in the Board's Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the Board's Annual Report has been prepared in accordance with applicable legal requirements.

Matters on which we are required to report by exception

In the light of our knowledge and understanding of the charity and its environment obtained in the course of the audit, we have not identified material misstatements in the trustees' report.

We have nothing to report in respect of the following matters in relation to which the Charities Accounts (Scotland) Regulations 2006 (as amended) requires us to report to you if, in our opinion:

- adequate accounting records have not been kept, or returns adequate for our audit have not been received from branches not visited by us; or
- the financial statements are not in agreement with the accounting records and returns; or
- certain disclosures of directors' remuneration specified by law are not made; or
- we have not received all the information and explanations we require for our audit.

Responsibilities of trustees

As explained more fully in the trustees' responsibilities statement set out on page 8, the trustees are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustees are responsible for assessing the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the trustees either intend to liquidate the charity or to cease operations, or have no realistic alternative but to do so.

FIFE HEALTH BOARD ENDOWMENT FUND

Independent Auditors' Report to the Trustees of Fife Health Board Endowment Fund

Auditor's responsibilities for the audit of the financial statements

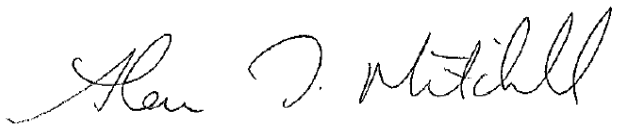
We have been appointed as auditor under section 44(1)(c) of the Charities and Trustee Investment (Scotland) Act and report in accordance with those Acts and relevant regulations made or having effect there under. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Use of our report

This report is made solely to the charity's trustees, as a body, in accordance with section 44(1)(c) of the Charities and Trustee Investment (Scotland) Act 2005 and regulation 10 of the Charities Accounts (Scotland) Regulations 2006 (as amended). Our audit work has been undertaken so that we might state to the charity's trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and the charity's trustees as a body, for our audit work, for this report, or for the opinions we have formed.



Alan Mitchell (Senior Statutory Auditor)
for and on behalf of Thomson Cooper, Statutory Auditor
Accountants
Dunfermline
28th October 2020

Thomson Cooper is eligible to act as an auditor in terms of section 1212 of the Companies Act 2006

FIFE HEALTH BOARD
ENDOWMENT FUND

STATEMENT OF FINANCIAL ACTIVITIES
(INCLUDING INCOME & EXPENDITURE ACCOUNT)
FOR THE YEAR ENDED 31 MARCH 2020

	Notes	Unrestricted Funds £'000	Restricted Funds £'000	2020 Total Funds £'000	2019 Total Funds £'000
Income and endowments from:					
Donations and legacies	4	66	498	564	947
Investment income	5	117	304	421	478
Total income		183	802	985	1,425
Expenditure on:					
Raising funds	7	9	23	32	37
Charitable activities	8	275	667	942	1,219
Total expenditure		284	690	974	1,256
Net income/(expenditure) and net movement in funds before gains and losses on investments		(101)	112	11	169
Net gains/(losses) on investments	12	60	156	216	580
Net income		(41)	268	227	749
Other recognised gains/(losses):					
Gains/(losses) on revaluation of fixed assets	11/12	(235)	(579)	(814)	2
Net movement of funds		(276)	(311)	(587)	751
Reconciliation of Funds					
Total funds brought forward		3,743	9,505	13,248	12,497
Total funds carried forward		**3,467**	**9,194**	**12,661**	**13,248**

The Statement of Financial Activities includes all gains and losses recognised in the year.

All incoming resources and resources expended derive from continuing operations.

The notes on pages 15 to 26 form part of these financial statements

FIFE HEALTH BOARD
ENDOWMENT FUND

BALANCE SHEET AS AT 31 MARCH 2020

	Notes	Unrestricted Funds £'000	Restricted Funds £'000	2020 Total Funds £'000	2019 Total Funds £'000
Fixed Assets:					
Tangible fixed assets	11	62	163	225	117
Investments	12	2,996	7,839	10,835	12,423
Total fixed assets		3,058	8,002	11,060	12,540
Current Assets:					
Debtors	13	128	455	583	532
Cash at bank and in hand		304	796	1,100	263
Total current assets		432	1,251	1,683	795
Liabilities:					
Creditors falling due within one year	14	(23)	(59)	(82)	(87)
Net Current Assets		409	1,192	1,601	708
Total Net Assets		3,467	9,194	12,661	13,248
The Funds of the Charity:					
Unrestricted Funds	15	3,467	-	3,467	3,743
Restricted Funds	16	-	9,194	9,194	9,505
Total Charity Funds		3,467	9,194	12,661	13,248

The financial statements were approved by the Trustees on 28 October 2020 and signed on their behalf by:

Tricia Marwick
Chair

Margo McGurk
Director of Finance

The notes on pages 15 to 26 form part of these accounts

FIFE HEALTH BOARD
ENDOWMENT FUND

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2020

	Notes	2020 £'000	2019 £'000
Net cash used in operating activities	21	(466)	(794)
Cash flows from investing activities:			
Dividends and interest from investments		421	478
Proceeds from sale of investments		13,752	500
Purchase of investments		(12,870)	(256)
Cash provided by (used in) investing activities		1,303	722
Increase/(decrease) in cash and cash equivalents in the year		837	(72)
Cash and cash equivalents at the beginning of the year		263	335
Total cash and cash equivalents at the end of the year		1,100	263

FIFE HEALTH BOARD
ENDOWMENT FUND

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2020

1. Accounting policies

The significant accounting policies applied in the preparation of these financial statements are set out below. These policies have been consistently applied to all years presented unless otherwise stated.

(a) Basis of Preparation

The financial statements have been prepared in accordance with Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2015) - (Charities SORP (FRS 102), and the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102), the Charities and Trustee Investment (Scotland) Act 2005 and the Charities Accounts (Scotland) Regulations 2006 (as amended).

The charity constitutes a public benefit entity as defined by FRS 102.

The financial statements are prepared on a going concern basis under the historical cost convention, modified to include certain items at fair value. The financial statements are prepared in sterling which is the functional currency of the charity.

(b) Funds Structure

Unrestricted funds are available for use at the discretion of the Trustees in furtherance of the general objectives of the charity and which have not been designated for other purposes.

Restricted funds are funds which are to be used in accordance with specific restrictions imposed by donors or which have been raised by the charity for particular purposes. The cost of raising and administering such funds are charged against the specific fund. The aim and use of each restricted fund is set out in the notes to the financial statements.

(c) Income Recognition

All incoming resources are recognised when the charity has entitlement to the funds, any performance conditions have been met, it is probable that the income will be received and the amount can be measured reliably.

For donations to be recognised the charity will have been notified of the amounts and the settlement date in writing. If there are conditions attached to the donation and this requires a level of performance before entitlement can be obtained then income is deferred until those conditions are fully met or the fulfilment of those conditions is within the control of the charity and it is probable that they will be fulfilled.

1. Accounting policies (cont'd)

(d) Income Recognition (cont'd)

No amount is included in the financial statements for volunteer time in line with the SORP (FRS 102). Further detail is given in the Board's Annual Report.

For legacies, entitlement is the earlier of the charity being notified of an impending distribution or the legacy being received. At this point income is recognised. On occasion legacies will be notified to the charity however it is not possible to measure the amount expected to be distributed. On these occasions, the legacy is treated as a contingent asset and disclosed.

Investment income is earned through holding assets for investment purposes such as shares, and includes dividends and interest. Investment management costs incurred are shown separately as they can be measured reliably. Interest income is recognised using the effective interest method and dividend income is recognised as the charity's right to receive payment is established.

(d) Expenditure Recognition

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to the category. Expenditure is recognised where there is a legal or constructive obligation to make payments to third parties, it is probable that the settlement will be required and the amount of the obligation can be measured reliably.

Expenditure is classified under the following activity headings:

- Cost of raising funds comprises the investment management costs.
- Expenditure on charitable activities comprises those costs incurred by the charity in the delivery of its activities and services for its beneficiaries, including the improvement of staff and patient welfare, and their associated support costs.
- Other expenditure (where relevant) comprises costs not falling into any other heading.

Where possible, expenses are attributed directly to the Fund to which they relate. Where this is not possible, they are apportioned on the basis of Fund size.

(e) Allocation of Support and Governance Costs

Support and governance costs are those functions that assist the work of the charity but do not directly undertake charitable activities. Support costs include office costs, payroll and audit fees and are incurred directly in support of expenditure on the objects of the charity. These costs have been allocated between cost of raising funds and expenditure on charitable activities. The bases on which support and governance costs have been allocated are on a direct basis or as a proportion of time spent.

1. Accounting policies (cont'd)

(f) VAT

Government departments including the NHS can recover VAT on contracted-out services provided the conditions on the refund schemes are met.

(g) Operating Leases

The total cost of assets held under operating leases is charged to the profit and loss account as they fall due.

(h) Tangible Fixed Assets and Depreciation

Tangible fixed assets are stated at cost (or deemed cost) or valuation less accumulated depreciation and accumulated impairment losses. Depreciation is provided on all tangible fixed assets, at rates calculated to write off the cost, less estimated residual value, of each asset on a systematic basis over its expected useful life.

The NHS Fife Endowment Art Collection is valued as per the details contained within the Board's Art Catalogue. Purchased or donated items in the art collection are not depreciated.

(i) Investments

Investments are recognised initially at fair value which is normally the transaction price excluding transaction costs. Subsequently, they are measured at fair value with changes recognised in 'net gains / (losses) on investments' in the Statement of Financial Activities if the shares are publicly traded or their fair value can otherwise be measured reliably. Other investments, where applicable, are measured at cost less impairment.

Investments are apportioned to Funds based on the value of the Fund at the year end.

(j) Realised Gains and Losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and their opening carrying value or their purchase value if acquired subsequent to the first day of the financial year. Unrealised gains and losses are calculated as the difference between the fair value at the year end and their carrying value. Realised and unrealised investment gains and losses are combined in the Statement of Financial Activities.

(k) Debtors

Trade and other debtors are recognised at the settlement amount due after any discount offered. Prepayments are valued at the amount prepaid net of any discounts due

(l) Cash at Bank and in Hand

Cash at bank and cash in hand includes cash and all amounts held within bank current and deposit accounts.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2020

1. Accounting policies (cont'd)

(m) Creditors and Provisions

Creditors and provisions are recognised where the charity has a present obligation resulting from a past event that will probably result in the transfer of funds to a third party and the amount due to settle the obligation can be measured or estimated reliably. Creditors and provisions are normally recognised at their settlement amount after allowing for any discounts due.

(n) Financial Instruments

The charity only has financial assets and financial liabilities of a kind that qualify as basic financial instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at their settlement value. Investments in shares which can be publicly traded and be measured at fair value (market value).

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2020

2. Taxation

As Fife Health Board Endowment Fund is recognised by HMRC as a charity, there is no liability to taxation.

3. Auditor's remuneration

	2020 £'000	2019 £'000
Audit fees	9	9

4. Income from donations and legacies

	2020 £'000	2019 £'000
Donations and gifts	306	345
Legacies	258	602
	564	947

Income from donations and legacies was £564,000 (2019: £947,000) of which £498,000 (2019: £836,000) was attributable to restricted and £66,000 (2019: £111,000) was attributable to unrestricted funds.

5. Investment income

	2020 £'000	2019 £'000
Dividends received	411	427
Interest received	10	51
	421	478

Income from investments was £421,000 (2019: £478,000) of which £304,000 (2019: £412,000) was attributable to restricted and £117,000 (2019: £66,000) was attributable to unrestricted funds.

6. Donated goods, facilities or services

The charity benefits greatly from the involvement and support of its volunteers, details of which are given in the annual report. In accordance with FRS 102 and the Charities SORP (FRS 102), the economic contribution of general volunteers is not recognised in the accounts.

7. Analysis of expenditure on raising funds

	Patient Welfare £'000	Staff Welfare £'000	College of Nursing £'000	Total 2020 £'000	Total 2019 £'000
Investment management costs	30	-	2	32	37
	30	-	2	32	37

Expenditure on raising funds was £32,000 (2019: £37,000) of which 23,000 (2019: £32,000) was attributable to restricted and £9,000 (2019: £5,000) was attributable to unrestricted funds.

8. Analysis of expenditure on charitable activities

	Patient Welfare £'000	Staff Welfare £'000	College of Nursing £'000	Total 2020 £'000	Total 2019 £'000
Salaries & Professional Fees	296	-	-	296	283
Administration Charges & Supplies	21	-	-	21	17
Property Development & Maintenance	48	-	-	48	110
Christmas Expenditure	27	21	-	48	39
Equipment	236	-	-	236	540
Functions & Conferences	96	-	-	96	86
Patient Activity	87	-	-	87	75
Governance costs (Note 9)	94	-	7	101	60
Support costs (Note 9)	9	-	-	9	9
	914	21	7	942	1,219

Expenditure on charitable activities was £942,000 (2019: £1,219,000) of which £667,000 (2019: £721,000) was attributable to restricted and £275,000 (2019: £498,000) was attributable to unrestricted funds.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2020

9. Analysis of governance and support costs

The charity initially identifies the costs of its support functions. It then identifies those costs which relate to the governance function. Having identified its governance costs, the remaining support costs together with the governance costs are apportioned between its key charitable activities undertaken (see Note 8) in the year. Refer to the table below for the basis for apportionment and the analysis of support and governance costs.

	Basis of Apportionment	Support Costs £'000	Governance Costs £'000	Total 2020 £'000	Total 2019 £'000
Recharge Of Relevant Salaries	Time spent	-	101	101	60
Audit Services	Direct cost	9	-	9	9
		9	101	110	69

10. Analysis of staff costs and trustee and key management remuneration and expenses

The Endowment Fund has no employees, therefore no employee received emoluments in excess of £60,000 during the year (2019 – nil).

The salaries and professional fees (Note 8) represent fees paid for professional services from companies and individuals external to NHS Fife.

The recharge of relevant salaries included within Governance costs (Note 9) relate to the cost of NHS staff time spent administering the Endowment Fund. The cost relates to staff time recharged to the Endowment Fund, as the Endowment Fund itself has no employees.

The charity considers its key management personnel comprise the Trustees. None of the Trustees have been paid any remuneration or received any other benefits from employment with the charity.

No Trustee expenses have been incurred in the current and previous year,

11. Tangible fixed assets

	Art Collection £'000
Cost or valuation	
At 1st April 2019	117
Revaluation	108
At 31st March 2020	225
Depreciation	
At 1st April 2019 and 31st March 2020	-
Net Book Value	
At 31st March 2019	117
At 31st March 2020	225

12. Investments

	2020 £'000	2019 £'000
Market value brought forward at 1st April 2019	12,423	12,087
Additions to investments at cost	12,870	256
Disposals at carrying value	(13,752)	(500)
Realised gains/(losses)	216	54
Unrealised gains/(losses)	(922)	526
Market value at 31st March 2020	10,835	12,423
Investments at fair value comprised:		
Equities	9,283	11,429
Fixed interest securities	1,552	994
Total	10,835	12,423

All investments are carried at their fair value. Investment in equities and fixed interest securities are all traded in quoted public markets, primarily the London Stock Exchange. Holdings in common investment funds, unit trusts and open-ended investment companies are at the bid price. The basis of fair value for quoted investments is equivalent to the market value, using the bid price. Asset sales and purchases are recognised at the date of trade at cost (that is their transaction value). Cash held within the investment portfolio is shown within "Cash at bank and in hand" and is therefore not included within the value of investments.

The significance of financial instruments to the ongoing financial sustainability of the charity is considered in the financial review and investment policy and performance sections of the Trustees Annual Report.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2020

13. Debtors and prepayments

	2020 £'000	2019 £'000
Tax Recoverable	1	1
Legacy Receivable	571	513
Fife Health Board	-	-
Other Debtors	11	18
	583	532

14. Creditors falling due within one year

	2020 £'000	2019 £'000
Trade Creditors	15	20
Audit Fee	9	9
Portfolio Management Fee	-	9
IR35	9	10
Fife Health Board	49	39
	82	87

15. Unrestricted Funds

	Balance at 01/04/19 £'000	Incoming Resources £'000	Outgoing Resources £'000	Gains and Losses £'000	Balance at 31/03/20 £'000
General Fund	3,743	183	(284)	(175)	3,467

16. Restricted Funds

The charity has 310 individual restricted funds, which for the purposes of the accounts are grouped together into five main categories, and further subcategorised by either location or type of care.

16. Restricted Funds (continued)

	Balance at 31/03/19 £'000	Incoming Resources £'000	Outgoing Resources £'000	Gains and Losses £'000	Balance at 31/03/20 £'000
Acute Services Division					
Victoria Hospital	2,698	284	(162)	(98)	2,722
Queen Margaret Hospital	1,342	81	(89)	(54)	1,280
Diabetic	607	37	(41)	(25)	578
Cardiology	670	41	(37)	(23)	651
Glaucoma	41	2	(4)	(2)	37
Other	72	105	-	-	177
	5,430	550	(333)	(202)	5,445
Community Services Division – Fife Wide					
Stratheden Hospital	93	6	-	-	99
Whyteman's Brae Hospital	15	1	(1)	-	15
Queen Margaret Hospital	61	4	-	-	65
Lynebank Hospital	25	2	(3)	(2)	22
Fife Rheumatic Disease Unit	59	4	(16)	(10)	37
Nutrition & Dietetic	81	5	(5)	(3)	78
Other	100	10	(7)	(4)	99
	434	32	(32)	(19)	415
Community Services Division – East Fife					
Adamson Hospital	211	13	(12)	(7)	205
Cameron Hospital	192	12	(7)	(4)	193
Glenrothes Hospital	64	4	(9)	(5)	54
Randolph Wemyss Hospital	12	1	(1)	(1)	11
St Andrews Community Hospital	136	8	(13)	(8)	123
Other	43	3	(2)	(1)	43
	658	41	(44)	(26)	629
Community Services Division – West Fife					
Fife Specialist Palliative Care	111	7	(30)	(18)	70
Palliative Care Other	260	16	(22)	(14)	240
Queen Margaret Hospice	433	26	(32)	(19)	408
Victoria Hospice	1,424	86	(151)	(92)	1,267
Other	102	6	(9)	(6)	93
	2,330	141	(244)	(149)	2,078
Corporate Division					
College Of Nursing	541	33	(37)	(22)	515
Other	112	5	-	(5)	112
	653	38	(37)	(27)	627
Total restricted funds	9,505	802	(690)	(423)	9,194

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2020

17. Analysis of assets between funds

	Unrestricted General Funds £'000	Restricted Funds £'000	Total Funds £'000
Tangible fixed assets	62	163	225
Investments	2,996	7,839	10,835
Debtors	128	455	583
Bank and cash	304	796	1,100
Creditors	(23)	(59)	(82)
	3,467	9,194	12,661

18. Operating leases

The Endowment Fund has no annual commitments under non-cancellable operating leases expiring.

19. Potential Legacies

William Ramsay Executry

A payment of £30,833 was received in April 2020 and has been accounted for as a debtor.

Watt Executry

An payment of £165,165 was received in June 2020 and has been accounted for as a debtor.

Peter MacNaughton Executry

An interim payment of £375,000 has been proposed which has been accounted for as a debtor.

20. Related party transactions

There are no related party transactions during the current or prior accounting period.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2020

21. Reconciliation of net movement in funds to net cash flow from operating activities

	2020 £'000	2019 £'000
Net movement in funds	(695)	749
Adjustments for:		
(Gains)/losses on investments	706	(580)
Dividends and interest from investments	(421)	(478)
(Increase)/Decrease in debtors	(51)	(517)
Increase/(Decrease) in creditors	(5)	32
	(466)	(794)

NHS Fife provides accessible communication in a variety of formats including for people who are speakers of community languages, who require Easy Read versions, who speak BSL, read Braille or use Audio formats.

NHS Fife SMS text service number 07805800005 is available for people who have a hearing or speech impairment.

To find out more about accessible formats contact:
fife-UHB.EqualityandHumanRights@nhs.net or phone 01592 729130

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Telephone: 01592 643355
www.nhsfife.org

Fife Health Board Endowment Fund

Thomson Cooper
Statutory Auditors
3 Castle Court
Carnegie Campus
Dunfermline
Fife
KY11 8PB

Date	28 October 2020
Your Ref	
Our Ref	MMcG/ED
Enquiries to	Margo McGurk
Extension	28139
Direct Line	
Email	Margo.mcgurk@nhs.scot

Dear Sirs,

This representation letter is provided in connection with your audit of the financial statements of Fife Health Board Endowment Fund for the year ended 31 March 2020 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view of the financial position of Fife Health Board Endowment Fund as of 31 March 2020 and of the results of its operations and cash flows for the year then ended in accordance with United Kingdom Generally Accepted Accounting Practice.

We acknowledge our responsibility for the fair presentation of the accounts in accordance with United Kingdom Generally Accepted Accounting Practice.

We confirm to the best of our knowledge and belief, the following representations:

1. **General**
   We acknowledge as Trustees of the Fund our responsibilities under the Charities Accounts (Scotland) Regulations 2006 (as amended), for preparing financial statements which give a true and fair view and for making accurate representations to you. All the accounting records have been made available to you for the purpose of your audit and all the transactions undertaken by the Fund have been properly reflected and recorded in the accounting records. All other records and related information, including Minutes of Trustees meetings, have been made available to you.

2. **Going Concern**
   We believe that the Fund's financial statements should be prepared on a going concern basis on the grounds that current and future sources of funding will be more than adequate for the Fund's needs. We have considered a period of twelve months from the date of the approval of the financial statements. We believe that no disclosure relating to the Fund's ability to continue as a going concern need be made in the financial statements.

3. **Loans and arrangements**
   The Fund has not had, or entered into, at any time during the period any arrangement, transaction or agreement to provide credit facilities (including loans, quasi loans or credit transactions) for Trustees or to guarantee or provide security for such matters.

4. **Transactions with related parties**
All transactions with related parties have been disclosed in the financial statements. We have made available to you all relevant information concerning such transactions and are not aware of any other matters which require disclosure in order to comply with the requirement of the Financial Reporting Standard 102.

5. **Law and regulations**
We are not aware of any irregularities involving Trustees or employees of the Fund; nor are we aware of any breaches or possible breaches of statute, regulations, contracts or agreements which might prejudice the going concern status or that might result in the Fund suffering significant penalties or other loss. No allegations of such irregularities or such breaches have come to our notice.

6. **Fraud**
We acknowledge our responsibility for the design and implementation of internal controls and procedures to prevent and detect fraud. We have disclosed to you any actual or suspected fraud involving Trustees, employees with significant roles in internal controls, and all instances where the fraud could have a material effect on the financial statements.

7. **Legacies**
We confirm that we have disclosed to you all legacies which have been received or which are receivable. We confirm that there have been no further legacies intimated to the Fund during the year ended 31 March 2020.

8. **Art Collection**
We confirm that we consider the valuation of the artwork, included in the financial statements at 31 March 2020 at £225,000 to be a fair reflection of the market value of the assets.

9. **Post-balance sheet events**
There have been no events since the balance sheet date which necessitate revision of the figures included in the financial statements or inclusion of a note thereto.

10. **Restricted funds**
All grants, legacies, donations and other income, the receipt of which is subject to specific terms or conditions, have been notified to you. There have been no breaches of terms or conditions during this period in the application of such income.

Yours faithfully

Tricia Marwick

.....
Tricia Marwick
Chair

.....
Margo McGurk
Trustee
Date:…28 October 2020…….

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**19 November 2020**
Title:	**Service Auditor Reports**
Responsible Executive/Non-Executive:	Mrs Margo McGurk, Director of Finance
Report Author:	Robert MacKinnon, Associate Director of Finance

1 Purpose

To provide assurance to the Board in terms of the Service Auditor Reports (ISAE3402) of the Board relating to services provided by other Boards and their implications for the control environment.

This is presented to the Committee for:

- Assurance

This report relates to a:

- Government policy/directive

This aligns to the following NHS Scotland quality ambition(s):

- Effective

2 Report summary

2.1 Situation

Each year NHS Fife, in common with other Scottish NHS Boards, receives Assurance Reports on systems operated by NHS National Services Scotland (NSS) and NHS Ayrshire and Arran on behalf of all NHS Scotland Boards.

2.2 Background

The purpose of these reports is to provide assurance to customer Audit and Risk Committees and share the findings and outcome of the three Service Audits undertaken in 2019/20. Copies of the reports have also been made available to the Board's External Auditors.

Each of the Service Audits, has been undertaken in accordance with the International Standard on Assurance Engagements 3402 (ISAE 3402), "Assurance Reports on Controls at a Service Organisation", issued by the International Auditing and Assurance Standards Board. This requires management to provide a written assertion regarding the service organisation's responsibilities for systems and controls, with the

aim of the Service Audits providing NHS Fife with assurance on the controls in operation that meet specified control objectives. The service auditor is required to provide an opinion on the suitability of the design of controls related to the control objectives throughout the period.

2.3 Assessment

NSS Practitioner Payments and CFS Service Audit (Appendix 1)

The full report prepared by KPMG, as Independent Service Auditors for NSS, covers the audit of systems and processes surrounding the payment of Primary Care Practitioners by NSS Practitioner and Counter Fraud Services under the 4 streams:

- General Medical Services
- General Pharmaceutical Services
- General Dental Services
- General Ophthalmic Services

The auditors provided a qualified opinion in this their first year as service auditors in this area, having identified weaknesses that prevented them from being satisfied that three of five control objectives set out in the report had been evidenced.

All the weaknesses that gave rise to the qualified audit opinion are of moderate or serious risk and were impacted by a change of audit approach and COVID-19.

An explanation of the meaning of a service audit report is set out at the Risk Assessment section of this report, below. In accordance with this, the NSS Director of Finance has advised that there were no findings related to payment transaction processing and their external auditor has determined that there is no need for further testing. Relative to the scope of the service audit, its outcome as qualified, rather than adverse, and the NSS Director of Finance's advice, the Committee can take assurance that there is no impact upon the Board's financial statements.

The NSS Director of Finance has provided assurance that:

- detailed management responses have been provided for each finding, and
- an Improvement Plan is being monitored by the NSS Audit and Risk Committee and good progress is being made during 2020/21 (e-mail to ADOF 2/10/20).

NSS IT Services (Appendix 2)

The report has been prepared by KPMG as Independent Service Auditor for NSS and covers the audit of the IT Services provided by NSS Digital and Security (NSSDAS) and its commercial partner, Atos, to support the NHS Scotland ePharmacy Programme, Payments to Practitioners and the national ePayroll System.

Tests of the control environment included the following procedures, to the extent considered necessary by the auditors:

- Reviews of NSS organisational structure, including policy statements, policies and the segregation of functional responsibilities within each team to carry out assigned activities; and
- Discussions with management, operations, administrative and other personnel who are responsible for developing, ensuring adherence to, and applying controls; and
- Observations of personnel in the performance of their assigned duties; and
- Discussion with management regarding the risk, operational and compliance management process.

The auditors provided a qualified opinion in this their first year as service auditors in this area, having identified weaknesses that prevented them from being satisfied that three of six control objectives set out in the report had been evidenced.

As with the Practitioner Services service audit report, the NSS Director of Finance has advised that there were no findings related to payment transaction processing and their external auditor has determined that there is no need for further testing. Relative to the scope of the service audit, its outcome as qualified, rather than adverse, and the NSS Director of Finance's advice, the Committee can take assurance that there is no impact upon the Board's financial statements.

All the required improvements are deemed by the NSS Director of Finance to be of low risk and a commitment to address them, while not increasing expenditure on legacy systems, has been given that good progress is being made (e-mail to ADOF 2/10/20).

NHS Ayrshire and Arran Financial Ledger Services (Appendix 3)

The report has been prepared by BDO UK LLP as Service Auditor to NHS A&A and covers the audit of the national finance ledger system provided to NHS in Scotland. A Management Statement has been provided by the Director of Finance at NHS A&A and the report was approved at their Audit and Risk Committee.

The scope of the Service Audit covered the following areas:

- Access to eFinancials and business Objects reports
- Standing Data changes
- System Upgrades
- Helpdesk functions
- Financial ledger Closedown
- Service Level Agreement compliance

The auditors provided an unqualified opinion and reported no critical or significant risk findings.

2.3.1 Quality/ Patient Care

No direct impact.

2.3.2 Workforce

No direct impact.

2.3.3 Financial

No direct impact on NHS Fife resources.

2.3.4 Risk Assessment/Management

Covered in the assessment section.

2.3.5 Equality and Diversity, including health inequalities

N/A.

2.3.6 Other impacts

N/A.

2.3.7 Communication, involvement, engagement and consultation

The Director of Finance and Director of Primary Care Services at NSS and the Fife Director of Finance have been consulted in the preparation of this document.

2.3.8 Route to the Meeting

As above.

2.4 Recommendations

The Committee is asked to note the reports and audit opinions of the independent service auditors in 2019/20 for each of the services hosted by NSS and by NHS Ayrshire & Arran (NHSAA) on behalf of NHS Fife.

3 List of appendices

The following appendices which relate to this report may be accessed here:

- NSS Practitioner Services ISAE 3402 Report 2019/20
- NSS IT Services ISAE 3402 Report 2019/20
- NHS Ayrshire & Arran ISAE 3402 Report 2019/20

NHS National Services Scotland

Practitioner and Counter Fraud Services

ISAE 3402
Type II Report

1 April 2019 to 31 March 2020

CONTENTS

FOREWORD

The Practitioner and Counter Fraud Service (P&CFS) Service Audit is intended to provide assurance around the internal controls frameworks in place for the services provided to NHS Scotland. This report describes the specific control environment of NHS National Services Scotland - Practitioner Services - for the payment of family health service practitioners. The report has been prepared for the use of NHS Boards in Scotland (NHS Boards) and their auditors in accordance with International Standards for Assurance Engagements (ISAE) 3402, "Assurance Reports on Controls at a Service Organisation."

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

KPMG LLP were awarded this Service Audit contract in 2018, taking effect on 1 April 2019. This report represents the first year of this new relationship. The Independent Service Auditor's Report is contained at Section 1 and is qualified, "*due to the lack of documentation on the checks performed* … [in relation to] *verification and reconciliation*." This represents a shift from previous reported positions.

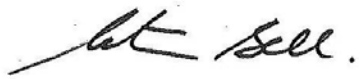
Both management and auditors have worked hard this year to build relationships and mutual understanding. As hoped, the new auditors have given a new perspective on the controls currently in place. Recognition is given that all measures are continually reviewed and assessed by our internal, ISO accredited, quality assurance and improvement system. It is also noted that with the exception of new electronic claims processes for dental and optometric practitioners, which tighten controls through automation, no other material changes to control measures have taken place.

While there is no suggestion that our systems need to be overhauled, it is clear that improvements can and will be made. The methodology employed by KPMG has been different to historical norms, resulting in challenge around the evidence base to meet specific requirements of the ISAE 3402 standards. This was further exacerbated by staff availability in the latter weeks of the period due to COVID-19. The management team and I have started the engagement required with the auditors to ensure solutions can be put in place to mitigate this lack of evidence without resorting to bureaucratic paper systems long since removed.

Detailed management responses to the auditor's comments and recommendations are given at Section 3. It is recognised that some of the recommendations might not be appropriate in the short term. Some would necessitate financial investment in legacy systems that are already scheduled for replacement over the next two years. Engagement between the auditors and management continues to ensure the replacement systems have the recommended controls in place on initiation and that interim measures are put in place to mitigate the lack of automation while legacy systems remain.

Only the IT controls and control objectives for which Practitioner Services is solely responsible are included within the scope of this audit. NSS uses a third-party supplier, Atos (comprising Atos, Sopra Group and IBM), for the provision of IT services. The Practitioner Services systems controls for which Atos is responsible are excluded from this service audit as they are subject to a separate service audit, i.e. the National IT Services Contract Service Audit Report. Readers of this report may wish to consider the extent to which any findings within the National IT Services Contract Service Audit Report may impact on the reader's assessment of the payment processes.

In conclusion, I welcome the fresh perspective and robust scrutiny undertaken by KPMG. I also look forward to further growing relationships and mutual understanding between auditors and management. Collaborative discussions have commenced on identifying novel solutions that can mitigate the evidence gap going forward whilst minimising bureaucracy. It is my intent to have an agreed improvement plan in place by the end of quarter one. This will then be reported quarterly to the NSS Audit and Risk Committee; providing assurance on progress that will take our control environment for family health service contractors payments from good to great.



Martin Bell

Director of Primary Care and Counter Fraud Services

KPMG LLP
1 Sovereign Square
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Leeds LS1 4DA
United Kingdom

Tel +44 (0) 113 231 3000

SECTION 1 - INDEPENDENT SERVICE AUDITOR'S ASSURANCE REPORT

Private & confidential
The Directors
NHS National Services Scotland
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

18 May 2020

Dear Directors

ISAE 3402 Type II Independent Service Auditor's Assurance Report

In accordance with our Call Off Contract dated 11 April 2019 (our "Contract"), we have examined the accompanying description on pages 10 – 34 of the controls in place at the service organisation called NHS National Services Scotland ("NSS") and carried out procedures to enable us to form an independent opinion on whether NSS's management has fairly described its controls system applicable to certain aspects of the Practitioner and Counter Fraud Services ("P&CFS") from offices at Edinburgh, Glasgow, Livingstone and Aberdeen throughout the specified period 1 April 2019 to 31 March 2020 (the "Description") and on the design and operation of controls related to the control objectives stated in the Description. Our opinion is set out below and should be read and considered in conjunction with this report in full.

NSS Management's Responsibilities

In this report, references to NSS's "management" means the directors of NSS and those employees to whom the directors of NSS have properly delegated day-to-day conduct over matters for which the directors of NSS retain ultimate responsibility.

Management of NSS is responsible for (1) preparing its statement on pages 8 – 9 and describing in the Description within the statement its controls system for processing customers' transactions, including the completeness, accuracy and method of presentation of the same, (2) having a reasonable basis for its statement, (3) selecting the criteria to be used and stating them in the statement, (4) specifying the control objectives and stating them in the Description, and (5) identifying the risks that threaten the achievement of the control objectives and designing, implementing, and documenting controls that are suitably designed and implemented to provide reasonable assurance that the control objectives stated in the Description will be achieved.

Service Auditor's Responsibilities

Our responsibility is to express an independent opinion to NSS based on the procedures performed and evidence obtained, as to whether (1) NSS's management Description fairly presents the controls system that was designed and implemented throughout the specified period and the aspects of the controls that may be relevant to a user organisation's internal control, as it relates to an audit of financial statements; (2) the controls included in the Description were suitably designed throughout the specified period to provide reasonable assurance that the control objectives specified would be achieved if the described controls were complied with satisfactorily, and (3) such controls were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the specified period. The criteria we used to form our judgements are the criteria used by management in making the Description, and are set out on pages 8 – 9.

Framework applied

Our work was performed having regard to the framework set out by the International Auditing and Assurance Standards Board (IAASB) International Standard on Assurance Engagements 3402 (ISAE 3402) "*Assurance Reports on Controls at a Service Organisation*". That standard requires that we obtain sufficient, appropriate evidence on which to base our conclusion.

Our Independence and Quality Control

We comply with the Code of Ethics for Professional Accountants issued by the International Ethics Standards Board for Accountants and we apply the International Standard on Quality Control (UK and Ireland) 1 *Quality Control for Firms that Perform Audits and Reviews of Historical Financial Information, and Other Assurance and Related Services Engagements*. Accordingly, we maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements and professional standards (including independence, and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour) as well as applicable legal and regulatory requirements.

Scope of work

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

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

Limitations of Controls at a Service Organisation

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

The relative effectiveness and significance of specific controls at NSS, and their effect on assessments of control risk at user organisations, are dependent on their interaction with the controls and other factors present at individual user organisations. We have performed no procedures to evaluate the effectiveness of controls at individual user organisations.

Opinion

Basis for Qualified Opinion

NSS provide a range of P&CFS services under the NHS Scotland National IT Services Contract. Within the scope of our work, we have identified qualifications relating to four out of five control objectives during the period, as summarised below.

With regard to control objective 1, NSS states in the Description that NSS has controls in place over the verification of completeness, validity and accuracy of General Medical Services (GMS) payments. However, during the period 1 April 2019 to 31 March 2020, as noted on pages 36 – 50, the evidence of the verification and reconciliation activities performed had not been formally documented and retained. Furthermore, control design failures were noted on payment claim authorisation, and the addition and removal of authorisers from the approvers list. These are due to the lack of documentation on the checks performed to verify that requests had come from verified sources. Hence, these issues have resulted in the non-achievement of the control objective '*Controls provide reasonable assurance that: GMS payments are made completely and accurately based on authorised claims to the valid contractors; GMS payments are made only once; and verification is performed in accordance with Scottish Government guidance.*'

With regard to control objective 2, NSS states in the Description that NSS has controls in place over the verification of completeness, validity and accuracy of General Pharmaceutical Services (GPS) payments. However, during the period 1 April 2019 to 31 March 2020, as noted on pages 51 – 64, the evidence of the verification and reconciliation activities performed had not been formally documented and retained. Furthermore, control design failures were noted on payment claim authorisation, and the addition and removal of authorisers from the approvers list. These are due to the lack of documentation on the checks performed to verify that requests had come from verified sources. In addition, the DCVP system only retains data for two months, therefore, we were unable to test controls around checking of payments across the period. Hence, these issues have resulted in the non-achievement of the control objective '*Controls provide reasonable assurance that: GPS payments are*

made completely and accurately based on authorised claims to the valid contractors; GPS payments are made only once; and verification is performed in accordance with Scottish Government guidance.'

With regard to control objective 3, NSS states in the Description that NSS has controls in place over the verification of the completeness, validity and accuracy of General Dental Services (GDS) payments. However, during the period 1 April 2019 to 31 March 2020, as noted on pages 65 – 81, the evidence of the verification and reconciliation activities performed had not been formally documented and retained. Furthermore, control design failures were noted on payment claim authorisation, and the addition and removal of authorisers from the approvers list. These are due to the lack of documentation on the checks performed to verify that requests had come from verified sources. Hence, these issues have resulted in the non-achievement of the control objective '*Controls provide reasonable assurance that: GDS payments are made completely and accurately based on authorised claims to the valid contractors; GDS payments are made only once; and verification is performed in accordance with Scottish Government guidance.'*

With regard to control objective 4, NSS states in the Description that NSS has controls in place over the verification of the completeness, validity and accuracy of General Ophthalmic Services (GOS) payments. However, during the period 1 April 2019 to 31 March 2020, as noted on pages 82 – 96, the evidence of the verification and reconciliation activities performed had not been formally documented and retained. Furthermore, control design failures were noted on payment claim authorisation, and the addition and removal of authorisers from the approvers list. These are due to the lack of documentation on the checks performed to verify that requests had come from verified sources. Hence, these issues have resulted in the non-achievement of the control objective '*Controls provide reasonable assurance that: GOS payments are made completely and accurately based on authorised claims to the valid contractors; GOS payments are made only once; and verification is performed in accordance with Scottish Government guidance.'*

Qualified Opinion

Our opinion has been formed on the basis of the matters outlined in this report. In our opinion, in all material respects, except for the matters described in the Basis for Qualified Opinion paragraphs:

1) The Description fairly presents the controls system as designed and implemented throughout the period from 1 April 2019 to 31 March 2020;

2) The controls related to the control objectives stated in the Description were suitably designed throughout the period from 1 April 2019 to 31 March 2020; and

3) The controls tested, which were those necessary to provide reasonable assurance that the control objectives stated in the Description were achieved, operated effectively throughout the period from 1 April 2019 to 31 March 2020.

Emphasis of Matter

We draw attention to the controls around completeness and accuracy of the population lists, as outlined in control objectives 1, 2, 3 and 4 and section 2.8. Due to the nature of the manually maintained lists, we were not able to determine the completeness and accuracy of the population provided for the controls in-scope for audit. Hence, these matters warrant specific emphasis for the users of this report.

Other Matter

We draw attention to the fact that NSS have published a separate ISAE 3402 Type II Report in relation to the IT controls ("the IT Report"). This report, on P&CFS, should be read in conjunction with the IT report. This is on the basis that the IT control environment directly supports the P&CFS controls.

Description of test of controls

The specific controls tested and the nature, timing and results of those tests are listed on pages 35 – 98.

Additional Information

The information provided on page 99 of this report is presented by NSS to provide additional information and is not a part of NSS management's Description of its controls system. This information has not been subjected to the same procedures applied in the examination of the Description of controls applicable to the processing of transactions for users, and accordingly, we express no opinion on it.

About this report including disclosure

This report is made to and has been prepared solely for the management of NSS, as a body, on the terms agreed and recorded in our Engagement Letter. In this report, by "management" we mean the directors of NSS and those

employees to whom the directors of NSS have properly delegated day-to-day conduct over matters for which the directors of NSS retain ultimate responsibility.

This report was designed to meet the agreed requirements of NSS and particular features of our engagement determined by NSS's needs at the time.

This report is confidential and is released on the basis that it shall not be copied, referred to or disclosed, in whole or in part, save as permitted by our Engagement Letter, without our prior written consent. We have consented to its disclosure to "User Entities", being NSS's customers, the independent auditors of NSS's customers, and the prospective customers of NSS. Our consent has been given without in any way or on any basis affecting our responsibility or giving rise to any duty or liability being accepted or assumed by or imposed on us to any party except NSS and its management. We have consented to enable NSS and its management to demonstrate, and such User Entities to verify, that an independent service auditor's assurance report has been commissioned by the management of NSS and issued in connection with the controls of NSS.

Intended Users and Purpose

This report and Description of tests of controls and results on pages 35 – 98 are only to be disclosed to User Entities who have a sufficient understanding to enable them to consider the matters stated including the basis of our consent to disclosure and their ability to rely on this report, along with other information including information about controls implemented by customers themselves, when assessing the risks of material misstatements of User Entities' financial statements. This report is not to be used by anyone other than these specified parties.

This report does not restrict use by User Entities on the basis that those User Entities remain responsible for their own work and consideration of this report and for evaluating the evidence presented by our report and for determining its effect on the assessment of control risk at the User Entities.

Any party other than NSS or its management, as a body, who obtains access to this report or a copy and chooses to use and rely on this report (or any part of it) will therefore do so at its own risk. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than NSS and its management, as a body, for our work, for this report, or for the opinions we have formed.

Yours faithfully

KPMG LLP

KPMG LLP

SECTION 2 - MANAGEMENT'S SYSTEM DESCRIPTION

2.1 MANAGEMENT STATEMENT LETTERS

2.1.1 NSS – P&CFS

The accompanying description has been prepared for customers who have used NHS National Services Scotland ("NSS") control system and their auditors who have a sufficient understanding to consider the description, along with other information including information about controls operated by subservice organisations and by customers themselves, when assessing the risks of material misstatements of customers' financial statements.

NSS confirms that, except for the items described in Section 1 of this report:

(a) The accompanying description at pages 10 – 34 fairly presents the NSS control system for processing customers' transactions throughout the period 1 April 2019 to 31 March 2020.

The criteria used in making this statement were that the accompanying description:

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

- The types of services provided, including, as appropriate, classes of transactions processed.
- The procedures, within both information technology and manual systems, by which those transactions were initiated, recorded, processed, corrected as necessary, and transferred to the reports prepared for customers.
- The related accounting records, supporting information and specific accounts that were used to initiate, record, process and report transactions; this includes the correction of incorrect information and how information was transferred to the reports prepared for customers.
- How the system dealt with significant events and conditions, other than transactions.
- The process used to prepare reports for customers.
- Relevant control objectives and controls designed to achieve those objectives.
- Controls that we assumed, in the design of the system, would be implemented by user entities, and which, if necessary to achieve control objectives stated in the accompanying description, are identified in the description along with the specific control objectives that cannot be achieved by ourselves alone.
- Other aspects of our control environment, risk assessment process, information system (including the related business processes) and communication, control activities and monitoring controls that were relevant to processing and reporting customers' transactions.

(ii) Includes relevant details of changes to the service organisation's system during the period 1 April 2019 to 31 March 2020.

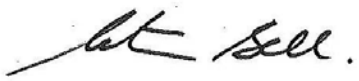
(iii) Does not omit or distort information relevant to the scope of the system being described, while acknowledging that the description is prepared to meet the common needs of a broad range of customers and their auditors and may not, therefore, include every aspect of the system that each individual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

(b) The controls related to the control objectives stated in the accompanying description were suitably designed and operated effectively throughout the period 1 April 2019 to 31 March 2020 to achieve those control objectives if subservice organisations and user entities applied the complementary controls assumed in the design of NSS's controls and operated effectively throughout the period 1 April 2019 to 31 March 2020. The criteria used in making this statement were that:

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

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

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



Martin Bell

Director of Primary Care and Counter Fraud Services

18 May 2020

Signed on behalf of the Board of Directors / Senior Management
National Services Scotland

2.2 NHS NATIONAL SERVICE SCOTLAND

2.2.1 INTRODUCTION

NHS National Services Scotland (NSS) provides national solutions to help improve the health and wellbeing of the people of Scotland. NSS provides national infrastructure services and solutions which are integral to the delivery of health and care services in Scotland locally, regionally and nationally.

Our national infrastructure covers clinical areas, such as the safe supply of blood, tissues and cells, through to non-clinical areas, such as providing digital platforms and cyber security for health and care.

NSS are working across health and care, aiming to ensure that the benefits and value we achieve through our national solutions can assist many different areas of local front line services to help improve outcomes for the people of Scotland and attainment of the National Performance Framework Goals.

Made up of a number of Strategic Business Units and Corporate Support services, it employs around 3,400 staff. Primary care support is delivered by one of the business units, Practitioner & Counter Fraud Services, which provides payment, patient registration and records transfer for primary and community care contractor services (general practice, community dental, community pharmacy and optometry).

2.2.2 SCOPE OF THIS ISAE 3402 REPORT

This ISAE 3402 Service Audit Type II report is for use by user organisations and their auditors (user auditors) regarding the controls operated by NSS that are likely to impact or be a part of the user organisation's system of internal control over financial reporting.

The scope is for an audit of services provided by NSS to NHS Scotland Boards in relation to services provided by P&CFS to NHS Scotland Boards.

The P&CFS Service Audit is intended to provide assurance around the internal controls frameworks in place for the services provided to the wider NHS Scotland.

Scope

NSS P&CFS acts on behalf of NHS Boards when making payments to Primary Care Contractors. The expenditure is recorded in the books of account of the NHS Boards and NSS is required to give assurance to the Boards that systems of control are in operation when calculating and making payments. NSS is also responsible for the patient registration system in regard to patient placement with General Practitioners.

There are four contractor groups providing services to NHS Scotland:

- General Practitioners who provide General Medical Services (GMS);
- Pharmacists who provide General Pharmaceutical Services (GPS);
- Dental Practitioners who provide General Dental Services (GDS); and
- Ophthalmologists who provide General Ophthalmic Services (GOS).

There is also a Digital and Security (DaS) IT services team who support P&CFS.

Payments to each contractor group are generally governed by extant regulatory or contractual terms, including the reimbursement for the cost of products dispensed in primary care.

Each of the groups of contractors is in the main discrete from the others, as are the systems controlling the calculation of remuneration. All contractor payments are made through the NSS financial ledger system. A small number of medical practitioners also carry out dispensing services for their patients.

The Scottish Government (SG) authorise NSS to 'draw down' the required funds each month and to pay contractors. NSS then notify the SG and the Boards of the sums paid out and the Boards are charged through the 'payments on behalf' system. This then allows the NHS Boards to account for the impact of each of the payments made.

The accuracy of the payments process is in part confirmed by payment verification processes, which occur both before and after the payments have been made. These tests vary in form and content depending on the nature of the payment.

The control systems for each stream will be considered separately, however certain controls over the final payment cycle are common.

2.2.3 PRACTITIONER & COUNTER FRAUD SERVICES

The Practitioner & Counter Fraud Services (P&CFS) Strategic Business Unit supports payments and patient registration processes for NHS Services to Scotland's GPs, dentists, community pharmacists, and optometrists, processing and checking millions of claims every month.

Each year, practitioner payments totalling approximately £2.7 billion are made by P&CFS and recorded in the NHS Boards' financial statements. The Scottish Government Health and Social Care Directorates (SGHSCD) allocate resources for monthly payments, which are processed by P&CFS. P&CFS notifies both SGHSCD and the NHS Boards of the payments made and the NHS Boards are then treated as having received and spent the appropriate amount by SGHSCD.

As the organisation that calculates and makes the practitioner payments, P&CFS must provide probity assurance evidence to each NHS Board and their external auditors.

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

In addition to the above, P&CFS is also responsible for undertaking payment verification procedures (probity assurance checks) on behalf of NHS Boards for all four practitioner payment streams.

