

Greater Glasgow NHS Board

Board Meeting