P&CFS supports four practitioner payment streams:

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

The services that P&CFS provides each NHS Board are documented in detail in a Partnership Agreement which operates on a triennial renewal cycle.

The P&CFS Senior Management Team (SMT) meet monthly to review service delivery performance, drive service improvement and to consider the strategic direction of the organisation. The SMT are responsible for helping ensure that governance is embedded throughout the organisation by management & staff from each payment stream holding monthly team meetings to discuss operational business and managing awareness of processes for all staff within each payment stream relating to their area of work.

P&CFS maintains patient registration details for GP practices and works with the Public Health & Intelligence (PH&I) Strategic Business Unit of NSS in maintaining GMS indices used in applying the Scottish Workload Formula in sharing GMS Global Sum payments and works with the eVadis team of PHI in maintaining the pricing file for pharmacy products and in producing reports for NSS and NHS Boards.

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

P&CFS is responsible for collating financial reports for all four practitioner payment streams and providing summarised data to NHS Boards and the SGHSCD to support budget allocation and financial reporting within NHS Scotland.

P&CFS Senior Management meets with each NHS Board annually to:

- review the effectiveness of the partnership agreement;
- discuss issues arising during the review year; and
- discuss any changes or enhancements to the services provided going forward.

P&CFS also works with the SGHSCD in the implementation of legislative and regulatory changes, as well as monitoring clinical standards within dentistry.

Policies, procedures and monitoring activities

P&CFS has a team of Quality Managers whose role is to support management of adherence and that policies and procedures are maintained, including checking on a sample basis that the necessary controls are in operation.

The four payment streams are also ISO 9001:2015 accredited. ISO 9001:2015 is an internationally recognised quality standard, relevant to organisations which provides some external assurance that its products and services satisfy its customers' quality requirements and comply with any regulatory requirements in respect of

the products and services provided.

In order to achieve and maintain this accreditation the key P&CFS processes for each payment stream need to be documented, described and supported by detailed manuals and procedures. Built into the quality procedures are quality checks and internal audit checks which are undertaken by dedicated P&CFS staff to confirm the key controls continue to be in place and operating as intended.

The ISO accreditation is subject to six-monthly external review, with action plans developed for any issues raised.

General Medical Services (GMS)

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

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

- Global Sum Payment – This is set out in the Statement of Financial Entitlements within the Contract and is based on an agreed Scottish Workload Formula;
- Seniority payments – Payments are earned based on the length of qualifying service of individual GPs; and
- Enhanced services and other payments – These payments are for services provided by the GP Practice as directed by the SGHSCD and/or NHS Boards.

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

The following processes and controls are operated by NSS under the General Medical Services:

- GMSQA team maintains a list of individuals and their delegates from the practices, NHS Boards, NHS Education for Scotland and Health Protection Scotland who are authorised to claim payments or request amendments on rates/data that will impact payments. On an annual basis as a minimum, GMSQA team obtains confirmation from NHS Boards to verify that the list remains accurate and up-to-date. The list is made accessible to the three regional offices through PSINet.
- Payment team verifies that requests to update the list of authorised signatures on the current practice mandate, are supported with an approval from the practice manager before the new practice mandate is uploaded to PSINet. Where there is a new Practice Manager, the Payment Team verifies that approval has been given by an authorised NHS Board Primary Care Administrator.
- For each circular that defines updates to payment rates, peer reviews on the completeness and accuracy of updates to payment rates to PMSPS are performed against the request received from Scottish Government Health and Social Care Directorate (SGHSCD). The updates are made within the system and reviewed by a different member of the Financial Services team. The review is documented on the input paperwork.

  Any issue on completeness, accuracy of timeliness of the rate update that results in incorrect payments being made is resolved to completion and tracked by the key performance indicators (KPI).

  If an expected update is not received, this will be discussed at the Finance Resource Oversight Group (FROG) meeting and an appropriate action agreed.
- On a quarterly basis, Edinburgh Regional Office (ERO) team verifies that the formula used for the Global Sum payment calculation is the latest and approved Scottish Workload Formula. The latest version of the formula is stored in Business Classification Scheme (BCS) folders.

  ERO team verifies that the appropriate approval from Scottish Government is in place before change is made to the formula or other input.
- The Payment team confirms, by looking up the NHS Board authorisation matrix, that approval is from an authorised individual before processing the GMS payments (excluding the Global Sum Correction Factor, Temporary Patient Adjustment, Opt Out adjustments, Training Grants and Sentinel Swabbing payments). The source e-mail and attached document is saved intact for verification.
- The Payment team verifies that approval from NHS Board is in place before processing any Temporary Patient Adjustment or Opt Out adjustments. The List of Authorised Individuals is used as part of the verification.
- Payment team verifies that approval from NHS Education for Scotland's authorised person or their

delegates are in place before processing the Quarterly Payments for training grants. The List of Authorised Individuals is used as part of the verification.

- Glasgow Regional Office (GRO) Payment team verifies that approval from Health Protection Scotland's authorised person or their delegates are in place before processing the payments for sentinel swabbing. The List of Authorised Individuals is used as part of the verification.
- A team member that is different from the inputter verifies that the amount of Enhanced Service Payments and Section 17C Practice Payments to be processed is in line with the amount provided by the NHS Boards through manual checking. The verification is documented in the monthly checklist.

  A member of the team verifies that the calculation is provided by an authorised person from NHS Boards who is part of the Board Authorised Signatory Mandate. The list of authorised individuals is used as part of the verification.
- At the end of each month before payments are processed, the Payments Manager responsible for each board performs a reconciliation between the source documentation and PMSPS to verify the accuracy of the amounts and identify if there are cases of duplicate payments. Completion of this reconciliation is documented by signing and dating the 'Month of Payment' document.
- The regional Registration Teams perform quarterly check to compare the current Global Sum payment amounts with the previous quarter. The check is documented in BCS folder.

  Any variance over +/-5% is investigated by the teams through to resolution.
- A member of the Payment team, other than those who process the payment, reviews each claim processed in PMSPS to:

  1) verify its accuracy by comparing it to the original documentation; and

  2) identify duplicate claims by checking if they have been paid already.

  The review is performed prior to the payments being made.
- Regional office management reviews the monthly BACS payments to practices by comparing it against the amount from last month/quarter, with differences that are more than expected, investigated to confirm accuracy of the payment and/or to identify duplicates. This review is performed prior to the payment being processed.
- A member of PS Finance Management Team authorise payments made by CHAPS or bank transfer before the payment is made by NSS Central Finance. This authorisation is documented in BCS folders and hard copy folders.
- A member of the Payments Team verifies that the following requests are supported with approval from an authorised person from the NHS Board before they are entered onto the PMSPS system:

  (1) New GP Practice/contractors, or

  (2) Amendments to existing GP Practice/contractors, or

  (3) Cessation of GP Practices.

  The List of Authorised Individuals is used in performing the verification.
- A member of the Payments Team, who is different from the inputter, verifies the accuracy of the following actions made in the PMSPS system against the details supplied by the NHS Board prior to the next payment run relevant to the date of the change.

  (1) New GP Practice/contractors, or

  (2) Amendments to existing GP Practice/contractors, or

  (3) Cessation of GP Practices.

  This check is documented in hard copy folders.

  Errors identified as a result of the verification is corrected and tracked using hard copy folders.
- On a quarterly basis, ERO Payment team reviews the discrepancies identified as a result of the automated reconciliation of contractors' data from the PMSPS system against the CHI system. These discrepancies are investigated, tracked and resolved to completion using PMSPS load. CHI file will not load if discrepancies are not resolved.
- Payment team verifies that an approval from an authorised person from the GP Practice is in place

before making an amendment/update on PMSPS system of the bank details, and other standing data, of the Practices and/or their contractors. The List of Authorised Individuals is used as part of the verification. This verification is documented in BCS folders and hard copy folders.

Payment team verifies that an approval from the named contractor is in place before making an amendment/update on General Ledger of the bank details of non-PMSPS contractors.

- As directed by the Practitioner Services Medical PV Lead & Chair of the Medical PV Implementation Group, the Medical PV Implementation Group reviews the Scottish Government Guidance on payment verification requirements as published in the relevant Primary Care Circular and makes recommendations regarding any amendments. The review and any amendments recommended are documented within the meeting minutes.
- The Data Quality department performs various checks on the accuracy of the CHI data. This includes Practice information Comparison Test (PiCT) exercises, as and when required, which compares Practice lists with the CHI, in order to ensure that accurate information is used in the Global Sum Calculation. These exercises are included in the PV Report to NHS Boards.

  Differences identified as a result of the PiCT exercises are investigated, corrected and tracked in CHI.
- As per the Scottish Government guidance on PV, the PV department visits (either physically or via remote IT link) a random sample of practices for Enhanced Services on an annual basis to review patient records to ensure services are provided in line with the Enhanced Service contract specification. Where service provision is not verified satisfactorily, payment recovery is sought. Confirmation of this review is documented in the payment verification visit register, detailed in the visit reports.

General Pharmaceutical Services (GPS)

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

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

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

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

The following processes and controls are operated by NSS under the General Pharmaceutical Services:

- GMSQA team maintains a list of individuals and their delegates from the practices, NHS Boards, NHS Education for Scotland and Health Protection Scotland who are authorised to claim payments or request amendments on rates/data that will impact payments. On an annual basis as a minimum, GMSQA team obtains confirmation from NSH Boards to verify that the list remains accurate and up-to-date.

  The list is made accessible to the three regional offices through PSINet.
- Payment team verifies that a request to add/amend the list of authorised individuals are supported with approvals from practice mandates or the NHS Board Director of Finance (or delegate) before the amendment is made. This is documented in PSINet.
- On publication of Scottish Government Circulars, eVadis team verifies that changes to the fee and allowance rates to General Pharmacy Services are received from an authorised person from the Government and the NHS Boards before making the changes/updates to the rates in the system. The List of Authorised Individuals is used as part of the verification. The verification is documented in a form detailing the change.
- A member of eVadis team other than the one who made the amendment reviews the updates to fee and allowance rates entered into the eVadis system to verify its accuracy against the source information provided by the Government and NHS Boards.

- Price changes for items on Part 7 of the SDT are documented on a manufacturer report and verified by a member of the eVadis team.

  Changes are then implemented on the eVadis system by a member of the eVadis team, and verified by a separate member of the eVadis team. This is verification performed prior to the monthly upload into the DCVP system and is documented in the Manufacturer's Report.

- On a monthly basis, DCVP Business Systems Administration to verify the accuracy and completeness of the changes to fees and allowances in advance of the fees being utilised by DCVP against the Scottish Government circular. Any errors identified are investigated and resolved with the eVadis team and an updated eVadis file is created and submitted to DCVP.

- The Document Handling team verifies that claims for payments relating to prescriptions and stock orders are supported with a claim form from the registered pharmacy, dispensing doctor or appliance supplier, by checking against the list of Registered Pharmacies, Dispensing Doctors and Appliance Suppliers in eVadis. The verification is performed before the claim is processed, and is documented in the GP34 form.

- Regional Payments team verify whether claims for payments relating to additional Health Board services provided by contractors are supported with approval from an individual from NHS Boards as listed on the NHS Board Delegate Matrix. The verification is performed before the claim is processed.

- On a monthly basis, Senior Data Analysts staff, other than the inputter verifies the accuracy of the manual price assigned to dispensed items listed without a price in eVadis. The latest and approved version of the manuals, dm+d Quick Search and over-ride price lists are used as part of the verification.

- Prior to the DCVP payment being processed each month, Payment management review the reports of payment variance for each NHS Board which compares the amount to be paid in the month against the amount from the previous month. Differences are further investigated to verify its accuracy, and to also prevent payment being made more than once to the same contractor. This check and the result of the investigation are documented in the BCS folder.

- Before Minor Ailment Scheme (MAS) payments are made, Patient Registration team check whether:

  - The payment schedule has been updated for new and closed contractors;

  - Patient numbers for last month's current total is equal to the current month's previous total for one contractor per NHS Board. Once checked all contractors are uploaded onto the DCVP system for payment by AOA.

- On a monthly basis, the NSS Document Processing Department performs a reconciliation between the number of contractors for whom prescriptions were received for each NHS Board in the batch headers and the number of items that have been scanned onto the DCVP system.

  Any discrepancies of more than 15% are investigated and resolved through to completion. The details of any investigation are held in a hard copy notebook within the department.

- On a monthly basis, post payment, the Adjustment team produce a report detailing individual item payments in excess of £500. To verify the accuracy of all manually keyed items reported against the individual script from contractors the adjustment team confirm correct item and quantity have been processed to ensure payment accuracy. A second member of the team reviews the result. Both members of staff sign the print out of the report to signify completion of this control.

  Errors identified as a result of the review are corrected by way of an adjustment by the Adjustment team. This is tracked using the SPSaA system.

- A member of PS Finance Management Team authorise payments made by CHAPS before the payment is made by NSS Central Finance. This authorisation is documented in payment documentation file

- A member of the Pharmacy Payments Team verifies that the following requests are supported with approval from an authorised person from the NHS Board before they are entered onto the eVadis system:

  (1) New Pharmacies/Dispensing Doctors/Appliance Suppliers; or

  (2) Cessation of dispensing contractors.

  The List of Authorised Individuals is used in performing the verification. The authorised notification is held in the Pharmacy payment department.

- A member of Pharmacy Payments Team, who is different from the inputter, verifies the accuracy of the

following actions made in the eVadis system against the details supplied by the NHS Board prior to the next payment run after the request is received

(1) New Pharmacies/Dispensing Doctors / Appliance Suppliers

(2) Cessation of Pharmaceutical contractors

This check is documented in our Business Classification Scheme. Errors identified as a result of the verification is corrected and tracked using Contractor Amendments

- Payments team verifies that an approval from an authorised person from NHS Board (as listed in the Authorised Persons list) or the Pharmacy contractor or the contractor's bank is in place before making an amendment/update to the contractor's bank details and other standing data on the General Ledger.

  This verification is documented on file in the changes file.

- A member of, Regional Payments Team, who is different from the inputter, verifies the accuracy of the amendment/update to the contractor's bank details and other standing data made in the Finance Process Manager (FPM) system against the details supplied by the NHS Board or the Pharmacy contractor or the contractor's bank prior to the next payment run from when the request is received.

- On an annual basis, the Payment Verification Manager reviews the Scottish Government Guidance verification requirements as published in relevant circular and document these requirements in team policy/procedure. The policy/procedure is communicated to internal NSS staff through meetings.

- Processing staff perform further verification at confirmation report in DCVP. In accordance with their instructions in the SDA manual to verify the validity of prescriptions and stock orders claims that fall into the following category after they are loaded into the DCVP system and before the claims are processed for payments to verify the accuracy and validity of the claims:

  - Foreign forms;

  - Urgent forms;

  - Unknown items;

  - Minimum gross ingredient cost;

  - Out of pocket expenses;

  - High value gross ingredient cost;

  - Rejected items;

  - Unusual fees/quantities; and

  - Pay and report items.

  The result of the verification is carried out within DCVP.

  Any invalid/inaccurate claims identified as a result of the review are investigated, resolved to completion and tracked using DCVP.

- Senior Data Analyst team performs a monthly sample check over a sample of contractors entered manually in batches in DCVP system, in accordance with the Random Sampling procedure. The check compares a system generated sample to confirm correct item and quantities have been processed. Errors found are resolved through to completion and tracked using DCVP.

  Where the number of errors found exceeds pre-defined limits, the full population is tested, and errors resolved through to completion and tracked using DCVP.

  All of the above are documented in Random Sampling procedure.

- As per the Scottish Government guidance, the PV team performs an annual review of dispensing payments made for 1% of contractors to verify their accuracy and validity of approval by comparing the records against the supporting approval records. The review is documented in PV department records.

  If an error is found, it is investigated and corrected to resolution. This is tracked using the PV tracker.

- On a quarterly basis, the PV team produces reports for all NHS Boards detailing the level of checking carried out in each area and highlighting any specific issues. Following the outcome of payment verification reporting / investigation into unusual prescribing, dispensing or claim patterns, the Payment Verification team liaise with the appropriate NHS Board and where necessary, make a referral to Counter Fraud Services.

General Dental Services (GDS)

Payments are made on a monthly basis for general dental services to dentists and specialist orthodontic contractors in accordance with the detailed Statement of Dental Remuneration. Key elements that contribute to dental payments are set out below:

- Continuing adult dental care payments;
- Specific dental treatment for eligible payments e.g. orthodontic treatment, fillings etc.;
- Treatment of children calculated based on the number of children registered with the practice;
- Other payments as set out in the Statement of Dental Remuneration, for example out-of-hours treatment and remote access payments; and
- P&CFS administer pension deductions from dental payments and remit these to SPPA.

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

The main processing systems used by GDS are eDental and the Management Information and Dental Accounting System (MIDAS). eDental provides real-time claim validation. MIDAS values the work claimed by Dentists, using electronic claims or paper dental claim forms and calculates the value for payment.

The following processes and controls are operated by NSS under the General Dental Services:

- GMSQA team maintains a list of individuals and their delegates from the practices, NHS Boards, NHS Education for Scotland and Health Protection Scotland who are authorised to claim payments or request amendments on rates/data that will impact payments. On an annual basis as a minimum, GMSQA team obtains confirmation from NHS Boards to verify that the list remains accurate and up-to-date. Changes required as a result of the confirmation are tracked to completion by GMSQA team. The list is made accessible to the Dental Payments Team through PSINet.
- Payment team verifies that a request to add/amend the list of authorised individuals are supported with approvals from practice mandates before the amendment is made. This is documented in PSINet.
- An Assistant Director reviews the approval and accuracy of updates to payment rates to PS against the request received from Scottish Government Health and Social Care Directorate (SGHSCD).

  This review is performed in the test environment prior to the new rates being implemented in the live MIDAS system, and the successful upload to live is also confirmed. This is documented in SDR update process control sheet.
- The Prior Approval team completes a validity check over paper claim forms before payments are processed to confirm that they contain:

  - The registered contractor's payment list number;

  - Signature of the patient;

  - Signature of the dentist; and

  - Acceptance date and completion date.
- The electronic dental claims system is configured to accept claims only from a registered contractor. A mechanism is built in the electronic form to prevent the claim to be submitted unless it specifies:

  - The registered contractor's payment list number;

  - Location code;

  - Electronic signature of the patient;

  - Electronic signature of the dentist;

  - Acceptance date and completion date.

  Changes to the above configuration follows the standard change management procedure.
- Dental Payment team verifies whether claims for all payments except for dental and orthodontic treatment claims are either:

  - supported with approval from an individual from NHS Boards as listed on the List of Authorised Individuals, or

- supported with a signed form from a valid contractor, and includes a list number.

The verification is performed before the claim is processed, and is documented in monthly claims file.

- Dental Payment team verifies that the requests for patient refunds are supported with confirmation of exemption status from department of work and pensions before the refunds are sent for payment. This is documented in refunds process.
- Any adjustment/non-payment/patient detail amendment claims are returned to the contractor with a comment to explain the reason for the action taken in response to the claim within 20 working days of receipt. This is logged in the adjustment/non-payment/patient detail amendment spreadsheet.
- MIDAS is configured to automatically check all claims relating to dental treatments to verify that they are not duplicate claims by comparing patient's treatment histories. Changes to this configuration follow the standard change management procedure.

  On a daily basis where applicable, the Customer Admin team will review all payments identified by the system as potential duplicates. Any duplicate claims identified reviewed and found to be a valid duplicate, are returned to the contractor as unpaid by the Customer admin team. Claims which are not valid duplicates are processed for payment.
- A member of the Dental Payments team other than the inputter verifies the accuracy of claims for all payments except for dental and orthodontic treatment claims by comparing the entry in MIDAS system against the instruction from NHS Board. This is documented in a dental top sheet within the payments file.

  Any errors identified as a result of this verification is corrected and tracked in the payments file.
- A list is maintained of all contractors who exhibit unusual prescribing/treatment patterns. These identified contractors are recorded in a CPA list and all of their prior approval requests are assessed by a Clinical Advisor.
- The weekly calculation of patient refunds is independently reviewed by a member of the Dental Payments Team to verify that the refund is accurately calculated based on HC1/2.
- A member of the Test and Support Team performs a verification on the number of claims and values relating to each NHS Board by comparing it against the supporting detail of the calculation from the system / against the amount from last month, with significant differences investigated to resolution. This review is performed prior to transmission to the NSS Finance Department for BACS processing to confirm completeness and accuracy of the amounts. This is documented in the BACS payment documentation.

  Dental Payments Team provides NSS Treasury a control sheet of the total amount authorised to be paid and this is authorised prior to BACs transmission.

  A member of the senior management team reviews the result.
- A member of PS Finance Management Team authorises payments made by CHAPS, Paymaster General or bank transfer before the payment is made by NSS Central Finance. This authorisation is documented as a hard copy.
- Following completion of BACS and CHAPS processing, PS team reconcile the total amount of BACS and CHAPS payments against the supporting calculation from Midas to verify that all payments had been processed. Differences are investigated and resolved to completion.
- Prior to raising cheques or other payments for patient refunds, NSS Central Finance Department verifies that an approval from an authorised person in the Dental Payments Team, as listed in authorised signatory list, is in place along with the electronic listing of all refund amounts. The approval and verification are documented in BCS folder.
- A member of the Customer Administration Team verifies that the following requests are supported with approval from an authorised person from the NHS Board before they are entered onto the MIDAS system:

  (1) New Dental Contractors; and

  (2) Removal of Dental Contractors.

  The List of Authorised Individuals is used in performing the verification.
- On a monthly schedule basis for a selection of new contractors / ceased practices, a member of Customer Admin Team who is different from the processor/inputter verifies the accuracy of the

following actions made in MIDAS against the details supplied by the NHS Board:

(1) New Dental Practice/contractors, and

(2) Cessation of Dental Practices.

The size of the selection is determined by sample check process. This check is documented in Sample check training guide.

Errors identified as a result of the verification is corrected and tracked within MIDAS.

- Customer Admin team verifies that the request for patient addition/withdrawal/removal are supported by a signed form from NHS Boards before the addition/withdrawal/removal is processed. This is documented in BCS folder.

  Customer Admin Team monitors completion of the withdrawal requests to help ensure that they are processed within 20 working days of the requests being received.

- Dental Payments team verifies that an approval from an appropriately signed bank mandate is in place before making an amendment/update to the contractor's bank details and other standing data in MIDAS and on the General Ledger.

- A member of the Dental Payments team, who is different from the inputter, verifies the accuracy of the amendment/update to the dental contractor's bank details and other standing data made in MIDAS against the details supplied by the Contractor prior to the next payment run when the request is received.

- On an annual basis, the Payment Verification Manager reviews the Scottish Government Guidance verification requirements as published in relevant circular and document these requirements in team policy/procedure. The policy/procedure is communicated to internal NSS staff through meetings.

- The Dental PV and Monitoring team performs further verification of dental and orthodontic treatment claims that have been uploaded to the MIDAS system by Test & Support Team on a quarterly basis and reports the dataset to NHS Boards in accordance with the SGHSCD regulation as outlined in PV protocol document to verify the accuracy and validity of the claims.

- CFS team (patient claims team) also verifies that the amount of patient contributions as specified in the claim forms are deducted against the payments to be made to the dental practitioners.

  These reviews are performed after the claims are processed for payments.

  The result of the verification is documented and any invalid/inaccurate claims identified as a result of the review is investigated, resolved to completion and tracked.

  The result of the verification is documented. Any invalid/inaccurate claims identified as a result of the review is investigated, resolved to completion and tracked by CFS.

- Before each monthly payment is made, the amounts to be paid in MIDAS for a sample of three contractors are checked against the SDR by the Payment Verification team.

- As per the Scottish Government guidance, the Dental Monitoring Team performs an annual check over a minimum of 1% of contractors for the following:

  - Items of service;

  - Patient registration and list size;

  - Level of Earnings; and

  - Cost per claim and throughput.

  The check is performed by comparing the above against historical records and national averages.

- As per the Scottish Government Guidance, for 12,000 of the total claims received in the year, the Dental monitoring team pick patients on a random and targeted basis and provide to Scottish Dental Reference Services (SDRS) to perform detailed checks of claim entitlement and clinical nature.

General Ophthalmic Services (GOS)

Payments are made on a monthly basis for GOS to Optometric and Ophthalmic Contractors under the GOS regulations. Key elements that contribute to ophthalmic providers payments are:

- Ophthalmic treatments received are priced based on agreed fee rates;

- Fee paid for eye tests undertaken; and
- Relevant spectacles and repairs payments.

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

- GOS claim forms are submitted via P&CFS' eOphthalmic platform for processing and then loaded to OPTIX for further validation and payment calculation. HES claims are manually keyed directly into OPTIX.
- The eOphthalmic platform provides real-time validation of GOS claims, meaning that nearly all claims reaching OPTIX are valid. If OPTIX determines that a claim form has been completed incorrectly it is sent back to the individual optician for re-submission.

  Where an optician has been identified as exhibiting unusual treatment patterns, these claims will be discussed with the NHS Board and a decision on whether an investigation is required will be taken. Claims are priced automatically by OPTIX based on agreed fee rates, which are reviewed and updated within OPTIX when required.

The following processes and controls are operated by NSS under the General Ophthalmic Services:

- GMSQA team maintains a list of individuals and their delegates from the practices, NHS Boards, NHS Education for Scotland and Health Protection Scotland who are authorised to claim payments or request amendments on rates/data that will impact payments. On an annual basis as a minimum, GMSQA team obtains confirmation from NHS Boards to verify that the list remains accurate and up-to-date.

  The list is made accessible to the three regional offices through PSINet.
- Payment team verifies that a request to add/amend the list of authorised individuals are supported with approvals from practice mandates before the amendment is made. This is documented in PSINet.
- A member of the Dental Payments team other than the inputter verifies the accuracy of claims for all payments except for dental and orthodontic treatment claims by comparing the entry in MIDAS system against the instruction from NHS Board. This is documented in a dental top sheet within the payments file.

  Any errors identified as a result of this verification is corrected and tracked in the payments file.
- Customer Admin Team verifies that claim for payments relating to Hospital Eye Services is supported with a valid claim form which is signed by an optician and includes the list number and payment location code of a registered contractor, as listed on the Ophthalmic List.

  GOS forms are submitted electronically by practitioners, the system validates that information submitted by practitioners include a valid list number, and payment location code of a registered contractor. If the form fails validation it is rejected
- The GOS team receives a GOS6A form from the NHS Board authorising an optometrist to be added to their performers list. The OPTIX system is configured to only accept GOS6A forms containing a valid list number that matches the pre-existing list number for the optometrist configured in the Optix database.
- Prior to payment, patient refunds are prepared by a Payment Officer and checked by another member of the Payment team. Following this, patient refunds are authorised by a Senior Officer, as per the List of Nominated Senior Officers held by NSS Central Finance.
- Ophthalmic Payment team verifies that the requests for patient refunds are supported with confirmation of exemption status from department of work and pensions before the refunds are sent for payment. This is documented in refunds process.
- Any adjustment/non-payment/patient detail amendment claims are returned to the contractor with a comment to explain the reason for the action taken in response to the claim within 20 working days of receipt. This is logged in the adjustment/non-payment/patient detail amendment spreadsheet.
- OPTIX is configured with duplicate workflow rules to automatically check all claims relating to optometric claims treatments to verify that they are not duplicate claims by comparing for that patient acceptance/completion dates for duplicate / overlapping claims. Changes to this configuration follows the standard change management procedure.

  On a daily basis, the Customer Admin team will review all payments identified by the system as potential duplicates. Any duplicate claims identified reviewed and found to be a valid duplicate, are returned to the contractor as unpaid by the Customer admin team. Claims which are not valid

duplicates are processed for payment.

- Once a month prior to the payment run, a member of the GOS team, other than the inputter, verifies the accuracy of claims for all payments by comparing the entry in the Optix Payment System against the instruction from the NHS Board. This data is held in each Boards Payment Variation Lever Arch files.

  Any errors identified as a result of this verification is corrected using Optix.

- PV is performed on a Monthly basis by GOS PV to identify practices who exhibit prescribing/treatment patterns over the average outlier.

  GOS PV performs investigation of the identified practices or refer them to the Counter Fraud Services. This is documented in BCS.

- The calculation of Ophthalmic Patient Refunds is prepared ad-hoc (when there is a suitable number of claims to process). Once the calculation has been prepared by a Payment Officer, another member of the GOS team will check the calculation and ensure that the correct amounts has been keyed to the payment spreadsheet from the claim prior to payment.

- Once a month, a member of the GOS Team will ensure all NHS Board reports balance prior to transmission to the NSS Finance Department to confirm completeness and accuracy of the amounts. If any of the reports don't balance, Test & Support will investigate the reason advising the GOS team of a solution and the GOS Team will rectify the issue before finalising the payment.

  A member of the senior management team reviews the result. This is documented in BCS.

- A member of PS Finance Management Team authorise payments made by CHAPS or bank transfer before the payment is made by NSS Central Finance. This authorisation is documented in BCS.

- Following completion of BACS and CHAPS processing, GOS PS team reconcile the total amount of BACS and CHAPS payments against the supporting calculation from Optix to verify that all payments had been processed. Differences are investigated and resolved to completion.

- Prior to raising cheques for patient refunds, NSS Central Finance Department verifies that an approval from an authorised person in the Ophthalmic Payments Team is in place along with the electronic listing of all refund amounts.

- A member of the Customer Administration Team verifies that the following requests are supported with approval from an authorised person from the NHS Board before they are entered onto the OPTIX system:

  (1) New Ophthalmic Contractors, and

  (2) Cessation/removal of Ophthalmic Contractors.

  The NHS Board Delegate Matrix is used in performing the verification.

- On a schedule basis for a selection of new contractors / ceased practices, a member of Customer Admin Team who is different from the processor/inputter verifies the accuracy of the following actions made in OPTIX against the details supplied by the NHS Board:

  (1) New Ophthalmic Contractors, and

  (2) Cessation/removal of Ophthalmic Contractors.

  The size of the selection is determined by sample guide. This check is documented in BCS folder.

- NSS Central Finance team and the PS Finance Department verifies that an approval from an authorised person from member of PS team is in place before making an amendment/update to the contractor's bank details and other standing data in OPTIX and on the General Ledger. This verification is documented in bank mandate file.

- A member of PS Team, who is different from the inputter, verifies the accuracy of the amendment/update to the ophthalmic contractor's bank details and other standing data made in OPTIX against the details supplied by the Contractor prior to the next payment run.

- On an annual basis, the Payment Verification Manager reviews the Scottish Government Guidance verification requirements as published in relevant circular and document these requirements in team policy/procedure. The policy/procedure is communicated to internal NSS staff through meetings.

- Ophthalmic PV team performs further verification of all claims relating to sight tests, spectacles, repairs and hospital eye services that have been uploaded to the OPTIX system by comparing against approved

history of claims and payments to identify and outliers requiring further investigation. These reviews are performed after the claims are processed for payments. The result of the verification is documented in GOS PV records.

Any invalid/inaccurate claims identified as a result of the review is investigated, resolved to completion and tracked using GOS PV records.

- Before each monthly payment is made, the amounts to be paid in OPTIX for a sample of three contractors are checked by the Customer Admin Team. Any issues noted to test and Support team, are followed up and resolved prior to payment.
- As per the Scottish Government Guidance, on an annual basis a random selection of patient records are inspected by performing annual check over a minimum of 1% of contractors for the following:

  -Items of service.

  - Level of earnings

  - Cost per claims and throughput

  The check is performed by comparing the above against historical and national averages.

  Any discrepancies or issues identified are investigated, followed up and tracked in BCS.
- Where unusual prescribing or treatment patterns, are identified through PV analysis, this is referred to the NHS Board and Counter Fraud Services. The referral and the investigation is tracked to completion in GOS PV and CFS records.

Reports to NHS Boards and Scottish Government for all payment streams

The following processes and controls are operated by NSS at the end of each month that impact all payment streams:

- The quarterly NHS board report (the "appendices") covering all four payment streams are reviewed for completeness and accurate by a member of PS team, independent from the preparer of the report, by comparing it against the source documentation compiled by the preparer from PS team. This review is performed before the report is submitted. Completion of this review is documented as a sign off on the report.
- PS team performs reconciliation of the total amount from each monthly NHS Board report against the total amount recorded in eFinancials before the report is submitted. Reconciling items are investigated and resolved through to completion.
- On a quarterly basis, a member of the PS Finance Department Team other than the inputter reviews the completeness and accuracy of the Form12 report summarising the financial information across all four payment streams by comparing it against 4 streams spreadsheets before the report is submitted to each NHS Board and SGHSCD. This review is documented in BCS Folder.
- A member of the PS team performs a reconciliation between the information on the monthly board reports (the “appendices”) and the “Form 12” report to verify their completeness and accuracy before the reports are submitted. Reconciling items are investigated and resolved through to completion. The reconciliation and investigation are documented in BCS folder.

2.3 CONTROL ENVIRONMENT

2.3.1 NSS Board

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

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

In addition to the above, Board members meet formally with the Executive Management Team and other Senior

Managers on a quarterly basis to consider strategic and other business risks facing NSS as these arise.

2.3.2 RISK MANAGEMENT IN NSS

The Chief Executive is ultimately responsible for ensuring NSS has effective risk management processes in place. He is supported by the Audit and Risk Committee, the EMT, management groups, SBU/Directorate Directors, the Risk Manager Lead and Risk Champions.

2.3.3 NSS INFORMATION GOVERNANCE

NSS aims to be a leading organisation in NHS Scotland in the way information is used and handled. Our information governance framework that helps enable the safe and secure use of sensitive and other information to support the health and well-being of the people of Scotland. It helps ensure that we meet our legal and ethical duties in relation to handling and managing information to a high standard.

NSS is a partner in helping lead the use of information to improve health and well-being in Scotland.

Information governance covers the following:

- Caldicott Principles - is about protecting patient information;
- Confidentiality - is about the common law duty of protecting information given to us in confidence;
- Data Protection – helps enable the secure use of personal information and upholds the public's information rights;
- Information Security - is about protecting against the unauthorised use of information systems and the information held within them. It is also about the security of our buildings and people;
- Freedom of Information - is about providing information and openness; and
- Management of Records - is about managing all information in all formats including paper and electronic throughout their entire lifecycle.

2.3.4 INFORMATION AND COMMUNICATION

Communication within NSS is maintained through face to face meetings, daily interactions, email and regular communication bulletins. NSS staff have access to an internal intranet.

In respect of the services provided by NSS DaS in support of the services provided by P&CFS and NSS Payroll direct communications are between DaS and P&CFS and NSS Payroll. Communications to the customer base of P&CFS and NSS Payroll are managed by those organisations. Communications between DaS and P&CFS and NSS Payroll include the various governance groups already referenced with channels including face to face meetings, the inputs and outputs to those meetings (e.g. minutes, action trackers, performance and other reports).

Please refer to section 2.4 below for further description of the IT systems that are used by NSS in performing its service and their extent of responsibilities and controls over the systems listed.

2.4 IT SYSTEMS

The following IT systems tested in the IT report are relevant to the performance of the controls in scope for this service audit report:

System	Services Supported	Operating System	Database
General Medical Services (Primary Medical Services Payment System) PMSPS	This calculates the monthly payments to GP Practices.	Solaris 11	Oracle 12c
General Pharmaceutical Services (DCVP)	This system validates and values scripts submitted by dispensing contractors once or twice per month.	Solaris 8/10	Oracle 8/9
General Dental Services (MIDAS)	Primary system for dental payments.	Solaris 11	Oracle 12c
General Ophthalmic Services (OPTIX)	The main system used by GOS to calculate payments to contractors.	Solaris 11	Oracle 12c

eVadis	eVadis is a pharmacy drug dictionary and contractors database. Pricing information from eVadis is uplifted into DCVP monthly.	Solaris 10	Oracle 10.2.0.4

The following systems are not within the scope of this report, therefore not subject to examination by KPMG LLP:

System	Services Supported
SPSS algorithm known as Scottish Workload Formula (SWF)	This tool is used in GMS to bridge payments while negotiations between BMA and SG are ongoing for a final contract position.
CHI	This tool is used in GMS provide patient information.
eDental	eDental provides real-time claim validation for GDS.
eOphthalmic	Electronic front end system to OPTIX which manages transfer of claims from contractor systems or permits direct input by contractors to web-based claim form.
ePrior	Electronic prior approval processing for dental claims.
ePharmacy	Comprised of a suite of systems including the following: • Electronic Pharmacy Messaging Store - means by which GP & Pharmacist Practice Management systems can transmit information about prescriptions; • eMessage Console - used in the processing of electronic prescription messages; and • ePay - used to map DM+D coding used by Pharmacist/GP systems into legacy eVadis coding utilised by NSS data warehouse.
eFinancials	eFinancials application is the NSS finance system used to record payments to all suppliers. For P&CFS, this is mainly contractors but can include third parties. eFinancials also provides the link to BACS to complete the payment to bank accounts.

2.5 SUB-SERVICE ORGANISATIONS

NSS uses a number of sub-service organisations, to support the services described below. The following describes the type of sub-service organisation used by NSS and the approach for this report.

System	Services Supported	Approach	Justification
Atos	Atos provides managed Technical Services (including hardware and associated software); storage; application support and development. The control objectives applicable are: 1. Verification on completeness, validity and accuracy of General Medical Services payments; 2. Verification on completeness, validity and accuracy of General	Carved-out Please refer to the IT report for the testing performed on the Atos controls.	A material component of the service is outsourced to Atos as an IT infrastructure and service provider. Furthermore, the provisioning of the service from Atos is managed by NSS. Therefore, to help ensure that this report provides sufficient coverage for user auditors, we have adopted an inclusive approach.

	Pharmaceutical Services payments; 3. Verification on completeness, validity and accuracy of General Dental Services payments; 4. Verification on completeness, validity and accuracy of General Ophthalmic Services payments; and 5. Reports to NHS Boards and Scottish Government for all payment streams.		
NHS Ayrshire and Arran	The provision of the National Single instance eFinancial product utilised by P&CFS and NSS Payroll Team. The control objectives applicable are: 1. Verification on completeness, validity and accuracy of General Medical Services payments; 2. Verification on completeness, validity and accuracy of General Pharmaceutical Services payments; 3. Verification on completeness, validity and accuracy of General Dental Services payments; 4. Verification on completeness, validity and accuracy of General Ophthalmic Services payments; and 5. Reports to NHS Boards and Scottish Government for all payment streams.	Carved-out	NSS rely on the ISAE 3402 Independent Assurance report from NHS Ayrshire and Arran to provide assurance over the control objectives mentioned. The report covers the period between 1 April 2019 and 31 March 2020 which is the same period as this report.

2.6 CONTROL OBJECTIVES

In the context of the control environment described above, the following control objectives have been identified for testing. The results of the testing are detailed in Section 3.

1. Verification on completeness, validity and accuracy of General Medical Services payments

Controls provide reasonable assurance that:

- GMS payments are made completely and accurately based on authorised claims to the valid contractors;
- GMS payments are made only once; and
- Verification is performed in accordance with Scottish Government guidance.

2. Verification on completeness, validity and accuracy of General Pharmaceutical Services payments

Controls provide reasonable assurance that:

- GPS payments are made completely and accurately based on authorised claims to the valid contractors;
- GPS payments are made only once; and
- Verification is performed in accordance with Scottish Government guidance.

3. Verification on completeness, validity and accuracy of General Dental Services payments

Controls provide reasonable assurance that:

- GDS payments are made completely and accurately based on authorised claims to the valid contractors;
- GDS Payments are made only once; and
- Verification is performed in accordance with Scottish Government guidance.

4. Verification on completeness, validity and accuracy of General Ophthalmic Services payments

Controls provide reasonable assurance that:

- GOS payments are made completely and accurately based on authorised claims to the valid contractors;
- GOS payments are made only once; and
- Verification is performed in accordance with Scottish Government guidance.

5. Reports to NHS Boards and Scottish Government for all payment streams

Controls provide reasonable assurance that reports to NHS Boards and Scottish Government outlining all payment streams are complete and accurate.

2.7 COMPLEMENTARY USER ENTITY CONSIDERATIONS

NSS processing and the associated controls were designed with the assumption that certain controls will be placed in operation by the NHS Boards and practices. This section describes some of the controls that should be considered to complement the controls operated at NSS. The exact nature of the required control will vary according to the circumstances of each organisation and additional controls may also be required. Consequently, the user controls listed should not be taken to be comprehensive.

Specific NHS Board responsibilities and controls include:

- Manage expenditure and cash to ensure sufficient funds are available to NSS to make payments to Primary Care contractors.
- Account for Primary Care expenditure, maintaining appropriate controls over the payment authorisation processes within the NHS Board and their communication with Practitioner Services.
- Request NSS to make payments to contractors for unified budget payments, which at present comprise of parts of General Dental Services, Primary Medical Services, parts of General Pharmaceutical Services and Drugs. These payments may also include Hospital and Community Health Service payments made to Primary Care Contractors where they are the service provider. (NSS is authorised to make non-cash-limited payments in accordance with NHS Scotland regulations.)
- NHS Boards should also as a general rule ensure that any recoveries or repayments from or repayments made by contractors are routed through Practitioner Services. This will ensure that

expenditure analysis by Practitioner Services reflects the actual net expenditure incurred and will ensure consistency with recovery of overpayments where Practitioner Services is the recovering body where it has made the payment under specific Regulations.

- Ensure that effective PV takes place for each contractor group in accordance with current guidelines, including the actions required by the NHS Boards to achieve the required level of PV assurance.
- Work with Practitioner Services to provide operational support which may include appointment management, premises, equipment and staffing resources, to enable Practitioner Services to deliver the SDRS service for dental contractors and the Public Dental Service within that NHS Board area and to take appropriate action on PV outcomes and on reports from the Scottish Dental Reference Service.
- Support Practitioner Services in ensuring that Primary Care contractors provide complete and accurate patient information to ensure registration processes and payment claims including using the CHI number to identify the patient's most current details.
- Providing IT support to Primary Care contractors to implement SGHSC initiatives regarding electronic transmission of information.

The exception to these payment arrangements is where the Primary Care provider is an employee of the NHS Board and/or the service is managed by the NHS Board when payments will be made directly by the NHS Board. Funding of any non-cash-limited payments made directly by the NHS Board should be obtained through NSS, normally by the NHS Board raising an invoice for the relevant amount.

2.8 MANUALLY MAINTAINED POPULATIONS USED IN OPERATION OF CONTROLS

Certain control activities set out on Section 3 operate on an ad hoc basis, and system generated lists of populations could not be provided. The table below outline each of the controls where completeness and accuracy of the populations could not be tested and NSS management's response to this issue.

Control Ref.	Control Description	Rationale
1.6	Payment adjustments/corrections authorisation The Payment team verifies that approval from NHS Board is in place before processing any Temporary Patient Adjustment or Opt Out adjustments. The List of Authorised Individuals is used as part of the verification.	Temporary Patient Adjustments and Opt-out adjustments are held at a practice level within PMSPS. Changes are a result of a practice altering services provided or changes to practice configurations which are by their nature ad hoc, infrequent and external to P&CFS and do not lend themselves to being listed as a full population.
1.8	Sentinel swabbing payment authorisation GRO Payment team verifies that approval from Health Protection Scotland's authorised person or their delegates are in place before processing the payments for sentinel swabbing. The List of Authorised Individuals is used as part of the verification.	Item of service claims is a result of a practice activity for the services provided which are by their specific to individual practices, external to P&CFS and do not lend themselves to being listed as a full population.
1.9	Enhanced Service Payments and Section 17C Practice Payments authorisation and accuracy *Manual check of amount* A team member that is different from the inputter verifies that the amount of Enhanced Service Payments and Section 17C Practice Payments to be processed is in line with the amount provided by the NHS Boards through manual checking. The verification is documented in the monthly checklist. *Verification of authorised person*	By their very nature, item of service claims are a result of practice activity for the services provided which are specific to individual practices, external to P&CFS and do not lend themselves to being listed as a full population.

Control Ref.	Control Description	Rationale
	A member of the team verifies that the calculation is provided by an authorised person from NHS Boards who is part of the Board Authorised Signatory Mandate. The list of authorised individuals is used as part of the verification.	
1.14	<u>CHAPS payment authorisation</u> A member of PS Finance Management team authorise payments made by CHAPS or bank transfer before the payment is made by NSS Central Finance.	CHAPS payments are a last resort used to make payment at very short notice. All CHAPS Payments are appropriately validated and authorised. BACS and CHAPS payments are recorded using the same payment code. There are separate codes for cheque payments. The list can be analysed by payment method and timing (weekly/monthly) and from this, CHAPS payments can be identified. The treasury team also keep a spreadsheet of all CHAPS payments made for the organisation which can be split by FHS and NSS payments.
1.16	<u>Verification of new entry/amendment and cessation of practice/contractors</u> A member of Payments team, who is different from the inputter, verifies the accuracy of the following actions made in the PMSPS system against the details supplied by the NHS Board prior to the next payment run relevant to the date of the change: — new GP Practice/contractors; — amendments to existing GP Practice/contractors; and — cessations of GP Practices. This check is documented in hard copy folders. Errors identified as a result of the verification is corrected and tracked using hard copy folders.	Changes are a result of a practice altering or changes to practice configurations which are by their nature ad hoc, external to P&CFS and do not lend themselves to being listed as a full population. Any changes advised by NHS Boards would be noticed in the financial returns at the month end were they not applied by P&CFS.
2.4	<u>Fee and allowance changes</u> A member of eVadis team other than the one who made the amendment reviews the updates to fee and allowance rates entered into the eVadis system to verify its accuracy against the source information provided by the Government and NHS Boards.	Fee and allowance changes are notified by SG in official circulars in their website. Details of updates can be examined by reviewing the eVadis system.
2.5	<u>Verification on the validity of pricing information update</u> Price changes for items on Part 7 of the SDT are documented on a manufacturer report and verified by a member of the eVadis team. Changes are then implemented on the eVadis system by a member of the eVadis	Price changes are initiated by manufacturers externally to P&CFS and do not lend themselves to being listed from the eVadis system as a full population.

Control Ref.	Control Description	Rationale
	team, and verified by a separate member of the eVadis team; this verification performed prior to the monthly upload into the DCVP system and is documented in the Manufacturers Report.	
2.7	Verification of prescriptions and stock orders claim validity The Document Handling team verifies that claims for payments relating to prescriptions and stock orders are supported with a claim form from the registered pharmacy, dispensing doctor or appliance supplier, by checking against the list of Registered Pharmacies, Dispensing Doctors and Appliance Suppliers in eVadis. The verification is performed before the claim is processed, and is documented in the GP34 form.	This process covers the processing of approximately 5.5m pieces of paper from around 1,200 contractors each month. An early part of the process involves scanning submissions summaries from each bundle of submitted scripts and this is input into DCVP. In the event that DCVP does not capture data for a particular contractor, then processing is stopped whilst the bundle is located, or if it is lost, some alternative processing and payment arrangements are put in place. Any changes to the listed contractor made in eVadis must be matched by changes to the batches scanned or the system cannot continue to process without over-ride by a Senior Manager.
2.12	Prescriptions reconciliation On a monthly basis, the NSS Document Processing Department performs a reconciliation between the number of contractors for whom prescriptions were received for each NHS Board in the batch headers and the number of items that have been scanned onto the DCVP system. Any discrepancies of more than 15% are investigated and resolved through to completion. The details of any investigation are held in a hard copy notebook within the department.	This process covers the processing of approximately 5.5m pieces of paper from around 1,200 contractors each month. An early part of the process involves scanning submissions summaries from each bundle of submitted scripts and this is input into DCVP. In the event that DCVP does not capture data for a particular contractor, then processing is stopped whilst the bundle is located, or if it lost some alternative processing and payment arrangements are put in place. Any changes to the listed contractor made in eVadis must be matched by changes to the batches scanned or the system cannot continue to process without over-ride by a Senior manager.
2.14	CHAPS payment authorisation A member of PS Finance Management team authorise payments made by CHAPS or bank transfer before the payment is made by NSS Central Finance. This authorisation is documented in the payment documentation file.	CHAPS payments are a last resort used to make payment at very short notice. All CHAPS Payments are appropriately validated and authorised. BACS and CHAPS payments are recorded using the same payment code. There are separate codes for cheque payments. The list can be analysed by payment method and timing (weekly/monthly) and from this, CHAPS payments can be identified. The treasury team also keep a spreadsheet of all CHAPS payments made for the organisation which can be split by FHS and NSS payments.
2.15	Validity checking of the request to add/amend/remove practice/contractors A member of the Pharmacy Payments team verifies that the following requests are supported with approval from an authorised person from the NHS Board before they are entered onto the eVadis system: — new Pharmacies/Dispensing Doctors/Appliance Suppliers; or	Changes are a result of a contractor altering or changes to contractor configurations which are by their nature ad hoc, external to P&CFS and do not lend themselves to being listed as a full population. Any changes advised by NHS Boards would be noticed in the financial returns at the month end were they not applied by P&CFS

Control Ref.	Control Description	Rationale
	— cessation of dispensing contractors. The List of Authorised Individuals is used in performing the verification. The authorised notification is held in the Pharmacy Payment department.	
2.16	<u>Verification of the accuracy of new entry and cessation of practice/contractors</u> A member of Pharmacy Payments team, who is different from the inputter, verifies the accuracy of the following actions made in the eVadis system against the details supplied by the NHS Board prior to the next payment run after the request is received: — new Pharmacies/Dispensing Doctors/Appliance Suppliers; or — cessation of dispensing contractors. Errors identified as a result of the verification is corrected and tracked using Contractor Amendments.	Changes are as a result of a contractor altering or changes to contractor configurations which are by their nature ad hoc, external to P&CFS and do not lend themselves to being listed as a full population. Any changes advised by NHS Boards would be noticed in the financial returns at the month end were they not applied by P&CFS.
2.18	<u>Verification of the accuracy of amendments</u> A member of Regional Payments team who is different from the inputter, verifies the accuracy of the amendment/update to the contractor's bank details and other standing data made in the Finance Process Manager (FPM) system against the details supplied by the NHS Board or the Pharmacy contractor or the contractor's bank prior to the next payment run from when the request is received.	Changes are a result of a contractor altering or changes to contractor configurations which are by their nature ad hoc, external to P&CFS and do not lend themselves to being listed as a full population.
3.3	<u>SGHSCD payment rate updates</u> An Assistant Director reviews the approval and accuracy of updates to payment rates to PS against the request received from Scottish Government Health and Social Care Directorate (SGHSCD). This review is performed in the test environment prior to the new rates being implemented in the live MIDAS system, and the successful upload to live is also confirmed. This is documented in SDR update process control sheet.	The population is determined by Scottish Government who issues controlled updates to the SDR. We have a process where once a new SDR is applied in test, we run some payments and once successful, an Assistant Director signs off the transfer to live.
3.4	<u>Verification on validity of paper orthodontic payment claims</u> The Prior Approval team completes a validity check over paper claim forms before payments are processed to confirm that they contain:	By their very nature, item of service claims is a result of practice activity for the services provided which are specific to individual practices, external to P&CFS and do not lend themselves to being listed as a full population.

Control Ref.	Control Description	Rationale
	— the registered contractors payment list number; — signature of the patient; — signature of the dentist; and — acceptance date and completion date.	
3.6	Verification of other claims validity Dental Payment team verifies whether claims for all payments except for dental and orthodontic treatment claims are either: — supported with approval from an individual from NHS Boards as listed on the List of Authorised Individuals; or — supported with a signed form from a valid contractor, and includes a list number. The verification is performed before the claim is processed, and is documented in monthly claims file.	By their very nature, other claims are a result of practice activity for the services provided or reimbursement for expenditure which are specific to individual practices, external to P&CFS and do not lend themselves to being listed as a full population.
3.7	Validity of the request for patient refunds Dental Payment teams verifies that the requests for patient refunds are supported with confirmation of exemption status from department of work and pensions before the refunds are sent for payment. This is documented in the refunds process.	By their very nature, patient refund claims are a result of patients recovering money they paid to the dentist when they should not have done so. They are initiated externally to P&CFS and do not lend themselves to being listed as a full population.
3.8	Payment adjustment, non-payment and patient detail amendment claims Any adjustment/non-payment/patient detail amendment claims are returned to the contractor with a comment to explain the reason for the action taken in response to the claim within 20 working days of receipt. This is logged in the adjustment/non-payment/patient detail amendment spreadsheet.	By their very nature, other claims are a result of practice activity for the services provided or reimbursement for expenditure which are specific to individual practices, external to P&CFS and do not lend themselves to being listed as a full population.
3.11	Large or unusual prescribing and treatment patterns A list is maintained of all contractors who exhibit unusual prescribing/treatment patterns. These identified contractors are recorded in a CPA list and all of their prior approval requests are assessed by a Clinical Advisor.	This is a list of contractor who may be subject to additional scrutiny over and above the normal validation, based on a set of parameters. This does not lend itself to being listed as a full population.
3.14	CHAPS payment authorisation A member of PS Finance Management Team authorise payments made by CHAPS, Paymaster General or bank transfer before the payment is made by NSS Central Finance.	CHAPS payments are a last resort used to make payment at very short notice. All CHAPS Payments are appropriately validated and authorised. BACS and CHAPS payments are recorded using the same payment code. There are separate codes for cheque payments. The list can be analysed by

Control Ref.	Control Description	Rationale
		payment method and timing (weekly/monthly) and from this, CHAPS payments can be identified. The treasury team also keep a spreadsheet of all CHAPS payments made for the organisation which can be split by FHS and NSS payments.
3.18	Verification of new contractors and cessation of practice/contractors On a monthly schedule basis, for a selection of new contractors / ceased practices, a member of Customer Admin team who is different from the processor/inputter verifies the accuracy of the following actions made in MIDAS against the details supplied by the NHS Board: — new Dental Practice/contractors; and — cessation of Dental Practices. The size of the selection is determined by sample check process. This check is documented in sample check training guide. Errors identified as a result of the verification is corrected and tracked within MIDAS.	Changes are a result of a contractor altering or changes to contractor configurations which are by their nature ad hoc, external to P&CFS and do not lend themselves to being listed as a full population.
3.20	Validity of bank Detail and standing data amendments Dental Payments team verifies that an approval from an appropriately signed bank mandate is in place before making an amendment/update to the contractor's bank details and other standing data in MIDAS and on the general ledger.	Changes are a result of a contractor altering or changes to contractor configurations which are by their nature ad hoc, external to P&CFS and do not lend themselves to being listed as a full population.
3.21	Verification of the accuracy of amendments A member of the Dental Payments team, who is different from the inputter, verifies the accuracy of the amendment/update to the dental contractor's bank details and other standing data made in MIDAS against the details supplied by the Contractor prior to the next payment run when the request is received.	Changes are a result of a contractor altering or changes to contractor configurations which are by their nature ad hoc, external to P&CFS and do not lend themselves to being listed as a full population.
4.6	Patient refunds authorisation Prior to payment, patient refunds are prepared by a Payment Officer and checked by another member of the Payment team. Following this, patient refunds are authorised by a Senior Officer, as per the List of Nominated Senior Officers held by NSS Central Finance.	By their very nature, patient refund claims are a result of patients recovering money they paid to the dentist when they should not have done so. They are initiated externally to P&CFS and do not lend themselves to being listed as a full population.
4.7	Validity of the request for patient refunds Ophthalmic Payment team verifies that the requests for patient refunds are supported with confirmation of exemption status from	By their very nature, patient refund claims are a result of patients recovering money they paid to the dentist when they should not have done so. They are initiated externally to P&CFS and do not

Control Ref.	Control Description	Rationale
	department of work and pensions before the refunds are sent for payment. This is documented in refunds process.	lend themselves to being listed as a full population.
4.8	Payment adjustment, non-payment and patient detail amendment claims Any adjustment/non-payment/patient detail amendment claims are returned to the contractor with a comment to explain the reason for action taken in response to the claim within 20 working days of receipt. This is logged in the adjustment/non-payment/patient detail amendment spreadsheet.	By their very nature, other claims are a result of practice activity for the services provided or reimbursement for expenditure which are specific to individual practices, external to P&CFS and do not lend themselves to being listed as a full population.
4.10	Verification on the accuracy of other claims Once a month prior to the payment run, a member of the GOS team, other than the inputter, verifies the accuracy of claims for all payments by comparing the entry in the Optix Payment System against the instruction from the NHS Board. This data is held in each Boards Payment Variation Lever Arch files. This is documented in BCS. Any errors identified as a result of this verification is corrected using Optix.	By their very nature, other claims tend to be a result of practice activity for the services provided or reimbursement for expenditure which are specific to individual practices, external to P&CFS and do not lend themselves to being listed as a full population.
4.17	Validity checking of the request to add/remove contractors A member of the Customer Administration Team verifies that the following requests are supported with approval from an authorised person from the NHS Board before they are entered onto the OPTIX system: (1) new Ophthalmic Contractors, and (2) cessation/removal of Ophthalmic Contractors. The NHS Board Delegate Matrix is used in performing the verification.	Changes tend to be as a result of a contractor altering or changes to contractor configurations which are by their nature ad hoc, external to P&CFS and do not lend themselves to being listed as a full population.
4.18	Verification of new contractors and cessation of practice/contractors On a schedule basis for a selection of new contractors / ceased practices, a member of Customer Admin team who is different from the processor/inputter verifies the accuracy of the following actions made in OPTIX against the details supplied by the NHS Board: — new Ophthalmic Contractors; and — cessation/removal of Ophthalmic Contractors. The size of the selection is determined by sample guide.	Changes are as a result of a contractor altering or changes to contractor configurations which are by their nature ad hoc, external to P&CFS and do not lend themselves to being listed as a full population.

Control Ref.	Control Description	Rationale
4.20	Verification of the accuracy of amendments A member of PS team, who is different from the inputter, verifies the accuracy of the amendment/update to the ophthalmic contractor's bank details and other standing data made in OPTIX against the details supplied by the Contractor prior to the next payment run.	Changes are as a result of a contractor altering or changes to contractor configurations which are by their nature ad hoc, external to P&CFS and do not lend themselves to being listed as a full population.

SECTION 3 - NHS NSS CONTROL OBJECTIVES AND RELATED CONTROLS, AND KPMG LLP'STESTS OF CONTROLS AND RESULTS OF TESTS

TESTS OF THE CONTROL ENVIRONMENT

The control environment represents the collective effect of various elements in establishing, enhancing or mitigating the effectiveness of specific controls. In addition to the tests of specific controls described below, our tests included tests of relevant elements within NHS NSS's control environments.

Our tests of the control environment included the following procedures, to the extent we considered necessary:

1) Reviews of NSS organisational structure, including policy statements, policies and the segregation of functional responsibilities within each team to carry out assigned activities;
2) Discussions with management, operations, administrative and other personnel who are responsible for developing, ensuring adherence to, and applying controls;
3) Observations of personnel in the performance of their assigned duties; and
4) Discussion with management regarding the risk, operational and compliance management process.

The control environment was considered in determining the nature, timing and extent of the testing of controls relevant to achievement of the control objectives.

When using information produced by NHS NSS we performed additional test procedures to determine whether we were able to place reliance on the information provided by NHS NSS, including, as necessary, obtaining evidence about the completeness and accuracy of the information and evaluating whether the information was sufficiently precise and detailed for our purposes.

DESCRIPTION OF TESTS PERFORMED

Tests performed to determine the design of the controls detailed in this section are described below:

TEST PROCEDURE	DESCRIPTION
Enquiry	Enquired of appropriate NHS NSS personnel. Enquiries were used to obtain, among other things, knowledge and additional information about the control.
Observation	Observed the application of a specific control.
Inspection	Read documents and reports that contain an indication of performance of the control. This includes, but is not limited to, examining management reports, operational logs and other relevant documentation.

TESTS OF THE CONTROL ENVIRONMENT

The detailed control objectives and supporting control descriptions; along with a summary of the tests performed to determine the design, implementation and operating effectiveness of the controls, the test results and management responses on the exceptions are presented in sections 3.1 to 3.5 below. Each section considers a specific component of the NHS NSS control environment.

3.1 GENERAL MEDICAL SERVICES PAYMENTS

VERIFICATION ON COMPLETENESS, VALIDITY AND ACCURACY OF GENERAL MEDICAL SERVICES PAYMENTS

Controls provide reasonable assurance that:

- GMS payments are made completely and accurately based on authorised claims to the valid contractors;
- GMS payments are made only once; and
- Verification is performed in accordance with Scottish Government Guidance.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
1.1	Payment claim to authorised individuals GMSQA team maintains a list of individuals and their delegates from the practices, NHS Boards, NHS Education for Scotland and Health Protection Scotland who are authorised to claim payments or request amendments on rates/data that will impact payments. On an annual basis as a minimum, GMSQA team obtains confirmation from NHS Boards to verify that the list remains accurate and up-to-date. Changes required as a result of the confirmation are updated in PSINet. The list is made accessible to the three regional offices through PSINet.	For a selection of practices and boards, inspected the delegate authority matrix and email communications, and noted that the GMSQA team had maintained a list of individuals and their delegates from the practices, NHS Boards, NHS Education for Scotland and Health Protection Scotland, who had been authorised to claim payments or request amendments on rates/data that impact payments. Further noted that the GMSQA team had obtained confirmation from NHS Boards to verify that the list remained accurate and up-to-date within the last 12 months, and that changes required as a result of the confirmation had been updated in PSINet. For a selection of practices and boards, inspected PSINet system and noted that the list had been made accessible to the three regional offices.	No exceptions noted.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
1.2	Additions and removals to the list of authorised individuals Payment team verifies that requests to update the list of authorised signatures on the current practice mandate, are supported with an approval from the Practice Manager before the new practice mandate is uploaded to PSINet. Where there is a new Practice Manager, the Payment Team verifies that approval has been given by an authorised NHS Board Primary Care Administrator.	Enquired of management to determine whether the Payments team had verified that requests to update the list of authorised signatures on the current practice mandate had been supported with an approval from the Practice Manager, before the new practice mandate had been uploaded to PSINet. Further enquired to determine whether the Payment team had verified that approval had been given by an authorised NHS Board Primary Care Administrator, where there had been a new Practice Manager.	**Exception noted:** We were informed that evidence was not available to demonstrate that the Payment team had verified that requests to update the list of authorised signatures on the current practice mandate had been supported with an approval from the Practice Manager. We were informed that evidence was not available to demonstrate that the Payment team had verified that approval had been given by an authorised NHS Board Primary Care Administrator, where there had been a new Practice Manager. **Management response:** The procedures require staff members to confirm that the request is appropriately authorised before the item is passed to the next step. The procedure is an 'on screen' check and verification and the requirement for signed paperwork evidence was removed some years ago as we moved to digital processes. The evidence of the operation of the control is that the item is uploaded to PSINet.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
1.3	SGH SCD payment rate updates For each circular that defines updates to payment rates, peer reviews on the completeness and accuracy of updates to payment rates to PMSPS are performed against the request received from Scottish Government Health and Social Care Directorate (SGHSCD). The updates are made within the system and reviewed by a different member of the Financial Services team. The review is documented on the input paperwork. Any issue on the completeness and accuracy of the rate update, that results in incorrect payments being made, are resolved and tracked through the key performance indicators (KPIs). If an expected update is not received, actions are agreed at the next FROG meeting, which are documented in the meeting minutes.	Inspected Scottish Government Circulars published during the period to determine whether there had been any updates to payment rates within the period of review.	We noted that there had been no updates to payment rates during the period of review. Consequently, we were unable to test the implementation and operating effectiveness of this control.
1.4	Scottish Workload Formula verification On a quarterly basis, ERO team verifies that the formula used for the Global Sum payment calculation is the latest and approved Scottish Workload Formula. ERO team verifies that the appropriate approval from Scottish Government is in place before change is made to the formula or other input.	Inspected the review spreadsheets and noted that the ERO team verified that the formula used for the Global Sum payment calculation had been the latest and approved Scottish Workload Formula, within the period of review. Enquired of management to determine whether the ERO team had verified that the appropriate approval from Scottish Government had been in place before a change had been made to the formula or other input.	We were informed that there were no changes made to the formula or other input. Consequently, we were unable to test the operating effectiveness of the change verification element of the control.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
1.5	GMS payments authorisation The Payment team confirms, by looking up the NHS Board authorisation matrix, that approval is from an authorised individual before processing the GMS payments (excluding the Global Sum Correction Factor, Temporary Patient Adjustment, Opt Out adjustments, Training Grants and Sentinel Swabbing payments). The source e-mail and attached document is saved intact for verification.	Enquired of management to determine whether the Payment team had confirmed, by looking up the NHS Board authorisation matrix, that approval had been from an authorised individual before processing the GMS payments. Further enquired to determine whether the source e-mail and attached document had been saved intact for verification.	**Exception noted:** We were informed that evidence was not available to demonstrate that the Payment team had confirmed that approval had been from an authorised individual before processing the GMS payments. We were informed that evidence was not available to demonstrate that the source e-mail and attached document had been saved intact for verification. **Management response:** The procedures require staff members to confirm that the request is appropriately authorised before the item is passed to the next step. The procedure is an 'on screen' check and verification and the requirement for signed paperwork evidence was removed some years ago as we moved to digital processes. The evidence of the operation of the control is that the item is passed to the next step.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
1.6	Payment adjustments/corrections authorisation The Payment team verifies that approval from NHS Board is in place before processing any Temporary Patient Adjustment or Opt Out adjustments. The List of Authorised Individuals is used as part of the verification.	Enquired of management to determine whether the Payment team had verified that approval from an NHS Board had been in place before processing any Temporary Patient Adjustment or Opt Out adjustments. Further enquired to determine whether the list of authorised individuals had been used as part of the verification.	**Exception noted:** We were informed that evidence was not available to demonstrate that the Payment team had verified that approval from an NHS Board had been in place before processing any Temporary Patient Adjustment or Opt Out adjustments. We were informed that evidence was not available to demonstrate that the list of authorised individuals had been used as part of the verification. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.* **Management response:** The procedures require staff members to confirm that the request is appropriately authorised before the item is passed to the next step. The procedure is an 'on screen' check and verification and the requirement for signed paperwork evidence was removed some years ago as we moved to digital processes. The evidence of the operation of the control is that the item is passed to the next step. It is impracticable with the current systems in use to document this electronically and it would only be our intention to revisit this if we were to move generally to an electronic workflow environment, which is not currently planned.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
1.7	Quarterly training grant payment authorisation Payment team verifies that approval from NHS Education for Scotland's authorised person or their delegates are in place before processing the Quarterly Payments for training grants. The List of Authorised Individuals is used as part of the verification.	Enquired of management to determine whether the Payment team had verified that approval from NHS Education for Scotland's authorised person or their delegate had been in place before processing the Quarterly Payments for training grants, for the period of review. Further enquired to determine whether the list of authorised individuals had been used as part of the verification.	**Exception noted:** We were informed that evidence was not available to demonstrate that the Payment team had verified that approval from NHS Education for Scotland's authorised person or their delegate had been in place before processing the Quarterly Payments for training grants. We were informed that evidence was not available to demonstrate that the list of authorised individuals had been used as part of the verification. **Management response:** The procedures require staff members to confirm that the request is appropriately authorised before the item is passed to the next step. The procedure is an 'on screen' check and verification and the requirement for signed paperwork evidence was removed some years ago as we moved to digital processes. The evidence of the operation of the control is that the item is passed to the next step.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
1.8	Sentinel swabbing payment authorisation GRO Payment team verifies that approval from Health Protection Scotland's authorised person or their delegates are in place before processing the payments for sentinel swabbing. The List of Authorised Individuals is used as part of the verification.	Enquired of management to determine whether the GRO Payment team had verified that approval from Health Protection Scotland's authorised person or their delegates had been in place before processing payments for sentinel swabbing. Further enquired to determine whether the list of authorised individuals had been used as part of the verification.	**Exception noted:** We were informed that evidence was not available to demonstrate that the GRO Payment team had verified that approval from Health Protection Scotland's authorised person or their delegates had been in place before processing payments for sentinel swabbing. We were informed that evidence was not available to demonstrate that the list of authorised individuals had been used as part of the verification. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.* **Management response:** The procedures require staff members to confirm that the request is appropriately authorised before the item is passed to the next step. The procedure is an 'on screen' check and verification and the requirement for signed paperwork evidence was removed some years ago as we moved to digital processes. The evidence of the operation of the control is that the item is passed to the next step.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
1.9	Enhanced Service Payments and Section 17C Practice Payments authorisation and accuracy *Manual check of amount* A team member that is different from the inputter verifies that the amount of Enhanced Service Payments and Section 17C Practice Payments to be processed is in line with the amount provided by the NHS Boards through manual checking. The verification is documented in on the monthly checklist. *Verification of authorised person* A member of the team verifies that the calculation is provided by an authorised person from NHS Boards who is part of the Board Authorised Signatory Mandate. The list of authorised individuals is used as part of the verification.	*Manual check of amount* For a selection of payments, inspected monthly checklist and noted that team member that was different from the inputter had verified that the amount of Enhanced Service Payments and Section 17C Practice Payments to be processed had been in line with the amount provided by the NHS Boards. *Verification of authorised person* Enquired of management to determine whether a member of the team had verified that the calculation had been provided by an authorised person from NHS Boards who had been part of the Board Authorised Signatory Mandate. Further enquired to determine whether the list of authorised individuals had been used as part of the verification.	*Manual check of amount* No exceptions noted. *Verification of authorised person* **Exception noted:** We were informed that evidence was not available to demonstrate that a member of the team had verified that the calculation had been provided by an authorised person from NHS Boards who had been part of the Board Authorised Signatory Mandate. We were informed that evidence was not available to demonstrate that the list of authorised individuals had been used as part of the verification. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.* **Management response:** The procedures require staff members to confirm that the request is appropriately authorised before the item is passed to the next step. The procedure is an 'on screen' check and verification and the requirement for signed paperwork evidence was removed some years ago as we moved to digital processes. The evidence of the operation of the control is that the item is passed to the next step.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
1.10	Monthly PMSPS payment reconciliations At the end of each month, before payments are processed, the Payments Manager responsible for each board performs a reconciliation between the source documentation and PMSPS to verify the accuracy of the amounts and identify if there are cases of duplicate payments. Completion of this reconciliation is documented by signing and dating the Month of Payment document.	For a selection of months and boards, inspected the Month of Payment document and noted that, at the end of each month before payments had been processed, the Payments Manager responsible for each board had performed a reconciliation between the source documentation and PMSPS to verify the accuracy of the amounts and identify if there had been any cases of duplicate payments. Further noted that the completion of this reconciliation had been documented by signing and dating the Month of Payment document.	No exceptions noted.
1.11	Global Sum payment calculation variance checks The regional Registration teams perform quarterly check to compare the current Global Sum payment amounts with the previous quarter. Any variance over +/-5% is investigated by the teams through to resolution.	For a selection of quarters, inspected the Global Sum payments calculation spreadsheet and noted that a member of the regional Registration teams had performed a quarterly check to compare the current Global Sum payment amounts with the previous quarter. Further noted that any variances over +/- 5% had been investigated by the teams through to resolution.	No exceptions noted.
1.12	Review of the accuracy of PMSPS payment entries A member of Payment team, other than those who process the payment, reviews each claim processed in PMSPS to: — verify its accuracy by comparing it to the original documentation; and — identify duplicate claims by checking if paid already. The review is performed prior to the payments being made.	For a selection of months and boards, inspected the monthly payment document and noted that a member of Payment team, other than those who had processed the payment, had reviewed each claim processed in PMSPS. Further noted that the review had been performed prior to the payment being made.	No exceptions noted.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
1.13	Monthly BACS payments review Regional office management reviews the monthly BACS payments to practices by comparing it against the amount from last month/quarter, with differences that are more than expected investigated to confirm accuracy of the payment and/or to identify duplicates. This review is performed prior to the payment being processed.	For a selection of months and boards, inspected monthly BACS payment review control sheet to determine whether regional office management had reviewed the monthly BACS payments to practices by comparing the monthly payment against the amount from the last month/quarter, prior to the payment being processed. Further enquired to determine whether differences that were more than expected had been investigated to confirm accuracy of the payment and/or to identify duplicates.	**Exception noted:** For 17 of 25 BACS payments selected, the evidence did not demonstrate that the monthly BACS payments review had been performed by regional office management. Further, the evidence did not demonstrate whether the review had been performed prior to the payment being processed. We were informed that evidence was not available to demonstrate that differences that were more than expected had been investigated to confirm accuracy of the payment and/or to identify duplicates. **Management response:** Following the Contractor Finance Organisational Change programme which was implemented in January 2020, procedures are being standardised across all three offices and will address the exception noted above. This will be carried out by the National Finance Manager – Medical and will be completed by September 2020.
1.14	CHAPS payment authorisation A member of PS Finance Management team authorise payments made by CHAPS or bank transfer before the payment is made by NSS Central Finance.	For a selection of CHAPS payments, inspected the CHAPS payment request form and noted that a member of PS Finance Management team had authorised the payment before the payment had been made by NSS Central Finance.	No exceptions noted. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.*

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
1.15	Validity checking of the request to add/amend/remove practice/contractors A member of the Payment team verifies that the following requests are supported with approval from an authorised person from the NHS Board before they are entered onto the PMSPS system: — new GP Practice/contractors; — amendments to existing GP Practice/contractors; and — cessations of GP Practices. The List of Authorised Individuals is used in performing the verification.	Enquired of management to determine whether a member of the Payment team had verified that the following requests were supported with approval from an authorised person from the NHS Board before they had been entered onto the PMSPS system: — new GP Practice/contractors; — amendments to existing GP Practice/contractors; and — cessations of GP Practices. Further enquired to determine whether the List of Authorised Individuals had been used in performing the verification.	**Exception noted:** We were informed that evidence was not available to demonstrate that a member of the Payment team had verified that requests were supported with approval from an authorised person from the NHS Board before they had been entered onto the PMSPS system. We were informed that evidence was not available to demonstrate that the List of Authorised Individuals had been used in performing the verification. **Management response:** The procedures require staff members to confirm that the request is appropriately authorised before the item is passed to the next step. The procedure is an 'on screen' check and verification and the requirement for signed paperwork evidence was removed some years ago as we moved to digital processes. The evidence of the operation of the control is that the item is passed to the next step.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
1.16	<u>Verification of new entry/amendment and cessation of practice/contractors</u> A member of Payments team, who is different from the inputter, verifies the accuracy of the following actions made in the PMSPS system against the details supplied by the NHS Board prior to the next payment run relevant to the date of the change: — new GP Practice/contractors; — amendments to existing GP Practice/contractors; and — cessations of GP Practices. This check is documented in hard copy folders. Errors identified as a result of the verification is corrected and tracked using hard copy folders.	For a selection of new, amendments to and cessations of practice/contractors, inspected the request form to determine whether a member of Payments team, who is different from the inputter, had verified the accuracy of the actions made in the PMSPS system against the details supplied by the NHS Board, prior to the next payment run relevant to the date of the change. Enquired of management to determine whether errors identified as a result of the verification had been corrected and tracked using hard copy folders.	**Exception noted:** For 10 out of 40 request forms selected, management were unable to provide evidence that a member of Payments team, who is different from the inputter, had verified the accuracy of the actions made in the PMSPS system. We were informed that evidence was not available to demonstrate that errors identified as a result of the verification had been corrected and tracked. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.* **Management response:** The procedures require staff members to confirm that the entry of the payment is checked. We will ensure that the forms retained contain details of the checks carried out This will be carried out by the National Finance Manager – Medical and will be completed by September 2020.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
1.17	PMSPS and CHI contractor detail reconciliation On a quarterly basis, ERO Payment team reviews the discrepancies identified as a result of the automated reconciliation of contractors' data from the PMSPS system against the CHI system. These discrepancies are investigated, tracked and resolved to completion using PMSPS load. CHI file will not load if discrepancies are not resolved.	*Review of discrepancies* Enquired of management to determine whether the ERO Payment team had reviewed the discrepancies identified as a result of the automated reconciliation of contractors' data from the PMSPS system against the CHI system. *Investigation, tracking and resolution of discrepancies* For a selection of discrepancies identified following the review, inspected email communications and noted that discrepancies had been investigated, tracked and resolved to completion using PMSPS load. Further noted that the CHI file did load when discrepancies had been resolved.	*Review of discrepancies* **Exception noted:** We were informed that evidence was not available to demonstrate that the ERO Payment team had reviewed the discrepancies identified as a result of the automated reconciliation. *Investigation, tracking and resolution of discrepancies* No exceptions noted. **Management response:** There is an automated email if the CHI file fails to load; the email is a PMSPS email. A failure is where a GP Practice exists in one system but not in the other. In the case of a failure, changes will be made to PMSPS or CHI as appropriate and a new file will be generated and loaded. The file cannot proceed until it passes validation. The control is therefore managed by the system and we do not see a need to make changes to this.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
1.18	Bank detail and standing data amendments Payment team verifies that an approval from an authorised person from the GP Practice is in place before making an amendment/update on PMSPS system of the bank details, and other standing data, of the practices and/or their contractors. The List of Authorised Individuals is used as part of the verification.	Enquired of management to determine whether the Payment team had verified that an approval from an authorised person from the GP Practice was in place before making an amendment/update on PMSPS system of the bank details, and other standing data, of the practices and/or their contractors. Further enquired to determine whether the List of Authorised Individuals was used as part of the verification.	**Exception noted:** We were informed that evidence was not available to demonstrate that the Payment team had verified that an approval from an authorised person from the GP Practice was in place before making an amendment/update on PMSPS. We were informed that evidence was not available to demonstrate that the List of Authorised Individuals was used as part of the verification. **Management response:** The procedures require staff members to confirm that the request is appropriately authorised before the item is passed to the next step. The procedure is an 'on screen' check and verification and the requirement for signed paperwork evidence was removed some years ago as we moved to digital processes. The evidence of the operation of the control is that the item is passed to the next step.
1.19	Scottish Government Guidance on payment verification policy/protocol As directed by the Practitioner Services Medical PV Lead & Chair of the Medical PV Implementation Group, the Medical PV Implementation Group reviews the Scottish Government Guidance on payment verification requirements as published in the relevant Primary Care Circular. The review and any amendments recommended are documented within the meeting minutes.	Inspected PV Medical Group meeting minutes and noted that the Medical PV Implementation Group had reviewed the Scottish Government Guidance on payment verification requirements and any amendments recommended had been documented, within the last 12 months.	No exceptions noted.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
1.20	Data Quality department checks The Data Quality department performs various checks on the accuracy of the CHI data. This includes PiCT exercises, as and when required, which compares practice lists with the CHI, in order to help ensure that accurate information is used in the Global Sum calculation. These exercises are included in the PV Report to NHS Boards. Differences identified as a result of the PiCT exercises are investigated, corrected and tracked in CHI, or confirmed that the practice will resolve.	For a selection of practices, inspected PV Report and noted that the Data Quality department had performed various checks on the accuracy of CHI data, including PiCT exercises, within the last 12 months. For a selection of differences identified as a result of the PiCT exercises, inspected records within the CHI system and email communications with practices, and noted that differences had been investigated, corrected and tracked in CHI, or confirmed that the practice will resolve.	No exceptions noted.
1.21	Annual sample check of practice payment validity As per the Scottish Government guidance on PV, the PV department visits (either physically or via remote IT link) a random sample of practices for Enhanced Services on an annual basis to review patient records to verify services are provided in line with the Enhanced Service contract specification. Confirmation of this review is documented in the payment verification visit register. Where service provision is not verified satisfactorily, payment recovery is sought, detailed in the visit reports.	For a selection of practices visited, inspected the Payment Verification Visit Log and Payment Verification Visit Report and noted that: — the PV department had visited a random sample of practices within the last 12 months; — patient records had been reviewed to verify that services had been provided in line with the Enhanced Service contract specification; and — where service provision was not verified satisfactorily, payment recovery had been sought.	No exceptions noted.

3.2 GENERAL PHARMACEUTICAL SERVICES PAYMENTS

VERIFICATION ON COMPLETENESS, VALIDITY AND ACCURACY OF GENERAL PHARMACEUTICAL SERVICES PAYMENTS

Controls provide reasonable assurance that:

- GPS payments are made completely and accurately based on authorised claims to the valid contractors;
- GPS payments are made only once; and
- Verification is performed in accordance with Scottish Government Guidance.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
2.1	Payment Claim authorised individuals GMSQA team maintains a list of individuals and their delegates from the practices, NHS Boards, NHS Education for Scotland and Health Protection Scotland who are authorised to claim payments or request amendments on rates/data that will impact payments. On an annual basis as a minimum, GMSQA team obtains confirmation from NSH Boards to verify that the list remains accurate and up-to-date. Changes required as a result of the confirmation are updated in PSINet. The list is made accessible to the three regional offices through PSINet.	For a selection of practices and boards, inspected the delegate authority matrix and email communications, and noted that the GMSQA team had maintained a list of individuals and their delegates from the practices, NHS Boards, NHS Education for Scotland and Health Protection Scotland, who had been authorised to claim payments or request amendments on rates/data that impact payments. Further, noted that the GMSQA team had obtained confirmation from NHS Boards to verify that the list remained accurate and up-to-date within the last 12 months, and that changes required as a result of the confirmation had been updated in PSINet. Inspected PSINet system and noted that the list had been made accessible to the three regional offices.	No exceptions noted.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
2.2	Additions and removals to the list of authorised individuals Payment team verifies that a request to add to or amend the list of authorised individuals are supported with approvals from the NHS Board Director of Finance (or delegate) before the amendment is made. This is documented in PSINet.	Enquired of management to determine whether the Payment team had verified that requests to add to or amend the list of authorised individuals had been supported with an approval from the NHS Board Director of Finance (or delegate), before the amendment had been made. Further enquired to determine whether this had been documented in PSINet.	**Exception noted:** We were informed that evidence was not available to demonstrate that the Payment team had verified that requests to add to or amend the list of authorised individuals had been supported with an approval from the NHS Board Director of Finance (or delegate), before the amendment had been made. **Management response:** The procedures require staff members to confirm that the request is appropriately authorised before the item is passed to the next step. The procedure is an 'on screen' check and verification and the requirement for signed paperwork evidence was removed some years ago as we moved to digital processes. The evidence of the operation of the control is that the item is uploaded to PSINet.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
2.3	Verification on the validity of changes to fee/allowance rates to GPS On publication of Scottish Government circulars, eVadis team verifies that changes to the fee and allowance rates to General Pharmacy Services are received from an authorised person from the Government and the NHS Boards before making the changes/updates to the rates in the system. The verification is documented in a form detailing the change.	*1 April 2019 – 31 December 2019* Enquired of management to determine whether the eVadis team had verified that changes to the fee and allowance rates to General Pharmacy Services had been received from an authorised person from the Government and NHS Boards before making the changes/updates to rates in the system. *1 January 2020 – 31 March 2020* For a selection of Scottish Government circulars published, inspected request form and noted that the eVadis team had verified that the circulars had been received from an authorised person from the Government and the NHS Boards before making the changes/updates to the rates in the system.	*1 April 2019 – 31 December 2019* **Exception noted:** We were informed that evidence was not available to demonstrate that the eVadis team had verified that the changes to the fee and allowance rates had been received from an authorised person from the Government and NHS Boards before making the changes/updates to rates in the system. **Management response:** The lack of evidence resulted from failing to keep copies of the details of change document. As noted below this is now in place and no further action is planned. *1 January 2020 – 31 March 2020* No exceptions noted.
2.4	Fee and allowance changes A member of eVadis team other than the one who made the amendment reviews the updates to fee and allowance rates entered into the eVadis system to verify its accuracy against the source information provided by the Government and NHS Boards.	For a selection of updates to fee and allowance rates, inspected the Process Control Forms and noted a member of eVadis team other than the one who made the amendment had reviewed the updates to fee and allowance rates entered into the eVadis system to verify its accuracy against the source information provided by the Government and NHS Boards.	No exceptions noted. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.*
2.5	Verification on the validity of pricing information update Price changes for items on Part 7 of the SDT are documented on a manufacturer report and verified by a member of the eVadis team. Changes are then implemented on the eVadis system by a member of the eVadis team, and verified by a separate member of the eVadis team; this verification performed prior to the monthly upload into the DCVP system and is documented in the Manufacturers Report.	For a selection of price changes, inspected the Manufacturers Report and noted that details of the price changes had been documented and that they had been verified by a member of the eVadis team. For the above selection of price changes, inspected the Process Control Forms and noted that the changes had been implemented on the eVadis system by a member of the eVadis team, and verified by a separate member of the eVadis team. Further noted that the verification had been performed prior to the monthly upload into the DCVP system.	No exceptions noted. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.*

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
2.6	Peer review of the update to check for its accuracy and completeness On a monthly basis, DCVP Business Systems Administration to verify the accuracy and completeness of the changes to fees and allowances in advance of the fees being utilised by DCVP against the Scottish Government circular. Any errors identified are investigated and resolved with the eVadis team and an updated eVadis file is created and submitted to DCVP.	*1 April 2019 – 30 September 2019* Enquired of management to determine whether, on a monthly basis, DCVP Business Systems Administrator had verified the accuracy and completeness of the changes to fees and allowances in advance of the fees being utilised by DCVP against the Scottish Government circular. Further enquired to determine whether any errors identified had been investigated and resolved with the eVadis team and an updated eVadis file had been created and submitted to DCVP. *1 October 2019 – 31 March 2020* For a selection of months, inspected email communications and noted that DCVP Business Systems Administrator had verified the accuracy and completeness of the changes to fees and allowances in advance of the fees being utilised by DCVP against the Scottish Government circular. For a selection of errors identified, inspected email communications and records within the eVadis system, and noted that errors had been investigated and resolved with the eVadis team and an updated eVadis file had been created and submitted to DCVP.	*1 April 2019 – 30 September 2019* **Exception noted:** We were informed that evidence was not available to demonstrate that the DCVP Business Systems Administrator had verified the accuracy and completeness of the changes to fees and allowances in advance of the fees being utilised by DCVP against the Scottish Government circular. **Management response:** The lack of evidence resulted from failing to keep copies of relevant emails. As noted below this is now in place and no further action is planned. *1 October 2019 – 31 March 2020* No exceptions noted.
2.7	Verification of prescriptions and stock orders claim validity The Document Handling team verifies that claims for payments relating to prescriptions and stock orders are supported with a claim form from the registered pharmacy, dispensing doctor or appliance supplier, by checking against the list of Registered Pharmacies, Dispensing Doctors and Appliance Suppliers in eVadis. The verification is performed before the claim is processed, and is documented in the GP34 form.	For a selection of months and claims for payment, inspected GP34 forms and noted that the Document Handling team had verified that claims for payments relating to prescriptions and stock orders had been supported with a claim form from the registered pharmacy, dispensing doctor or appliance supplier, by checking against the list of Registered Pharmacies, Dispensing Doctors and Appliance Suppliers in eVadis. Further noted that the verification had been performed before the claim was processed.	No exceptions noted. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.*

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
2.8	Verification of other claims validity Regional Payments team verify whether claims for payments relating to additional Health Board services provided by contractors are supported with approval from an individual from NHS Boards as listed on the NHS Board Delegate Matrix. The verification is performed before the claim is processed.	Enquired of management to determine whether Regional Payments team had verified whether claims for payments relating to additional Health Board services provided by contractors were supported with approval from an individual from NHS Boards as listed on the NHS Board Delegate Matrix. Further enquired to determine whether the verification had been performed before the claim was processed.	**Exception noted:** We were informed that evidence was not available to demonstrate that the Regional Payments team had verified whether claims for payments relating to additional Health Board services provided by contractors were supported with approval from an individual from NHS Boards as listed on the NHS Board Delegate Matrix. **Management response:** The procedures require staff members to confirm that the request is appropriately authorised before the item is passed to the next step. The procedure is an 'on screen' check and verification and the requirement for signed paperwork evidence was removed some years ago as we moved to digital processes. The evidence of the operation of the control is that the item is passed to the next step.
2.9	Verification on the accuracy of manual pricing On a monthly basis, Senior Data Analysts staff other than the inputter verifies the accuracy of the manual price assigned to dispensed items listed without a price in eVadis. The latest and approved version of the manuals, dm+d Quick Search and over-ride price lists are used as part of the verification.	Enquired of management to determine whether, on a monthly basis, Senior Data Analysts staff other than the inputter had verified the accuracy of the manual price assigned to dispensed items listed without a price in eVadis. Further enquired, to determine whether the latest and approved version of the manuals, dm+d Quick Search and over-ride price lists had been used as part of the verification.	**Exception noted:** We were informed that evidence was not available to demonstrate that Senior Data Analysts staff other than the inputter had verified the accuracy of the manual price assigned to dispensed items listed without a price in eVadis. **Management response:** The current design of the DCVP system holds detailed auditing of processing for only the current month and one month previously. There is no intention to change current DCVP to address this, but we can arrange for more frequent review by KPMG to meet the audit requirements.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
2.10	Variance analysis Prior to the DCVP payment being processed each month, Payment Managers review the reports of payment variance for each NHS Board which compares the amount to be paid in the month against the amount from the previous month. Differences are further investigated to verify its accuracy, and to also prevent payment being made more than once to the same contractor.	For a selection of NHS Boards and months, inspected the sign off spreadsheet to determine whether Payment Managers had reviewed the reports of payment variance for each NHS Board which compared the amount to be paid in the month against the amount from the previous month, prior to the DCVP payment being processed. Enquired of management to determine whether differences that exceeded 50% had been further investigated to verify its accuracy, and to also prevent payment being made more than once to the same contractor.	**Exception noted:** For five of 25 sign off spreadsheets, it was noted that Payment Managers had not reviewed the reports of payment variance for each NHS Board. We were informed that there had been no instances where differences of more than 50% had been identified during the period of review. Consequently, we were unable to test the operating effectiveness of the corrective element of the control. **Management response:** Following the Contractor Finance Organisational Change programme which was implemented in January 2020, procedures are being standardised across all three offices and will address the exception noted above. This will be carried out by the National Finance Manager – Pharmacy and will be completed by September 2020.
2.11	Minor Ailment Scheme payments Before Minor Ailment Scheme (MAS) payments are made, Patient Registration team check whether: — the payment schedule has been updated for new and closed contractors; and — patient numbers for last month's current total is equal to the current month's previous total for one contractor per NHS Board. Once checked, all contractors are uploaded onto the DCVP system for payment by AOA.	For a selection of months and NHS Board, inspected MAS Registrations Checklist and email communications, and noted that checks had been performed by the Patient Registration team to check whether: — the payment schedule had been updated for new and closed contractors; and — patient numbers for last month's current total was equal to the current month's previous total for one contractor per NHS Board. Further noted that once checked, all contractors had been uploaded onto the DCVP system for payment by AOA.	No exceptions noted.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
2.12	Prescriptions reconciliation On a monthly basis, the NSS Document Processing Department performs a reconciliation between the number of contractors for whom prescriptions were received for each NHS Board in the batch headers and the number of items that have been scanned onto the DCVP system. Any discrepancies of more than 15% are investigated and resolved through to completion. The details of any investigation are held in a hard copy notebook within the department.	For a selection of months, inspected the reconciliation spreadsheet and noted that the NSS Document Processing Department had performed a reconciliation between the number of contractors for whom prescriptions were received for each NHS Board in the batch headers and the number of items that had been scanned onto the DCVP system. For the above selection of months, inspected the hard copy notebook and noted that discrepancies of more than 15% had been investigated and resolved through to completion.	No exceptions noted. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.*
2.13	High Value Payments review On a monthly basis, post payment, the Adjustment team produce a report detailing individual item payments in excess of £500. To verify the accuracy of all manually keyed items reported against the individual script from contractors, the Adjustment team confirm correct items and quantity have been processed to verify payment accuracy. A second member of the team reviews the result. Both members of staff sign the print out of the report to signify completion of this control. Errors identified as a result of the review are corrected by way of an adjustment by the Adjustment team. This is tracked using the SPSaA system.	For a selection of months, inspected the High Value Payments Reports and noted that the Adjustment team had produced a report detailing individual item payments in excess of £500. Further noted that, to verify the accuracy of all manually keyed items reported against the individual script from contractors, the Adjustment team had confirmed correct items and quantity have been processed to verify payment accuracy, and that a second member of the team had reviewed the result. For a selection of errors identified, inspected records within the SPSaA system and noted that errors had been corrected by way of an adjustment by the Adjustment team.	No exceptions noted.
2.14	CHAPS payment authorisation A member of PS Finance Management team authorise payments made by CHAPS or bank transfer before the payment is made by NSS Central Finance. This authorisation is documented in the payment documentation file.	For a selection of CHAPS payments, inspected the payment documentation file and noted that a member of PS Finance Management team had authorised payments made by CHAPS or bank transfer before the payment had been made by NSS Central Finance.	No exceptions noted. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.*

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
2.15	<u>Validity checking of the request to add/amend/remove practice/contractors</u> A member of the Pharmacy Payments team verifies that the following requests are supported with approval from an authorised person from the NHS Board before they are entered onto the eVadis system: — new Pharmacies/Dispensing Doctors/Appliance Suppliers; or — cessation of dispensing contractors. The List of Authorised Individuals is used in performing the verification. The authorised notification is held in the Pharmacy Payment department.	For a selection of requests for new Pharmacies/Dispensing Doctors/Appliance Suppliers and cessations of dispensing contractors, inspected New/Cessation to Pharmaceutical List form and noted that a member of the Pharmacy Payments team had verified that the requests were supported with approval from an authorised person from the NHS Board before they had been entered onto the eVadis system. Further, noted that the authorised notification had been held in the Pharmacy payment department. Enquired of management to determine whether the List of Authorised Individuals had been used in performing the verification.	**Exception noted:** We were informed that evidence was not available to demonstrate that the List of Authorised Individuals had been used in performing the verification hence we were unable to test whether the List of Authorised Individuals had been used in performing the verification. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.* **Management response:** The procedures require staff members to confirm that the request is appropriately authorised before the item is passed to the next step. The procedure is an 'on screen' check and verification and the requirement for signed paperwork evidence was removed some years ago as we moved to digital processes. The evidence of the operation of the control is that the item is passed to the next step. It is impracticable with the current systems in use to document this electronically and it would only be our intention to revisit this if we were to move generally to an electronic workflow environment, which is not currently planned.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
2.16	<u>Verification of the accuracy of new entry and cessation of practice/contractors</u> A member of Pharmacy Payments team, who is different from the inputter, verifies the accuracy of the following actions made in the eVadis system against the details supplied by the NHS Board prior to the next payment run after the request is received: — new Pharmacies/Dispensing Doctors/Appliance Suppliers; or — cessation of dispensing contractors. Errors identified as a result of the verification is corrected and tracked using Contractor Amendments.	For a selection of requests for new Pharmacies/Dispensing Doctors/Appliance Suppliers and cessations of dispensing contractors, inspected New/Cessation to Pharmaceutical List form and noted that a member of Pharmacy Payments team, who is different from the inputter, had verified the accuracy of the actions made in the eVadis system against the details supplied by the NHS Board, prior to the next payment run. Enquired of management to determine whether errors identified as a result of the verification had been corrected and tracked using Contractor Amendments.	We were informed that there had been no errors identified as a result of the verification during the period of review, hence evidence was not available to demonstrate that errors identified as a result of the verification had been corrected and tracked. Consequently, we were unable to test the operating effectiveness of the corrective element of the control. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.*
2.17	<u>Validity of bank detail and standing data amendments</u> Payments team verifies that an approval from an authorised person from NHS Board (as listed in the Authorised Persons list) or the Pharmacy contractor or the contractor's bank is in place before making an amendment/update to the contractor's bank details and other standing data on the general ledger. This verification is documented on file in the changes file.	Enquired of management to determine whether the Payments team had verified that an approval from an authorised person from NHS Board (as listed in the Authorised Persons list) or the Pharmacy contractor or the contractor's bank was in place before making an amendment/update to the contractor's bank details and other standing data on the general ledger. Further enquired to determine whether this verification had been documented on file in the changes file.	**Exception noted:** We were informed that evidence was not available to demonstrate that the Payments team had verified that an approval from an authorised person was in place before making an amendment/update to the contractor's bank details and other standing data on the general ledger. **Management response:** The procedures require staff members to confirm that the request is appropriately authorised before the item is passed to the next step. The procedure is an 'on screen' check and verification and the requirement for signed paperwork evidence was removed some years ago as we moved to digital processes. The evidence of the operation of the control is that the item is passed to the next step.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
2.18	Verification of the accuracy of amendments A member of Regional Payments team who is different from the inputter, verifies the accuracy of the amendment/update to the contractor's bank details and other standing data made in the Finance Process Manager (FPM) system against the details supplied by the NHS Board or the Pharmacy contractor or the contractor's bank prior to the next payment run from when the request is received.	For a selection of amendments, inspected Amendment Request form to determine whether a member of Regional Payments team, different from the inputter, had verified the accuracy of the amendment/update to the contractor's bank details and other standing data made in the Finance Process Manager (FPM) system against the details supplied by the NHS Board or the Pharmacy contractor or the contractor's bank, prior to the next payment run.	**Exception noted:** For 13 out of 40 Amendment Request forms, it was noted that amendments has not been verified by a member of the Regional Payments team, different from the inputter. For four of 40 Amendment Request forms, it was noted that the verification had not been performed prior to the next payment run. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.* **Management response:** The procedures require staff members to confirm that the entry of the payment is checked. We will ensure that the forms retained contain details of the checks carried out. This will be carried out by the National Finance Manager – Pharmacy and will be completed by September 2020.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
2.19	Scottish Government guidance verification policy/procedure On an annual basis, Payment Verification Manager reviews the Scottish Government guidance verification requirements as published in relevant circular and document these requirements in team policy/procedure. The policy/procedure is communicated to internal NSS staff through meetings.	Enquired of management to determine whether Payment Verification Manager had reviewed the Scottish Government guidance verification requirements, as published in relevant circular, and had documented these requirements in team policy/procedure, within the last 12 months. Further enquired to determine whether the policy/procedure had been communicated to internal NSS staff through meetings.	**Exception noted:** We were informed that evidence was not available to demonstrate that Payment Verification Manager had reviewed the Scottish Government guidance verification requirements and had documented these requirements in team policy/procedure. **Management response:** The staff meetings were not documented. However, following the Contractor Finance Organisational Change programme which was implemented in January 2020, responsibility for Payment Verification now rests with the new roles of National Finance Managers. Procedures around this will be revised. This will be carried out by the National Finance Manager – Pharmacy and will be completed by September 2020.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
2.20	<u>Secondary review of prescriptions and stock orders claim validity</u> Processing staff perform further verification at confirmation report in DCVP. In accordance with their instructions in the SDA manual to verify the validity of prescriptions and stock orders claims that fall into the following category after they are loaded into the DCVP system and before the claims are processed for payments to verify the accuracy and validity of the claims: — foreign forms; — urgent forms; — unknown items; — minimum gross ingredient cost; — out of pocket expenses; — high value gross ingredient cost; — rejected items; — unusual fees/quantities; and — pay and report items. The result of the verification is carried out within DCVP. Any invalid/inaccurate claims identified as a result of the review is investigated, resolved to completion and tracked using DCVP.	Enquired of management to determine whether processing staff had performed further verification at confirmation report in DCVP, in accordance with instructions in the SDA manual, to verify the validity of prescriptions and stock orders claims after they had been loaded into the DCVP system, and before the claims had been processed for payments. Further enquired to determine whether any invalid/inaccurate claims identified as a result of the review had been investigated, resolved to completion and tracked using DCVP.	**Exception noted:** We were informed that evidence was not available to demonstrate that processing staff had performed further verification of the accuracy and validity of the claims at confirmation report in DCVP. **Management response:** The current design of the DCVP system holds detailed auditing of processing for only the current month and one month previously. There is no intention to change current DCVP to address this, but we can arrange for more frequent review by KPMG to meet the audit requirements.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
2.21	Monthly sampling over contractor processing A Senior Data Analyst performs a monthly sample check over a sample of contractors entered manually in batches in DCVP system, in accordance with the Random Sampling procedure. The check compares a system generated sample to confirm correct item and quantities have been processed. Errors found are resolved through to completion and tracked using DCVP. Where the number of errors found exceeds pre-defined limits, the full population is tested, and errors resolved through to completion and tracked using DCVP. All of the above are documented in Random Sampling procedure.	Enquired of management to determine whether a Senior Data Analyst had performed a monthly sample check over a sample of contractors entered manually in batches in DCVP system, in accordance with the Random Sampling procedure and whether the check compared a system generated sample to confirm correct item and quantities have been processed and had been documented in Random Sampling procedure. Enquired of management to determine whether Errors found had been resolved through to completion and tracked using DCVP and had been documented in Random Sampling procedure. Enquired of management to determine whether where the number of errors found exceeded pre-defined limits, the full population had been tested, and errors had been resolved through to completion and tracked using DCVP and had been documented in Random Sampling procedure.	**Exception noted:** We were informed that evidence was not available to demonstrate that a Senior Data Analyst had performed a monthly sample check over a sample of contractors entered manually in batches in DCVP system. **Management response:** The current design of the DCVP system holds detailed auditing of processing for only the current month and one month previously. There is no intention to change current DCVP to address this, but we can arrange for more frequent review by KPMG to meet the audit requirements
2.22	Annual sample check of dispensing payments validity As per the Scottish Government guidance, the PV team performs an annual reviews of dispensing payments made for 1% of contractors to verify its accuracy and validity of approval by comparing the records against the supporting approval records. The review is documented in the PV department records. If an error is found, it is investigated and corrected to resolution. This is tracked using the PV tracker.	For a selection of contractors, inspected the PV department records and noted that the PV team had performed a review of dispensing payments made for 1% of contractors, to verify its accuracy and validity of approval by comparing the records against the supporting approval records, within the last 12 month. For a selection of errors identified following the review, inspected the PV tracker and noted that errors found had been investigated and corrected to resolution.	No exceptions noted.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
2.23	PV referral to Counter Fraud Services. On a quarterly basis, the PV team produces reports for all NHS Boards detailing the level of checking carried out in each area and highlighting any specific issues. Following the outcome of payment verification reporting / investigation into unusual prescribing, dispensing or claim patterns, the Payment Verification team liaise with the appropriate NHS Board and where necessary, make a referral to Counter Fraud Services.	For a selection of quarters and boards, inspected the Payment Verification team meeting minutes and Level 3 & 4 Reports, and noted that the PV department had produced reports for NHS Boards detailing the level of checking carried out in each area and highlighting any specific issues. Further, noted that following the outcome of payment verification reporting / investigation into unusual prescribing, dispensing or claim patterns, the Payment Verification team had liaised with the appropriate NHS Board. Enquired of management to determine whether any referrals to Counter Fraud Services where required within the period.	We were informed that there had been no referrals to Counter Fraud Services required during the period of review. Consequently, we were unable to test the operating effectiveness of the referral element of the control.

3.3 GENERAL DENTAL SERVICES PAYMENTS

VERIFICATION ON COMPLETENESS, VALIDITY AND ACCURACY OF GENERAL DENTAL SERVICES PAYMENTS

Controls provide reasonable assurance that:

- GDS payments are made completely and accurately based on authorised claims to the valid contractors;
- GDS payments are made only once; and
- Verification is performed in accordance with Scottish Government Guidance.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
3.1	Payment claim authorised individuals GMSQA team maintains a list of individuals and their delegates from the NHS Boards, NHS Education for Scotland and Health Protection Scotland who are authorised to approve claim payments or request amendments on rates/data that will impact payments. On an annual basis as a minimum, GMSQA team obtains confirmation from NHS Boards to verify that the list remains accurate and up-to-date. Changes required as a result of the confirmation are updated in PSINet. The list is made accessible to the Dental Payments Team through PSINet.	For a selection of practices and boards, inspected the delegate authority matrix and email communications, and noted that the GMSQA team had maintained a list of individuals and their delegates from the practices, NHS Boards, NHS Education for Scotland and Health Protection Scotland, who had been authorised to claim payments or request amendments on rates/data that impact payments. Further noted that the GMSQA team had obtained confirmation from NHS Boards to verify that the list remained accurate and up-to-date within the last 12 months, and that changes required as a result of the confirmation had been updated in PSINet. Inspected PSINet system and noted that the list had been made accessible to the three regional offices.	No exceptions noted.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
3.2	Additions and removals to the list of authorised individuals Payment team verifies that a request to add/amend the list of authorised individuals are supported with approvals from the NHS Board Director of Finance (or delegate) before the amendment is made. This is documented in PSINet.	Enquired of management to determine whether the Payments team had verified that requests to add to or amend the list of authorised individuals had been supported with an approval from practice mandates, before the amendment had been made. Further enquired to determine whether this had been documented in PSINet.	**Exception noted:** We were informed that evidence was not available to demonstrate that the Payments team had verified that requests to add to or amend the list of authorised individuals had been supported with an approval practice mandate, before the amendment had been made. **Management response:** The procedures require staff members to confirm that the request is appropriately authorised before the item is passed to the next step. The procedure is an 'on screen' check and verification and the requirement for signed paperwork evidence was removed some years ago as we moved to digital processes. The evidence of the operation of the control is that the item is uploaded to PSINet.
3.3	SGHSCD payment rate updates An Assistant Director reviews the approval and accuracy of updates to payment rates to PS against the request received from Scottish Government Health and Social Care Directorate (SGHSCD). This review is performed in the test environment prior to the new rates being implemented in the live MIDAS system, and the successful upload to live is also confirmed. This is documented in SDR update process control sheet.	For a selection of updates to payment rates, inspected the SDR sign-off sheet and noted that an Assistant Director had reviewed the approval and accuracy of updates to payment rates to PS against the request received from the Scottish Government Health and Social Care Directorate (SGHSCD).	No exceptions noted. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.*

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
3.4	<u>Verification on validity of paper orthodontic payment claims</u> The Prior Approval team completes a validity check over paper claim forms before payments are processed to confirm that they contain: — the registered contractors payment list number; — signature of the patient; — signature of the dentist; and — acceptance date and completion date.	For a sample of claims, inspected the batch cover sheet to determine whether a member of the Prior Approval team had completed a validity check over the claims to confirm that they contain: — the registered contractors payment list number; — signature of the patient; — signature of the dentist; and — acceptance date and completion date.	**Exception noted:** For three of 40 claims, management were unable to provide evidence that a member of the Prior Approval team had completed a validity check over the claims to confirm that they contain: *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.* **Management response:** Prior Approval has been migrated to an electronic approval process and will be subject to post implementation review which will address any control issues. This will be carried out by the National Services Manager D&O and the Senior Dental Adviser once prior approval claims are being submitted again post COVID-19, probably by March 2021.
3.5	<u>Validation of electronic dental payment claims</u> The electronic dental claims system is configured to accept claims only from a registered contractor. A mechanism is built in the electronic form to prevent the claim to be submitted unless it specifies: — the registered contractors payment list number; — location code; — electronic signature of the patient; and — electronic signature of the dentist. Changes to the above configuration follows the standard change management procedure.	Inspected dental claims system configurations and noted that the system has been configured to accept claims only from a registered contractor, and that a mechanism had been built in the electronic form to prevent the claim being submitted unless it specified: — the registered contractors payment list number; — location code; — electronic signature of the patient; and — electronic signature of the dentist. Enquired of management to determine whether changes to the above configuration followed the standard change management procedure.	We were informed that there had been no changes to the dental claims system configurations during the period of review. Consequently, we were unable to test the operating effectiveness of the change management element of the control.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
3.6	Verification of other claims validity Dental Payment team verifies whether claims for all payments except for dental and orthodontic treatment claims are either: — supported with approval from an individual from NHS Boards as listed on the List of Authorised Individuals; or — supported with a signed form from a valid contractor, and includes a list number. The verification is performed before the claim is processed, and is documented in monthly claims file.	For a selection of claims for payments (except for dental and orthodontic treatment claims), inspected monthly claims file to determine whether the Dental Payment team had verified that treatment claims were either: — supported with approval from an individual from NHS Boards as listed on the List of Authorised Individuals; or — supported with a signed form from a valid contractor, and included a list number. Further enquired to determine whether verification had been performed before the claim was processed.	**Exception noted:** For 13 of 40 claims for payments, the Dental Payment team had not performed verification on claims for payments. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.* **Management response:** We will remind staff members of the need to follow the established procedures and evidence such check appropriately. This will be carried out by the Dental Payment Lead by September 2020.
3.7	Validity of the request for patient refunds Dental Payment teams verifies that the requests for patient refunds are supported with confirmation of exemption status from department of work and pensions before the refunds are sent for payment. This is documented in the refunds process.	For a selection of dental refunds, inspected the Dental Cheque Refund Status Authorisation Chart and noted that the Dental Payment team had verified that the requests for patient refunds had been supported with confirmation of exemption status from department of work and pensions before the refunds was sent for payment.	No exceptions noted. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.*

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
3.8	Payment adjustment, non-payment and patient detail amendment claims Any adjustment/non-payment/patient detail amendment claims are returned to the contractor with a comment to explain the reason for the action taken in response to the claim within 20 working days of receipt. This is logged in the adjustment/non-payment/patient detail amendment spreadsheet.	For a selection of adjustment, non-payment and patient detail amendment claims, inspected amendment spreadsheet and claim form, and noted claims had been returned to the contractor with a comment to explain the reason for the action taken in response to the claim. For the above selection of adjustment, non-payment and patient detail amendment claims, inspected amendment spreadsheet and claim form, to determine whether the return has been completed within 20 working days of the receipt of the claim.	No exceptions noted. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.*
3.9	Duplicate Claim Checking MIDAS is configured to automatically check all claims relating to dental treatments to verify that they are not duplicate claims by comparing patient's treatment histories. Changes to this configuration follows the standard change management procedure. On a daily basis where applicable, the Customer Admin team will review all payments identified by the system as potential duplicates. Any duplicate claims identified reviewed and found to be a valid duplicate, are returned to the contractor as unpaid by the Customer admin team. Claims which are not valid duplicates are processed for payment.	Inspected MIDAS system configurations and noted that the system had been configured to automatically check all claims relating to dental treatments to verify that they are not duplicate claims, by comparing patient's treatment histories. For a selection of duplicates identified, inspected records within the MIDAS system and noted that the Customer Admin team had reviewed payments, and any duplicate claims identified had been returned to the contractor as unpaid, and claims which were not valid duplicates had been processed for payment Inspected MIDAS system configurations to determine whether changes to this configuration had followed the standard change management procedure.	*We noted that there had been no changes to the MIDAS system configurations during the period of review. Consequently, we were unable to test the operating effectiveness of the change management element of the control.*

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
3.10	<u>Verification on the accuracy of other claims</u> A member of the Dental Payments team other than the inputter verifies the accuracy of claims for all payments except for dental and orthodontic treatment claims by comparing the entry in MIDAS system against the instruction from NHS Board. This is documented in a dental top sheet within the payments file. Any errors identified as a result of this verification is corrected and tracked in the payments file.	For a selection of months and boards, inspected the dental top sheet and noted that a member of the Dental Payments team, other than the inputter, had verified the accuracy of the claim by comparing the entry in MIDAS system against the instruction from the NHS Board. Enquired of management to determine whether errors identified as a result of the verification had been corrected and tracked in the payments file.	**Exception noted:** We were informed that evidence was not available to demonstrate that errors identified as a result of the verification had been corrected. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.* **Management response:** The procedures require staff members to confirm that the entry of the payment is checked. We will review the control to determine if we can record additional details of compliance This will be carried out by the Payments Lead, D&O by September 2020.
3.11	<u>Large or unusual prescribing and treatment patterns</u> A list is maintained of all contractors who exhibit unusual prescribing/treatment patterns. These identified contractors are recorded in a CPA list and all of their prior approval requests are assessed by a Clinical Advisor.	Inspected CPA list and noted that a list had been maintained of all contractors who exhibit unusual prescribing/treatment patterns. For a selection of prior approval claims, inspected records within the eDental system to determine whether prior approval request had been assessed by a Clinical Advisor.	**Exception noted:** For 11 out of 40 prior approval claims selected, we noted that these hadn't been assessed by an approved Clinical Advisor. *Please refer to section [2.8] of this report for information on manually maintained populations relied on for the testing of this control.* **Management response:** Prior Approval has been migrated to an electronic approval process and will be subject to post implementation review which will address any control issues. This will be carried out by the National Services Manager D&O and the Senior Dental Adviser once prior approval claims are being submitted again post COVID-19, probably by March 2021.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
3.12	Patient refunds review The weekly calculation of patient refunds is independently reviewed by a member of the Dental Payments team to verify that the refund is accurately calculated based on HC1/2.	For a selection of weeks, inspected the weekly calculation spreadsheet and noted that a calculation of patient refunds had been independently reviewed by a member of the Dental Payments team to verify that the refund is accurately calculated based on HC1/2.	No exceptions noted.
3.13	Monthly BACS payments review A member of the Test and Support team performs a verification on the number of claims and values relating to each NHS Board by comparing it against the supporting detail of the calculation from the system / against the amount from last month, with significant differences that investigated to resolution. This review is performed prior to transmission to the NSS Finance Department for BACS processing to confirm completeness and accuracy of the amounts. This is documented in the BACS payment documentation. Dental Payments team provides NSS Treasury a control sheet of the total amount authorised to be paid and this is authorised prior to BACs transmission. A member of the Senior Management team reviews the result.	For a selection of months, inspected the control sheets and noted that: — A member of the Test and Support team had performed a verification on the number of claims and values relating to each NHS Board by comparing it against the supporting detail of the calculation from the system / against the amount from last month; — The review had been performed prior to the transmission to NSS Finance Department for BACS processing to confirm completeness and accuracy of the amounts; — Dental Payments team had provided NSS Treasury a control sheet of the total amount authorised to be paid and this had been authorised prior to BACs transmission; and — A member of the Senior Management team had reviewed the result. Enquired of management to determine where significant differences had been investigated to resolution.	**Exception noted:** We were informed that evidence was not available to demonstrate that significant differences had been investigated to resolution. **Management response:** We will remind staff members of the need to follow the established procedures and evidence such check appropriately. This will be carried out by the Dental Payment Lead by September 2020.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
3.14	CHAPS payment authorisation A member of PS Finance Management Team authorise payments made by CHAPS, Paymaster General or bank transfer before the payment is made by NSS Central Finance.	For a selection of payments made by CHAPS, Paymaster General or bank transfer, inspected the cover sheet and noted that a member of the PS Finance Management team had authorised the payment prior to payment being made by NSS Central Finance.	No exceptions noted. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.*
3.15	Post-payments reconciliation Following completion of BACS and CHAPS processing, PS team reconcile the total amount of BACS and CHAPS payments against the supporting calculation from MIDAS to verify that all payments had been processed. Differences are investigated and resolved to completion.	For a selection of weeks, inspected the cover sheet and noted that a member of the PS team had reconciled the total amount of BACS and CHAPS payments against the supporting calculation from MIDAS to verify that all payments had been processed. Enquired of management to determine whether differences had been investigated and resolved to completion.	We were informed that there were no differences identified during the audit period. Consequently, we were unable to test the operating effectiveness of the corrective element of the control.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
3.16	Patient refunds authorisation Prior to raising cheques or other payments for patient refunds, NSS Central Finance Department verifies that an approval from an authorised person in the Dental Payments team, as listed in authorised signatory list, is in place along with the electronic listing of all refund amounts.	Enquired of management to determine whether, prior to raising cheques or other payments for patient refunds, NSS Central Finance Department had verified that an approval from an authorised person in the Dental Payments team, as listed in authorised signatory list, had been in place along with the electronic listing of all refund amounts.	**Exception noted:** We were informed that evidence was not available to demonstrate that NSS Central Finance Department had verified that an approval from an authorised person had been in place, prior to raising cheques or other payments for patient refunds. **Management response:** We will remind staff members of the need to follow the established procedures and evidence such check appropriately. This will be carried out by the Dental Payment Lead by September 2020.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
3.17	Validity checking of the request to add/remove contractors A member of the Customer Administration team verifies that the following requests are supported with approval from an authorised person from the NHS Board before they are entered onto the MIDAS system: — new Dental Contractors; and — removal of Dental Contractors. The List of Authorised Individuals is used in performing the verification.	*1 April 2019 – 31 December 2019* Enquired of management to determine whether a member of the Customer Administration team had verified that the requests for new Dental Contractors and removal of Dental Contractors, had been supported with approval from an authorised person from the NHS Board before they were entered onto the MIDAS system. Further enquired to determine whether the List of Authorised Individuals had been used in performing the verification. *1 January 2020 – 31 March 2020* For a selection of new Dental contractors and removal of Dental contractors, inspected the sign off spreadsheet to and noted that a member of the Customer Administration team had verified that the requests for new Dental contractors and removal of Dental contractors, had been supported with approval from an authorised person from the NHS Board before they were entered onto the MIDAS system. Further noted that the List of Authorised Individuals had been used in performing the verification.	*1 April 2019 – 31 December 2019* **Exception noted:** We were informed that evidence was not available to demonstrate that the Customer Administration team had verified that the requests for new Dental Contractors and removal of Dental Contractors, had been supported with approval from an authorised person from the NHS Board. *1 January 2020 – 31 March 2020* No exception noted. **Management response:** The procedures require staff members to confirm that the request is appropriately authorised before the item is passed to the next step. The procedure is an 'on screen' check and verification and the requirement for signed paperwork evidence was removed some years ago as we moved to digital processes. The evidence of the operation of the control is that the item is passed to the next step.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
3.18	<u>Verification of new contractors and cessation of practice/contractors</u> On a monthly schedule basis, for a selection of new contractors / ceased practices, a member of Customer Admin team who is different from the processor/inputter verifies the accuracy of the following actions made in MIDAS against the details supplied by the NHS Board: — new Dental Practice/contractors; and — cessation of Dental Practices. The size of the selection is determined by sample check process. This check is documented in sample check training guide. Errors identified as a result of the verification is corrected and tracked within MIDAS.	For a selection of new contractors and ceased practices, inspected the request form and noted that a member of the Customer Admin team who is different from the processer/inputter had verified the accuracy of the actions made in MIDAS against the details supplied by the NHS Board. Inspected sample check training guide and noted that the size of the selection determined by sample check process had been documented. Enquired of management to determine whether errors identified as a result of the verification had been corrected and tracked within MIDAS.	**Exception noted:** We were informed that evidence was not available to demonstrate that errors identified as a result of the verification had been corrected and tracked. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.* **Management response:** The procedures require staff members to confirm that the request is appropriately authorised before the item is passed to the next step. However, from 2020 recording of related checks was captured in the spreadsheet control list of changes, so we will consider whether this control can be evidenced in that control sheet. This will be carried out by the National Service Delivery Manager - D&O by September 2020.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
3.19	<u>Verification on the approval for patient withdrawal</u> Customer Admin team verifies that the request for patient withdrawal are supported by a signed form from NHS Boards before the withdrawal is processed. Customer Admin team monitors completion of the withdrawal requests to help ensure that they are processed within 20 working days of the requests being received.	Enquired of management to determine whether a member of the Customer Admin team had verified that the request for patient addition/withdrawal/ removal was supported by a signed form from NHS Boards before the addition/ withdrawal/ removal had been processed. Further enquired to determine whether Customer Admin team had monitored completion of the addition/withdrawal/removal requests to help ensure that they had been processed within 20 working days of the requests being received.	**Exception noted:** We were informed that evidence was not available to demonstrate that a member of the Customer Admin team had verified that the request for patient withdrawal was supported by a signed form from NHS Boards before the withdrawal has been processed. **Management response:** The procedures require staff members to confirm that the request is appropriately authorised before the item is passed to the next step. The procedure is an 'on screen' check and verification and the requirement for signed paperwork evidence was removed some years ago as we moved to digital processes. The evidence of the operation of the control is that the item is passed to the next step. It is impracticable with the current systems in use to document this electronically and it would only be our intention to revisit this if we were to move generally to an electronic workflow environment, which is not currently planned.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
3.20	Validity of bank Detail and standing data amendments Dental Payments team verifies that an approval from an appropriately signed bank mandate is in place before making an amendment/update to the contractor's bank details and other standing data in MIDAS and on the general ledger.	For a selection of amendments to bank details and other standing data, inspected the Supplier Set Up/Amendment forms to determine whether Dental Payments team had verified that an approval from an appropriately signed bank mandate had been in place before making an amendment/update to the contractor's bank details and other standing data in MIDAS and on the general ledger.	**Exception noted:** For two of 40 amendments to bank details and other standing data selected, verification had not been performed prior to making an amendment/update to the contractor's bank details and other standing data in MIDAS and on the general ledger. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.* **Management response:** We will remind staff members of the need to follow the established procedures and evidence such check appropriately. This will be carried out by the Dental Payment Lead by September 2020.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
3.21	Verification of the accuracy of amendments A member of the Dental Payments team, who is different from the inputter, verifies the accuracy of the amendment/update to the dental contractor's bank details and other standing data made in MIDAS against the details supplied by the Contractor prior to the next payment run when the request is received.	For a selection of amendments to bank details and other standing data, inspected the Supplier Set Up/Amendment Forms to determine whether a member of the Dental Payments team, who is different than the inputter, had verified the accuracy of the amendment/update to the dental contractor's bank details and other standing data made in MIDAS against the details supplied by the Contractor, prior to the next payment run when the request is received.	**Exception noted:** For two of 40 amendments to bank details and other standing data selected, it was noted that a member of the Dental Payments team, who is different than the inputter, had not verified the accuracy of the amendment/update to the dental contractor's bank details, prior to the next payment run. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.* **Management response:** We will remind staff members of the need to follow the established procedures and evidence such check appropriately. This will be carried out by the Dental Payment Lead by September 2020.
3.22	Scottish Government guidance verification policy/procedure On an annual basis, Payment Verification Manager reviews the Scottish Government guidance verification requirements as published in relevant circular and document these requirements in team policy/procedure. The policy/procedure is communicated to internal NSS staff through meetings.	Enquired of management to determine whether Payment Verification Manager had reviewed the Scottish Government guidance verification requirements, as published in relevant circular, and had documented these requirements in team policy/procedure, within the last 12 months. Further enquired to determine whether the policy/procedure had been communicated to internal NSS staff through meetings.	**Exception noted:** We were informed that evidence was not available to demonstrate that Payment Verification Manager had reviewed the Scottish Government guidance verification requirements and had documented these requirements in team policy/procedure. **Management response:** This particular request coincided with particular pressures on Dental Payments and PV staff in dealing with COVID-19 in March/ April 2020. Details of work carried out are stored in the BCS and will be made available to KPMG next year. No further action is planned.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
3.23	<u>Secondary review of the validity and accuracy of dental and orthodontic treatment claims</u> The Dental PV and Monitoring team performs further verification of dental and orthodontic treatment claims that have been uploaded to the MIDAS system by Test & Support Team on a quarterly basis and reports the dataset to NHS Boards in accordance with the SGHSCD regulation as outlined in PV protocol document to verify the accuracy and validity of the claims. CFS team (patient claims team) also verifies that the amount of patient contributions as specified in the claim forms are deducted against the payments to be made to the dental practitioners. These reviews are performed after the claims are processed for payments. The result of the verification is documented, and any invalid/inaccurate claims identified as a result of the review is investigated, resolved to completion and tracked by CFS.	Enquired of management to determine whether Dental PV and Monitoring team performed further verification of dental and orthodontic treatment claims that had been uploaded to the MIDAS system by Test & Support Team on a quarterly basis and reports the dataset to NHS Boards in accordance with the SGHSCD regulation as outlined in PV protocol document to verify the accuracy and validity of the claims. Enquired of management to determine whether the CFS team also verified that the amount of patient contributions as specified in the claim forms are deducted against the payments to be made to the dental practitioners. Enquire of management to determine whether these reviews are performed after the claims are processed for payments. Enquired of management to determine whether the result of the verification is documented and any invalid/inaccurate claims identified as a results of the review are investigated, resolved to completion and tracked.	**Exception noted:** We were informed that there was no evidence to demonstrate that the Dental PV and Monitoring team performed further verification of dental and orthodontic treatment claims. We were informed that there was no evidence to demonstrate that CFS team also verified that the amount of patient contributions as specified in the claim forms are deducted against the payments to be made to the dental practitioners. **Management response:** This particular request coincided with particular pressures on Dental Payments and PV staff in dealing with COVID-19 in March/ April 2020. Details of work carried out are stored in the BCS and Dental Investigations database and will be made available to KPMG next year. No further action is planned.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
3.24	Monthly payment samples Before each monthly payment is made, the amounts to be paid in MIDAS for a sample of three contractors are checked against the SDR by the Payment Verification team. Any issues noted are followed up and resolved prior to payment.	For a selection of months, inspected Dental Payment Schedule Sign-off and noted that the amounts to be paid in MIDAS for a sample of three contractors had been checked against the SDR by the Payment Verification team. Further noted that any issues noted had been followed up and resolved prior to payment.	No exceptions noted.
3.25	Annual sample check of dental contractors As per the Scottish Government guidance, the Dental Monitoring team performs an annual check over a minimum of 1% of contractors for the following: — items of service; — patient registration and list size; — level of Earnings; and — cost per claim and throughput. The check is performed by comparing the above against historical records and national averages. Any discrepancies or issues identified are investigated.	Enquired of management to determine whether the Dental Monitoring team had performed a check over a minimum of 1% of contractors for the following, within the last 12 months: — items of service; — patient registration and list size; — level of Earnings; and — cost per claim and throughput. Further enquired to determine whether the check has been performed by comparing the above against historical records and national averages, and any discrepancies or issues identified had been investigated.	**Exception noted:** We were informed that evidence was not available to demonstrate that the Dental Monitoring team had performed checks over a minimum of 1% of contractors, within the last 12 months. **Management response:** This particular request coincided with particular pressures on Dental Payments and PV staff in dealing with COVID-19 in March/ April 2020. Details of work carried out are stored in the BCS and Dental Investigations database and will be made available to KPMG next year. No further action is planned.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
3.26	Referral of patients to Scottish Dental Reference Services As per the Scottish Government Guidance, for 12,000 of the total claims received in the year, the Dental Monitoring team pick patients on a random and targeted basis and provide to Scottish Dental Reference Services (SDRS) to perform detailed checks of claim entitlement and clinical nature.	Enquired of management to determine whether, as per the Scottish Government guidance, for 12,000 of the total claims received in the year, the Dental Monitoring team had picked patients on a random and targeted basis and provided to SDRS to perform detailed checks of claim entitlement and clinical nature.	**Exception noted:** We were informed that evidence was not available to demonstrate that the Dental Monitoring team had picked patients on a random and targeted basis and provided the patients to SDRS. **Management response:** This particular request coincided with particular pressures on Dental Payments and PV staff in dealing with COVID-19 in March/ April 2020. Details of work carried out are stored in the SDRS system and will be made available to KPMG next year. No further action is planned.

3.4 GENERAL OPHTHALMIC SERVICES PAYMENTS

VERIFICATION ON COMPLETENESS, VALIDITY AND ACCURACY OF GENERAL OPHTHALMIC SERVICES PAYMENTS

Controls provide reasonable assurance that:

- GOS payments are made completely and accurately based on authorised claims to the valid contractors;
- GOS payments are made only once; and
- Verification is performed in accordance with Scottish Government Guidance

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
4.1	Payment claim authorised individuals GMSQA team maintains a list of individuals and their delegates from the NHS Boards, NHS Education for Scotland and Health Protection Scotland who are authorised to approve claim payments or request amendments on rates/data that will impact payments. On an annual basis as a minimum, GMSQA team obtains confirmation from NHS Boards to verify that the list remains accurate and up-to-date. Changes required as a result of the confirmation are updated in PSINet. The list is made accessible to the Ophthalmic payment team through PSINet.	For a selection of practices and boards, inspected the delegate authority matrix and email communications, and noted that the GMSQA team had maintained a list of individuals and their delegates from the practices, NHS Boards, NHS Education for Scotland and Health Protection Scotland, who had been authorised to claim payments or request amendments on rates/data that impact payments. Further, noted that the GMSQA team had obtained confirmation from NHS Boards to verify that the list remained accurate and up-to-date with the last 12 months, and that changes required as a result of the confirmation had been updated in PSINet. Inspected PSINet system and noted that the list had been made accessible to the three regional offices.	No exceptions noted.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
4.2	Additions and removals to the list of authorised individuals Payments team verifies that a request to add/amend the list of authorised individuals are supported with approvals from the NHS Board Director of Finance (or delegate) before the amendment is made. This is documented in PSINet.	Enquired of management to determine whether the Payments team had verified that requests to add to or amend the list of authorised individuals had been supported with an approval from practice mandates, before the amendment had been made. Further enquired to determine whether this had been documented in PSINet.	**Exception noted:** We were informed that evidence was not available to demonstrate that the Payments team had verified that requests to add to or amend the list of authorised individuals had been supported with an approval from practice mandates, before the amendment had been made. **Management response:** The procedures require staff members to confirm that the request is appropriately authorised before the item is passed to the next step. The procedure is an 'on screen' check and verification and the requirement for signed paperwork evidence was removed some years ago as we moved to digital processes. The evidence of the operation of the control is that the item is uploaded to PSINet.
4.3	SGHSCD payment rate updates When the payment rates to PS are updated, a member of GOS team other than the processor reviews the approval and accuracy of the updates to payment rates to PS against the request received from Scottish Government Health and Social Care Directorate (SGHSCD). This review is performed by comparing the updated rate in the live OPTIX system against the supporting request.	Enquired of management to determine whether, when the payment rates to PS are updated, a member of the GOS team, other than the processer had reviewed the approval and accuracy of updates to payment rates to PS against the request received from SGHSCD). Further enquired to determine whether this review had been performed by comparing the updated rate in the live OPTIX system against the supporting request.	We were informed that there had been no updates to payment rates within the period of review. Consequently, we were unable to test the implementation and operating effectiveness of this control.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
4.4	Verification of GOS claims validity Customer Admin Team verifies that claim for payments relating to Hospital Eye Services is supported with a valid claim form which is signed by an optician and includes the list number and payment location code of a registered contractor, as listed on the Ophthalmic List. GOS forms are submitted electronically by practitioners, the system validates that information submitted by practitioners include a valid list number, and payment location code of a registered contractor. If the form fails validation, it is rejected.	On a selection of dates, inspected OPTIX system configurations, and noted that the system had been configured to validate claims for payments relating to Hospital Eye Services were supported with a valid claim form which had been signed by an optician and included the list number and payment location code of a registered contractor, as listed on the Ophthalmic List. On a selection of date, inspected OPTIX system configurations, and noted that the system had been configured to validate that information submitted by practitioners had included a valid list number, and payment location code of a registered contractor. If the form fails validation, it is rejected.	No exceptions noted.
4.5	Verification of other claims validity The GOS team receives a GOS6A form from the NHS Board authorising an optician to be added to their performers list. The OPTIX system is configured to only accept GOS6A forms containing a valid list number that matches the pre-existing list number for the optician configured in the OPTIX database.	Enquired of management to determine whether the GOS team had received a GOS6A form from the NHS Board authorising an optician to be added to their performers list. Further enquired to determine whether the OPTIX system had been configured to only accept GOS6A forms containing a valid list number that matches the pre-existing list number for the optician configured in the OPTIX database.	**Exception noted:** We were informed that evidence was not available to demonstrate that the GOS team had received a GOS6A form from the NHS Board authorising an optician to be added to their performers list. We were informed that evidence was not available to demonstrate that the OPTIX system had been configured to only accept GOS6A forms containing a valid list number that matches the pre-existing list number for the optician configured in the OPTIX database. **Management response:** During 2019/20 all Ophthalmic claims were transferred to electronic submission and some details of the controls require to be reviewed and updated. This will be carried out by a Quality Assurance Manager by December 2020.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
4.6	Patient refunds authorisation Prior to payment, patient refunds are prepared by a Payment Officer and checked by another member of the Payment team. Following this, patient refunds are authorised by a Senior Officer, as per the List of Nominated Senior Officers held by NSS Central Finance.	For a selection of patient refunds, inspected the patient refund spreadsheets and noted that, prior to payment, patient refunds had been prepared by a Payment Officer and checked by another member of the Payment team. Further noted that, following this, patient refunds had been authorised by a Senior Officer, as per the List of Nominated Senior Officers held by NSS Central Finance.	No exceptions noted. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.*
4.7	Validity of the request for patient refunds Ophthalmic Payment team verifies that the requests for patient refunds are supported with confirmation of exemption status from department of work and pensions before the refunds are sent for payment. This is documented in refunds process.	For a selection of dental refunds, inspected the Refund to Patients documentation and noted that a member of the Ophthalmic Payment team had verified that the requests had been supported with confirmation of exemption status from department of work and pensions before the refunds were sent for payment.	No exceptions noted. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.*

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
4.8	<u>Payment adjustment, non-payment and patient detail amendment claims</u> Any adjustment/non-payment/patient detail amendment claims are returned to the contractor with a comment to explain the reason for action taken in response to the claim within 20 working days of receipt. This is logged in the adjustment/non-payment/patient detail amendment spreadsheet.	For a selection of adjustment, non-payment and patient detail amendment claims, inspected amendment spreadsheet and claim form, and noted claims had been returned to the contractor with a comment to explain the reason for the action taken in response to the claim. Further noted that the return had been completed within 20 working days of the receipt of the claim.	No exceptions noted. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.*
4.9	<u>Duplicate claim checking</u> OPTIX is configured with duplicate workflow rules to automatically check all claims relating to optometric claims treatments to verify that they are not duplicate claims by comparing for that patient acceptance/completion dates for duplicate / overlapping claims. Changes to this configuration follows the standard change management procedure. On a daily basis, the Customer Admin team review all payments identified by the system as potential duplicates. Any duplicate claims identified reviewed and found to be a valid duplicate, are returned to the contractor as unpaid by the Customer admin team. Claims which are not valid duplicates are processed for payment.	Inspected OPTIX system configurations, and noted that OPTIX had been configured with duplicate workflow rules to automatically check all claims relating to optometric claims treatments, to verify that they were not duplicate claims, by comparing for that patient acceptance/completion dates for duplicate / overlapping claims. Enquired of management to determine whether changes to this configuration had followed the standard change management procedure. For a selection of dates, inspected the workflow in OPTIX and noted that noted that a member of the Customer Admin team had reviewed payments, and any duplicate claims identified had been returned to the contractor as unpaid, and claims which were not valid duplicates had been processed for payment.	We were informed that there had been no changes to configurations within the period of review. Consequently, we were unable to test the operating effectiveness of the change management element of the control.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
4.10	Verification on the accuracy of other claims Once a month prior to the payment run, a member of the GOS team, other than the inputter verifies the accuracy of claims for all payments by comparing the entry in the OPTIX Payment System against the instruction from the NHS Board. This data is held in each Boards Payment Variation Lever Arch files. Any errors identified as a result of this verification is corrected using OPTIX.	For a selection of claims for payments, inspected the Boards Payment Variation Lever Arch files to determine whether a member of the GOS team, other than the inputter had verified the accuracy of claims for all payments by comparing the entry in the OPTIX Payment System against the instruction from the NHS Board, prior to the payment run. Enquired of management to determine whether any errors identified as a result of this verification had been corrected using OPTIX.	**Exception noted:** For one of 40 claims for payments selected, claims had not been verified by a member of the GOS team, other than the inputter. We were informed that evidence was not available to demonstrate that any errors identified as a result of the verification had been corrected using OPTIX. **Management response:** We will remind staff members of the need to follow the established procedures and evidence such check appropriately. This will be carried out by the D&O Payment Lead by September 2020.
4.11	Large or Unusual Prescribing Patterns PV is performed on a quarterly basis by GOS PV team to identify practices who exhibit prescribing/treatment patterns over the average outlier. GOS PV performs investigation of the identified practices or refer them to the Counter Fraud Services.	For a selection of quarters and boards, inspected PV reports and investigation spreadsheet, and noted that PV had been performed by a member of the GOS PV team to identify practices who exhibited prescribing/treatment patterns over the average outlier. Further, noted that the member of the GOS PV team had performed investigation of the identified practices or had referred them to the Counter Fraud Services.	No exceptions noted.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
4.12	Patient refunds review The calculation of Ophthalmic Patient Refunds is prepared ad-hoc (when there is a suitable number of claims to process). Once the calculation has been prepared by a Payment Officer, another member of the GOS team will check the calculation to verify that the correct amounts has been keyed to the payment spreadsheet from the claim prior to payment.	For a selection of weeks, inspected the calculation of Ophthalmic Patient Refunds and noted that the calculation had been prepared by a Payment Officer and that another member of the GOS team had checked the calculation to verify that the correct amounts had been keyed to the payment spreadsheet from the claim prior to payment.	No exceptions noted.
4.13	Monthly BACS payments review Once a month, a member of the GOS team will verify that all NHS Board reports balance prior to transmission to the NSS Finance Department to confirm completeness and accuracy of the amounts. If any of the reports do not balance, the Test and Support team will investigate the reason advising the GOS team of a solution and the GOS team will rectify the issue before finalising the payment.	*Verification that NHS Board reports balance prior to transmission* For a selection of months, inspected the authorisation sheets and noted that a member of the GOS team had verified that all NHS Board reports balanced prior to transmission to the NSS Finance Department, to confirm completeness and accuracy of the amounts. *Investigation of unbalanced reports* Enquired of management to determine whether the Test and Support team had investigated reports that did not balance, advised the GOS team of a solution, and they rectified the issue before finalising the payment.	*Verification that NHS Board reports balance prior to transmission* No exceptions noted. *Investigation of unbalanced reports* **Exception noted:** We were informed that evidence was not available to demonstrate that the Test and Support team had investigated reports that did not balance. **Management response:** We will remind staff members of the need to follow the established procedures and evidence such check appropriately. This will be carried out by the D&O Payment Lead by September 2020.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
4.14	<u>CHAPS payment authorisation</u> A member of PS Finance Management team authorise payments made by CHAPS or bank transfer before the payment is made by NSS Central Finance.	Enquired of Management to determine whether a member of PS Finance Management team authorise payments made by CHAPS or bank transfer before the payment is made by NSS Central Finance.	We were informed that there had been no CHAPS payments within the period of review. Consequently, we were unable to test the implementation and operating effectiveness of this control.
4.15	<u>Post-payments reconciliation</u> *Reconciliation of BACS and CHAPS payments* Following completion of BACS and CHAPS processing, GOS PS team reconcile the total amount of BACS and CHAPS payments against the supporting calculation from OPTIX to verify that all payments had been processed. *Investigation of reconciling differences* Differences are investigated and resolved to completion.	*Reconciliation of BACS payments* For a selection of months, inspected the cover sheets and noted that GOS PS team had reconciled the total amount of BACS payments against the supporting calculation from OPTIX, to verify that all payments had been processed. *Reconciliation of CHAPS payments* Enquired of Management to determine whether a member of GOS PS team had reconciled the total amount of BACS payments against the supporting calculation from OPTIX, to verify that all payments had been processed. *Investigation of reconciling differences* Enquired of management to determine whether differences had been investigated and resolved to completion.	*Reconciliation of BACS payments* No exceptions noted. *Reconciliation of CHAPS payments* We were informed that there had been no CHAPS payments within the period of review. Consequently, we were unable to test the implementation and operating effectiveness of this control. *Investigation of reconciling differences* **Exception noted:** We were informed that evidence was not available to demonstrate that differences had been investigated and resolved to completion. **Management response:** We will remind staff members of the need to follow the established procedures and evidence such check appropriately. This will be carried out by the D&O Payment Lead by September 2020.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
4.16	Approval for patient refunds Prior to raising cheques for patient refunds, NSS Central Finance Department verifies that an approval from an authorised person in the Ophthalmic Payments team is in place along with the electronic listing of all refund amounts.	Enquired to management to determine whether the NSS Central Finance Department had verified that an approval from an authorised person in the Ophthalmic Payments team was in place, along with the electronic listing of all refund amounts.	**Exception noted:** We were informed that evidence was not available to demonstrate that the NSS Central Finance Department had verified that an approval from an authorised person in the Ophthalmic Payments team was in place. **Management response:** We will remind staff members of the need to follow the established procedures and evidence such check appropriately. This will be carried out by the D&O Payment Lead by September 2020.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
4.17	Validity checking of the request to add/remove contractors A member of the Customer Administration team verifies that the following requests are supported with approval from an authorised person from the NHS Board before they are entered onto the OPTIX system: — new Ophthalmic Contractors; and — cessation/ removal of Ophthalmic Contractors. The NHS Board Delegate Matrix is used in performing the verification.	*1 April 2019 – 31 December 2019* Enquired of management to determine whether a member of the Customer Administration team had verified that the requests for new Dental Contractors and removal of Dental Contractors, had been supported with approval from an authorised person from the NHS Board before they were entered onto the OPTIX system. Further enquired to determine whether the NHS Board Delegate Matrix had been used in performing the verification. *1 January 2020 – 31 March 2020* For a selection of new Dental Contractors and removal of Dental Contractors, inspected the sign off spreadsheet to and noted that a member of the Customer Administration team had verified that the requests for new Dental Contractors and removal of Dental Contractors, had been supported with approval from an authorised person from the NHS Board before they were entered onto the OPTIX system. Further noted that the NHS Board Delegate Matrix had been used in performing the verification.	*1 April 2019 – 31 December 2019* **Exception noted:** We were informed that evidence was not available to demonstrate that the Customer Administration team had verified that the requests for new Dental Contractors and removal of Dental Contractors, had been supported with approval from an authorised person from the NHS Board. *1 January 2020 – 31 March 2020* No exception noted. **Management response:** The procedures require staff members to confirm that the request is appropriately authorised before the item is passed to the next step. The procedure was an 'on screen' check and verification and the requirement for signed paperwork evidence was removed some years ago as we moved to digital processes. The evidence of the operation of the control is that the item is passed to the next step. However, from 2020 recording of this check was captured in the spreadsheet control list of changes.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
4.18	Verification of new contractors and cessation of practice/contractors On a schedule basis for a selection of new contractors / ceased practices, a member of Customer Admin team who is different from the processor/inputter verifies the accuracy of the following actions made in OPTIX against the details supplied by the NHS Board: — new Ophthalmic Contractors; and — cessation/ removal of Ophthalmic Contractors. The size of the selection is determined by sample guide.	*1 April 2019 – 31 December 2019* Enquired of management to determine whether a member of the Customer Admin team who is different from the processer/inputter had verified the accuracy of the actions made in OPTIX against the details supplied by the NHS Board. Further enquired to determine whether the size of the selection had been determined by the sample guide. *1 January 2020 – 31 March 2020* For a selection of new contractors and ceased contractors, inspected request form and noted that a member of the Customer Admin team who is different from the processer/inputter had verified the accuracy of the actions made in OPTIX against the details supplied by the NHS Board. For a selection of months, inspected verification spreadsheet and sample guide, and noted that the size of the selection had been determined by the sample guide.	*1 April 2019 – 31 December 2019* **Exception noted:** We were informed that evidence was not available to demonstrate that a member of Customer Admin team who is different from the processor/inputter had verified the accuracy of actions made in OPTIX. *1 January 2020 – 31 March 2020* No exception noted. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.* **Management response:** The procedures require staff members to confirm that the request is appropriately authorised before the item is passed to the next step. The procedure was an 'on screen' check and verification and the requirement for signed paperwork evidence was removed some years ago as we moved to digital processes. The evidence of the operation of the control is that the item is passed to the next step. However, from 2020 recording of this check was captured in the spreadsheet control list of changes.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
4.19	Validity of bank detail and standing data amendments NSS Central Finance team and the PS Finance Department verifies that an approval from an authorised person from member of PS team is in place before making an amendment/update to the contractor's bank details and other standing data in OPTIX and on the general ledger.	Enquired of management to determine whether NSS Central Finance team and the PS Finance Department had verified that an approval from an authorised person from member of PS team had been in place before making an amendment/update to the contractor's bank details and other standing data in OPTIX and on the general ledger.	**Exception noted:** We were informed that evidence was not available to demonstrate that the NSS Central Finance team and the PS Finance Department had verified that an approval from an authorised person from member of PS team had been in place before making an amendment/update to the contractor's bank details and other standing data in OPTIX and on the general ledger. **Management response:** We will remind staff members of the need to follow the established procedures and evidence such check appropriately. This will be carried out by the D&O Payment Lead by September 2020.
4.20	Verification of the accuracy of amendments A member of PS team, who is different from the inputter, verifies the accuracy of the amendment/update to the ophthalmic contractor's bank details and other standing data made in OPTIX against the details supplied by the Contractor prior to the next payment run.	For a selection of amendments to bank details and other standing data, inspected amendment/update form and bank mandate checklist, and noted that that a member of the PS team, who is different than the inputter, had verified the accuracy of the amendment/update to the ophthalmic contractor's bank details and other standing data made in OPTIX against the details supplied by the Contractor, prior to the next payment run.	No exceptions noted. *Please refer to section 2.8 of this report for information on manually maintained populations relied on for the testing of this control.*

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
4.21	Scottish Government guidance verification policy/procedure On an annual basis, Payment Verification Manager reviews the Scottish Government guidance verification requirements as published in relevant circular and document these requirements in team policy/procedure. The policy/procedure is communicated to internal NSS staff through meetings.	Enquired of management to determine whether, on an annual basis, the Payment Verification Manager reviewed the Scottish Government Guidance verification requirements as published in relevant circular and documented these requirements in a team policy/procedure. Further enquired to determine whether the policy/procedure had been communicated to internal NSS staff through meetings.	**Exception noted:** We were informed that evidence was not available to demonstrate that the Payment Verification Manager reviewed the Scottish Government Guidance verification requirements as published in relevant circular and documented these requirements in a team policy/procedure. **Management response:** The Ophthalmic PV manager did not document staff meetings. However, following the Contractor Finance Organisational Change programme which was implemented in January 2020, responsibility for Payment Verification now rests with the National Finance Managers, so procedures around this will be being revised. This will be carried out by the National Finance Manager – D&O by September 2020.
4.22	Secondary review of the validity and accuracy of ophthalmic claims Ophthalmic PV team performs further verification of all claims relating to sight tests, spectacles, repairs and hospital eye services that have been uploaded to the OPTIX system by comparing against approved history of claims and payments to identify and outliers requiring further investigation. These reviews are performed after the claims are processed for payments. The result of the verification is documented in the GOS PV records. Any invalid/inaccurate claims identified as a result of the review is investigated, resolved to completion and tracked using the GOS PV records.	For a selection of NHS Boards, inspected the PV toolkit and noted the following: — a member of the Ophthalmic PV team had performed verification of claims relating to sight tests, spectacles, repairs and hospital eye services that had been uploaded to the OPTIX system, by comparing against approved history of claims and payments to identify and outliers requiring further investigation; — these reviews had been performed after the claims were processed for payments; and, — any invalid/inaccurate claims identified, as a result of the review, had been investigated, resolved to completion and tracked using the GOS PV records.	No exceptions noted.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
4.23	Monthly payment samples Before each monthly payment is made, the amounts to be paid in OPTIX for a sample of three contractors are checked by the Customer Admin Team. Any issues noted to Test and Support team, are followed up and resolved prior to payment.	For a selection of months, inspected the monthly payment schedule and noted that, before each monthly payment was made, the amounts to be paid in OPTIX for a sample of three contractors had been checked by the Customer Admin Team. For a selection of months, inspected the monthly payment schedule to determine whether any issues noted to Test and Support team, are followed up and resolved prior to payment.	There had been no issues noted during the period of review. Consequently, we were unable to test the operating effectiveness of the corrective element of the control.
4.24	Patient record random sampling As per the Scottish Government guidance, on an annual basis, a random selection of patient records are inspected by performing annual check over a minimum of 1% of contractors for the following: - Items of service; - Level of earnings; and - Cost per claims and throughput. The check is performed by comparing the above against historical and national averages. Any discrepancies or issues identified are investigated, followed up and tracked.	For a selection of boards, inspected PV report determine whether: — as per the Scottish Government guidance, a random selection of patient records had been inspected by performing checks over a minimum of 1% of contractors, within the last 12 months; — the check had been performed by comparing against historical and national averages; and — any discrepancies or issues identified had been investigated, followed up and tracked.	**Exception noted:** We were informed that evidence was not available to demonstrate that a random selection of patient records had been inspected by performing checks over a minimum of 1% of contractors. **Management response:** Significant absence in the Ophthalmic PV team meant this work fell behind target. However, following the Contractor Finance Organisational Change programme which was implemented in January 2020, responsibility for Payment Verification now rests with the National Finance Managers, so procedures around this will be being reviewed and record sampled once practices re-open following COVID-19. This will be carried out by the National Finance Manager – D&O by March 2021.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
4.25	PV referral to Counter Fraud Services. Where unusual prescribing or treatment patterns, are identified through PV analysis, this is referred to the NHS Board and Counter Fraud Services. The referral and the investigation is tracked to completion in GOS PV and CFS records.	For a selection of quarters, inspected the KPI reports and noted that there were no unusual prescribing or treatment patterns identified through PV analysis for referral to the NHS Board and Counter Fraud Services.	We noted that there were no unusual prescribing or treatment patterns identified through PV analysis that had been referred to the NHS Board and Counter Fraud Services. Consequently, we were unable to test the implementation and operating effectiveness of this control.

3.5 REPORTS TO NHS BOARDS AND SCOTTISH GOVERNMENT FOR ALL PAYMENT STREAMS

REPORTS TO NHS BOARDS AND SCOTTISH GOVERNMENT FOR ALL PAYMENT STREAMS

Controls provide reasonable assurance that reports to NHS Boards and Scottish Government outlining all GMS Payment streams are complete and accurate.

Control Ref.	Control Descriptions Specified by NHS NSS	Tests Performed by KPMG LLP	Results of Testing
5.1	Monthly NHS Board reports (the "appendices") The monthly NHS board report (the "appendices") covering all four payment streams are reviewed for completeness and accurate by a member of PS team, independent from the preparer of the report, by comparing it against the source documentation compiled by the preparer from PS team. This review is performed before the report is submitted. Completion of this review is documented as a sign off on the report.	For a selection of months and boards, inspected NHS Board report appendices to determine whether the appendices had been reviewed for completeness and accuracy by a member of the PS team, independent from the preparer of the report, by comparing it against the source documentation. Further enquired to determine whether that this review had been performed before the report was submitted.	**Exception noted:** For seven of 32 quarters and boards selected, it was noted that the appendices had not been reviewed for completeness and accuracy by a member of PS team. **Management response:** We will remind staff members of the need to follow the established procedures and evidence such check appropriately. This will be carried out by the Senior Finance Analyst by September 2020.
5.2	Reconciliation against eFinancials PS team performs reconciliation of the total amount from each monthly NHS Board report against the total amount recorded in eFinancials before the report is submitted. Reconciling items are investigated and resolved through to completion.	For a selection of months and boards, inspected eFinancials reconciliation spreadsheet and noted that the PS team had performed a reconciliation of the total amount from each NHS Board report against the total amount recorded in eFinancials, before the report was submitted. Enquired of management to determine whether reconciling items had been investigated and resolved through to completion.	**Exception noted:** We were informed that evidence was not available to demonstrate that reconciling items had been investigated and resolved through to completion. **Management response:** The overall reconciliation differences for all contractor streams were £33,638 against expenditure of £2,662 million. Most of this relates to reconciling items from the previous or following year, but we will remind staff members of the need to include details of all such reconciling items in future. This will be carried out by the Senior Finance Analyst by September 2020.

Control Ref.	Control Descriptions Specified by NHS NSS	Tests Performed by KPMG LLP	Results of Testing
5.3	Form 12 report On a quarterly basis, a member of the PS Finance department, other than the inputter, reviews the completeness and accuracy of the Form 12 report summarising the financial information across all four payment streams by comparing it against four streams spreadsheets before the report is submitted to each NHS Board and SGHSCD.	For a selection of quarters and boards, inspected Form 12 report and noted that a member of the PS Finance department, other than the inputter, had reviewed the completeness and accuracy of the Form 12 report summarising the financial information across all four payment streams, by comparing it against four streams spreadsheets, before the report had been submitted to each NHS Board and SGHSCD.	No exceptions noted.
5.4	Reconciliation of Form 12 report and the appendices A member of the PS team performs a reconciliation between the information on the quarterly board reports (the "appendices") and the Form 12 report to verify their completeness and accuracy before the reports are submitted. Reconciling items are investigated and resolved through to completion.	For a selection of quarters and boards, inspected the appendices and Form 12 reconciliation sign-off sheet and noted that a member of the PS team had performed a reconciliation between the information on the quarterly board report appendices and the Form 12 report, to verify their completeness and accuracy, before the reports were submitted. For a selection of boards, inspected the appendices and Form 12 reconciliation sign-off sheet, to determine whether reconciling items had been investigated and resolved through to completion.	We noted that there had been no reconciling items during the period of review. Consequently, we were unable to test the operating effectiveness of the corrective element of the control.

SECTION 4 - ADDITIONAL INFORMATION PROVIDED BY NHS NSS (NOT COVERED AS PART OF THE OPINION PROVIDED BY KPMG)

4.1 PLANNED FUTURE DEVELOPMENTS

P&CFS plans a number of changes to the systems supporting the current payment processes, some of which have been progressed during 2019/20 and some of which are planned for 2020/21. Details of some of the key changes are set out below, although some of these may be affected by COVID 19:

Dental

- eOrtho will be fully delivered. 100% of orthodontic prior approval requests and payment claims electronic by January 2020.
- Oral Health action plan and other items emerging from SG dental consultation.
- SDRS changes to accommodate eDental & potential addition of appointments system.

Medical

- Review what changes may be required to systems and to PMSPS to support the new 2018 GP contract and developments.

Ophthalmic

- Ophthalmic eClaim level at 100% by March 2019.

Pharmacy

- Development of replacement for DCVP continue towards testing in 2020/21.
- eClaim Automation level raised from 90% to 92% by March 2020.

We will consult with the Service Auditor to consider the impact these developments may have on the design and description of the controls set out in Section 3 during the planning of the 2020/21 service audit.

4.2 COVID-19 UPDATES

P&CFS will implement changes to contractor payments in accordance with Scottish Government direction or by instruction from NHS Boards. Due to the quick change to the services provided, including the reduction or cessation of some services there may be no or limited activity data to make items of service payments and therefore some payments are made to support contractors and the continuation of services after COVID-19.

- **Dental** Scottish Government circulars have been implemented to help ensure Dental contractors maintain a level of income related to their historical NHS earnings. Any further changes to ensure the continuation of General Dental Services post-COVID-19 will be implemented as need be.
- **Medical** Calculation of the Scottish Workload Formula for 2020/21 has been implemented and agreement on an NHS Board-by-Board basis has been reached to make payments to cover Enhanced Services and Local Board payments during COVID-19. These payments are based on either historical or live data depending on what is authorised by the NHS Board. Scottish Government circulars on increased funding to cover COVID costs, including Bank Holiday opening have been implemented by making additional payments to contractors.
- **Ophthalmic** Scottish Government circulars have been implemented to ensure NHS Ophthalmic contractors are provided to reimburse for the limited emergency services and also to help ensure payment is representative of their NHS earnings.
- **Pharmacy** Scottish Government circulars have been implemented, including an enhanced payment to help ensure Pharmaceutical contractors have sufficient advance funding to cover any increase in dispensing costs due to increased prescribing during COVID-19. This advance will be reconciled and recovered during 2020-21 and the early part of 2021-22. Additional payments have been made to pharmaceutical contractors to provide funding to cover COVID-19 costs and for Bank Holiday opening.

P&CFS have also had to alter its service delivery in order to concentrate on the priorities of continuing to operate safely for our staff and to deliver the priority services which are contractor payments and GP practice registration. As a result of this, significantly more staff are working from home and pharmacy keying is now also able to be carried out from home. As a result, some of the controls may be operated virtually rather than by physical signature. It should be noted also that NSS Central Finance staff are also operating from home utilising electronic connections to ledgers and banking services for making payments.

NHS National Services Scotland

IT Services

ISAE 3402
Type II Report

1 April 2019 to 31 March 2020

Contents

FOREWORD

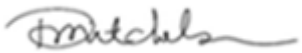
I present the ISAE 3402 Type II 19/20 Report for NSS which outlines the state of our control environment for the period 19/20.

NSS Digital and Security has continued to develop and enhance services and has continued to develop a structure and operating model which will result in a more efficient, cost effective service to meet the needs of our clients and their stakeholders.

As the requirement for Corporate Governance continues, NSS Digital and Security has used the globally recognised standard for Service Auditor`s reports - International Auditing and Assurance Standards Board (IAASB) International Standard on Assurance (ISAE 3402) “Assurance Reports on Controls at a Service Organisation.” The opinion section and the test results of the controls that are presented in this report have been produced by an independent body (KPMG) for NSS and its clients within the scope of the audit.

I am grateful for the support of all involved in the production of this year`s ISAE 3402 interim report, including all NSS staff and KPMG.

NSS Digital and Security provides a range of services and remains committed to addressing the issues listed in this report and have already made further changes to our approach, specifically around the documentation of checks when completed and the system access control framework. The governance surrounding our control framework continues to get significant focus from NSS senior management and the entire NSS team, ensuring that we continue to evolve the framework and ensure greater compliance as we move to our improved transformed solutions.



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SECTION 1 – INDEPENDENT SERVICE AUDITOR'S ASSURANCE REPORT

Private & confidential
The Directors
NHS National Services Scotland
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

20 May 2020

Dear Directors

ISAE 3402 Type II Independent Service Auditor's Assurance Report

In accordance with our Call Off Contract dated 11 April 2019 (our "Contract"), we have examined the accompanying description on pages 11 – 41 of the controls in place at the service organisation called NHS National Services Scotland ("NSS") and carried out procedures to enable us to form an independent opinion on whether NSS's management has fairly described its controls system applicable to certain aspects of the IT services for Payroll and Practitioner and Counter Fraud Services ("P&CFS") activities from offices at Edinburgh, Glasgow and Aberdeen throughout the specified period 1 April 2019 to 31 March 2020 (the "Description") and on the design and operation of controls related to the control objectives stated in the Description. Our opinion is set out below and should be read and considered in conjunction with this report in full.

NSS have outsourced some of the provision of the IT services to Atos. NSS's management Description includes the relevant Atos controls and the aspects of the controls that may be relevant to a user organisation's internal control, as it relates to an audit of financial statements. The control objectives were specified by the management of NSS.

NSS and Atos Managements' Responsibilities

In this report, references to NSS's "management" means the directors of NSS and those employees to whom the directors of NSS have properly delegated day-to-day conduct over matters for which the directors of NSS retain ultimate responsibility. References to Atos's "management" means the directors of Atos and those employees to whom the directors of Atos have properly delegated day-to-day conduct over matters for which the directors of Atos retain ultimate responsibility.

Management of NSS is responsible for (1) preparing its statement on pages 7 – 8 and describing in the Description within the statement its controls system for processing customers' transactions, including the completeness, accuracy and method of presentation of the same, (2) having a reasonable basis for its statement, (3) selecting the criteria to be used and stating them in the statement, (4) specifying the control objectives and stating them in the Description, and (5) identifying the risks that threaten the achievement of the control objectives and designing, implementing, and documenting controls that are suitably designed and implemented to provide reasonable assurance that the control objectives stated in the Description will be achieved.

Management of Atos is responsible for (1) preparing its statement on pages 9 – 10 and describing in the Description within the statement its controls system for processing customers' transactions, including the completeness, accuracy and method of presentation of the same, (2) having a reasonable basis for its statement, (3) selecting the criteria to be used and stating them in the statement and (4) identifying the risks that threaten the achievement of the control objectives and designing, implementing, and documenting controls that are suitably designed and implemented to provide reasonable assurance that the control objectives stated in the Description will be achieved.

Service Auditor's Responsibilities

Our responsibility is to express an independent opinion to NSS based on the procedures performed and evidence obtained, as to whether (1) NSS's management Description fairly presents the controls system that was designed and implemented throughout the specified period and the aspects of the controls that may be relevant to a user organisation's internal control, as it relates to an audit of financial statements; (2) the controls included in the Description were suitably designed throughout the specified period to provide reasonable assurance that the control objectives specified would be achieved if the described controls were complied with satisfactorily, and (3) such controls were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the specified period. The criteria we used to form our judgements are the criteria used by management in making the Description, and are set out on pages 7 – 10. .

Framework applied

Our work was performed having regard to the framework set out by the International Auditing and Assurance Standards Board (IAASB) International Standard on Assurance Engagements 3402 (ISAE 3402) "*Assurance Reports on Controls at a Service Organisation.*" That standard requires that we obtain sufficient, appropriate evidence on which to base our conclusion.

Our Independence and Quality Control

We comply with the Code of Ethics for Professional Accountants issued by the International Ethics Standards Board for Accountants and we apply the International Standard on Quality Control (UK and Ireland) *Quality Control for Firms that Perform Audits and Reviews of Historical Financial Information, and Other Assurance and Related Services Engagements*. Accordingly, we maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements and professional standards (including independence, and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour) as well as applicable legal and regulatory requirements.

Scope of work

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

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

Limitations of Controls at a Service Organisation

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

The relative effectiveness and significance of specific controls at NSS, and their effect on assessments of control risk at user organisations, are dependent on their interaction with the controls and other factors present at individual user organisations. We have performed no procedures to evaluate the effectiveness of controls at individual user organisations.

Opinion

Basis for Qualified Opinion

NSS provide a range of IT services under the NHS Scotland National IT Services Contract. Within the scope of our work, we have identified qualifications relating to three out of six control objectives during the period, as summarised below.

With regard to control objective 1, NSS and Atos state in their Description that they have controls in place over access by staff to the systems in-scope for audit through password control, quarterly review of access to verify the

appropriateness of the existing system accounts, authorisation of new accounts, revocation of leavers' accounts in a timely manner and restriction of privileged access to authorised personnel. However, during the period 1 April 2019 to 31 March 2020, as noted on pages 20 – 27 of the results of testing, numerous exceptions were identified across six out of seven controls relating to the technology components of the databases, operating systems and the applications for the systems in scope for audit. These issues have resulted in the non-achievement of the control objective *'Controls provide reasonable assurance that logical access to applications, operating systems and databases is restricted to authorised individuals.'*

With regard to control objective 3, NSS and Atos state in their Description that they have controls in place in respect of change management through the evaluation, testing and approval of changes made to the systems in-scope for audit. However, during the period 1 April 2019 to 31 March 2020, as noted on pages 29 – 33 of the results of testing, it was not possible to obtain sufficient evidence to perform testing over change management controls for DCVP and to obtain sufficient evidence in respect of the completeness and accuracy of the list of changes to the systems in scope for audit as the list was manually maintained. This issue has resulted in the non-achievement of the control objective *'Controls provide reasonable assurance that changes to the infrastructure, data, software, and procedures managed by Atos for NSS are: evaluated to understand their impact to NSS' processing environment and its security; tested and approved prior to their implementation to the live environment.'*

With regard to control objective 4, NSS and Atos state in their Description that they have controls in place over automated interface and job processing and monitoring in respect of failures of interfaces and jobs. However, as noted on pages 34 – 35 of the results of testing, as it was not possible to obtain evidence to verify that the job processing was performed completely as per the defined schedules and that failures had been identified and remediated. These issues have resulted in the non-achievement of the control objective '*Controls provide reasonable assurance that automated interfacing and job processing are performed completely as per the defined schedules, and that failures are identified and remediated.'*

Qualified Opinion

Our opinion has been formed on the basis of the matters outlined in this report. In our opinion, in all material respects, except for the matters described in the Basis for Qualified Opinion paragraphs:

1) The Description fairly presents the controls system as designed and implemented throughout the period from 1 April 2019 to 31 March 2020;

2) The controls related to the control objectives stated in the Description were suitably designed throughout the period from 1 April 2019 to 31 March 2020; and

3) The controls tested, which were those necessary to provide reasonable assurance that the control objectives stated in the Description were achieved, operated effectively throughout the period from 1 April 2019 to 31 March 2020.

Emphasis of Matter

We draw attention to the controls around completeness and accuracy of the population list, as outlined in control objective 1 and control objective 3. With regard to control objective 1, it was noted that the user access review had relied on a user listing which was manually maintained instead of system generated listings from the systems in-scope for audit, hence we were not able to determine the completeness and accuracy of the user lists provided for the systems in-scope for audit. With regard to control objective 3, it was noted that the list of changes was maintained separately in the Service Now ticket system in Atos which is independent of the systems in-scope for audit, hence we were not able to determine the completeness and accuracy of the change list provided for the systems in-scope for audit. Hence, these matters warrant specific emphasis for the users of this report.

Description of test of controls

The specific controls tested and the nature, timing and results of those tests are listed on pages 19 – 41.

Additional Information

The information provided on page 42 of this report is presented by NSS to provide additional information and is not a part of NSS management's Description of its controls system. This information has not been subjected to the same procedures applied in the examination of the Description of controls applicable to the processing of transactions for users, and accordingly, we express no opinion on it.

About this report including disclosure

This report is made to and has been prepared solely for the management of NSS, as a body, on the terms agreed and recorded in our Contract. In this report, by "management" we mean the directors of NSS and those employees to whom the directors of NSS have properly delegated day-to-day conduct over matters for which the directors of NSS retain ultimate responsibility.

This report was designed to meet the agreed requirements of NSS and particular features of our engagement determined by NSS's needs at the time.

This report is confidential and is released on the basis that it shall not be copied, referred to or disclosed, in whole or in part, save as permitted by our Contract, without our prior written consent. We have consented to its disclosure to "User Entities", being NSS's customers, the independent auditors of NSS's customers, and the prospective customers of NSS. Our consent has been given without in any way or on any basis affecting our responsibility or giving rise to any duty or liability being accepted or assumed by or imposed on us to any party except NSS and its management. We have consented to enable NSS and its management to demonstrate, and such User Entities to verify, that an independent service auditor's assurance report has been commissioned by the management of NSS and issued in connection with the controls of NSS.

Intended Users and Purpose

This report and Description of tests of controls and results on pages 19 – 41 are only to be disclosed to User Entities who have a sufficient understanding to enable them to consider the matters stated including the basis of our consent to disclosure and their ability to rely on this report, along with other information including information about controls implemented by customers themselves, when assessing the risks of material misstatements of User Entities' financial statements. This report is not to be used by anyone other than these specified parties.

This report does not restrict use by User Entities on the basis that those User Entities remain responsible for their own work and consideration of this report and for evaluating the evidence presented by our report and for determining its effect on the assessment of control risk at the User Entities.

Any party other than NSS or its management, as a body, who obtains access to this report or a copy and chooses to use and rely on this report (or any part of it) will therefore do so at its own risk. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than NSS and its management, as a body, for our work, for this report, or for the opinions we have formed.

Yours faithfully

KPMG LLP

KPMG LLP

SECTION 2 – MANAGEMENT'S SYSTEM DESCRIPTION

2.1 MANAGEMENT STATEMENT LETTERS

2.1.1 NSS

The accompanying description has been prepared for customers who have used NHS National Services Scotland ("NSS") control system and their auditors who have a sufficient understanding to consider the description, along with other information including information about controls operated by subservice organisations and by customers themselves, when assessing the risks of material misstatements of customers' financial statements.

NSS confirms that, except for the items described in Section 1 of this report:

(a) The accompanying description at pages 11 – 18 fairly presents NSS control system for processing customers' transactions throughout the period 1 April 2019 to 31 March 2020.

The criteria used in making this statement were that the accompanying description:

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

- The types of services provided, including, as appropriate, classes of transactions processed.
- The procedures, within both information technology and manual systems, by which those transactions were initiated, recorded, processed, corrected as necessary, and transferred to the reports prepared for customers.
- The related accounting records, supporting information and specific accounts that were used to initiate, record, process and report transactions; this includes the correction of incorrect information and how information was transferred to the reports prepared for customers.
- How the system dealt with significant events and conditions, other than transactions.
- The process used to prepare reports for customers.
- Relevant control objectives and controls designed to achieve those objectives.
- Controls that we assumed, in the design of the system, would be implemented by user entities, and which, if necessary to achieve control objectives stated in the accompanying description, are identified in the description along with the specific control objectives that cannot be achieved by ourselves alone.
- Other aspects of our control environment, risk assessment process, information system (including the related business processes) and communication, control activities and monitoring controls that were relevant to processing and reporting customers' transactions.

(i) Includes relevant details of changes to the service organization's system during the period 1 April 2019 to 31 March 2020.

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

(b) The controls related to the control objectives stated in the accompanying description were suitably designed and operated effectively throughout the period 1 April 2019 to 31 March 2020 to achieve those control objectives if subservice organisations and user entities applied the complementary controls assumed in the design of NSS's controls and operated effectively throughout the period 1 April 2019 to 31 March 2020. The criteria used in making this statement were that:

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

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

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

Deryck Mitchelson
Director, Digital and Security
20 May 2020
Signed on behalf of the Board of Directors / Senior Management
National Services Scotland

2.1.2 ATOS

The accompanying description has been prepared for customers who have used Atos ("Atos") control system applicable to service provided by NSS and their auditors who have a sufficient understanding to consider the description, along with other information including information about controls operated by subservice organisations and by customers themselves, when assessing the risks of material misstatements of customers' financial statements.

Atos confirms that, except for the items described in Section 1 of this report:

(a) The accompanying description at pages 14 – 16 fairly presents Atos control system applicable to service provided by NSS for processing customers' transactions throughout the period 1 April 2019 to 31 March 2020.

The criteria used in making this statement were that the accompanying description:

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

- The types of services provided, including, as appropriate, classes of transactions processed.
- The procedures, within both information technology and manual systems, by which those transactions were initiated, recorded, processed, corrected as necessary, and transferred to the reports prepared for customers.
- The related accounting records, supporting information and specific accounts that were used to initiate, record, process and report transactions; this includes the correction of incorrect information and how information was transferred to the reports prepared for customers.
- How the system dealt with significant events and conditions, other than transactions.
- The process used to prepare reports for customers.
- Relevant control objectives and controls designed to achieve those objectives.
- Controls that we assumed, in the design of the system, would be implemented by user entities, and which, if necessary to achieve control objectives stated in the accompanying description, are identified in the description along with the specific control objectives that cannot be achieved by ourselves alone.
- Other aspects of our control environment, risk assessment process, information system (including the related business processes) and communication, control activities and monitoring controls that were relevant to processing and reporting customers' transactions.

(ii) Includes relevant details of changes to the service organization's system during the period 1 April 2019 to 31 March 2020.

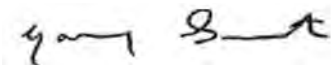
(iii) Does not omit or distort information relevant to the scope of the system being described, while acknowledging that the description is prepared to meet the common needs of a broad range of customers and their auditors and may not, therefore, include every aspect of the system that each individual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

(b) The controls related to the control objectives stated in the accompanying description were suitably designed and operated effectively throughout the period 1 April 2019 to 31 March 2020 to achieve those control objectives if subservice organisations and user entities applied the complementary controls assumed in the design of Atos's controls system applicable to service provided by NSS and operated effectively throughout the period 1 April 2019 to 31 March 2020. The criteria used in making this statement were that:

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

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

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



Gary Smith
Client Executive Partner, NHS Scotland Account (Atos)
20 May 2020
Signed on behalf of the Board of Directors / Senior Management of Atos

2.2 NHS NATIONAL SERVICES SCOTLAND

2.2.1 Introduction

NHS National Services Scotland (NSS) provides national support services and advice to NHS Scotland. NSS also plays a role in the delivery of healthcare to patients and the public. NSS' support role to NHS Scotland means that it works with partner organisations, especially NHS boards, in the delivery of its services. Made up of a number of Strategic Business Units and Corporate Support services, it employs around 3,400 staff.

NHS National Services Scotland (NSS) provides national infrastructure services and solutions which are integral to the delivery of health and care services – locally, regionally and nationally.

NSS are working across health and care, aiming to ensure that the benefits and value we achieve through our national infrastructure can assist many different areas of local front-line services to help improve outcomes for the people of Scotland.

Our national infrastructure covers clinical areas, such as the safe supply of blood, tissues and cells, through to non-clinical areas, such as providing digital platforms and cyber security for health and care.

2.2.2 Services Provided

NSS Digital and Security (DaS) provide IT services in support of the services provided by Practitioner and Counter Fraud Services (P&CFS) which reimburse the various primary care practitioners/contractors for the services that they provide and in accordance with the appropriate legislation governing those payments. These payments include those made to General Practitioners, Dentists, Orthodontists, Ophthalmologists and Community Pharmacy supporting NHS Scotland.

NSS DaS also provide IT services in support of the delivery of a 'packaged' Payroll Service by the NSS Payroll Department to a number of NHS Scotland Boards in accordance with the Service Level Agreement in place between the NSS Payroll Department and those Boards.

This report covers the IT services underpinning the P&CFS and Payroll services provided by NSS.

In providing these services, NSS DaS utilises a combination of its own resources and a number of third party service providers including its principal IT delivery partner, Atos. On a day-to-day basis, the contract is managed by the NSS Contract, Vendor and Service Management Team (CVSMT) who are responsible for liaising between the NHS Boards and Atos.

2.2.3 NSS Digital and Security (DaS)

NSS Digital and Security (DaS) aims to work collaboratively with our public sector partners to identify and deliver trusted and secure digital solutions to help achieve the ambitions for health and social care in Scotland. NSS DaS was formerly the NSS Information Technology Strategic Business Unit. Services provided by DaS are the following:

- Cyber Security and Compliance – Helping secure Scotland's health and care information.
- Innovation Enablement - Accelerating ideas from concept to solutions.
- Professional Digital Services - A partner, supporting the delivery journey by providing architecture, governance and delivery activities to help reduce risk and effort.
- Enterprise Digital Solutions - Providing tailored technology and advice to automate services, to help increase productivity and save time.
- Digital Infrastructure - Cloud services and network solutions to deliver Scotland's health and care.
- Business Insight and Intelligence - Delivering intelligent data which help organisations to make business decisions.
- Clinical Informatics - A clinical advisory service, aiming to enhance individual, population and health outcomes by analysing, designing, implementing, reviewing and evaluating clinical systems.

NSS DaS is organised into a number of service delivery towers represented in the following table:

Digital & Security provided by NSS					
Clinical Informatics	**Cyber Security & information Governance**	**Cloud Engineering & Operations**	**Portfolio Services**	**Innovation & Transformation**	**Office of the Chief Digital Officer**
Help ensure clinical outcomes for IT delivered services from Digital and Security are assured and improved through subject matter consideration at the outset of new capabilities and throughout the lifecycle and delivery of IT services.	Help ensure the integrity of the IT estate and that the quality and security of service across our critical business systems remain without breach and that our processes advance to stay ahead of external and internal threats. Information governance processes and repositories are managed and maintained.	Aim to maintain and improve the Digital and Security suite of scalable production services, infrastructure and telecoms across the entire customer and user based focusing on quality of service and asset management. Support NHS Scotland in its transition from data centre to Cloud.	Portfolio Services help deliver scaled National programmes across NHS Scotland in a consistent approach. Relationship management of our customer pipeline opportunities supported by contract and vendor management services and support.	Digital Innovation and Transformation are driving a roadmap of technology solutions to replace legacy and provision national digital capabilities across channels, integration and data, and platforms. Through solution design, DevOps and Agile methods, efficiencies of scale and rapid delivery of value is aimed to achieve.	Connect strategy to delivery through portfolio and workforce planning, intake governance and alignment to enterprise objectives, operational controls, reporting, talent development and communications and engagement.

A number of teams within those towers contribute to the delivery of the services provided to P&CFS and NSS Payroll as described in the following sections.

Cloud Engineering and Operations – Business IT Department (P&CFS)

The Business IT department demonstrates and delivers value to P&CFS through specific IT services. These services are not an operational overhead but are viewed as a critical business partner in the delivery of P&CFS objectives. The focus is always on meeting the changing needs of the business and it's constantly evolving IT estate, with agility, efficiency and quality services.

The magnitude of the business services encompass approx. 10 major technical service system groupings below which process and validate the £1.5bn worth of Primary Care payments in Scotland across approx. 100 million transactions.

- Portfolio Services – IT change and programme management of the yearly P&CFS development portfolio. Helping ensure that the activity surrounding all P&CFS system changes is managed and reported on regarding progress.
- Service Management – Management of supplier group to help ensure all services delivered provide business benefit to the customer group.
- Business Application Development Lifecycle Services – Business Systems Analysis (BSA) of emerging business changes with provision of requirements. The BSA service primarily focusses on the mechanisation and automation of business processes. The BSA works with business processes, tools, people, and culture, and has a focus on the business's strategy. Also encompassed under this service is full acceptance testing of all software or hardware components aiming to achieve stability, quality, compliance with requirements whilst assessing whether they are acceptable for delivery to production environments.
- Operational Services – This includes service operation, information requests and provision, business as usual (BAU) / service testing including accreditation, primary care payment schedule activities, service review meetings, major incident reports review, service audit, statistics relating to service and management reporting, system training, system administration, downtime and release to production as well as early life support and post development implementations.
- Technical Services – Technical guidance, provision and foundation support of all department specialisms. This covers various areas such as tooling, strategic direction and developing solutions and etc.

Cloud Engineering and Operations – Local Infrastructure

This team is responsible for a range of core IT services to all parts of NSS as follows:

- Administration of user accounts including setting up, termination, changes to privileges and rights.
- Provision of local IT facilities including telephone and IT workstation facilities, local and network file storage and associated networking and associated back-up and restoration facilities, virus and malware facilities.
- Provision of service desk for local telephone and IT related issues.
- First and second line support for local telephone and IT related issues.
- Specifically in relation to the P&CFS Pharmacy payment stream, the management of the eVadis drug pricing database including the monthly updates that are part of the processing schedule (noting this service is provided to P&CFS only).

Portfolio Services – Contract, Vendor and Service Management Team

This team is responsible for:

- Establishing and supporting the contract governance structures and associated processes in accordance with the provisions of the contract.
- Management of contract payments in accordance with the provisions of the contract and in accordance with NSS Standing Financial Instructions.
- In association with NSS Finance, to determine the apportionment of contract charges from customer organisations in accordance with the mechanisms agreed with Scottish Government Health and Social Care Directorate and recovery of those amounts from the Customer organisations.
- Managing the contract change procedure in accordance with the provisions of the contract.
- Managing the review of service delivery by the contractor in accordance with the provisions of the contract including those which relate to managing instances where performance falls below expected standards.
- Supporting the Contract Management Board in undertaking strategic reviews of the contract including those activities associated with the decision making process in respect of contract extension options and the associated cost vs. benefits analysis.
- Managing the benchmarking process in accordance with the provisions of the contract to help ensure ongoing value for money can be evidenced throughout the term of the agreement.

2.3 NHS SCOTLAND NATIONAL IT SERVICES CONTRACT

2.3.1 BACKGROUND

Within the range of services provided by DaS to P&CFS and NSS Payroll, a part of those services is delivered through the strategic National IT Services Contract (NITC) with Atos. The current contract is the latest generation of a series of strategic contracts of broadly similar scope and purpose through which key business and clinical information systems have been delivered to NHS Scotland since the 1980s.

The contract operates as an 'outsourced services' model with NSS acting in an intelligent customer and supervisory role on behalf of and in consort with the other NHS Scotland Health Boards to which the services are provided – including those services provided to other parts of NSS, namely P&CFS and NSS Payroll.

Included within the systems, applications and services provided under the NITC within the scope of this audit are:

- Provision of the systems which support ePharmacy Programme throughout Scotland;
- Provision of the systems which are used to calculate payments for the four payment stream to primary care practitioners (General Practitioners, Pharmacists, Dentists and Opticians) under the management of NSS Practitioner and Counter Fraud Services Strategic Business Unit (SBU); and
- Provision of the NHS Payroll System utilised by in scope Health Boards in Scotland to make salary and associated payments to their staff.

Key features of the contract include:

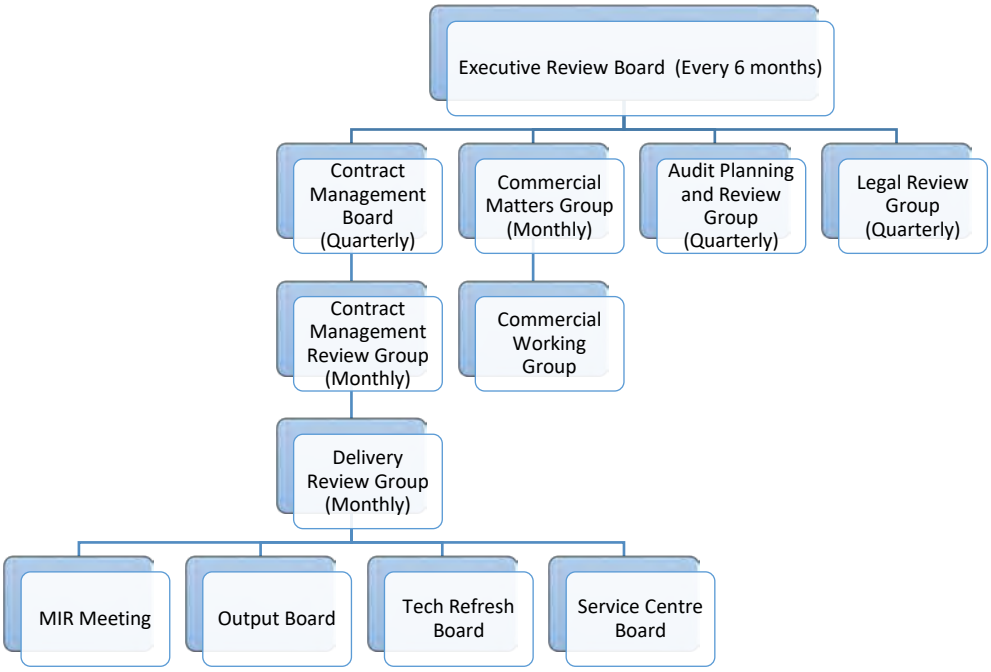
- A range of Key Performance Indicators and Performance Indicators across the range of services provided under the contract which are specified in the NITC and which Atos are required to deliver their services to;

- The facility to terminate individual services with six months' notice and with any associated termination costs capped; and
- Charges rebates (Service Credits) linked to failure to meet Key Performance Indicators.

2.3.2 Contract Governance

Service delivery and performance under the NITC contract is managed via a range of Contract Governance structures which are formally defined within the contract and take representation from across the NHS Scotland Health Boards. This Contract Governance interfaces with and dovetails into further governance arrangements established for specific systems and Health Board purposes for systems and services delivered by the NITC.

The Contract Governance is represented in the following diagram.



Contract Risk Management is considered a part of the remit of the Contract Management Review Group (CMRG) with escalation to the wider Atos and NSS Risk Management processes as needed.

The NITC incorporates a defined Contract Change Procedure. This includes a specific approval process compliant with NSS's Standing Financial Instructions. This procedure is utilised both for making changes which are of a non-commercial nature (e.g. those which vary the terms and conditions of the contract without any commercial impact), as well as for commissioning additional services which may involve variation to terms and conditions as well as commercial considerations. DaS CVSMT administer the Contract Change Procedure for services delivered under the NITC.

The principal operational service delivery assurance mechanism within the NITC Contract Governance is the Delivery Review Group (DRG) which meets monthly to review performance to the contract Key Performance Indicators and Performance Indicators. The group membership is from senior operational staff within the Health Boards who receive the services. The group operates to defined terms of reference and defined inputs (including performance and project and application delivery reports) and outputs. Where necessary, matters arising from the DRG are escalated to other groups within the overall NITC Contract Governance.

In parallel with the DRG, a Major Incident Review process operates which focuses on learning lessons and helping to ensure continuous improvement from any major service affecting incidents that arise. This operates to a process managed by CVSMT with an associated monthly meeting and records.

2.4 ATOS

2.4.1 INTRODUCTION

Atos provides IT services to support key infrastructure and applications for NHS Scotland.

Atos' aim is to use its capability, capacity and experience to support all NHS Scotland organisations in helping improve patient care for the people of Scotland. Atos works with a range of providers/partners to present NHS

Scotland with a range of services – these range from SMEs with niche products through to global players within the industry.

By utilising its own capability and those of partners and suppliers, Atos aims to fulfil the spectrum of requirements to meet NHS Scotland's Digital Health and Care Strategy needs for technology enabled health care both now and in the future. The scope of Atos' contract with NHS Scotland spans both Health and Care. This includes a range of offerings involving managed services, systems integration, application development and business consulting.

The contract took effect on 1 April 2007 and is in place until 31st March 2026.

Not all controls within the scope of this report are managed by Atos. For those controls that do fall to Atos to manage, Atos is responsible for the design, implementation and maintenance of controls to help ensure with reasonable assurance and on an ongoing basis that the control objectives are achieved. Atos utilises the COBIT 5.0 ICT Governance framework to identify those control measures most critical to the efficient and effective delivery of information technology services, particularly those provided by Atos to the NHS in Scotland, under the contract.

Atos complies with the NHS Scotland standards as detailed in the contract schedule part 10 (Agency Policies and Standards) including certification to ISO/IEC9001 (Quality Management Standard), ISO/IEC27001 (Information Security Standard), ISO/IEC20000 (IT Service Management Standard) and follow ISO/IEC27002 (Information Security Standard – Code of Practice) and ITIL (IT Infrastructure) guidelines. Atos has an annual programme of internal and external audit reviews which seeks to confirm conformance with all of the above standards.

2.4.2 CONTROLS FOR THE AREAS COVERED BY ATOS

A summary of the controls for each of these areas is provided below:

(a) Logical Access Management

Logical Security management helps ensure the confidentiality, integrity and availability of information technology services.

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

(b) Physical Access Management

Physical Security management helps ensure the confidentiality, integrity and availability of information technology services.

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

Atos complies and is certified to ISO/IEC27001 (Information Security Standard), ISO/IEC20000 (IT Service Management Standard) and follow ISO/IEC27002 (Information Security Standard – Code of Practice) and ITIL (IT Infrastructure) guidelines.

(c) Change Management

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

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

A master record of configuration items against which changes are implemented is maintained. It provides reference baselines for the change management service and an information point for the ITIL functions for the current states of the server and desktop estate.

(d) Interface and Job Scheduling

Atos have an automated system for job-scheduling implemented. Operations Control personnel monitor job execution and follow defined job handling directives in case of events (errors), according to the Error

Management procedures described in the Production Plan Management Operational Blueprint or equivalent local procedure.

(e) Third Party Risk Management

Atos uses a number of third party organisations for the provision of NHS Scotland services, within the scope of this service report. These third party organisations provide application development and support services primarily for NSS Practitioner and Counter Fraud Services. The Atos Programme Management Office maintains a Register of Sub-Contractors that are used on the NSS' account which specifies the contractual arrangement in place with each supplier, the services provided by them, the risks that relate to them/the services that they provide and the Technical Service Line Towers that are assigned as owners of the relationship with the third parties. The register is updated and reviewed on a yearly basis as a minimum, or when there are changes to any contractual arrangement/services from the third-party.

(f) Incident and Problem Management

A 24/7 national Service Desk operated by Atos is the first point of contact for NHS Scotland users for the reporting of faults, issues or any other request for services. The operation of a Service Desk requires that all user issues are logged and managed to a resolution within specified timeframes, according to the relative priority of the issue being experienced. These timeframes will typically be identified in a service level agreement.

In addition, it is essential that the Service Desk works towards building a knowledge base in order that they can quickly diagnose and resolve issues effectively and efficiently. The Service Desk also works closely with the ITIL team, known as Service Management Centre within Atos, who provide incident management and problem management systems in order that issues are fully resolved to prevent their recurrence rather than provide temporary resolutions.

2.5 CONTROL ENVIRONMENT

2.5.1 NSS Board

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

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

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

2.5.2 RISK MANAGEMENT IN NSS

The Chief Executive is ultimately responsible for ensuring NSS has effective risk management processes in place. He is supported by the Audit and Risk Committee, the EMT, management groups, SBU/Directorate Directors, the Risk Manager Lead and Risk Champions.

2.5.3 NSS INFORMATION GOVERNANCE

NSS aims to be a leading organisation in NHS Scotland in the way information is used and handled. Our information governance framework helps enable the safe and secure use of sensitive and other information to support the health and well-being of the people of Scotland. It helps ensure that we meet our legal and ethical duties in relation to handling and managing information to a high standard.

NSS is a partner in helping lead the use of information to improve health and well-being in Scotland.

Information governance covers the following:

- Caldicott Principles - is about protecting patient information;
- Confidentiality - is about the common law duty of protecting information given to us in confidence;

- Data Protection – helps enable the secure use of personal information and upholds the public's information rights;
- Information Security - is about protecting against the unauthorised use of information systems and the information held within them. It is also about the security of our buildings and people;
- Freedom of Information - is about providing information and openness; and
- Management of Records - is about managing all information in all formats including paper and electronic throughout their entire lifecycle.

2.5.4 NSS INFORMATION AND COMMUNICATION

Communication within NSS is maintained through face to face meetings, daily interactions, email and regular communication bulletins. NSS staff have access to an internal intranet.

In respect of the services provided by NSS DaS in support of the services provided by P&CFS and NSS Payroll direct communications are between DaS and P&CFS and NSS Payroll. Communications to the customer base of P&CFS and NSS Payroll are managed by those organisations. Communications between DaS and P&CFS and NSS Payroll include the various governance groups already referenced with channels including face to face meetings, the inputs and outputs to those meetings (e.g. minutes, action trackers, performance and other reports).

Please refer to section 2.6 below for further description of the IT systems that are used by NSS in performing its service and their extent of responsibilities and controls over the systems listed.

2.6 IT SYSTEMS

The following IT systems fall within the scope of this service audit report:

System	Entities Responsible	Services Supported	Operating System	Database
ePayroll	Atos (application and database) Fujitsu (operating system)	Primary system for the payroll process.	Fujitsu VME	IDMS
General Medical Services (Primary Medical Services Payment System) PMSPS	Sopra Steria (application layer and database) Atos (operating system)	This calculates the monthly payments to GP Practices.	Solaris 11	Oracle 12c
General Pharmaceutical Services (DCVP)	Sopra Steria (application layer and database) Atos (operating system)	This system validates and values scripts submitted by dispensing contractors once or twice per month.	Solaris 8/10	Oracle 8/9
General Dental Services (MIDAS)	Sopra Steria (application layer and database) Atos (operating system)	Primary system for dental payments.	Solaris 11	Oracle 12c
General Ophthalmic Services (OPTIX)	Sopra Steria (application layer and database) Atos (operating system)	The main system used by GOS to calculate payments to contractors.	Solaris 11	Oracle 12c
eVadis	NSS (application, operating system and database)	eVadis is a pharmacy drug dictionary and contractors database. Pricing information from eVadis is uplifted into DCVP monthly.	Solaris 10	Oracle 10.2.0.4

2.7 SUB-SERVICE ORGANISATIONS

System	Services Supported	Approach	Justification
Atos	Atos provides managed technical services (including hardware and associated software), storage, application support and development. The control objectives applicable are: 1. Logical Access Management; 2. Physical Access Management; 3. Change Management; 4. Interface and Job Scheduling; 5. Third Party Risk Management; and 6. Incident and Problem Management.	Inclusive	A material component of the service is outsourced to Atos as an IT infrastructure and service provider. Furthermore, the provisioning of the service from Atos is managed by NSS. Therefore, to help ensure that this report provides sufficient coverage for user auditors, we have adopted an inclusive approach.

2.8 CONTROL OBJECTIVES

1. **Logical access management** – Controls provide reasonable assurance that logical access to applications, operating systems and databases is restricted to authorised individuals.
2. **Physical access management** – Controls provide reasonable assurance that physical access to the data centres for NSS services are restricted to authorised personnel.
3. **Change management** – Controls provide reasonable assurance that changes to the infrastructure, data, software, and procedures managed by Atos for NSS are evaluated to understand their impact to the NSS' processing environment and its security; and tested and approved prior to their implementation to the live environment.
4. **Interface and job scheduling management** – Controls provide reasonable assurance that automated interfacing and job processing are performed completely as per the defined schedules, and that failures are identified and remediated.
5. **Third party risk management** – Controls provide reasonable assurance that risks associated with vendors and business partners that contribute to the delivery of services are assessed, monitored and managed.
6. **Incident and problem management** – Controls provide reasonable assurance that incidents and problems are responded to, investigated, tracked and resolved through to completion following a defined incident and problem management policy.

2.9 COMPLEMENTARY USER ENTITY CONTROLS

The effectiveness of the controls relating to the services provided by NSS DaS to NSS P&CFS and NSS Payroll team in contributing to the services that they in turn provide to their customer organisations within the NHS Scotland Health Boards rely upon NSS P&CFS, NSS Payroll team and NHS Health Boards implementing their own complementary controls. The complementary controls are included in the respective P&CFS and Payroll reports. They describe other internal controls that are expected be in operation within user organisations to complement the controls operated by NSS.

The independent service auditor's opinion presented in this ISAE 3402 report does not include a review over the design, implementation and operating effectiveness of the user entity controls. The independent auditors of the user organisations should consider whether these user entity controls are present and operating effectively.

SECTION 3 – NSS CONTROL OBJECTIVES AND RELATED CONTROLS, AND KPMG LLP'S TESTS OF CONTROLS AND RESULTS OF TESTS

TESTS OF THE CONTROL ENVIRONMENT

The control environment represents the collective effect of various elements in establishing, enhancing or mitigating the effectiveness of specific controls. In addition to the tests of specific controls described below, our tests included tests of relevant elements within NSS and Atos control environments.

Our tests of the control environment included the following procedures, to the extent we considered necessary:

1) Reviews of NSS organisational structure, including policy statements, policies and the segregation of functional responsibilities within each team to carry out assigned activities;
2) Discussions with management, operations, administrative and other personnel who are responsible for developing, ensuring adherence to, and applying controls;
3) Observations of personnel in the performance of their assigned duties; and
4) Discussion with management regarding the risk, operational and compliance management process.

The control environment was considered in determining the nature, timing and extent of the testing of controls relevant to achievement of the control objectives.

When using information produced by NSS and Atos, we performed additional test procedures to determine whether we were able to place reliance on the information provided by NSS and Atos including, as necessary, obtaining evidence about the completeness and accuracy of the information and evaluating whether the information was sufficiently precise and detailed for our purposes.

DESCRIPTION OF TESTS PERFORMED

Tests performed to determine the design of the controls detailed in this section are described below:

TEST PROCEDURE	DESCRIPTION
Enquiry	Enquired of appropriate NSS and Atos personnel. Enquiries were used to obtain, among other things, knowledge and additional information about the control.
Observation	Observed the application of a specific control.
Inspection	Read documents and reports that contain an indication of performance of the control. This includes, but is not limited to, examining management reports, operational logs and other relevant documentation.

TESTS OF THE CONTROL ENVIRONMENT

The detailed control objectives and supporting control descriptions; along with a summary of the tests performed to determine the design, implementation and operating effectiveness of the controls, the test results and management responses on the exceptions are presented in sections one to six. Each section considers a specific component of the NSS and Atos service or control environment.

3.1 LOGICAL ACCESS

Controls provide reasonable assurance that logical access to applications, operating systems and databases is restricted to authorised individuals.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
1.1	Logical access controls are defined in the following documents: — UK and Ireland Information Security Policy; — Password Standard; — Emergency Access to Production System procedure; and — Access Management Policy. These policies and procedures documents are reviewed on an annual basis as a minimum or when there are major changes to the in-scope systems.	Inspected the UK and Ireland Information Security Policy, Password Standard, Emergency Access to Production System procedure, and the Access Management Policy and noted that logical access controls had been defined within these documents. Further noted that these documents had been reviewed within the last 12 months or when there had been major changes to the in-scope systems.	No exceptions noted.
1.2	Each user ID in the NSS network is unique except for generic/service accounts that are hard coded into the systems. Password for these generic accounts are updated every six months and are stored in a secure password protected tool, the access of which is restricted to the authorised support staff.	Enquired of management to determine whether each user ID in the NSS network was unique except for generic/service accounts that were hard coded into the systems. Inspected user listing to determine whether there had been generic/service accounts that were hard coded into the systems. Enquired of management to determine whether generic accounts had been updated every six months and had been stored in a secure password protected tool, the access of which had been restricted to the authorised support staff.	**Exception noted:** *DCVP, Optix and PMSPS (application level), and eVadis (application, operating system and database level)* We were informed that the management of passwords for the generic accounts had not been documented by management. **Management response:** For DCVP, Optix and PMSPS, legitimate generic/service accounts do exist within the systems across the P&CFS estate. We will undertake to review all generic accounts on an annual basis alongside the supplier to ensure they remain necessary. For eVadis, privileged operating systems and database accounts are subject to a password rotation policy and stored in an encrypted keystore (for operating system accounts) and an encrypted

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
			directory (for database passwords) both of which are password protected and only accessible to a small number of staff. It should be emphasised that these accounts cannot be used to access the application itself. For application access, the authentication of the user account is linked to the Active Directory. These can be provided in the next audit. For eVadis, Public Health Scotland team will request a list of active users from the system DBA and carry out a complete review of active accounts. A call will be raised in Service Now to close off the accounts of those no longer actively involved in maintaining the eVadis database. A quarterly review of active users will be carried out. *DCVP, ePayroll, MIDAS, Optix and PMSPS (operating system and database level)* We were informed that there had been no system generated user list available to identify the generic accounts. **Management response:** Atos to discuss with NSS to decide the next step on generating the system user list. *ePayroll and MIDAS (application level)* *We inspected the user lists and noted that there had been no generic accounts in ePayroll and MIDAS at the application level. Therefore, we were unable to test the implementation and operating effectiveness of part of the control relating to the password control for the generic accounts.*

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
1.3	*DCVP, ePayroll, MIDAS, Optix and PMSPS (application level)* The NHS Scotland Security Policy and Standards document defines the minimum password requirements to be implemented within the in-scope system. The requirements are as below: — Minimum length of six characters; — Alphanumeric character; — Password is valid for a maximum of 30 days; and — Password cannot be the same as the previous passwords for 12 months. These requirements are enforced through the system settings across the in-scope systems. *DCVP, eVadis, MIDAS, Optix, PMSPS and ePayroll (operating system and database)* The Security Policy and Password Standard document define the minimum password requirements to be implemented within the in-scope system. The requirements are as below: — Passwords should consist of a minimum of six characters, at least one of which should be a non-alphabet character; — Where users maintain their own passwords, enforce a password change	*DCVP, ePayroll, MIDAS, Optix and PMSPS (application level)* Inspected password policy and noted that the minimum password requirements to be implemented within the in-scope system had been defined in the NHS Scotland Security Policy and Standards document. Enquired of management to determine whether the password requirements had been enforced through the system settings across the in-scope systems. *eVadis* Inspected password settings to determine whether the password requirements had been enforced through the system settings across the in-scope systems. *DCVP, MIDAS, Optix, PMSPS and ePayroll (operating system and database)* Inspected password policy and noted that the minimum password requirements to be implemented within the in-scope system had been defined in the Security Policy and Password Standard document. Inspected password screenshots and noted that the password requirements had been enforced through the system settings across the in-scope systems.	**Exception noted:** *DCVP, ePayroll, MIDAS, Optix and PMSPS (application level)* We were informed that there was no evidence available for the enforced password requirement through the system settings across DCVP, ePayroll, MIDAS, Optix and PMSPS. **Management response:** For DCVP, it is not a monolithic entity and is made up of co-dependant systems and interfaces. Certain elements of end-user access can therefore be verified from Active Directory group policy which can be supplied for future audits. For MIDAS, Optix and PMSPS, the password security features are an intrinsic part of the application code. Since an officially supplied textual description of the operation of the system is deemed inadequate, the only recourse is potentially direct inspection of the code for future audits. For ePayroll, evidence for the password setting in script format can be provided for future audit. *eVadis* We inspected the password settings for the eVadis database and noted that the password history and the password life had not been enforced through the system settings in accordance with the settings according to NHS Scotland Security Policy and Standards. **Management response:** For operating system and database, passwords are cycled every 6 months and stored in an encrypted keystore (for o/s accounts) and an encrypted directory (for database passwords) both of which are password protected and only accessible to a small number of key staff (the Unix and DBA teams). This can be provided in the next audit.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
	at regular intervals, 90 days is recommended; and — Maintain a record of previously used passwords, for the past twelve months, and prevent users from re-using them. These requirements are enforced through the system settings across the in-scope systems.		For application access, the authentication of the user account is linked to the Active Directory. This can be provided in the next audit. *DCVP, MIDAS, Optix, PMSPS and ePayroll (operating system and database)* No exceptions noted.
1.4	*DCVP, eVadis, MIDAS, Optix, PMSPS (application, operating system and database level) and ePayroll (operating system and database level)* On a quarterly basis, a review is performed over account creation and amendment activities and confirmation is obtained over the appropriateness of active accounts with the respective Line Managers. Issues identified are investigated, tracked and resolved to completion using the Service Now ticketing system. *ePayroll (application level)* On an annual basis, a review is performed over account creation and amendment activities and confirmation is obtained over the appropriateness of active accounts with the respective Line Managers. Issues identified are investigated, tracked and resolved to completion using the Service Now ticketing system.	*DCVP, eVadis, MIDAS, Optix, PMSPS (application, operating system and database level) and ePayroll (operating system and database level)* Enquired of management to determine whether on a quarterly basis, a review had been performed over account creation and amendment activities and confirmation had been obtained over the appropriateness of active accounts with the respective Line Managers. Enquired of management to determine whether the issues identified from the review had been investigated, tracked and resolved to completion using the Service Now ticketing system. *ePayroll (application level)* Inspected email correspondence and noted that the review had been performed over account creation and amendment activities and confirmation had been obtained over the appropriateness of active accounts with the respective Line Managers Enquired of management to determine whether the issues identified from the review had been investigated, tracked and resolved to completion using the Service Now ticketing system.	*DCVP, eVadis, MIDAS, Optix, PMSPS (application, operating system and database level) and ePayroll (operating system and database level)* **Exception noted:** We were informed that there had been no review of a system generated user list performed over account creation and amendment activities. **Management response:** Discussions to be undertaken with P&CFS business & Information Governance representation and Atos regarding the extent of what confirmatory checks are required. The basis of these discussions will incorporate a system generated user list rather than the current manually created user list. For eVadis, operating system and database accounts are created during initial installation and configuration, and are not added, removed, or amended other than for password rotation. These are reviewed either during the password rotation process or when there are any changes in staffing in the DBA team. For application accounts, the user account review is a process undertaken by the business owners of the data. Documentation relating to the

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
			review of these accounts can be provided for the next audit. *ePayroll (application level)* As there had been no issues noted from the user access review, we were unable to test the implementation and operating effectiveness of part of the control relating to the investigating, tracking and resolving of issues to completion using the Service Now ticketing system.
1.5	*DCVP, eVadis, ePayroll, MIDAS, Optix and PMSPS* The Atos Service Desk team (for operating system and database users) and Business IT team (application users) verifies that approval from the Team Leader is in place before access to NSS' applications, operating systems and databases are provided. The level of access requested, approved and assigned are outlined and documented by Atos or the Business IT team. *ePayroll (application level)* The Payroll team verifies that approval from the Team Leader is in place before access to NSS' applications, operating systems and databases are provided. The level of access requested and approval are outlined and documented by the Payroll team.	*DCVP, eVadis, ePayroll, MIDAS, Optix and PMSPS (operating system and database level)* For a selection of new user access requests, inspected the ticket raised and noted that the approval from the Team Leader had been verified by the Atos Service Desk to be in place before access to the NSS' applications, operating systems and databases were provided. Further noted that the approval and the level of access requested, approved and assigned are outlined and documented by Atos. *DCVP, eVadis, ePayroll, MIDAS, Optix and PMSPS (application level)* For a selection of new user access request, inspected email to determine whether the approval from the Team Leader had been verified by the Business IT Team to be in place before access to NSS' applications, operating systems and databases were provided. Further noted whether the approval and the level of access requested, approved and assigned had been outlined and had been documented by the Business IT team.	**Exception noted:** *DCVP (application level)* For four out of five new user access requests selected, it was noted that the documentation of the level of access requested and approval had not been formally documented. *MIDAS and Optix (application level)* It was noted that the details of the access required had not been formally documented as part of the email request. *PMSPS (application level)* For one out of five new user access requests selected, it was noted that the access that had been granted to the user in the system did not match the access requested and approved **Management response:** For future user access requests of DCVP, MIDAS, Optix and PMSPS, we will ensure that all Service Now tickets will have a user ID, User name and job function before being progressed. This will be instead of the existing verbal confirmation with raising P&CFS Managers. *eVadis (application, operating system and database level)* It was noted that the details of the access required had not been formally documented as part of the email request. **Management response:**

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
			The revised instructions as to the required information when raising requests for access will be issued to the service desk, to include more complete details of the access required. This information will be provided in the next audit. *DCVP, ePayroll, MIDAS, Optix and PMSPS (operating system and database level)* No exceptions noted. *ePayroll (application level)* For two of two new user access requests, it was noted that the documentation of the level of access requested and approval was not available for review. **Management response:** As this is such a small cohort it is normally just done without the requirement for a formal process however we will introduce a process where one member of the team requests and another sets up access.
1.6	*DCVP, eVadis, MIDAS, Optix, and PMSPS (application, operating system and database level), and ePayroll (operating system and database level)* The Atos Service Desk team (for operating system and database users) and Business IT team (application users) remove leaver's access to the applications, operating systems and databases within 5 days of their leaving date. This is documented by Atos. *ePayroll (application level)* The Payroll team remove leaver's access to the applications, operating systems and databases within 5 days of their leaving date. This is documented by Payroll Team.	*DCVP, MIDAS, Optix and PMSPS (application, operating system and database level), eVadis and ePayroll (operating system and database level)* Inspected the Service Now ticket to determine whether the leaver's access to the applications, operating systems and databases had been removed by the Atos or Business IT Team within 5 days of their leaving date and had been documented by Atos or Business IT team. *eVadis and ePayroll (application level)* Inspected leavers list and user listing to determine whether the leaver's access to the applications, operating systems and databases had been removed by the Atos or Business IT Team within 5 days of their leaving date and had been documented by Atos or Business IT team.	**Exception noted:** *DCVP, eVadis, MIDAS, Optix and PMSPS (application, operating system and database level) and ePayroll (operating system and database level)* We were informed that there had been no formalised procedure to keep track of the user access removal request via the Service Desk system and the leave date and removal date had not been formally documented. **Management response:** For NSS, there is currently no process to delete leavers within a defined time bound period. There is also no single process for managing all the organisation's systems so the process currently is centred on the manual checks. Management will expand the utilisation of automatic leaver notifications through Service Now. For Atos, it is not currently a mandatory requirement to capture

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
			the leaving date of employees within the Service Now ticket and data restrictions bought in by GDPR have limited the information available. We will ask requestors to include the users leaving date (either account exit or Atos exit) within the SNOW request to enable the timeliness of account removal to be tracked. *eVadis and ePayroll (application level)* As there had been no leavers in eVadis and ePayroll, we were unable to test the implementation and operating effectiveness of part of the control relating to the removal and documentation of leaver's access to the system.
1.7	*DCVP, eVadis, MIDAS, Optix, and PMSPS (application, operating system and database level), and ePayroll (operating system and database level)* Privileged accounts within the applications, operating systems and databases are restricted to designated individuals within the relevant support teams. Active privileged accounts are reviewed quarterly for application accounts and monthly for operating systems and databases accounts. Privileged access that is no longer required / applicable are revoked. This is tracked and monitored using the service desk monitoring tool. *ePayroll (application level)* Active privileged accounts are reviewed annually. Privileged access that is no longer required / applicable are revoked. This is tracked and monitored using the	*DCVP, eVadis, MIDAS, Optix, and PMSPS (application, operating system and database level), and ePayroll (operating system and database level)* Inspected the user list to determine whether the privileged accounts within the applications, operating systems and databases had been restricted to designated individuals within the relevant support teams. Enquired of management to determine whether the active privileged accounts had been reviewed quarterly, the privileged access that is no longer required / applicable had been revoked, tracked and monitored using the service desk monitoring tool. *ePayroll (application level)* Inspected the user list and noted that the privileged accounts within the applications, operating systems and databases had been restricted to designated individuals within the relevant support teams. For a selection of months, inspected the privileged access review document and noted that active privileged accounts had been reviewed. For a selection of changes, inspected the service ticket to determine whether the privileged access that was no longer required / applicable	*DCVP, eVadis, MIDAS, Optix, and PMSPS (application, operating system and database level), and ePayroll (operating system and database level)* **Exception noted:** We were informed that the appropriateness of the privileged accounts had not been documented by management. We were informed that there had been no review of active privileged accounts performed during the period. **Management response:** Specifically in relation to accounts utilised by the supplier, they are acting in accordance with their contractual obligations which are overseen by CVSMT. Atos to discuss with NSS to decide the next step on generating the system user list. *ePayroll (application level)* We inspected the user list and noted that there had been no change required to the privileged access, we were unable to test the implementation and operating effectiveness of part of the control relating to the removal and

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
	service desk monitoring tool.	had been revoked. Further noted that the action had been tracked and had been monitored using the service desk monitoring tool.	documentation of privileged access to the systems.

3.2 PHYSICAL ACCESS MANAGEMENT

Controls provide reasonable assurance that physical access to the data centres for NSS services are restricted to authorised personnel.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
2.1	ATOS performs annual assessment of the physical security of the Data Centres in the form of ISO 27001 report.	Inspected that the ISO 27001 assessment results of the physical security of the third-party Data Centres within the last 12 months and noted that assessment of the physical security of the Data Centres in the form of ISO 27001 report had been performed by ATOS.	No exceptions noted.

3.3 CHANGE MANAGEMENT

Controls provide reasonable assurance that changes to the infrastructure, data, software, and procedures managed by Atos for NSS are:

- evaluated to understand their impact to NSS' processing environment and its security;
- tested and approved prior to their implementation to the live environment.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
3.1	The processes for managing Change and Configuration Management are formally documented and controlled. These cover changes to NSS' applications and the underlying operating systems, databases, servers and infrastructures that are managed by Atos. The document is reviewed and approved on an annual basis. The process document and any subsequent changes are disseminated to the internal support teams in Atos and to NSS.	Inspected the Change Management Policy and noted that the process for managing the change and configuration management had been documented and the changes to NSS' applications and the underlying operating systems, databases, servers and infrastructures that were managed by Atos had been covered. Further noted that these documents had been reviewed and had been approved within the last 12 months and subsequent changes had been disseminated to the internal support teams in Atos and to NSS.	No exceptions noted.
3.2	*MIDAS, Optix, PMSPS, ePayroll, DCVP and eVadis* Non-emergency changes to NSS' applications and the supporting operating systems, databases, servers and infrastructures are developed and tested in separate environments prior to approval for implementation to the live environment. This is documented in Service Now.	*MIDAS, Optix, PMSPS and ePayroll* For a selection of non-emergency changes, inspected the change ticket raised and supporting documentation from Service Now and noted that the changes had been developed and had been tested in separate environments prior to approval for implementation to the live environment, and had been documented in Service Now. *DCVP and eVadis* Enquired of management to determine whether the changes had been developed and had been tested in separate environments prior to approval for implementation to the live environment, and had been documented in Service Now.	*MIDAS, Optix, PMSPS and ePayroll* No exceptions noted. *eVadis* We were informed that there had been no changes in eVadis, we were unable to test the implementation and operating effectiveness of part of the control relating to the segregation of the environments for development and testing. *DCVP* **Exception noted:** We were informed that there had been no formal documentation for changes in DCVP, therefore we were unable to test the implementation and operating effectiveness of part of the control relating to the segregation of the environments for development and testing. **Management response:** The composition of DCVP has now been provided which for future audits can be mapped to the

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
			portfolio details to evidence the presence of any changes or lack of. The P&CFS Portfolio is a definitive list of all year in year changes used by all relevant stakeholders including suppliers. This portfolio documentation whilst currently manually managed is in the process of being migrated to Service Now to improve transparency and reporting.
3.3	*MIDAS, Optix, PMSPS, ePayroll, MIDAS, Optix, PMSPS and ePayroll* Non-emergency changes to NSS' applications and the supporting operating systems, databases, servers and infrastructures are approved by the management (Atos and NSS) and/or the Change Advisory Board and are implemented to the production environment only after the testing is completed and approval is provided in accordance with the Change Management Process document. The dates and track record of the testing, approval and implementation are recorded in the Service Management Change Tool.	*MIDAS, Optix, PMSPS and ePayroll* For a selection of non-emergency changes, inspected the change ticket raised and supporting documentation from the Service Management Change Tool and noted that non-emergency changes to NSS' applications and the supporting operating systems, databases, servers and infrastructures had been approved by the management (Atos and NSS) and/or the Change Advisory Board and had been implemented to the production environment only after the testing had been completed and approval had been provided in accordance with the Change Management Process document. *MIDAS, Optix, PMSPS and ePayroll* Enquired of management to determine whether non-emergency changes to NSS' applications and the supporting operating systems, databases, servers and infrastructures had been approved by the management (Atos and NSS) and/or the Change Advisory Board and had been implemented to the production environment only after the testing had been completed and approval had been provided in accordance with the Change Management Process document.	*MIDAS, Optix, PMSPS and ePayroll* We inspected the list extracted from Service Now and noted that system generated list from the systems in scope for audit were not available to obtain sufficient reliance over the completeness and accuracy of the list of changes for the systems in scope for testing. *eVadis* As there had been no changes in eVadis, we were unable to test the implementation and operating effectiveness of part of the control relating to the change testing and change approval in accordance with the Change Management Process document. *DCVP* **Exception noted:** We were informed that there had been no formal documentation for changes in DCVP, we were unable to test the implementation and operating effectiveness of part of the control relating to the segregation of the environments for development and testing. **Management response:** Refer to the comment in control 3.2.
3.4	*MIDAS, Optix, PMSPS, ePayroll, MIDAS, Optix, PMSPS and ePayroll* Privileged access to make changes to the production applications is restricted to a job role independent of	*MIDAS, Optix , PMSPS and ePayroll* Inspected the list of users with access to make changes to production applications and noted that privileged access to make changes to the production applications had been restricted to	*MIDAS, Optix, PMSPS and ePayroll* No exceptions noted. *eVadis* We inspected user listing and noted that the developer has

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
	developers, in accordance with the Change Management Process document.	a job role independent of developers, in accordance with the Change Management Process document. *DCVP and eVadis* Enquired of management to determine whether privileged access to make changes to the production applications had been restricted to a job role independent of developers, in accordance with the Change Management Process document.	privileged access to the production applications in eVadis. **Management response:** For eVadis, approved changes are packaged and deployed to the individual's client machine, software is client server based. The implementation of any changes to the client machine is managed by the Desktop Management Team which is separate from the developer team. *DCVP* **Exception noted:** We were informed that there had been no formal evidence of privileged access to make changes to the production applications in DCVP, thus we were unable to test the implementation and operating effectiveness of part of the control relating to the segregation of the environments for development and testing. **Management response:** Refer to the comment in control 3.2.
3.5	*MIDAS, Optix, PMSPS, ePayroll, MIDAS, Optix, PMSPS and ePayroll* Emergency changes are supported with the incident tickets that require the changes to be made. Emergency changes are subject to retrospective CAB review and approval within 5 working days after its implementation. This is documented in the Service Management Change Tool.	*MIDAS, Optix, PMSPS and ePayroll* For a selection of emergency changes, inspected change tickets and noted that the emergency changes had been supported with the incident tickets that required the changes to be made. Further noted that these changes had been subjected to retrospective CAB review and approval within 5 working days after its implementation and had been documented in the Service Management Change Tool. *DCVP and eVadis* Enquired of management to determine whether emergency changes had been supported with incident tickets that required changes to be made. Enquired of management to determine whether emergency changes had been subjected to	*MIDAS, Optix, PMSPS and ePayroll* No exceptions noted. *eVadis* As there had been no changes in eVadis, we were unable to test the implementation and operating effectiveness of part of the control relating to the supporting document and retrospective CAB review and approval for the emergency changes. *DCVP* **Exception noted:** We were informed that there had been no formal documentation for changes in DCVP, therefore we were unable to test the implementation and operating effectiveness of part of the control relating to the supporting document and retrospective CAB

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
		retrospective CAB review and approval within 5 working days after its implementation and had been documented in the Service Management Change Tool.	review and approval for the emergency changes. **Management response:** Refer to the comment in control 3.2.
3.6	*MIDAS, Optix, PMSPS, ePayroll, MIDAS, Optix, PMSPS and ePayroll* On a weekly basis, all ongoing non-standard changes in the applications and the supporting operating systems, databases, servers and infrastructures are reviewed by CAB to verify that the change process has been followed. System generated lists of changes from Service Management Change Tool are used by the Change Manager to perform the review. If the Change Manager identifies changes that do not follow the change management process, queries are raised with the staff that makes the change to verify the appropriateness of the change and confirm whether any further actions are needed on those changes. This is tracked through to completion using the Service Management Change Tool.	*MIDAS, Optix, PMSPS and ePayroll* For a selection of weeks, inspected the meeting minutes from the CAB meetings and noted that all ongoing non-standard changes in the applications and the supporting operating systems, databases, servers and infrastructures had been reviewed by CAB to verify that the change process had been followed. Further noted that system generated lists of changes from Service Now were used by the Change Manager to perform the review. Inspected communication email and noted that for changes that do not follow the change management process, queries had been raised with the staff that made the change to verify the appropriateness of the change and confirm whether any further actions were needed on those changes. *DCVP and eVadis* Enquired of management to determine whether all ongoing non-standard changes in the applications and the supporting operating systems, databases, servers and infrastructures had been reviewed by CAB to verify that the change process had been followed.	*MIDAS, Optix, PMSPS and ePayroll* As there had been no changes which required tracking, we were unable to test the implementation and operating effectiveness of part of the control regarding tracking through completion of further actions from the verification of the changes through the Service Management Change Tool. *eVadis* As there had been no documented changes in eVadis, we were unable to test the implementation and operating effectiveness of part of the control relating to change compliance review. *DCVP* **Exception noted:** We were informed that there had been no formal documentation for changes in DCVP, we were unable to test the implementation and operating effectiveness of part of the control relating to change compliance review. **Management response:** Refer to the comment in control 3.2.
3.7	Configuration baseline for the hardware infrastructure used for the NSS service is maintained in the Configuration Management Database within the Service Now ticketing system. The database is updated by IT support teams when there is a change to the infrastructure or the configuration. The previous	For a selection of configuration baselines, inspected the configuration baseline for the hardware infrastructure used for the NSS service and noted that it had been maintained in the Configuration Management Database within the Service Now ticketing system. For a selection of updates to the database, inspected the ticket raised and noted that the database	No exceptions noted.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
	version of the configuration is kept to enable rollback of the change.	had been updated by the IT support teams following a change to the infrastructure or the configuration. Further noted that the previous version of the configuration had been kept to enable rollback of the change.	

3.4 INTERFACE AND JOB SCHEDULING MANAGEMENT

Controls provide reasonable assurance that automated interfacing and job processing are performed completely as per the defined schedules, and that failures are identified and remediated.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
4.1	Business and service requirements as well as the procedures to monitor completion of interface and job scheduling are documented. This is reviewed and approved on an annual basis as a minimum, or when there is a change in the interface and job scheduling tools.	Inspected the policies and procedures and noted that business and service requirements as well as the procedures to monitor completion of interface and job scheduling had been documented. Further noted that these documents had been reviewed and had been approved within the last 12 months or following a major change to the interface and job scheduling tools.	No exceptions noted.
4.2	The completion of data interface is monitored for NSS' applications managed by Atos. A notification is issued when an interface does not finish completely. The cause of the error is investigated and the sender notified to either repeat the transmission or combine the data with the next batch. This is tracked through to completion using the service management toolset.	Enquired of management to determine whether the completion of data interface had been monitored for NSS' applications managed by Atos and cause of error had been investigated and tracked through completion using the service management toolset.	**Exception noted:** We were informed that evidence of the monitoring of data interfaces was not available. **Management response:** Monitoring of these jobs is done automatically, within the system, within the code. NSS will discuss internally to evaluate the control. This will include establishing if there is a monitoring control in place for the interface job error and the retention of evidence to demonstrate that this monitoring is in place.
4.3	Automated jobs are scheduled in the specified tool with a pre-determined frequency as defined. Scheduled jobs are compared against the list within the document to verify that all jobs had been scheduled accordingly.	Enquired of management to determine whether automated jobs had been scheduled with a pre-determined frequency as defined and the scheduled jobs had been compared against the list within the document to verify that all jobs had been scheduled accordingly.	**Exception noted:** We were informed that there had been no documentation retained following the verification that jobs have been scheduled accordingly. **Management response:** Team to log checks via a spreadsheet or send an email to the team confirming checks have taken place.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
4.4	The documented list of job schedules is amended, as well as the scheduled job in the tool, after receiving an approved request. Records of the request, approval and amendment made to the document and tool are maintained.	For a selection of amendment requests, inspected the request and noted that the documented list of job schedules had been amended, as well as the scheduled job in the tool, after receiving an approved request. Further noted that the record of the request, approval and amendment made to the document and tool had been maintained.	No exceptions noted.
4.5	The completion of jobs scheduled is monitored. A notification is issued when a job does not finish completely. The cause of error is investigated and the job is re-run either by repeating the task manually or combining it with the next scheduled job. This is tracked through to completion using the Service Now ticketing system.	Enquired of management to determine whether the completion of jobs scheduled had been monitored and a notification had been raised when a job did not finish completely. Enquired of management to determine whether the cause of error had been investigated and tracked through to completion using the Service Now ticketing system.	**Exception noted:** We were informed that there had been no evidence retained for monitoring of the scheduled jobs. **Management response:** Team to log checks via a spreadsheet or send an email to the team confirming checks have taken place.

3.5 THIRD PARTY RISK MANAGEMENT

Controls provide reasonable assurance that risks associated with vendors and business partners that contribute to the delivery of services are assessed, monitored and managed.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
5.1	On a monthly basis, the NSS' Account Service Manager from Atos chairs an internal Service Review meeting with the Technical Service Line Towers owners to review the SLA performance of the third parties. This is documented. When there is a breach in the SLA, the Technical Service Line Towers owners obtain a corrective action plan from the third party to address the failure. This is tracked through to resolution using the Service Now ticketing system.	For a selection of months, inspected the minutes taken during the internal Service Review meetings and noted that the internal Service Review meeting with the Technical Service Line Towers owners to review the SLA performance of the third parties had been chaired by the NSS' Account Service Manager from Atos chairs and had been documented. For a selection of breaches identified, inspected the incident ticket raised in the Service Now ticketing system and noted that when there had been a breach in the SLA, corrective action plan from the third party to address the failure had been obtained by the Technical Service Line Towers owners. Further noted that it had been tracked through to resolution using the Service Now ticketing system	No exceptions noted.
5.2	The strategy and processes to manage third parties are outlined in the Supplier policy/procedure document. The document is updated and reviewed by a manager on a yearly basis as a minimum.	Inspected the third-party management policy and noted that the strategy and processes to manage third parties had been outlined in the document. Further noted that the document had been updated and reviewed by a manager within the last 12 months.	No exceptions noted.
5.3	The Atos Programme Management Office maintains a Register of Sub-Contractors that are used on the NSS' that are used on the NSS' account. This register specifies the contractual arrangement in place with each	Inspected the Register of Sub-Contractors used on the NSS account and noted that a Register of Sub-Contractors that are used on the NSS' account had been by the Atos	No exceptions noted.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
	supplier, the services provided by them, the risks that relate to them/the services that they provide and the Technical Service Line Towers that are assigned as owners of the relationship with the third parties. The register is updated and reviewed on a yearly basis as a minimum, or when there are changes to any contractual arrangement/services from the third-party.	Programme Management Office. Further note that the contractual arrangement in place with each supplier, the services provided by them, the risks that relate to them/the services that they provide and the Technical Service Line Towers that are assigned as owners of the relationship with the third parties had been specified in the register. Inspected the register's audit log and noted that the register had been updated and had been reviewed within the last 12 months, or when there were changes to any contractual arrangement/services from the third-party.	
5.4	Compliance reports in respect of key services provided by third parties in respect of services within the scope of the National IT Services Contract are received on a no less frequent than annual basis. The associated Description of Services and the list of control failures/exceptions is assessed by the contract team to verify that it covers all the controls related with physical access management, information security management, incident management, change management, disaster recovery and business continuity. The implications of any control failures/exceptions to the ability to achieve the agreed service levels are assessed between Atos and NSS. The result of the discussion and analysis is recorded.	For a selection of third parties, enquired of management to determine whether compliance reports for key services within the scope of the National IT Services Contract had been received within the year.	**Exception noted:** We were informed that there had been no third party compliance reports provided in respect of services within the scope of the National IT Services Contract for Atos. **Management response:** The NHSS account will conduct a review of suppliers they work with directly to understand the ISAE/ISO requirements. The suitability of this control will be discussed with NHSS. Evidence that the supplier review has been undertaken and evidence of the discussion with NHSS will be retained.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
5.5	Service Level Agreements (SLAs) are established with all service providers and business partners in the form of contract or scope of work. It is verified that the agreements include defined terms, conditions, responsibilities and requirements relating to processes and controls that feed into NSS' service delivery. Evidence of the above verification is documented.	For a selection of service providers and business partners, inspected the Service Level Agreements (SLAs) to determine whether the Service Level Agreements (SLAs) had been established with the service providers and business partners in the form of contract or scope of work. Further noted that defined terms, conditions, responsibilities and requirements relating to processes and controls that feed into NSS' service delivery had been included in the agreement, had been verified and had been documented.	**Exception noted.** For 21 out of 25 samples, it was noted that the contract document / scope of work was not available for review. **Management responses:** A lot of these agreements are not owned by the NHS Scotland account so reviews will be done at a UK level. Going forward Atos will carry out reviews with the suppliers we work with directly. Evidence of the reviews will be provided going forward but cannot be provided retrospectively.

3.6 INCIDENT AND PROBLEM MANAGEMENT

Controls provide reasonable assurance that incidents and problems are responded to, investigated, tracked and resolved through to completion following a defined incident and problem management policy.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
6.1	Incident response policies and procedures are in place and documented. The policies define: — the classification and prioritisation definition of each incident; — the SLA for each type of classification and priority; and — The stakeholders of each system to whom updates on incident should be sent. These policies are reviewed on an annual basis, as a minimum, and are communicated to the Service Desk team through advisory communications and made available via the service management toolset.	Inspected the Incident Management policies and procedures and noted that the Incident response policies and procedures had been in place and had been documented. Further noted that the following had been defined: - the classification and prioritisation definition of each incident; - the SLA for each type of classification and priority, and; - The stakeholders of each system to whom updates on incident should be sent. Inspected the Incident Management policies and procedures and noted that these policies had been reviewed within the last 12 months, and had been communicated to the Service Desk team through advisory communications and had been made available via the service management toolset.	No exceptions noted.
6.2	Problem Management Process is in place and documented. It defines the mechanism to identify problems from incidents and root cause assessment procedure. The document is reviewed and approved an annual basis, and the review recorded. Any changes to the document that arise are communicated to the Service Desk team through advisory communications and made available via the service management toolset.	Inspected the Problem Management Process document and noted that the mechanism to identify problems from incidents and root cause assessment procedure had been defined. Further noted that the document had been reviewed and had been approved within the last 12 months, and the review had been recorded. For a selection of changes to the document, inspected the communication to the Service Desk team and noted that the changes had been communicated through advisory communications and had been made available via the service management toolset.	No exceptions noted.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
6.3	Problems are reviewed by NSS and Atos and stakeholders through a monthly review meeting which is combined with the Monthly Incident Review (MIR). This meeting operates to a formal agenda, documentation set and is formally minuted. This meeting approves the closure of problems by the customer.	For a selection of months, inspected the minutes from the review meetings and noted that the problems had been reviewed by NSS and Atos and stakeholders through a monthly review meeting which had been combined with the Monthly MIR review. Further noted that the meeting had been operated to a formal agenda, documentation set and had been formally minuted and the closure of problems by the customer had been approved in the meeting.	No exceptions noted.
6.4	The Service Desk team assigns a classification, priority and engages team(s) for the incident ticket logged in the service management tool. Incidents that are not resolved within the SLA are automatically escalated via the service management toolset. In respect of P1 and P2 incidents, the Incident Manager reviews the ticket and assesses the appropriateness of the priority based on the circumstances of the incident, which may result in the priority being either increased or decreased. The Incident Manager engages the technical resolver team(s), and the Service Desk team assigns the ticket to the engaged team(s).	For a selection of incidents, inspected the incident ticket and noted that classification, priority and engaged team(s) had been assigned by the Service Desk team for the incident ticket logged in the service management tool. Further noted that the incidents that were not resolved within the SLA had been automatically escalated via the service management toolset. For a selection of P1 and P2 incidents, inspected the incident ticket and noted that the ticket had been reviewed by the Incident Manager and the appropriateness of the priority based on the circumstances of the incident had been assessed, which may result in the priority being either increased or decreased. Further noted that the technical resolver team(s) had been engaged, and the ticket had been assigned by the Service Desk Team to the engaged team(s).	No exceptions noted.

Control Ref.	Control Descriptions Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
6.5	The Service Desk Management Team Leaders reviews SLA report and the KPI performance report to assess trends on incidents, repeat incidents that require to be escalated as a problem, and identify incidents that are not resolved or likely not to be resolved within the agreed SLA timeline on a monthly basis. The review is documented, including actions taken to expedite the incidents resolution or recurring incidents that need to be escalated as a problem. Actions and changes determined as a result of the MIR is assigned and tracked using the service management toolset. Changes follow the standard change management procedure.	For a selection of months, inspected the MIR reports and noted that the SLA report and the KPI performance report had been reviewed by the Service Desk Management Team Leaders to assess trends on incidents, repeat incidents that required to be escalated as a problem, and identify incidents that were not resolved or likely not to be resolved within the agreed SLA timeline on a monthly basis. For a selection of months, inspected the MIR reports and noted that actions taken to expedite the incidents resolution or recurring incidents that needed to be escalated as a problem had been documented. Further noted that actions and changes determined as a result of the MIR had been assigned and had been tracked using the service management toolset and the standard change management procedure had been followed.	No exceptions noted.

SECTION 4 – ADDITIONAL INFORMATION PROVIDED BY NSS (NOT COVERED AS PART OF THE OPINION PROVIDED BY KPMG)

4.1 OUR VALUES

The NSS values are a collection of guiding principles around what the organisation considers to be professional, ethical and effective personal conduct within a working environment.

In 2009, staff from across the organisation, were involved in creating and defining our values and translating them into behaviours to bring them to life.

This common set of values, endorsed by Staff Governance, helps us all create a better NSS community, whilst honouring the traditions and good work of our Strategic Business Units (SBUs) and Directorates.

Our values outlined below are communicated through the organisation's intranet:

- Committed to each other;
- Customer focus;
- Integrity;
- Openness;
- Respect and care;
- Excel and improve.

4.2 COVID-19

As a result of COVID-19 response activity, the teams have complied with guidance and the distributed workforce are in the most part working remotely with no impact to services and support provision. NSS continues to work in partnership to plan and adjust working practices for COVID-19 recovery plans in line with government guidance.

NHS Ayrshire & Arran

National Single Instance Financial Ledger Services for the year ended 31 March 2020

Our purpose

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

Contents

Introduction

NHS Ayrshire & Arran ("NHS A&A") operated the National Single Instance ("NSI") financial ledger services on behalf of all Customer NHS Boards for the financial year ended 31 March 2020. This report sets out the overarching control objectives in place for the service, as set out in the Service Level Agreement, along with the individual controls we have designed and operated for the year 1 April 2019 to 31 March 2020 to achieve the stated control objectives.

NHS A&A management detail in this report:

- The relevant control objectives, as agreed with the Customer NHS Boards;
- The specific controls which were operating as described during the year 1 April 2019 to 31 March 2020 to meet each of these agreed objectives; and
- The results of testing by the appointed Independent Service Auditor, BDO LLP.

Section 1: Management's Statement

Description

NHS Ayrshire & Arran ("NHS A&A") management is responsible for the design, implementation and maintenance of controls to ensure, with reasonable assurance, and on an ongoing basis, that the control objectives as set out are achieved. NHS A&A's management has reviewed the relevant National Single Instance ("NSI") financial ledger services control objectives and the relevant controls in operation for the year under review (1 April 2019 to 31 March 2020). These controls are reviewed and assessed with the agreement of the Customer NHS Boards concerned.

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

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

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

We confirm that:

a) The accompanying description at Sections 3-5 fairly presents the NSI financial ledger services throughout the period 1 April 2019 to 31 March 2020. The criteria used in making this assertion were that the accompanying description:

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

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

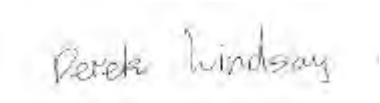
   iii) Does not omit or distort information relevant to the scope of the services being described, while acknowledging that the description is prepared to meet the common needs of the Customer NHS Boards and their auditors and may not, therefore, include every aspect of the services that the Customer NHS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

b) The controls related to the control objectives stated in the accompanying description were suitably designed and operated effectively throughout the period 1 April 2019 to 31 March 2020. The criteria used in making this assertion were that:

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

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

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



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

27 April 2020

Section 2: Independent Service Auditor's Assurance Report

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

To the Directors of NHS Ayrshire & Arran

Scope

We have been engaged to report on NHS Ayrshire & Arran's description of its National Single Instance ("NSI") Financial Ledger Service controls throughout the period 1 April 2019 to 31 March 2020 (the "description"), and on the suitability of the design and operating effectiveness of controls to achieve the related control objectives.

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

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

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

Service Organisation's Responsibilities

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

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

Service Auditor's Responsibilities

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

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

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

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

Limitations of Controls at a Service Organisation

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

Opinion

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

In our opinion, in all material respects:

a) The description in sections 3 to 5 fairly presents the Service Organisation's financial ledger services as designed and implemented throughout the period from 1 April 2019 to 31 March 2020;

b) The controls related to the control objectives stated in the description were suitably designed to provide reasonable assurance that the specified control objectives would be achieved if the described controls operated effectively throughout the period from 1 April 2019 to 31 March 2020 and customers applied the complementary user entity controls referred to in the scope paragraph of this assurance report; and

c) The controls tested which, together with the complementary user entity controls referred to in the scope paragraph of this assurance report, if operating effectively, were those necessary to provide reasonable assurance that the control objectives stated in the description were achieved, operated effectively throughout the period from 1 April 2019 to 31 March 2020.

Description of Test of Controls

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

Other information

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

Intended Users and Purpose

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

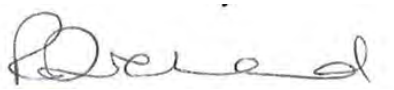
Our report must not be recited or referred to in whole or in part in any other document nor made available, copied or recited to any other party, in any circumstances, without our express prior written permission. We permit the disclosure of this report, in full only, including the description of tests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

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

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

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

Signature:



BDO LLP

Date of Assurance Report: 29 April 2020

Section 3: Management's description of system

Introduction

NHS Ayrshire & Arran ("NHS A&A") hosted the National Single Instance ("NSI") financial ledger services on behalf of all Customer NHS Boards in Scotland for the financial year ended 31 March 2020. These 22 Customer NHS Boards all used the NSI financial ledger services during 2019/20 for core financial transactions. The Finance System used is Advanced (formally Advanced Business Solutions- ABS) Ltd.'s eFinancials 5.0.2 Business Suite. The business suite also includes the third party product, RAM's Asset 4000/Forecast4000/Asset Modifier, for Fixed Asset Accounting. Use is also made of Business Objects Xi (BI v4) for reporting against the eFinancials database and a mirror copy of the Live database which is held on a Netezza server/database. These services are provided through a national contract managed on behalf of NHS Scotland by NHS Ayrshire & Arran.

Overview of Third Party Service Providers

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

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

Main Finance Systems accessed at Boards

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

Summary of Services Offered

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

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

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

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

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

Responsibilities of NHS Ayrshire & Arran and Individual Customer NHS Boards

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

Financial Ledger Arrangements – Processes

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

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

Authorised users

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

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

Business Objects

Access to Business Objects is managed by the NSI Team to ensure that only individuals authorised by the Customer Health Boards have access to their own Health Board data. Note that some Boards receiving services from other Boards allow access to their Board's data to staff from other Boards on a user by user basis.

Note that a third party, National Services Scotland Business Intelligence Team, processes requests logged with them by the NSI Team on behalf of the Boards.

Changes to eFinancials and RAM standing data

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

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

System upgrades and developments

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

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

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

System queries

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

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

Period-end general ledger close

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

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

Monitoring and governance

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

Financial Ledger Arrangements (In Scope)

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

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

Financial ledger Arrangements (Excluded from Scope)

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

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

Complementary Controls

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

- Reviewing and approving the authorisation matrices used to approve requests in eFinancials/FPM (for standing data and user access requests) and RAM/DbCapture (for user access requests);
- Communicating changes to the local authorisation matrices to NSI on a timely basis;
- Individual Customer NHS Boards perform user access reviews twice per calendar year and as a result of this review Boards will inform the NSI Team of any required changes to user access levels that should be undertaken;
- Any changes/updates to standing data records (including requests for new records) have been reviewed/validated by appropriate authorised individuals in the Customer NHS Boards before the request is submitted for input by the NSI Team; and

- Individual Customer NHS Boards undertake housekeeping and ensure that they process transactions in-line with agreed timetables as well as reviewing and resolving any issues with their ledgers that are identified and notified to them by the NSI Team.

Section 4: Summary of agreed control objectives

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

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

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

Section 5: Testing of Controls

CONTROL OBJECTIVE 1: Only authorised users (as determined by Customer NHS Boards) can access the Finance Systems used under this SLA.			
Ref	**NSI Team description of controls**	**Service Auditor's testing**	**Exceptions Noted**
1.1	User access rights to each of the Finance Systems managed under the SLA (eFinancials/RAM/FPM/BOXi/DbCapture/BACS & GoAnywhere) are granted/amended on receipt of an authorised request from individual Customer Boards (BACS and GoAnywhere reviews implemented from second half of 2018/19). ○ An up-to-date list of individuals allowed to authorise changes is maintained by Boards and shared with the NSI Team. The list is formally reviewed on a 6 monthly basis to ensure it remains accurate.	**Inspection** For a sample of user access right requests relating to systems eFinancials, RAM, FPM, BOXi, BACS, GoAnywhere and DbCapture, we inspected 40 service desk tickets against Board authoriser listings to confirm that requests were appropriately authorised prior to implementation.	No exceptions noted.
1.2	A review of user access is carried out on a six monthly basis by requesting information from Health Boards that user access remains appropriate.	**Inspection** For a bi-annual sample, and for a sample of five NHS Boards, we inspected evidence to confirm that the NSI team circulated user access listings to NHS Boards to allow them to review and confirm the validity of system access. Also, we inspected evidence to confirm that the feedback (i.e. user access changes) received from the NHS Boards was suitably actioned by the NSI service desk, and that the required service tickets were in place and completed for all reviews.	No exceptions noted.

Ref	NSI Team description of controls	Service Auditor's testing	Exceptions Noted
1.3	Logical access to eFinancials is controlled through an appropriate authentication method as defined in 'NHS Scotland eFinancials Business Suite National Single Instance Finance System - System Operating Procedures' (v6.1): ○ Authentication by unique user ID and complex password. ○ Minimum password length is 8 characters. ○ System enforced user password changes at regular intervals (30 days). ○ Automatic lockout of the user ID after a predetermined number of incorrect log-in attempts (3 failures). ○ Access to data/sub-ledgers is managed through the assignment of roles to users. ○ The number of users with full administrator access is restricted to members of the NSI Team.	**Inspection** We inspected the eFinancials system security settings to confirm that: ○ Board user authentication is by unique user ID and complex password; ○ Minimum password length is set to be 8 characters; ○ System enforced user password change is set to occur every 30 days; ○ Automatic lockout of user accounts will occur after 3 incorrect log-in attempts; ○ Access to data/sub-ledgers is managed through the assignment of roles to users; and ○ The number of users with full administrator access is restricted to members of the NSI Team.	No exceptions noted.

CONTROL OBJECTIVE 2: Business Objects reporting data is restricted to authorised users.			
Ref	**NSI Team description of controls**	**Service Auditor's testing**	**Exceptions Noted**
2.1	User access rights to Business Objects are granted/amended on receipt of an authorised request from individual Customer Boards.	**Inspection** For a sample of 20 user access right requests relating to the BOXi system, we inspected service desk tickets against Board authoriser listings to confirm that the requests were appropriately authorised prior to implementation.	Out of our sample of twenty user access right requests relating to the BOXi system, one was completed with authorisation provided by an unapproved authoriser for this type of request. We note that the ticket correspondence shows that the initial request was rejected, and that the authorised individuals were listed, however the approval that was then provided was by an individual who has authority to approve other requests within the NHS Board, but not for BOXi requests.
2.2	Users can only access specific Board data through the use of security views.	**Inspection** We inspected system settings to confirm that security views have been implemented, through SQL based queries against BOXi universe tables/objects, in order to prevent Boards from viewing data other than their own.	No exceptions noted.
2.3	Only the NSI Team can perform Business Objects Universe Maintenance. Requests for changes to the Universe are made through the helpdesk by users.	**Inspection** We inspected the LDAP security group membership setup to allow administration and maintenance level access to BOXi to confirm that access is restricted to members of the NSI team. **Enquiry** Confirmed through enquiry that	No exceptions noted.

CONTROL OBJECTIVE 2: Business Objects reporting data is restricted to authorised users.			
		the standard service desk change management process (see control objective 3) is followed to control any changes or amendments to the BOXi universe required by the Boards.	

CONTROL OBJECTIVE 3: Changes to eFinancials and RAM standing data will only be undertaken when appropriately authorised by the Customer NHS Board.			
Ref	**NSI Team description of controls**	**Service Auditor's testing**	**Exceptions Noted**
3.1	Customer standing data within eFinancials is amended on receipt of an authorised request from the relevant Customer Board.	**Inspection** For a sample of 30 changes to customer standing data within eFinancials, we inspected evidence to confirm that these were amended following receipt of an authorised request from the relevant NHS Board.	No exceptions noted.
3.2	Supplier standing data within eFinancials is amended on receipt of an authorised request from the relevant Customer Board.	**Inspection** For a sample of 30 supplier standing data changes within eFinancials, we inspected evidence to confirm that these were amended following receipt of an authorised request from the relevant NHS Board.	No exceptions noted.
3.3	Amendments to the Chart of Accounts, Cost Centres, Job Codes and Internal Delivery Addresses ("IDAs") within eFinancials are only made on receipt of an authorised request from Customer NHS Board.	**Inspection** For a sample of 30 amendments to the Chart of Accounts, Cost Centres, Job Codes and Internal Delivery Addresses (IDAs) within eFinancials, we inspected evidence to confirm that these were implemented following receipt of an authorised request from the relevant NHS Board.	No exceptions noted.
3.4	Ad-hoc Board specific standing data requests are created/amended within eFinancials on receipt of an authorised request from the relevant Customer Board.	**Inspection** For a sample of 30 ad-hoc Board specific standing data requests within eFinancials, we inspected evidence to confirm that these were created/amended following receipt of an authorised request from the relevant NHS Board.	Out of our sample of thirty user access right requests relating to Board specific standing data requests, one was completed with authorisation provided by an unapproved authoriser for this type of request. We note that the authoriser is an approved authoriser for other requests within the Board, but not this type of request.

CONTROL OBJECTIVE 3: Changes to eFinancials and RAM standing data will only be undertaken when appropriately authorised by the Customer NHS Board.			
3.5	Ad-hoc shared standing data areas are only created/amended within eFinancials on receipt of an authorised request through the appropriate governance channels.	**Inspection** For a sample of 30 ad-hoc shared standing data area requests within eFinancials, we inspected evidence to confirm that these were only created/amended following receipt of an authorised request through an appropriate NHS governance channel.	No exceptions noted.

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

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

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

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

CONTROL OBJECTIVE 6: Finance System queries received by the NSI Team are accurately recorded and managed through to closure using the helpdesk system.			
Ref	**NSI Team description of controls**	**Service Auditor's testing**	**Exceptions Noted**
6.1	All queries, standing data requests and issues are logged and recorded as tickets on the NSI Helpdesk and, where appropriate, with the Advanced (ABS-eFinancials and Atos) Helpdesks. ○ A minimum dataset is defined for all tickets; severity levels are agreed and actioned accordingly. ○ All requests are assigned a severity level by the NSI Team based on the policy defined in the Service Level Agreement in order to prioritise the requests and manage the timely resolution of queries. ○ All tickets have a current status and target resolution date logged on the system.	**Enquiry & Observation** Confirmed through enquiry and observation that a minimum dataset is enforced for all tickets raised on the NSI service desk (Zendesk). **Inspection** We inspected a sample of 210 service desk tickets to confirm that a minimum dataset, including severity levels, incident status and target resolution date, was recorded for each ticket logged on Zendesk. We also conducted data analytics on the populations provided with ticket extracts from Zendesk and verified that minimum datasets were met.	No exceptions noted.

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

CONTROL OBJECTIVE 8: Responsibilities set out in the Customer NHS Board Service Level Agreement are completed and reported as agreed.			
Ref	**NSI Team description of controls**	**Service Auditor's testing**	**Exceptions Noted**
8.1	Quarterly performance reports against agreed KPIs (as defined in the Service Level Agreement) are produced and provided to the Customer NHS Board in line with the Service Level Agreement.	**Inspection** For a sample of two quarters, we inspected evidence to confirm that performance reports with agreed KPI metrics were produced and submitted to NHS Boards, and we verified that our sample of five NHS Boards all had signed SLAs in place with NHS A&A.	No exceptions noted.
8.2	The National Financial Systems Management Group ("NFSMG") meets on a quarterly basis in order to monitor the NSI service provision. The members of the group receive performance reports on a quarterly basis in advance of the NFSMG meetings. This includes a performance summary overview from the monthly NSI KPI reports, monthly Atos service reports and Advanced incident reports to identify those areas which require follow-up and action.	**Inspection** For a sample of two quarters, we inspected evidence to confirm that the NFSMG met formally to monitor and review NSI service provision. Also, we inspected evidence to confirm that NFSMG received third party service performance information in advance of meetings and that this highlighted areas where service improvement was required.	No exceptions noted.
8.3	The 'NHS Scotland eFinancials Business Suite National Single Instance Finance System - System Operating Procedures' document is reviewed by an appropriate individual in the NSI Team. These are reviewed for completeness on an annual basis and updates are subject to authorisation by the NFSMG.	**Inspection** We inspected evidence to confirm that the SOP 'eFinancials Business Suite National Single Instance Finance System - System Operating Procedures' was subject to annual review by NSI Management and that any updates made were formally authorised by NFSMG.	No exceptions noted.

Ref	NSI Team description of controls	Service Auditor's testing	Exceptions Noted
8.4	System Disaster Recovery (DR) arrangements for the eFinancials system are tested annually by Atos to ensure systems can be run from the secondary hosting site in an emergency.	**Inspection** We inspected the Atos 'NHSS eFinancials DR' report to confirm that a disaster recovery test was performed for the eFinancials system and that the result of the test was documented. Also, we confirmed that the report details lessons learned and post-test improvement actions/requirements.	No exceptions noted.

Section 6: Other information provided by the Independent Service Auditor

Introduction

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

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

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

Tests of Controls

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

The tests, which are described in Section 5 included such tests as were considered necessary in the circumstances to evaluate whether those control procedures, and the extent of compliance with them, were sufficient to provide reasonable, but not absolute, assurance that the specified control objectives were achieved during the period from 1 April 2019 to 31 March 2020. Our tests were designed to cover a representative number of transactions and procedures throughout the period.

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

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

The types of testing performed are described briefly below.

Enquiry

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

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

Observation

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

Inspection

Inspected documents and records indicating performance of the controls. This included, amongst other things:

- Inspection of applicable management reports;
- Examination of source documentation and authorisations; and
- Examination of documents or records for evidence of performance such as the existence of initials or signatures.

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

Frequency of control	**Number of items tested**
Annual	1
Biannual	1
Quarterly	2
Monthly	4
Weekly	8
Daily	Lower of 10% and 30
Multiple Times per Day	Lower of 10% and 30

Section 7: Other information provided by management

Further information on reported exceptions

In relation to the exceptions noted within the Service Auditors procedures, set out in section 5, we provide the following explanations/disclosures.

Ref	NSI Team description of controls	Exception	Response
2.1	User access rights to Business Objects are granted/amended on receipt of an authorised request from individual Customer Boards.	Out of our sample of twenty user access right requests relating to the BOXi system, one was completed with authorisation provided by an unapproved authoriser for this type of request. We note that the ticket correspondence shows that the initial request was rejected, and that the authorised individuals were listed, however the approval that was then provided was by an individual who has authority to approve other requests within the NHS Board, but not for BOXi requests.	This was an oversight by the agent processing the request. As noted in the audit comments the individual who ended up approving this request did not have the appropriate approval rights for BOXi user requests however they did have approval rights for eFin user requests. This is an unusual scenario for this Board as all other users that can request eFin access for this Board can also request BOXi access.
3.4	Ad-hoc Board specific standing data requests are created/amended within eFinancials on receipt of an authorised request from the relevant Customer Board.	Out of our sample of thirty user access right requests relating to Board specific standing data requests, one was completed with authorisation provided by an unapproved authoriser for this type of request. We note that the authoriser is an approved authoriser for other requests within the Board, but not this type of request.	Again this was an oversight by the agent processing the request. The individual approving the request was approved to request a number of standing data items including new supplier requests but were not listed as being able to request new customers and this was missed by the agent.

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**19 November 2020**
Title:	**Internal Audit Annual Report 2019-20**
Responsible Executive:	**M McGurk, Director of Finance**
Report Author:	**T Gaskin, Chief Internal Auditor**

1 Purpose

This is presented to the Audit and Risk Committee for:

- Assurance

This report relates to a:

- Government policy/directive
- Legal requirement

This aligns to the following NHSScotland quality ambition(s):

- Effective

2 Report summary

2.1 Situation

The purpose of this report is to present the **FINAL** 2019/20 Annual Internal Audit Report to the NHS Fife Audit and Risk Committee. The draft report and related SBAR highlighted key themes, developments and exceptions and was discussed in detail at the September 2020 Audit and Risk Committee. The report has now been finalised with a completed action plan, management responses and appropriate timescales. This report is for the Committee to consider as part of the wider portfolio of year end governance assurances.

2.2 Background

The Audit & Risk Committee is asked to approve this report with completed action plan as part of the portfolio of evidence provided in support of its evaluation of the internal control environment and the Governance Statement.

This Annual Internal Audit Report provides details on the outcomes of the 2019/20 internal audit and the Chief Internal Auditor's opinion on the Board's internal control framework for the financial year 2019/20.

2.3 Assessment

Based on work undertaken throughout the year we have concluded that:

- The Board has adequate and effective internal controls in place;
- The 2019/20 internal audit plan has been delivered in line with Public Sector Internal Audit Standards.

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

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

Therefore, **it is my opinion** that:

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

We noted the following key themes:

- The opportunity to ensure that staffing reflects organisational priorities and the need for Board level assurance that capacity and capability are sufficient to update and drive strategy, achieve transformation and deliver required savings
- Different ways of working due to Covid19 and the opportunities and challenges these present;
- The requirement to review and potentially revise the Board's overall Strategy and all supporting strategies and ensure they are widely known and understood;
- Ongoing developments in risk management;
- The requirement to finalise governance aspects of integration;
- Recognition of eHealth as an essential enabler for change and the implementation of governance arrangements for eHealth and Information Governance;
- Improvement required around implementation of internal audit recommendations.
- The importance of remobilisation to the transformation process is vital moving forward. Internal Audit have developed a set of remobilisation principles and will be reviewing the adequacy of actions taken by the Board against these principles, with a report to be considered at the January 2021 Audit and Risk Committee meeting.

2.3.1 Quality/ Patient Care

The Triple Aim is a core consideration in planning all internal audit reviews.

2.3.2 Workforce

Management responsibilities, skill sets and structures are a core consideration in planning all internal audit reviews.

2.3.3 Financial

Financial Governance is a key pillar of the Annual Internal Audit Plan and value for money is a core consideration in planning all internal audit reviews.

2.3.4 Risk Assessment/Management

The internal audit planning process which produces the Annual Internal Audit Plan takes into account inherent and control risk for all aspects of the Audit Universe. Individual internal audit assignments identify the key risks at the planning stage and our work is designed to evaluate whether appropriate systems are in place and operating effectively to mitigate the risks identified. Legal requirements are a core consideration in planning all internal audit reviews.

2.3.5 Equality and Diversity, including health inequalities

All internal audit reviews which involve review of policies and procedures examine the way in which equality and diversity is incorporated in Board documentation.

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

All papers have been produced by Internal Audit and shared with the Director of Finance and the Associate Director of Finance.

2.3.8 Route to the Meeting

This paper has been produced by the Regional Audit Manager, reviewed by the Chief Internal Auditor and agreed by the Director of Finance.

2.4 Recommendation

The Audit and Risk Committee is asked to:

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

3 List of appendices

The following appendices are included with this report:

- Annual Internal Audit Report 2019/20

FTF Internal Audit Service

Annual Internal Audit Report 2019/20

Report No. B06/21

Issued To: C Potter, Chief Executive
M McGurk, Director of Finance

C McKenna, Medical Director
L Douglas, Director of Workforce
H Buchanan, Director of Nursing
G MacIntosh, Head of Corporate Governance & Board Secretary

Audit and Risk Committee
External Audit

Contents

Final Report Issued	10 November 2020

INTRODUCTION AND CONCLUSION

1. This annual report to the Audit and Risk Committee provides details on the outcomes of the 2019/20 internal audit and my opinion on the Board's internal control framework for the financial year 2019/20.

2. Based on work undertaken throughout the year we have concluded that:

- The Board has adequate and effective internal controls in place;
- The 2019/20 Internal Audit Plan has been delivered in line with Public Sector Internal Audit Standards.

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

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

ACTION

4. The Audit and Risk Committee is asked to **note** this report in evaluating the internal control environment and **report** accordingly to the Board.

AUDIT SCOPE & OBJECTIVES

5. The Strategic and Annual Internal Audit Plans for 2019/20 incorporated the requirements of the NHSScotland Governance Statement and were based on a joint risk assessment by Internal Audit and the previous Director of Finance. The resultant audits ranged from risk based reviews of individual systems and controls through to reviews of strategic governance and the control environment.

6. The authority, role and objectives for Internal Audit are set out in Section 3 of the Board's Standing Financial Instructions and are consistent with Public Sector Internal Audit Standards.

7. Internal Audit is also required to provide the Audit and Risk Committee with an annual assurance statement on the adequacy and effectiveness of internal controls. The Audit & Assurance Committee Handbook states:

The Audit Committee should support the Accountable Officer and the Board by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of the financial statements and the annual report. The scope of the Committee's work should encompass all the assurance needs of the Accountable Officer and the Board. Within this the Committee should have particular engagement with the work of Internal Audit, risk management, the External Auditor, and financial management and reporting issues.

INTERNAL CONTROL

8. The Internal Control Evaluation (ICE), issued on 6 January 2020, was informed by detailed review of formal evidence sources including Board, Standing Committee, Executive Directors Group (EDG) and other papers. The ICE noted many actions taken by NHS Fife to enhance governance and achieve transformation and whilst it concluded that NHS Fife assurance structures were adequate and effective, there were 15 recommendations for improvement by the end of June 2020, eight of which were classified as significant. Four recommendations have been implemented, with two partially completed and nine still outstanding. Further details are included within each governance section.

9. In this annual report we have provided an update on progress to date and, where appropriate, built on and consolidated recommendations to allow revised completion dates to be agreed. The completion dates for seven actions have been extended, with the latest completion date now February 2021. Four remaining actions have previously been extended and remain outstanding. The following key findings from our ICE remain extant:

    - Sustainable financial balance will not be achieved without greater progress on transformation and the revision of the IJB risk share agreement
    - Information Governance assurances are insufficient
    - Although progress has been made, Integration Governance arrangements have still not been concluded
    - Actions to address the recommendations within Internal Audit Report B15/17 & B18/18 - Clinical and Care Governance Strategy and Assurance have not progressed as expected.

10. Covid 19 has clearly had a substantial impact on the organisation's priorities and ability to complete all of the agreed actions. However, it is our view that many of the original recommendations would not have been completed on time had the pandemic not occurred. The EDG should revisit these outstanding actions together with further required actions identified in this Annual Report to ensure the timescales for completion are appropriate, achievable and are afforded the requisite priority.

11. The ICE was our main piece of assurance work for 2019/20 and this Annual Internal Audit Report is therefore less detailed than in previous years. In addition to our ICE follow-up we have tested to ensure that there were no material changes to the control environment in the period from the issue of the ICE to the year-end. We have reflected on the impact of Covid 19 and the special governance arrangements put in place at the end of the year. Some areas for further development were identified and will be followed up in the 2020/21 ICE and, where applicable, our detailed findings have been included in the NHS Fife 2019/20 Governance Statement.

12. For 2019/20, the Governance Statement format and guidance included within the NHSScotland Annual Accounts Manual has been updated to include reference to the March 2018 SPFM Audit Committee Handbook and the Blueprint for Good Governance, issued in January 2019, albeit without specific reference to the associated Treasury Guidance on assurance mapping in the Audit Committee Handbook. Whilst Health and Social Care Integration is not specifically referenced, the guidance does make it clear that the Governance Statement applies to the consolidated financial statements as a whole, which would therefore include activities under the direction of IJBs. We are pleased to note that the NHS Fife Governance Statement does include reference to the key areas omitted from SGHSCD guidance.

13. The Board has produced a Governance Statement which states that:

    - *For 2019-20, 2595 individuals have exceeded the Treatment Time Guarantee to have their treatment provided within 12 weeks. A letter of apology was sent to each patient and every effort was made to treat patients in as short a time as possible. A Waiting Times Improvement Plan is being implemented and progress and improvement actions continue to be monitored through monthly performance reviews within the Acute Services Division.*
    - *An unannounced Healthcare Environment Inspection (HEI) was conducted at Glenrothes Hospital in March 2019, the Hospital having been last inspected in April 2014. The inspection reported on areas where NHS Fife was performing well and areas for improvement, identifying two areas of good practice and three requirements for improvement. During the visit the Board received positive feedback about the standards of cleanliness and staff knowledge of standard infection control precautions. It was, however, noted that not all staff were aware of and completed mandatory requirements for infection prevention and control education and that all patient equipment was safe and clean. An action plan was prepared in response to the areas for improvement identified, with all actions since completed. A further unannounced inspection of Glenrothes Hospital, by Healthcare Improvement Scotland, was conducted in July 2020, focused on Safety and Cleanliness and Care of Older People in Hospital; publication of the report is expected in September 2020.*
    - *There were 13 potential personal data-related incidents or data protection breaches reported to the Information Commissioner's Office (ICO) during the financial year ended 31 March 2020. Six related to personal data breaches, of which one report was rejected by the ICO as it pertained to a deceased person and one was subsequently withdrawn on investigation. Three breaches related to the unavailability of data (unplanned system outage) and four related to personal data breaches within GP Practices (NHS Fife is now joint data controller of data held within GP practices and provides Data Protection serves to GPs). None resulted in any patient harm or financial penalties being imposed. For ten of the reports submitted, the ICO took no further action, though made a series of recommendations. One report remains outstanding at the time of writing of this report.*
    - *During the 2019-20 financial year, no other significant control weaknesses or issues have arisen, in the expected standards for good governance, risk management and control.*

14. Whilst we are content that these disclosures are sufficient, members should be aware that the issues we have raised in relation to Information Governance could well lead to a disclosure in 2021-22 unless remedial action is taken as a matter of priority.

However, management have recently reviewed eHealth and Information Governance and are confident that the implementation of new governance arrangements will raise the profile of Information Governance at the Clinical Governance Committee and should address these issues.

15. Our audit has provided evidence of compliance with the requirements of the Accountable Officer Memorandum, and this combined with a sound corporate governance framework in place within the Board throughout 2019/20, provides assurance for the Chief Executive as Accountable Officer.

16. Therefore, **it is my opinion** that:

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

17. Assurances have been received from all Executive Directors and Senior Managers that adequate and effective internal controls and risk management have been in place across their areas of responsibility and that there are no known control issues, nor breaches of Standing Orders / Standing Financial Instructions.

Covid 19

18. On 17 March 2020 NHS Scotland was placed on an emergency footing under section 1 and section 78 of the National Health Service (Scotland) Act 1978, for at least three months. Boards were given instructions *'to do all that is necessary to be ready to face a substantial and sustained increase in cases of COVID 19'*. A subsequent Directive from Scottish Government to Health Boards made clear that where directions are issued on behalf of the Cabinet Secretary there was to be no local interpretation and that these must be implemented in full and without delay in order to maintain the resilience of the NHS.

19. In recognition of the challenges caused by the rapid mobilisation of services to address Covid 19, a letter was issued by the Scottish Government Director of Health Finance to Board Chairs dated 25 March 2020, providing approval to revise governance arrangements. Individual Health Boards were invited to submit their specific proposals for governance during the pandemic period to the Office of the Chief Executive and NHS Fife submitted it on 30 March 2020. On 8 April 2020 NHS Fife Board considered a paper outlining the Board's planned approach to governance while NHS Fife continued to deal with the Covid 19 pandemic, based on the principles contained in the submission made to the Scottish Government. The paper outlined aims: to ensure the Board could effectively respond to Covid 19 as well as appropriately discharge its governance responsibilities, maximise time available for management and operational staff to deal with the significant challenges of addressing Covid 19 demand within clinical services and minimise the need for people to physically attend meetings.

20. In addition, meetings between the Chair and Vice-Chair and members of the EDG have taken place on a weekly basis and the minutes have been circulated to Board members. The Chief Executive has issued a weekly Covid update to all staff.

21. To ensure good governance around the restart of clinical services, the Remobilisation Oversight Group (ROG) was established with a wide representation of clinical leaders, to oversee the restarting of health and care services in Fife. As reported to the July 2020 Board, the purpose of this group is to take forward the reintroduction of clinical services in a safe, measured and Covid 19 sensitive way. The ROG aims to oversee the

whole system restart to improve integrated pathways from primary care, community, social care and secondary care, adhering to governance arrangements with learning from the Covid 19 response. The latest iteration of the Remobilisation plan, to March 2021, was submitted to the Scottish Government on 31 July in line with the requirements of the Scottish Government.

22. The draft NHS Fife Governance Statement recognises that *"In light of the ongoing impact of Covid 19 on NHS Fife, it is anticipated that the Board's strategic framework will require to be reviewed, in tandem with reassessment of the transformation programme and its relationship to the remobilisation / redesign of key services. As part of that work, the strategies of the IJB will also need to be considered and it is expected that all of the Board's supporting strategies will require review, to appropriately reflect a post-Covid environment."*

23. It is clear that recovery and reconfiguration will be key throughout the remainder of 2020-21. Remobilisation activity and transformation will need to be considered together in parallel with the fundamental review and, if required, revision of the Board's overall Strategy and supporting strategies. Additional responsibilities have been placed on Boards in relation to care homes and these will need to be considered in the context of the recognised need to formalise and enhance clinical and care assurance processes.

24. NHS Fife has contributed to the national response to the pandemic by piloting the Scottish Test and Protect software and the testing of the effectiveness of a Covid 19 treatment.

Key Themes

25. During 2019/20 the Chief Executive's departure resulted in changes to the NHS Fife Executive and senior leadership team structure, including appointment of the then Director of Finance as Interim Chief Executive and the subsequent appointment of an experienced Director of Finance from another Health Board on an interim basis. Other appointments during the year included a new Director of Workforce, Chief Operating Officer, Director of Health and Social Care, although the Director of Strategic Planning post remains vacant. The necessary prioritising of Covid 19 duties had emphasised the urgency to put in place effective controls and in particular the need for the Board to seek assurance from the EDG to assure itself that it had sufficient capacity and capability to deliver long-term strategic change and develop sustainable models of care whilst delivering significant short-terms savings and continuing to deliver business as usual.
26. Over recent years the challenges facing all Boards have increased significantly and NHS Fife has been no exception. Controls within the Board have not kept pace with changes to the environment in which the Board operates and may not be sufficient fully to mitigate the risks facing the Board in the coming years. Systems of control continued to have challenges to adequately resolve long-standing information governance, IJB governance and transformation issues. Capacity issues, specifically the loss of a number of key finance staff, have contributed to a delay in submission of the annual accounts in line with the agreed timetable; the audit commenced in September and will conclude with the NHS Fife Board receiving the accounts for approval in November. Covid 19 and the consequent need to revisit the Board's overall and supporting strategies will create additional pressures going forward. The Board must assure itself that it has sufficient capacity and capability to review and, where necessary revise its

strategies, deliver transformation and reconfiguration, and achieve significant short-term savings whilst continuing to deliver business in extremely challenging circumstances at a time when staff have been under significant pressure over a long period.

27. Other key themes emerging from our ICE and other audit work during the year include:

- As with all other NHS Boards, the Board's overall Strategy and all supporting strategies will require fundamental review and potentially significant revision to take account of the impact of Covid 19 on population need, resource availability and the impact on modes of delivery as well as embedding potential for more rapid change. This will require considerable work to understand the impact of the pandemic and greater focus by Committees on the formation of supporting strategies and the monitoring their delivery as well as the delivery of transformation which will need both to accelerate and be genuinely transformative.
- Covid 19 will have a considerable impact on the Board's risk profile and, given the improvements still required, as reported in B13/20, there is an opportunity fundamentally to embed Risk Management processes, incorporating assurance mapping principles to ensure coherence between Governance Structures, Performance Management, Risk Management and Assurance. The revision of the Board's overall strategies provides an opportunity for fundamental review of the Corporate Risk Register to ensure it links risk to strategic objective, and to allow Board members to participate fully.
- Implementation of Internal Audit recommendations requires improvement with the vital support of EDG to ensure completion of actions. In particular, the completion of actions agreed within the ICE has been poor. Whilst some of this has undoubtedly been affected by Covid 19, we would anticipate that progress with actions will improve as staff return to their substantive duties. There is a need for more robust monitoring of ICE recommendations by officers and via the appropriate governance committees, who should reflect on any significant non-compliance in their year-end assurances.
- Digital and Information (eHealth) will be an essential enabler for transformation and remobilisation. Whilst there have been enhancements in the Digital and Information function, the overall governance arrangements and assurance reporting for Digital and Information, particularly for Information Governance, require substantial improvement to reflect their increasing importance and substantially increased risk profile.
- Following Covid 19, NHS Fife should establish clear and comprehensive Remobilisation principles which cover:
    - Learning lessons and identifying what did and did not go well, and thereby what changes and improvements can be instigated (noting that lessons learnt exercises have been undertaken with reporting to the Gold Command).
    - Where processes revised as a result of Covid 19 are proving more effective and efficient, these should be incorporated into Business as Usual and there should be no assumption of a reversion to prior models; the past should have no special place

- Data to evidence success and failure should be identified at the outset for both formal transformation projects and changes introduced as a result of the Covid 19 pandemic.

- It was already clear that services were not sustainable without substantial change and Covid 19 has increased the requirement for rapid transformation. Our Transformation Programme Governance Follow-up review (B15A/20) found that only one of the six recommendations from our report B10/18 had been fully implemented. Transformation work must be fully aligned with remobilisation activity and the organisation must seize the opportunity for rapid, sustainable change, in accordance with the actions agreed with Internal and External Audit over the last two years. This should be a central priority for both for the NHS Fife Board and particularly the Clinical and Care Governance Committee which has been delegated with responsibility for monitoring progress.

28. As a result of the Covid 19 pandemic, the Scottish Government delayed the requirement for comprehensive review of Integration Schemes. Whilst there has been progress, two key areas still need to be agreed including Clinical and Care Governance, which will now require particular attention. There is a commitment by management to reach agreement by 31 December 2020 in readiness for an approved Integration Scheme for the start of 2021-22.

29. The Board has been working in different ways as a result of the pandemic. Again, this provides an opportunity to reflect on its governance structures to ensure that they focus on the delivery of key organisational objectives, the mitigation of risk and effective assurance. This would also be a good time to refresh the understanding of the Board and Standing Committees on governance, culture and principles, ensuring that they are evident in all aspects of business. Whilst national initiatives such 'active governance' are expected to be introduced in 2020-21, we would expect the Board and Standing Committees to demonstrate:

    - Clear expectations of acceptable progress and delivery, tempered with an understanding of risks and acknowledgement that risks may crystallise
    - An expectation that officers will notify and address poor performance in a timely way
    - A collective understanding from members that NHS Fife must deliver on realistic targets which requires the Board and its Committees to ensure that targets are meaningful and realistic and then to ensure that all possible actions have been taken to meet them
    - Clear focus on priority areas including transformation, integration and information governance.

AUDIT PRODUCTS AND OPINIONS

30. During 2019/20 we delivered 34 audit products, including 9 from 2018/19. These audits reviewed the systems of financial and management control operating within the Board. Our reviews assisted the Board by examining a wide range of controls in place across the organisation.

31. Our 2019/20 audits of the various financial and business systems provided opinions on the adequacy of controls in these areas. Summarised findings or the full report for each review were presented to the Audit and Risk Committee throughout the year.

32. A number of our reports, including reviews of areas such as eHealth Strategic Planning & Governance, Transport of Medicines, and Attendance Management (Workforce Planning) have been wide ranging and complex audits which have relevance to a wide range of areas within NHS Fife.

33. Board staff had previously maintained a system for the follow up of internal audit recommendations and reporting of results to Audit & Risk Committee. To improve the effectiveness of the Audit Follow Up system, a revised approach was adopted from October 2019 with Internal Audit conducting an exercise to identify all outstanding actions back to 2017/18.

34. Although the Audit & Risk Committee has acknowledged improvements in the quality of Audit Follow Up (AFU) reports since January, the AFU management response rate and the quality of responses still requires enhancement. Of the 177 recommendations made in the years 2017/18, 2018/19 and 2019/20, 74 have been reported as complete, 61 of which have been verified by internal audit (as at 22 June 2020). While progress with some of these actions has undoubtedly been affected by Covid 19, we would expect that as staff return to their substantive duties, there should be clear and significant evidence of progress.

ADDED VALUE

35. The Internal Audit Service has been responsive to the needs of the Board and has added value by:

- Providing opinion on and evidence in support of the Governance Statement at year-end and conducting an extensive Internal Control Evaluation which recommended remedial action to be taken in-year. This review made recommendations focused on enhancements to ensure NHS Fife has in place appropriate and proportionate governance, which supports and monitors the delivery of objectives and is commensurate with the challenging environment within which it is operating.
- Continuing to liaise with management and providing ad-hoc advice on a wide range of governance and control issues.
- Progressing the ongoing assurance mapping exercise to identify, assess, structure and develop assurances relating to key risks as well as those required from Directors. Internal Audit facilitated a joint approach across its four mainland clients as well as linking with national developments. In NHS Fife the Board Assurance Framework risk chosen for review was '*eHealth – Delivering Digital and Information Governance & Security*' which is described as '*There is a risk that due to failure of Technical Infrastructure, Internal & External Security, Organisational Digital Readiness, ability to reduce skills dilution within eHealth and ability to derive Maximum benefit from digital provision NHS Fife may be unable to provide safe, effective, person centred care*'. Work was progressing well, with very strong input from the Board Secretary, but was paused due to impact of Covid 19 and will continue as part of the 2020/21 Annual Internal Audit Plan.
- Continued participation in the development of information governance arrangements through attendance at Information Governance and Security Group and eHealth Board meetings and provision of support and advice on governance and assurance reporting.
- Detailed commentary on the developing Risk Management Framework.

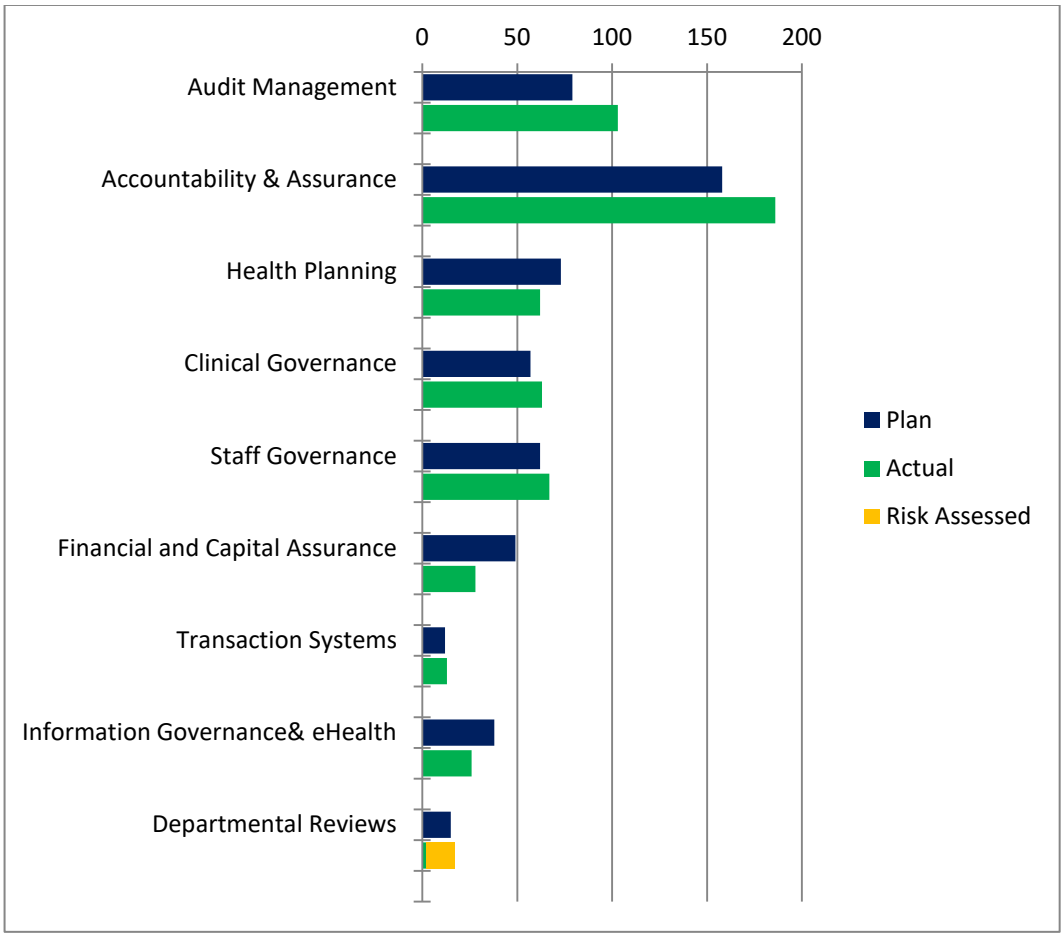
- The B21/20 Medicines Management review contributed to the broader Medicines Assurance Audit Programme by considering compliance with the controls included in the Safe and Secure Use of Medicines Policy and Procedures (SSUMPP) regarding the movement and transportation of medicines to Community Hospitals. The audit found a number of lapses in expected controls and these were communicated at the Safe and Secure Use of Medicines Group and the Medicines Transport Project Group.
- The B23A/20 Attendance Management review provided assurance over the implementation of the attendance management policies and procedures and provided positive feedback that the training and awareness sessions were having a positive impact.

36. Internal Audit developed a governance checklist tool to capture evidence and provide assurance on areas of good governance and identify any gaps in arrangements to support the work of the NHS Boards during the pandemic. An abbreviated checklist was considered by the NHS Fife Standing Committees between June and July 2020 and Internal Audit will provide a review of these completed checklists early in the autumn. Internal Audit has also developed reconfiguration and remobilisation principles to assist management and to inform the 2020-21 audit process.

37. Internal Audit has continued to highlight governance and assurance aspects of integration and the need for clear lines of accountability and ownership of risk and to advise on specific issues, as well as maintaining an awareness of the impact of the IJB control environment on NHS Fife and providing updated assurance principles for consideration by management.

INTERNAL AUDIT COVER

38. Figure 1: Internal Audit Cover 2019/20



39. Figure 1 summarises the 2019/20 outturn position against the planned internal audit cover. The Annual Internal Audit Plan was approved by the Audit and Risk Committee at its meeting on 20 June 2019. To date, we have delivered 550 days against the planned 543 days. Work is ongoing to ensure that the two remaining products from 2019/20 are completed by the September 2020 Audit and Risk Committee. All audit products required for External Audit and for year-end assurance have been delivered.

40. Following a recommendation from the External Quality Assessment carried out on Internal Audit in 2018/19, we continue with the agreed process of risk assessing outstanding 2019/20 audits for inclusion in the 2020/21 plan. Only one review, Recruitment and Retention, required risk assessment and has been included within the audit plan for 2020/21.

41. A summary of 2019/20 performance is shown in Section 4.

PERFORMANCE AGAINST THE SERVICE SPECIFICATION AND PUBLIC SECTOR INTERNAL AUDIT STANDARDS (PSIAS)

42. The FTF Partnership Board has produced as annual summary of activity for the year:

FTF Partnership Board
Annual Summary 2019/20

1. Introduction

This report sets out a summary of Partnership Board meetings held in 2019/20.

2. FTF Partnership Board Meetings

Meetings were held on the following dates:

- 12 April 2019
- 13 November 2019

3. Attendance

The following individuals attended meetings in person or via teleconference:

Members:

- Scott Urquhart, Director of Finance, NHS Forth Valley (Chair)
- Carol Potter, Director of Finance & Performance, NHS Fife (now Chief Executive, NHS Fife)
- Frances Gibson, Head of Finance – Governance & Assurance, NHS Tayside / Robert MacKinnon, Associate Director of Finance

In Attendance:

- Tony Gaskin, Chief Internal Auditor FTF
- Jocelyn Lyall Regional Audit Manager FTF
- Barry Hudson Regional Audit Manager FTF
- Angela McEwan NHS Forth Valley (Minutes)

4. Business

The committee considered both routine and specific work areas during the year:
Key items discussed and outputs included the following:

- Review of External Quality Assessment (EQA) of FTF Internal Audit Service
- Health & Social Care Integration issues
- Internal Audit Shared Service Agreement 2018-2023 - update and review
- Internal Audit Service Specification – update and review
- Governance Issues including Governance Statement Guidance, Assurance Mapping and SGHSCD Assurance letters
- Review of budget performance 2018/19
- Approval of budget proposals 2019/20
- Review of Performance including KPIs and Balanced Scorecard
- Recruitment

5. Conclusion

As Chair of the Partnership Board I can confirm that the breadth of the business undertaken, and the range of attendees at meetings of the Partnership Board has allowed us to fulfil our remit.

Scott Urquhart
Chairperson, FTF Partnership Board

43. We have designed protocols for the proper conduct of the audit work at the Board to ensure compliance with the specification and the Public Sector Internal Audit Standards (PSIAS).

44. Internal Audit is compliant with PSIAS, and has organisational independence as defined by PSIAS, except that, in common with many NHSScotland bodies, the Chief Internal Auditor reports through the Director of Finance rather than the Accountable Officer. There are no impairments to independence or objectivity.

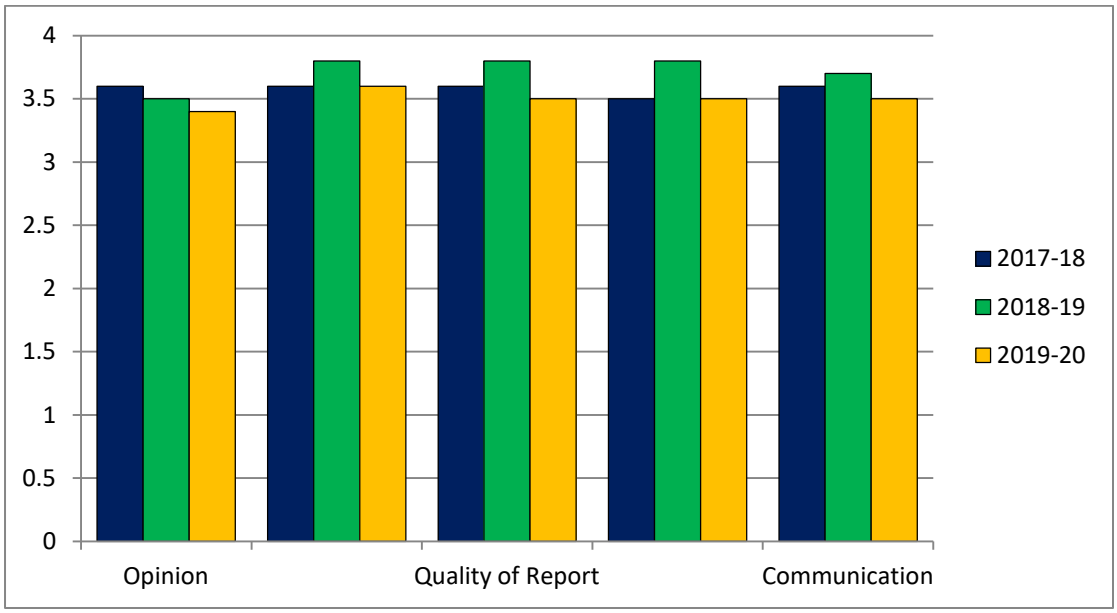
45. Internal and External Audit liaise closely to ensure that the audit work undertaken in the Board fulfils both regulatory and legislative requirements. Both sets of auditors are committed to avoiding duplication and securing the maximum value from the Board's investment in audit.

46. Public Sector Internal Audit Standards (PSIAS) require an independent external assessment of internal audit functions once every five years. The most recent external assessment of the Internal Audit Service was presented to the Audit Committee on 9 June 2019 and concluded that *'following completion of the comprehensive External Quality Assessment (EQA) Checklist and, based on the work undertaken, it is my opinion that the FTF Internal Audit service for Fife and Forth Valley generally conforms with the PSIAS.'* All actions are now complete and we are in the process of updating our self assessment of the EQA requirements. The outcomes will be reported to the FTF Partnership Board.

47. A key measure of the quality and effectiveness of the audits is the Board responses to our client satisfaction surveys, which are sent to line managers following the issue of each audit report. Figure 2 shows that, overall, our audits have been perceived as good or very good by the report recipients.

48. Figure 2: Summary of Client Satisfaction Surveys

Scoring: 1 = poor, 2 = fair, 3= good, 4 = very good.



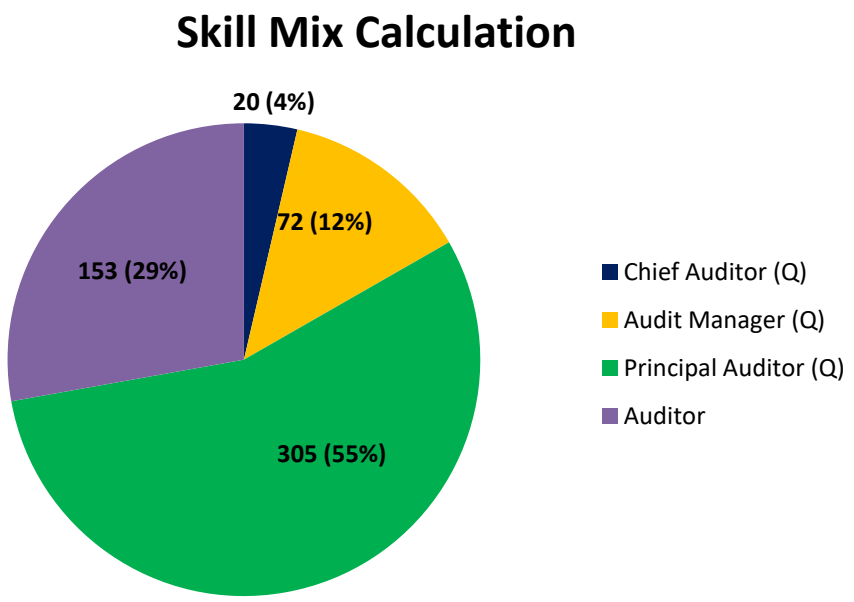
49. Other detailed performance statistics are shown in Section 4.

STAFFING AND SKILL *MIX*

50. Figure 3 below provides an analysis, by staff grade and qualification, of our time. In 2019/20 the audit was delivered with a skill mix of **71%**, which substantially exceeds the minimum service specification requirement of 50% and reflects the complexities of the work undertaken during the year.

51. **Figure 3: Audit Staff Skill Mix 2019/20**

Audit Staff Inputs in 2019/20 [days] Q= qualified input.



ACKNOWLEDGEMENT

52. On behalf of the Internal Audit Service I would like to take this opportunity to thank all members of staff within the Board for the help and co-operation extended to Internal Audit.

53. My team and I have greatly appreciated the positive support of the Chief Executive, Director of Finance, the Head of Corporate Governance & Board Secretary, and the Audit and Risk Committee.

A Gaskin, BSc. ACA
Chief Internal Auditor

Corporate Governance

Summary

The overall NHS Fife senior leadership structure and supporting sub structure should be reviewed and presented to the Board with clear assurance on capability, including Business as Usual arrangements, Strategy production, transformation and remobilisation. Assurance on the essential question of whether NHS Fife has the capacity and capability to deliver its operational and strategic objectives should be provided to the Board from the EDG.

Statements of Assurance

Assurance statements from Standing Committees include a Best Value Framework, which links to performance, governance and accountability as well as a separate section on risk management. However not all relevant key matters relating to governance, internal control and risk management were properly highlighted, including areas of significant concern which had already been identified by Internal and External Audit.

While we commend the more detailed and reflective style of the Standing Committee Annual Statements of Assurance, disclosures included in the Board's Governance Statement were not highlighted as such within either the Annual Statements of Assurance or Executive Directors' Assurance letters. For example, while the HIS inspection reports of Glenrothes and Victoria Hospitals were not referred to in the Clinical Governance Committee Annual Statement of Assurance, nor in the relevant Executive Director's letter, these required disclosure within the Board's Governance Statement.

Integration Arrangements

The 'Review of Progress with Integration of Health and Social Care', published by the Ministerial Strategic Group for Health and Community Care (MSG) in February 2019, outlined 25 practical proposals for NHS Boards, Local Authorities and Integration Authorities, working with key partners including the third and independent sectors, to increase the pace and effectiveness of integration by February 2020. The Director of Delivery, Health & Social Care Integration has met with Fife IJB and HSCI to support the governance and integration arrangements.

Internal audit report B08/20 - Evaluation of Internal Control Framework (ICE) recommended that updates on HSCI should be provided to the Board. The integration scheme review, including the financial risk share, is being undertaken by NHS Fife in conjunction with Fife Council, and was due to be completed by April 2020 but has been delayed due to Covid 19. As a consequence the 'Integration Joint Board' BAF has still not been revised.

Audit Scotland issued a Section 102 report for Fife IJB on financial management and sustainability. Internal Audit had previously highlighted delays in progressing joint governance arrangements, transformation and best value. There has been improvement in financial management with a medium to long term Financial Strategy developed. However, the financial strategy will require further development to reflect the more challenging financial environment created by Covid 19.

Governance Arrangements

The Scottish Government issued a Director's Letter DL(2019)24 – Model Standing Orders -in December 2019, these were adopted by the Board for implementation effective from 1 April 2020. Internal Audit report B10/20 reviewed the Board's progress on the *'Blueprint for Good Governance*' issued by the Scottish Government on 1 February 2019, with one recommendation to address issues to enhance future reiterations of the action plan by 31

October 2020.

An Internal Audit Governance Checklist regarding preserving governance during the pandemic was considered helpful by all standing committees and will be used to inform the development of agendas moving forward so that no element of risk is missed. Internal Audit have now also developed Remobilisation/ reconfiguration principles which it is hoped will be similarly helpful.

Transformation and Remobilisation

The response by clinical services to Covid 19 has presented an opportunity to enhance the scale and pace of delivery of transformation. Audit Report B15A/20 Transformation Governance Follow Up reported limited progress has been made and Covid 19 has now provided the opportunity for transformation work to be fully aligned with remobilisation activity, along with a fundamental review of strategies. As above we would recommend the adoption and monitoring of a clear set of principles for remobilisation which ensure that services are transformed wherever possible and that the past has no special place.

In response to the emerging situation of Covid 19, NHS Fife submitted versions of the mobilisation plans to the Scottish Government, in line with SGHSCD requirements. A Gold, Silver and Bronze emergency planning command structure was implemented by the Board at the start of the pandemic and a Remobilisation Oversight Group (ROG) has now been established to oversee the remobilisation and reconfiguration of clinical services.

During 2019/20, the Chief Executive and the Director of Finance commenced a series of formal executive, general management and Board discussions on the medium-term financial position of NHS Fife. This focused on delivering transformation and securing a recurring balanced financial position. The importance of delivering "value" based health and social care services through effective resource allocation across the organisation was a key underpinning principle in this work. We also note that the use of Digital Technologies has the potential to transform how people access services and how health and care is delivered moving forward. A range of strategic areas to support evaluation and measurement of impact have been identified, with a proposed suite of key performance indicators.

Performance

The Chief Executive provided an overview of performance reporting to the 27 May 2020 Board meeting, where it was highlighted that Elective activity was paused due to Covid 19, with the exception of areas of highest clinical priority including cancer. This has impacted on normal performance metrics, where the 12 Week Outpatient Wait, Access to Psychological Therapies and 18 week referral to treatment had been improving up to end February 2020. Considerable challenges remain in continuing to improve performance against the key national targets as business returns to normal.

Operational Planning

The Board received confirmation from the Scottish Government that the approval process for the draft Operational Plan 2020/21 – 2022/23 is presently on hold. The document submitted in mid March was considered by the Board's governance committees and will be used to establish a recovery plan in relation to Treatment Time Guarantee and other routine performance targets.

Risk Management

Sections of the Board Assurance Framework (BAF) were reported to relevant standing committees throughout 2019/20, however we noted that many scores for target and current risk have not changed during the year, which may indicate insufficient consideration of the

risk profile possibly connected to the capacity and capability issues highlighted earlier. For example, the scores or recorded information within the Integration BAF have not changed despite specific action being agreed in response to Internal Audit concerns. Integration continues to be reported as a moderate risk despite significant known issues and the s102 report. We understand that it was decided that the risk would be reviewed once the integration scheme was updated.

Internal Audit Report B13/20 - Risk Management Framework, presented to Audit & Risk Committee in July 2020, noted the following :

- A risk management appetite has been agreed by the Board and key performance indicators agreed by the EDG, although the KPIs have not yet been reported formally.
- Delegation of functions to the IJB and the implications for risk management, governance and assurance and the treatment of residual risk, have not yet been clarified.
- The Risk Management Policy was due to be presented to the Audit and Risk Committee and the Board in January 2020 but was delayed further until approval by the September 2020 Audit and Risk Committee.

A process has been developed for identification, reporting, review and management of Covid 19 related risks. The format of the annual Risk Management report requires further enhancement and whilst Covid 19 has impacted on timing, it will need to be produced by June next year.

Clinical Governance

Clinical and Care Governance Strategy

The Clinical and Care Governance Strategy had a review date of April 2020 but should have been updated before that in line with actions agreed in two previous Internal Audit reports (Clinical Governance Strategy and Assurance B15/17 & B18/18). Despite this and the Strategy review date of April 2020, the NHS Fife Clinical Governance Committee (CGC) has not been updated regarding the status of the strategy review or provided with a revised date for its production and approval.

A Fife multi-agency Care Home Oversight Group has been formed following the Scottish Government decision to increase responsibilities for Health Boards in relation to assurance around care homes. A Fife Care Home Action Plan has been produced by the Health and Social Care Partnership. These increased responsibilities may exacerbate existing weaknesses in the Clinical and Care Governance Framework previously highlighted by Internal Audit.

We are aware of ongoing discussions regarding revising the Integration Scheme for Fife. Management have advised that these discussions have considered Clinical and Care Governance arrangements in Fife and that any changes would need to be reflected in a revised Clinical and Care Governance strategy. We therefore propose to amend the Annual Internal Audit Plan for 2020/21 specifically to consider Clinical and Care Governance arrangements and revisiting weaknesses highlighted previously, thereby superseding our previous reports.

Clinical Governance Committee Annual Statement of Assurance

Our B08/20 Internal Control Evaluation (ICE) included 2 action plan findings (ref 3 & 4) related to Clinical Governance neither of which have been addressed. The implementation dates for actions to address these findings have been extended due to Covid 19. There was no reference within the CGC Annual Statement of Assurance to non-completion of audit recommendations and the impact this had on the control environment.

The CGC acknowledged that there will be ongoing implications for the Board's clinical governance oversight processes and structures due to the pandemic, and that new responsibilities placed on the Health Board regarding public health testing and care home support would need to be incorporated in these new arrangements. The CGC assurance statement did not highlight the failure to implement key internal audit recommendations, that the Strategy had not been updated by its due date, or major issues in relation to transformation. Most importantly, the assurance statement conclusion did not specifically refer to known Information Governance issues despite an agreed Internal Audit action and the acknowledged major improvement required.

In May 2019 Healthcare Improvement Scotland (HIS) published their Unannounced Inspection Report – Safety and Cleanliness of Hospitals report regarding their visit to Glenrothes Hospital on 19 & 20 March 2019. The CGC has not received an update on actions to address the report findings since it was informed at its 4 September 2019 meeting that '*The HIS report included errors which the Director of Nursing is working with HIS to resolve*'. The report is included as a disclosure in the Board's Governance Statement along with further HIS unannounced inspection reports for Glenrothes and Victoria Hospitals.

Transformation and Remobilisation

Our Transformation Programme Governance Follow-up review (B15A-20) found that only one of the six recommendations from our report B10/18 had been fully implemented. The

subsequent impact of the Covid 19 pandemic on all aspects of NHS Fife's operational and strategic planning will mean that the planning of transformational work will be even more complex and the need for proper oversight and control becomes more urgent and more important. We would recommend that the CGC gives this area an appropriate level of oversight as well as ensuring that there is appropriate coordination and integration with remobilisation and reconfiguration activity. Consideration of Internal Audit's draft remobilisation/reconfiguration principles may be helpful to the CGC in assessing the Board's arrangements.

The Remobilisation Oversight Group is considering the balance between remobilisation of services and redesign/transformation. The role of the Integrated Transformation Board will be reconsidered to learn lessons from Covid 19 and is intended to evolve into a Strategic Planning Group with links with both the H&SCP and Local Authority and spans all business including financial planning, workforce planning, clinical strategy and eHealth. The Winter Plan will be included in the next version of the Joint Mobilisation plan.

NHS Scotland Resilience

The CGC considered the NHS Fife self assessment against the NHS Scotland Health Resilience Unit standards NHS Fife self assessment which were submitted the SGHSCD, updated to include reference to Covid 19, on the due date. We will be undertaking an audit of Compliance with NHS Scotland Resilience: Preparing for Emergencies Guidance and Covid 19 impact in 2020/21 (B15/21).

Staff Governance

Staff Governance Action Plan

A mid-year review of the Staff Governance Action Plan (SGAP) was reported to the Staff Governance Committee (SGC) in November 2019. No year-end review of the SGAP has been undertaken but the SGC have been informed that it will be updated to reflect the impact of Covid 19 and brought back to SGC in November 2020. Each SGC meeting during 2019/20 reviewed a particular strand of the Staff Governance Standard.

Workforce Planning

Revised Integrated Health and Social Care Workforce Planning for Scotland: Guidance published in December 2019 requires a revisit of NHS Fife's Workforce Plan and publication of a revised plan covering the period from 2021 to 2024 (with a deadline of 31 March 2021). The Workforce Planning Group has been reconvened and will review all required actions. The SGC were advised that 'normal' working arrangements for Workforce Planning have been paused and that the Strategy will require significant edits to take account of changes in service delivery, as a result of Covid 19, although we would highlight that it will also need to reflect changes to the Board's overall strategy. The annual Workforce Projections exercise was formally suspended by the Scottish Government due to Covid 19. Services are being supported to consider the workforce implications of changes arising from mobilisation.

Whistleblowing

Draft National Whistleblowing standards were issued by the Independent National Whistleblowing Officer to Boards in anticipation of these receiving parliamentary approval in summer 2020. The SGC was advised on 6 March 2020 that an implementation plan is to be developed to ensure full compliance with the standards, although a date for its completion is not yet noted. A new NHS Fife Whistleblowing Champion took up their position in April 2020. No Whistleblowing Report for 2019/20 has been presented to SGC.

TURAS - Staff Appraisal System

No year-end update on TURAS compliance in 2019/20 was provided to the SGC. TURAS compliance was 43% at 31 May 2020 (compared to 42% at 30 April 2019).

Attendance Management

The Sickness absence rolling 12-month average remains above the 4% target at 4.95% in 12 months to 30 April 2020).

Internal Control Evaluation

There were four recommendations in our B08/20 ICE audit relating to staff governance, one of which remains outstanding in that there has been no update to the SGC on action taken to address Audit Scotland's 'NHS workforce planning (part 2) – The clinical workforce in general practice' report. The related Primary Care Improvement Plan has not been provided to SGC to date.

Covid 19

The SGC was updated at its 18 June 2020 meeting on the current position regarding the pandemic and the planned arrangements for the remobilisation of NHS Fife's workforce.

Financial Governance

Structure of Finance Department

There have been a number of recent changes within senior management in the Finance Department including the previous Director of Finance moving to cover the Chief Executive role from February 2020, the interim appointment of a new Director of Finance from April 2020 (with some part-time cover during February and March, the secondment of the Assistant Director of Finance (Financial Services) to NHS Orkney and the departure of some senior financial and management accounting staff during January 2020.

The Director of Finance is currently progressing a restructure of the directorate, in line with the direction of travel identified for the department, with the intention of ensuring a focus on key priorities as well as ensuring consistent senior leadership for each of the critical functions and allowing for succession planning.

The restructure process was paused, partly due to Covid 19 and the need for HR support and will be consulted on with all parties (including Internal Audit) in the coming months, after which the Finance, Performance & Resources Committee (FP&RC) will be provided with assurances that capacity and capability are sufficient to provide appropriate financial support for strategy, transformation and business as usual.

The Director of Finance arranged for interim senior support from NHS Tayside from April 2020 to September 2020 for the Financial Services and Endowment areas; however this arrangement changed at short notice in July 2020 which impacted on capacity at that key time. Consequently, and also due to the impact on availability of staff working remotely during the pandemic, financial accounts were submitted to Audit Scotland beyond the financial accounts timetable deadline with the potential to delay the year-end timetable beyond the statutory deadline. The Director of Finance is working with Audit Scotland and Scottish Government to ensure the accounts are laid within the statutory deadline of 31 December 2020.

Anticipated Year-end Financial Position

As reported to the 27 May 2020 Board, the draft financial outturn position to 31 March 2020, subject to external audit review, was:

- Revenue Resource Limit (RRL) - ££780.531 million - target met with £0.060m under spend
- Capital Resource Limit (CRL) - £9.286 million - a resource budget for net capital investment - target met.

For 2019/20 the financial year end position for NHS Fife includes costs incurred for Covid 19 of £3.711m split £2.090m NHS Fife and £1.621m IJB which the Director of Finance stated is expected to be funded in full.

Efficiency Savings

For 2019/20 NHS Fife was required to make £17.333m of cash efficiency savings. Reported savings at year end totalled £10.154m of which £5,397m (53%) was non recurring. Therefore, there was £7m of unidentified savings and 73% of the overall savings target has not been met on a recurring basis. Internal and External Audit have previously reported the reliance on non recurring savings to achieve financial balance in previous years. For 2019/20 the delivery of savings in Acute Care was significantly short of the planned amount and this area should be a focus of attention for the FP&RC for 2020/21.

Financial Reporting

Financial reporting throughout the year was consistent, with a visible financial improvement at year end and the position was clearly presented via the Integrated Performance & Quality Report to the FP&RC.

The Director of Finance advised at the weekly meeting between the Chair and Vice Chair on 26 June 2020 that the revenue and capital plans drawn up originally in January/ February 2020 required full reassessment to reflect changed priorities as part of the remobilisation process. Updates will be provided to the EDG with further detail on the position, covering core spend and additional Covid 19 related costs.

The January 2020 FP&RC considered its self assessment and agreed that it was operating as per its Terms of Reference with positive assessments from its members and attendees and no areas of major concern identified.

Risk Management

The narrative within the Financial Sustainability BAF (FSBAF) recognises the ongoing financial challenges facing Acute Services as well as the pressures within the Health and Social Care Partnership in relation to social care budgets and the impact of potential amendment to the risk share arrangement. The report to the July 2020 meeting of the FP&RC highlighted concern over the financial position for the 2020/21 year and the planned savings for Acute Services where much more work is required. The FSBAF states that the impact of the Social Care overspend has been highlighted to Scottish Government within the monthly reporting template.

Internal Control Evaluation

The challenging financial position was highlighted within B08/20 Evaluation of Internal Control Framework (ICE). We strongly reiterate that financial balance during 2020/21 and beyond will be challenging unless the pace of transformation accelerates significantly; the savings within Acute Services are significantly improved and the resolution of the IJB risk share agreement.

The sole ICE recommendation relating to Value for Money has been partly implemented in that Management have started a process of utilising Audit Scotland Best value toolkits and other benchmarking tools (e.g. Discovery) but this has not been reported to the FP&RC which is therefore not in a position to be able to provide assurance on this area as required.

Information Governance

Year-end Assurances

Assurances provided to the NHS Fife Clinical Governance Committee (CGC) in 2019/20 were not sufficient to allow it to conclude accurately on the adequacy and effectiveness of Information Governance arrangements. Such assurances that were provided were delivered via minutes and annual statements of assurance from the Information Governance and Security Group (IG&SG), eHealth Board and the eHealth Performance Report. However, these did not provide assurance regarding compliance with Data Protection Act 18/GDPR, NIS Regulations, NHS Scotland's Information Security Policy Framework and the Cyber Resilience Public Sector Action Plan, all of which have significant gaps in control.

The IG&SG and eHealth Board Annual Statements of Assurance did not highlight significant matters of concern and were not considered and agreed by members prior to being presented to the CGC. Similarly, the relevant Director's annual assurance letter did not highlight these major concerns.

The conclusion at section 8.1 of the CGC Annual Statement of Assurance regarding adequate and effective governance arrangements being in place for the year does not specifically refer to Information Governance and we would have expected any conclusion on this area to contain significant caveats.

Competent Authority Audit – NIS Regulations

The outcome of the NIS Regulations/ISPF audit undertaken by the Competent Authority for Health, issued on 30 March 2020, has not been reported to a Standing Committee of the Board or considered for inclusion in the Board's Governance Statement. NHS Fife was assessed as being compliant with 53% of the controls. The report included 58 recommendations to address areas of non-compliance 18 of which were in the 'Red-Urgent' category. A draft remediation plan grouping the recommendations and proposed action by related topics has been prepared but needs to be finalised and approved. The CGC Annual Statement of Assurance also makes no reference to this important piece of assurance to the Committee.

Cyber Resilience

The IG&SG have been informed that '*the timeframe (31 October 2018) for gaining Cyber Essentials as required by PSAP has already passed and it should be noted that the scale and complexity of the IT estate and reliance in places upon legacy systems, remains a significant challenge' and the plan provided IG&SG with the key dates towards achieving 'alignment with ISPF/NIS whilst completing the requirements of the Public Sector Action Plan for Cyber Resilience*'. This information has not been explicitly conveyed to the CGC.

eHealth and Information Governance Arrangements

We raised a number of significant concerns over Information Governance and have been assured by management that changes to governance arrangements to be implemented following a very recent review of eHealth and Information Governance arrangements, reported to the CGC in July 2020, will raise the profile of Information Governance at the CGC and will address our concerns.

However, the July paper only provided a direction of travel and did not explicitly and overtly address a number of concerns raised by Internal and External Audit. We will review both the adequacy of the final agreed arrangements and their implementation in 2020-21.

Internal Control Evaluation

The following fundamental recommendations, some of which had also been highlighted previously, from the ICE report B08/20 are still outstanding:

- Information Governance arrangements currently operating in NHS Fife do not provide Fife NHS Board with sufficient assurance regarding compliance with its legislative requirements
- The management of information governance risks needs to be addressed so that Fife NHS Board is assured that all significant risks have been identified and that the mitigating actions in place or planned will be sufficient to reduce the risk to a level acceptable to the Board within an acceptable timescale
- Reporting to the Board and NHS Fife CGC on ISPF/GDPR/DPA 2018 and Cyber Resilience Public Sector Action plan has been minimal
- Reporting on the eHealth Delivery Plan to a standing committee only occurred once in 2019/20 and did not overtly link projects to relevant national and local strategies

As part of our ICE work we followed up on recommendations made in Internal Audit report B31&B32/19 and concluded that nine issues regarding assurances provided to the IG&SG had still not been addressed. At year-end, two issues had been partly addressed and seven were still unresolved. Overall it is not clear that these issues are being progressed with sufficient urgency; NHS Fife must prioritise these issues and actively monitor progress in much greater detail than previously.

eHealth Strategic Planning

We are aware that the reaction to the Covid 19 pandemic included accelerating and bringing forward elements of the NHS Fife Digital and Information Strategy Delivery Plan for example to allow clinicians to consult with patients remotely.

Action Point Reference 1 – Corporate Governance

Finding:

Over recent years the challenges facing all Boards have increased significantly and NHS Fife has been no exception. Controls within the Board have not kept pace with changes to the environment in which the Board operates and be sufficient fully to mitigate the risks facing the Board in the coming years. Systems of control continued to have challenges to adequately resolve long-standing information governance, IJB governance and transformation issues. Capacity issues, specifically the loss of a number of key finance, have contributed to a delay in submission of the annual accounts, in line with the agreed timetable. Covid 19 and the consequent need to revisit the Board's overall and supporting strategies will create additional pressures going forward. The Board must assure itself that it has sufficient capacity and capability to review and, where necessary revise its strategies, deliver transformation and reconfiguration, and achieve significant short-term savings whilst continuing to deliver business in extremely challenging circumstances at a time when staff have been under significant pressure over a long period.

Audit Recommendation:

The EDG should consider the specific issues highlighted in this report and other known issues and reflect on its structures and priorities and the resources required to deliver activity in a post Covid 19 environment while updating strategies, implementing savings and designing and delivering remobilisation whilst seizing the very limited opportunity for radical transformational change to ensure long-term sustainability of services. It should then provide overt assurance to the Board which should specifically comment on whether NHS Fife has the capacity and capability to deliver its operational and strategic objectives in the current circumstances and outline any changes required and how they will be subject to appropriate governance monitoring.

Assessment of Risk:

Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**

Management Response/Action:

Whilst a range of governance improvement activity was delivered during 2019/20 it is necessary to continue that work into 2020/21. By the end of 2020/21 we plan to have fully embedded many of the improvements in Information Governance including improving reporting and assurance to the Board. In terms of the IJB governance there has been significant process however this also needs to continue. Progress was also made in establishing the Programme Board to support and drive transformation however this was understandably paused at the onset of the pandemic. The capacity of the finance team was an issue during 2019/20 however the Director of Finance has been working to address this through a review of the finance structure, roles and responsibilities and capabilities required to deliver the service.

In developing the forward strategy and priorities for the organisation we will take

significant learning from the service redesign delivered in our initial and ongoing response to the pandemic. We are working to build the process to support a full review of our strategy underpinned by a formal strategic planning and resource allocation process.	
Action by:	**Date of expected completion:**
Chief Executive	**31 March 2021**

Action Point Reference 2 – Corporate Governance	
Finding:	
Our Internal Control Evaluation report (B08/20) issued in December 2019 included 15 Action Plan points, many of which were significant and all of which should have been completed by year-end. However, progress to date has been limited.	
Audit Recommendation:	
Our Internal Control Evaluation report is undertaken part way through the financial year in order to allow management time to address the findings prior to year-end. Whilst we recognise that the pandemic has been a disruptive factor it is not clear that this is the sole or even the main factor in their non-delivery. The EDG should consider why these recommendations have not been delivered, why this was not recognised earlier and produce an action plan for monitoring by the Audit and Risk Committee. Any such plan should take into account the issues relating to capacity and capability raised in recommendation 1.	
Assessment of Risk:	
Significant 	Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**
Management Response/Action:	
EDG will focus on ensuring that the report recommendations are delivered as soon as possible. The pandemic influenced delivery of many aspects of our EDG work however we will prioritise clearance of this issue, albeit in the context of the ongoing pandemic.	
Action by:	**Date of expected completion:**
Chief Executive	**31 March 2021**

Action Point Reference 3 – Corporate Governance	
Finding:	
Whilst the introduction of standard templates for standing committee assurances and Directors' assurances has improved the assurance process, not all relevant key matters relating to governance, internal control and risk management were properly highlighted, including areas of significant concern which had already been identified by Internal and External Audit.	
Audit Recommendation:	
All potential areas for inclusion in the Governance Statement should be clearly identified in both Executive Director and Senior Manager assurances and in Standing Committee annual assurance reports. The information within these sources of assurance should be triangulated to ensure all issues to be considered within the Governance Statement are clearly and consistently identified.	
Assessment of Risk:	
Significant 	Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**
Management Response/Action:	
This recommendation is fully accepted. Further work will be undertaken in the coming financial year to improve the completeness and consistency of assurance information provided in the Directors' letters, Standing Committee Annual Reports and final text of potential disclosures within the Governance Statement.	
Action by:	**Date of expected completion:**
Director of Finance and Board Secretary	**31 May 2021**

Action Point Reference 4 – Corporate Governance

Finding:

The IJB is undergoing a governance review which is supported by the Director of Delivery, Health & Social Care Integration from Scottish Government. However, whilst progress has been made, the review has not yet been fully completed due to Covid 19. There is a revised timescale for implementation which appears appropriate

We noted that the BAF for the IJB reported to the July 2020 NHS Fife Board and throughout 2019/20 has remained at a Moderate Risk and does not reflect the current risk profile.

Audit Recommendation:

Monitoring and consideration of the arrangements for HSCI including the recommendations of the MSG report, should reflect the strategic importance of the activities directed by the IJB.

Whilst we understand that the risk cannot be fully articulated until the Integration Scheme is updated, the BAF for the IJB should be reviewed and updated urgently to at least reflect the known key issues.

Assessment of Risk:

Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**

Management Response/Action:

The review of the Integration Scheme is continuing with partners. Regular meetings have been held over the last few weeks. It is anticipated this will be completed by March 2021

Following the completion of the review, the IJB will undertake a further review of its Governance Framework and structures

An initial development session for IJB members with the Director of Delivery, Health and Social Care Integration, Scottish Government was held in Nov 2019 and a programme of development days has been progressed since May 2020. Four sessions have been completed to date with further sessions planned. Topics covered include; Governance, Directions, Roles and Responsibilities, the IJB Annual Report, Remobilisation of Services, Leadership and Structures, Best Value and Performance

Regular updates continue to be provided to the IJB and its Governance Committees and EDG and SLT.

Action by:	Date of expected completion:
Director of Health and Social Care	**31 March 2021**

Action Point Reference 5 – Clinical Governance

Finding:

The Clinical and Care Governance Strategy should have been updated in line with actions agreed in two previous Internal Audit reports (Clinical Governance Strategy and Assurance B15/17 & B18/18). The agreed dates were not met, nor was the official Strategy review date of April 2020. The NHS Fife Clinical Governance Committee (CGC) has not been updated regarding the status of the strategy review or provided with a revised date for its production and approval.

We are aware of ongoing discussions regarding revising the Integration Scheme for Fife. Management have advised that these discussions have considered Clinical and Care Governance arrangements in Fife and that any changes would need to be reflected in a revised Clinical and Care Governance strategy. We therefore propose to amend the Annual Internal Audit Plan for 2020/21 specifically to consider Clinical and Care Governance arrangements and revisiting weaknesses highlighted previously, thereby superseding our previous reports.

Audit Recommendation:

The CGC should take ownership of this issue and ensure that the Clinical and Care Governance Strategy is reviewed and presented to Fife NHS Board for approval in an appropriate timescale.

Assessment of Risk:

Significant  Weaknesses in control or design in some areas of established controls.

Requires action to avoid exposure to significant risks in achieving the objectives for area under review.

Management Response/Action:

A review of the integration scheme is nearing a close, but the timeline for completion has been adversely affected by the global Corona virus pandemic.

Meetings to discuss and agree the clinical governance processes and linkages between NHS Fife Health Board and the Integrated Joint Board have been had; which have included the Medical Director, Nurse Director, Vice Chair of the Health Board and the Chief Officer and other key partners in the IJB.

The output of these meetings is in the final stages of agreement and will ensure robust clinical governance reporting via the NHS Fife Clinical Governance Committee for safety and quality of all NHS Fife services, while complying with the legislative responsibilities delegated to the IJB.

Once agreed by the group the proposals will be taken through the relevant governance routes of the IJB and Health Board for approval.

Action by:	Date of expected completion:
Medical Director	**31 March 2021**

Action Point Reference 6 – Clinical Governance	
Finding:	
Healthcare Improvement Scotland (HIS) published their Unannounced Inspection Report – Safety and Cleanliness of Hospitals report regarding their visit to Glenrothes Hospital on 19 & 20 March 2019 in May 2019. The CGC has not received an update on this report since it was informed at its 4 September 2019 meeting that '*The HIS report included errors which the Director of Nursing is working with HIS to resolve*'. The report is included as a disclosure in the Board's Governance Statement along with further HIS unannounced inspection reports for Glenrothes and Victoria Hospitals.	
Audit Recommendation:	
The CGC should actively monitor actions arising from all HIS and other external inspections and reflect on them appropriately in the preparation of their annual assurance statement.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
The Director of Nursing reported to the Clinical Governance Committee in January 2020 that a formal meeting had been held with the Director of Nursing from HIS, who apologised for errors in the initial report. HIS carried out an unannounced Inspection, again in Glenrothes Hospital, in July 2020; the Report was published on 15 September 2020. The Report and Action Plan will be presented to the Clinical Governance Committee by the Director of Nursing on 4 November 2020 for review and discussion.	
Action by:	**Date of expected completion:**
Director of Nursing	**4 November 2020**

Action Point Reference 7 – Financial Governance

Finding:

For 2019/20 NHS Fife were required to make £17.333m of cash efficiency savings. Only £10,154m was delivered, over half of which was non-recurrent. In essence only 27% of the savings target was delivered recurrently and 40% was not delivered at all. In particular, the delivery of savings in Acute Services was significantly short of that planned. Internal and External Audit have repeatedly highlighted the reliance on non recurring savings to achieve financial balance, as well as the failure to deliver the transformational change required to deliver financial sustainability.

Audit Recommendation:

The Finance, Performance and Resources Committee workplan should include a series of focused deep-dives to understand the root cause of these issues, particularly within Acute Services and there should be congruence with the work of the CGC in assessing progress with Transformation.

Assessment of Risk:

Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**

Management Response/Action:

The key to ensuring recurring financial balance and effective resource allocation is delivery of service transformation. In Q1, 2020/21 the Director of Finance proposed and EDG approved a range of key workstreams to deliver the changes required, this work will have a 3-year timeframe linked to the Scottish Government Medium-term Financial Framework for Health and Social Care. In parallel work has begun on a benchmarking review of specialty costs and an assessment of the workforce requirements for service delivery, this remains a work in progress.

The focus will be developing financial planning for sustainable services, changing the narrative to focus on service transformation which is delivered through a strategic planning and resource allocation approach which integrates operational, workforce and financial planning, albeit with the context of managing through a global pandemic.

Action by:	Date of expected completion:
Director of Finance	**31 March 2021**

Action Point Reference 8 – Information Governance

Finding:

Action has not yet been taken to address the findings and recommendations included in internal audit report B08/20 Evaluation of Internal Control. A review of eHealth and Information Governance arrangements was reported to the CGC in July. We were advised by management that the implementation of new governance arrangements is expected to raise the profile of Information Governance at the Clinical Governance Committee and will address the issues raised by Internal Audit, although not all details of how this would be achieved were fully apparent in the July paper.

Audit Recommendation:

The CGC should monitor implementation of new governance arrangements for eHealth and Information Governance to determine whether they have addressed the issues in the narrative of this and the following reports:

- B31&32/19 Information Governance and eHealth – Action Plan Points 1, 2 & 3
- B06/20 Annual Internal Audit report – Action Plan Point 7
- B08/20 Evaluation of Internal Control – Action Plan Points 10, 12 & 15
- Competent Authority Report on Compliance with NIS Regulations – Recommendations 1.1.1 & 1.1.2

Revised governance arrangements should include providing the Clinical Governance Committee with explicit assurance regarding compliance with DPA 18/GDPR, NIS Regulations, NHS Scotland's Information Security Policy Framework and the Cyber Resilience Public Sector Action Plan and should result in more robust scrutiny of both Information and eHealth governance by the CGC.

Revised governance arrangements should be implemented at pace so that the CGC receives the required assurances regarding this critical area of governance in 2020/21.

Assessment of Risk:

Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**

Management Response/Action:

The recommendations are accepted.

The Clinical Governance Committee was provided an update at its meeting on 4th March 2020, on the corporate governance review of Digital and Information (D&I), including Information Governance & Security (IG&S), and further supported the direction of travel at its meeting on the 8th July 2020.

Delays have been inherent whilst responding to the Covid 19 incident, but progress is currently being made.

Digital and Information Board

The Board workplan has been updated to include a standing item for 'Audit/Action plans', the delivery plan and 'project on a page' reporting provided. Points to escalate to the Clinical Governance Committee will be noted and actioned.

The 20/21 annual report/assurance statement will be more detailed and set the context going forward.

Information Governance & Security Group

A key component due to the inherent information risks to the organisation and recommendations within previous audits the IG&S Group is being reformed to act as a strategic oversight group supported by an Operational Group.

An IG&S Group meeting is scheduled for 15th October 2020 with the focus will be on providing whole system leadership, oversight and assurance to the organisation and will ensure the 'lens is maintained' on all aspects of IG&S. It will be a transition period in its early stages moving through implementation.

Similar to the D&I board the IG&S Group workplan has been updated to include a standing item for 'Audit/Action plans'. Points to escalate to the Clinical Governance Committee will be noted and actioned.

The 20/21 annual report/assurance statement will be more detailed and set the context going forward.

Action by:	Date of expected completion:
Director of eHealth and Director of Finance (SIRO)	31 March 2021

Section 4 Key Performance Indicators

Key Performance Indicators – Performance against Service Specification

	Planning	Target	2019/20	2018/19
1	Strategic/Annual Plan presented to Audit and Risk Committee by April 30th	Yes	No (June 20)	May 2019
2	Annual Internal Audit Report presented to Audit and Risk Committee by June	Yes	Yes	Yes
3	Audit assignment plans for planned audits issued to the responsible Director at least 2 weeks before commencement of audit	75%	95%	78%
4	Draft reports issued by target date	75%	76%	65%
5	Responses received from client within timescale defined in reporting protocol	75%	57%	65%
6	Final reports presented to target Audit and Risk Committee	75%	76%	75%
7	Number of days delivered against plan	100% at year-end	101% at year-end	90%
8	Number of audits delivered to planned number of days (within 10%)	75%	76%	70%
9	Skill mix	50%	72%	74%
10	Staff provision by category	As per SSA/Spec	Pie chart	
	Effectiveness			
11	Client satisfaction surveys	Average score of 3	Bar chart	

Assessment of Risk

To assist management in assessing each audit finding and recommendation, we have assessed the risk of each of the weaknesses identified and categorised each finding according to the following criteria:

Risk Assessment		Definition	Total
Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	1 (9)
Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**	6 (1, 2, 3, 4, 5 & 7)
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	2 (6 & 8)

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**19 November 2020**
Title:	**Audit & Risk Committee Annual Statement of Assurance 2019-20**
Responsible Non-Executive:	**Martin Black, Committee Chair**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- Legal requirement
- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Effective

2 Report summary

2.1 Situation

All formal Committees of the NHS Board are required to provide an Annual Statement of Assurance for the NHS Board. The requirement for these statements is set out in the Code of Corporate Governance.

2.2 Background

The Audit & Risk Committee reviewed the draft of this year's report at its last meeting in September and this paper provides the final version for onward submission to the Board as part of the pack of papers supporting the Annual Accounts.

2.3 Assessment

The Audit & Risk Committee has a duty to provide an Annual Statement of Assurance on its own area of remit. The Statement for the Audit & Risk Committee for the year 2019/20 is attached for information. The final Statement has been signed by the Chair of the Committee.

The Audit & Risk Committee also reviews and considers the Annual Statements of Assurance of the other Committees, confirming whether they have fulfilled their remit and that there are adequate and effective internal controls operating within their particular area of operation. These were included in the September agenda as part of the overall governance and assurances linked to the annual accounts process.

2.3.1 Quality/ Patient Care

Delivering robust governance across the organisation is supportive of enhanced patient care and quality standards.

2.3.2 Workforce

N/A.

2.3.3 Financial

The production and review of year-end assurance statements are a key part of the financial year-end process.

2.3.4 Risk Assessment/Management

The identification and management of risk is an important factor in providing appropriate assurance to the NHS Board.

2.3.5 Equality and Diversity, including health inequalities

This paper does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people. Consequently, an EQIA is not required.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

N/A.

2.3.8 Route to the Meeting

This report has previously been considered in full by the Committee at its last meeting in September.

2.4 Recommendation

The paper is provided for:

- **awareness** – to note the Chair's signed approval of the enclosed Statement.

Report Contact
Dr Gillian MacIntosh
Head of Corporate Governance & Board Secretary
gillian.macintosh@nhs.scot

ANNUAL STATEMENT OF ASSURANCE
FOR THE AUDIT & RISK COMMITTEE 2019/20

1. Purpose of Committee

1.1 The purpose of the Audit & Risk Committee is to provide the Board with assurance that the activities of Fife NHS Board are within the law and regulations governing the NHS in Scotland and that an effective system of internal control is maintained.

1.2 The duties of the Audit & Risk Committee are in accordance with the principles and best practice outlined in the Scottish Government Audit & Assurance Committee Handbook, dated April 2018.

2. Membership of Committee

2.1 During the financial year to 31 March 2020, membership of the Audit & Risk Committee comprised:

Mr Martin Black	Chair / Non-Executive Member
Ms Sinead Braiden	Non-Executive Member
Cllr David Graham	Stakeholder Member
Ms Janette Owens	Area Clinical Forum Representative
Mrs Margaret Wells	Non-Executive Member

2.2 The Committee may choose to invite individuals to attend the Committee meetings for the consideration of particular agenda items, but the Board Chief Executive, Director of Finance, Director of Nursing (as the lead for risk), Board Secretary, Chief Internal Auditor and statutory External Auditor are normally in routine attendance at Committee meetings. Other attendees, deputies and guests are recorded in the individual minutes of each Committee meeting.

3. Meetings

3.1 The Committee met on five occasions during the year to 31 March 2020, on the undernoted dates:

- 16 May 2019
- 20 June 2019
- 5 September 2019
- 9 January 2020
- 13 March 2020

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 As the 2019/20 Financial Year drew to a close, the Covid-19 pandemic required an unprecedented mobilisation effort on behalf of NHS Fife in order to address the developing public health emergency. As cases of coronavirus increased and the Board subsequently placed on an emergency footing, staff responded with professionalism, speed and agility, effecting major service changes in an extremely short timescale. This report is written against that background, with the knowledge that the Committee's future schedule of business will adapt appropriately to reflect on the Board's ongoing response to Covid-19. Issues to consider in the forthcoming year

will include ongoing implications for the Board's strategic planning and risk management processes, as services begin to be remobilised and redesigned.

4.2 Minutes of Committee meetings have been approved by the Committee and presented to Fife NHS Board. The Board also receives a verbal update at each meeting from the Chair, highlighting any key issues discussed by the Committee at its preceding meeting. The Committee maintains an action register to record and manage actions agreed from each meeting, and reviews progress against deadline dates at subsequent meetings.

4.3 The range of business covered at the meeting demonstrates that the full range of matters identified in the Audit & Risk Committee's remit is being addressed. In line with its Constitution and Terms of Reference, the Committee has considered standing agenda items concerned with the undernoted aspects:

- Internal Control mechanisms;
- Internal & External Audit;
- Corporate Governance, including implementation of and compliance with the NHSScotland *Blueprint for Good Governance*;
- updates to the NHS Fife Code of Corporate Governance and the Board's Standing Orders;
- scrutiny of the Board's Annual Financial Accounts;
- Risk Management, including the Board Assurance Framework; and
- other relevant matters arising during the year.

4.4 In relation to the internal audit function, the Committee received information on the external quality evaluation of the FTF Internal Audit service, in accordance with Public Sector Internal Audit Standards. As key stakeholders and as part of the validated self-assessment exercise, Committee members were invited to submit a review questionnaire on the quality of the service provided. The final External Quality Assessment report and related action plan were considered by the Committee at its meeting in May 2019.

4.5 Members have reviewed and discussed in detail at meetings the annual audit plans; reports from the internal auditors covering a range of service areas; and management's progress in completing audit actions raised. In relation to the latter, the Committee has noted that further work is required to enhance the effectiveness and timeliness of completing audit recommendations, to reduce the number of outstanding actions, and the Director of Finance has undertaken to improve this as a priority action in the current year. At the January 2020 Audit & Risk Committee, it was agreed that any audit report which is categorised as Limited Assurance or No Assurance will be reported in full to the Audit & Risk Committee, with the Lead Executive Director invited to attend, to improve scrutiny of improvement activities required.

4.6 In reference to External Audit, the Committee has considered in detail the annual audit plan and the annual audit report. The annual audit report includes a report to those charged with governance on matters arising for the audit of the annual financial statements, as well as comment on financial sustainability, governance and best value. The Committee has also considered national reviews undertaken by Audit Scotland, including their report 'NHS in Scotland 2019', and its implications locally.

4.7 For assurance purposes, the Audit & Risk Committee has received and considered the annual assurance statements of each of the governance committees of the Board, namely: Clinical Governance Committee; Finance, Performance & Resources Committee; Remuneration Committee; and Staff Governance Committee. These detail the activity of each committee during the year and the business they have considered in discharging their respective remit. No significant issues were identified for disclosure in the financial statements. In reference to the assurance statement received from the Integration Joint Board, the findings of Section the 102 report requested by the Controller of Audit were highlighted. These were in relation to financial

management and sustainability of the Partnership; slow progress in embedding good governance and management arrangements; and lack of progress in development of transformation and best value arrangements. Improvements in these areas will be a high priority in the forthcoming year.

4.8 On behalf of the Board, the Audit & Risk Committee receives regular updates on the workstreams being progressed within NHS Fife for compliance with the NHSScotland *Blueprint for Good Governance*. NHS Fife's induction approach for new Non-Executive members has been recognised as best practice and has informed a model rolled out nationally via a Director's Letter to all Boards. In the reporting year, the Committee has considered the work being undertaken on the implementation of Model Standing Orders for the Board and a new covering template for Board agenda papers, which is part of the national work ongoing to develop a suite of standard documentation on a 'Once for Scotland' approach. NHS Fife, via the Board Secretary, is engaged in current work reviewing the Terms of Reference for Standing Committees, which is expected to result in new guidance being issued once this work is completed.

4.9 Over the year, members received an update on the implementation of a new Performance & Accountability Framework across NHS Fife, welcoming the structured, transparent and systematic approach to ensure the robust delivery of standards and targets across the areas of (i) Finance; (ii) Operational Performance; (iii) Quality; and (iv) Workforce.

4.10 Progress with fraud cases and counter fraud initiatives were discussed by the Committee in private session on a regular basis throughout the year. The Committee received quarterly fraud updates, which provided members with updates on NHS Fife fraud cases, counter fraud training delivered to staff, initiatives undertaken to identify and address fraud, and the work carried out by Practitioner & Counter Fraud Services in relation to detecting, deterring, disabling and dealing with fraud in the NHS. This has provided the Committee with the assurance that the risk of fraud is being managed and addressed across NHS Fife.

4.11 During the year, members of the Committee have engaged in a number of training opportunities, covering best practice arrangements for Audit & Risk Committees. A discussion session with the Internal and External Auditors was held in March 2020, outlining the year-end processes each undertake as part of the review of the financial statements and systems of internal control. A follow-up training session covering the annual accounts scrutiny process has been scheduled for September 2020, prior to the Committee's formal consideration of the 2019-20 financial statements.

5. Best Value

5.1 Since 2013/14 the Board has been required to provide overt assurance on Best Value. A revised Best Value Framework was considered and agreed by the NHS Board in January 2018. Appendix 3 provides evidence of where and when the Committee considered the relevant characteristics during 2019/20.

6. Risk Management

6.1 All NHS Boards are subject to the requirements of the Scottish Public Finance Manual (SPFM) and must operate a risk management strategy in accordance with the relevant guidance issued by Scottish Ministers. The general principles for a successful risk management strategy are set out in the SPFM.

6.2 In line with the Board's agreed risk management arrangements, the Audit & Risk Committee, as a governance committee of the Board, has considered risk through a range of reports and scrutiny, including oversight on the detail of the Board Assurance Framework. Progress and appropriate actions were noted, and a number of changes to mitigating and operational risks amended, including those to reflect external developments such as Brexit. A stand-alone eHealth BAF was introduced during the year and is currently being used to pilot a new Risk Assurance Mapping

process, which work is being taking forward in tandem with a number of other territorial boards. This work also intends to encompass the assurances required yearly from Executive Directors and the annual assurance reporting to the Board via its Committees.

6.3 The Committee received updates on activity related to the risk management workplan, including the ongoing discussions with Board members to determine the Board's risk appetite thresholds, in delivery of the risk management framework. A short-life working group, involving all Board standing Committee Chairs, was established in 2018 to help formalise a set of risk appetite statements and to define definitions of risk appetite and risk tolerance. This completed its work in the reporting year, as presented to the Board's Development Session in October 2019. Specific responsibilities and processes relating to all aspects of the Board's risk appetite and tolerance will be described in the updated version of the Risk Management Framework to be presented to the Committee and the Board in September 2020, with a plan developed to support implementation. The updated Risk Management Framework will also include a new suite of Key Performance Indicators and the process for formal reporting through the governance structure.

7. Self Assessment

7.1 The Committee has undertaken a self assessment of its own effectiveness, utilising a revised questionnaire considered and approved by the Committee Chair. Attendees were also invited to participate in this exercise, which was carried out via an easily-accessible online portal. A report summarising the findings of the survey was considered and approved by the Committee at its March 2020 meeting, and action points are being taken forward at both Committee and Board level.

8. Conclusion

8.1 As Chair of the Audit & Risk Committee during financial year 2019/20, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place throughout NHS Fife during the year. Audit & Risk Committee members conclude that they have given due consideration to the effectiveness of the systems of internal control in NHS Fife, have carried out their role and discharged their responsibilities on behalf of the Board in respect of the Committee's remit as described in the Standing Orders.

8.2 I can confirm that that there were no significant control weaknesses or issues at the year end which the Committee considers should be disclosed in the Governance Statement, as they may have impacted financially or otherwise in the year or thereafter.

8.4 I would 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.

Signed: Martin Black Date: 4 November 2020

Martin Black, Chair
On behalf of the Audit & Risk Committee

Appendix 1 – Attendance Schedule
Appendix 2 – Best Value

AUDIT & RISK COMMITTEE
ATTENDANCE RECORD 2019/20

	16.05.19	20.06.19	05.09.19	09.01.20	13.03.20
Mr M Black	√	√	√	√	√
Ms S Braiden	√	√	√	√	√
Mrs J Owens	√	√	√	√	x
Cllr D Graham	√	√	x	√	√
Ms M Wells	√	√	x	√	√

In attendance

Mr P Hawkins, Chief Executive (until 27 January 2020)	✓	✓	x	✓	
Mrs C Potter, Director of Finance (until 27 January 2020) / Chief Executive (from 28 January 2020)	✓	✓	✓	✓	x
Mrs M McGurk, Director of Finance (from 3 February 2020)					✓
Ms H Buchanan, Director of Nursing	✓	✓	✓	✓	x
Dr G MacIntosh, Board Secretary	✓	✓	✓	✓	✓
Mr T Gaskin, Chief Internal Auditor	x	✓	x	✓	x
Mr B Hudson, Regional Audit Manager, Fife	✓	x	✓	✓	✓
Mr A Brown, Principal Auditor		✓			
Ms Z Headridge, Audit Scotland					✓
Mr B Howarth, Audit Scotland		✓			
Mrs P Fraser, Audit Scotland					✓
Mrs P Tate, Audit Scotland	✓	✓			
Mr A Croxford, Thomson Cooper (Annual Accounts Endowments)		✓			

APPENDIX 2

BEST VALUE FRAMEWORK

Vision and Leadership

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

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
The Board has identified the risks to the achievement of its strategic and operational plans are identified together with mitigating controls.	Each strategic risk has an Assurance Framework which maps the mitigating actions/risks to help achieve the strategic and operational plans. Assurance Framework contains the overarching strategic risks related to the strategic plan.	**COMMITTEES** **AUDIT & RISK COMMITTEE** **BOARD**	Bi-monthly 5 times per year 2 times per year	Board Assurance Framework (to FP&R/CG/SG Committees) Board Assurance Framework (to A&R Committee) Board

GOVERNANCE AND ACCOUNTABILITY

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

OVERVIEW

A Best Value organisation will be able to demonstrate structures, policies and leadership behaviours which support the application of good standards of governance and accountability in how the organisation is improving efficiency, focusing on priorities and achieving value for money in delivering its outcomes. These good standards will be reflected in clear roles, responsibilities and relationships within the organisation. Good governance arrangements will provide the supporting framework for the overall delivery of Best Value and will ensure open-ness and transparency. Public reporting should show the impact of the organisations activities, with clear links between the activities and what outcomes are being delivered to customers and stakeholders. Good governance provides an assurance that the organisation has a suitable focus on continuous improvement and quality. Outwith the organisation, good governance will show itself through an organisational commitment to public performance reporting about the quality of activities being delivered and commitments for future delivery.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Board and Committee decision-making processes are open and transparent.	Board meetings are held in open session and minutes are publically available. Committee papers and minutes are publically available	**BOARD** **COMMITTEES**	On going	Internet Intranet
Board and Committee decision-making processes are based on evidence that can show clear links between activities and outcomes	Reports for decision to be considered by Board and Committees should clearly describe the evidence underpinning the proposed decision.	**BOARD** **COMMITTEES**	Ongoing	SBAR reports EQIA forms

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife has a robust framework of corporate governance to provide assurance to relevant stakeholders that there are effective internal control systems in operation which comply with the SPFM and other relevant guidance.	Explicitly detailed in the Governance Statement.	**AUDIT & RISK COMMITTEE** **BOARD**	Annual Annual Ongoing	Code of Corporate Governance review Annual Assurance statements Compliance with NHS Scotland Blueprint

USE OF RESOURCES

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

OVERVIEW
A Best Value organisation will show that it is conscious of being publicly funded in everything it does. The organisation will be able to show how its effective management of all resources (including staff, assets, information and communications technology (ICT), procurement and knowledge) is contributing to delivery of specific outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
NHS Fife maintains an effective system for financial stewardship and reporting in line with the SPFM.	Statutory Annual Accounts process	**AUDIT & RISK COMMITTEE**	Annual	Statutory Annual Accounts Assurance Statements SFIs
NHS Fife understands and exploits the value of the data and information it holds.	Annual Operational Plan Integrated Performance & Quality Report	**BOARD** **COMMITTEES**	Annual Bi-monthly	Annual Operational Plan Integrated Performance & Quality Report

PERFORMANCE MANAGEMENT

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

OVERVIEW

A Best Value organisation will ensure that robust arrangements are in place to monitor the achievement of outcomes (possibly delivered across multiple partnerships) as well as reporting on specific activities and projects. It will use intelligence to make open and transparent decisions within a culture which is action and improvement oriented and manages risk. The organisation will provide a clear line of sight from individual actions through to the National Outcomes and the National Performance Framework. The measures used to manage and report on performance will also enable the organisation to provide assurances on quality and link this to continuous improvement and the delivery of efficient and effective outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Performance is systematically measured across all key areas of activity and associated reporting provides an understanding of whether the organisation is on track to achieve its short and long-term strategic, operational and quality objectives	Integrated Performance & Quality Report encompassing all aspects of operational performance, AOP targets / measures, and financial, clinical and staff governance metrics. The Board delegates to Committees the scrutiny of performance Board receives full Integrated Performance & Quality Report and notification of any issues for escalation from Committees.	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Code of Corporate Governance Minutes of Committees

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
The Board and its Committees approve the format and content of the performance reports they receive	The Board / Committees review the Integrated Performance Report and agree the measures.	**COMMITTEES** **BOARD**	Annual	Integrated Performance Report
Reports are honest and balanced and subject to proportionate and appropriate scrutiny and challenge from the Board and its Committees.	Committee Minutes show scrutiny and challenge when performance is poor as well as good; with escalation of issues to the Board as required	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Minutes of Committees
The Board has received assurance on the accuracy of data used for performance monitoring.	Performance reporting information uses validated data.	**COMMITTEES** **BOARD**	Every meeting Annual	Integrated Performance & Quality Report Annual Accounts including External Audit report
NHS Fife's performance management system is effective in addressing areas of underperformance, identifying the scope for improvement, agreeing remedial action, sharing good practice and monitoring implementation.	Encompassed within the Integrated Performance & Quality Report	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Minutes of Committees

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife overtly links Performance Management with Risk Management to support prioritisation and decision-making at Executive level, support continuous improvement and provide assurance on internal control and risk.	Board Assurance Framework	**AUDIT & RISK COMMITTEE** **BOARD**	Ongoing	Board Assurance Framework Minutes of Committees

CROSS-CUTTING THEME – SUSTAINABILITY

The "Sustainability" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded a sustainable development focus in its work.

OVERVIEW

The goal of Sustainable Development is to enable all people throughout the world to satisfy their basic needs and enjoy a better quality of life without compromising the quality of life of future generations. Sustainability is integral to an overall Best Value approach and an obligation to act in a way which it considers is most sustainable is one of the three public bodies' duties set out in section 44 of the Climate Change (Scotland) Act 2009. The duty to act sustainably placed upon Public Bodies by the Climate Change Act will require Public Bodies to routinely balance their decisions and consider the wide range of impacts of their actions, beyond reduction of greenhouse gas emissions and over both the short and the long term. The concept of sustainability is one which is still evolving. However, five broad principles of sustainability have been identified as:

- promoting good governance;
- living within environmental limits;
- achieving a sustainable economy;
- ensuring a stronger healthier society; and
- using sound science responsibly.

Individual Public Bodies may wish to consider comparisons within the wider public sector, rather than within their usual public sector "family". This will assist them in getting an accurate gauge of their true scale and level of influence, as well as a more accurate assessment of the potential impact of any decisions they choose to make. A Best Value organisation will demonstrate an effective use of resources in the short-term and an informed prioritisation of the use of resources in the longer-term in order to bring about sustainable development. Public bodies should also prepare for future changes as a result of emissions that have already taken place. Public Bodies will need to ensure that they are resilient enough to continue to deliver the public services on which we all rely.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
NHS Fife can demonstrate that it is making a contribution to sustainable development by actively considering the social, economic and environmental impacts of activities and decisions both in the shorter and longer term.	Sustainability and Environmental report incorporated in the Annual Accounts process.	**AUDIT & RISK COMMITTEE** **BOARD**	Annual	Annual Accounts Climate Change Template

CROSS-CUTTING THEME – EQUALITY

The “Equality” theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded an equalities focus which will secure continuous improvement in delivering equality.

OVERVIEW
Equality is integral to all our work as demonstrated by its positioning as a cross-cutting theme. Public Bodies have a range of legal duties and responsibilities with regard to equality. A Best Value organisation will demonstrate that consideration of equality issues is embedded in its vision and strategic direction and throughout all of its work.

The equality impact of policies and practices delivered through partnerships should always be considered. A focus on setting equality outcomes at the individual Public Body level will also encourage equality to be considered at the partnership level.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
NHS Fife meets the requirements of equality legislation.		**BOARD** **COMMITTEES**	Ongoing	EQIA form on all reports
The Board and senior managers understand the diversity of their customers and stakeholders.	Equality Impact Assessments are reported to the Board and Committees as required and identify the diverse range of stakeholders.	**BOARD** **COMMITTEES**	Ongoing	EQIA form on all reports
NHS Fife’s policies, functions and service planning overtly consider the different current and future needs and access requirements of groups within the community.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments consider the current and future needs and access requirements of the groups within the community.	**BOARD** **COMMITTEES**	Ongoing	Clinical Strategy EQIA forms on reports

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
Wherever relevant, NHS Fife collects information and data on the impact of policies, services and functions on different equality groups to help inform future decisions.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments will collect this information to inform future decisions.	**BOARD** **COMMITTEES**	Ongoing	EQIA forms on reports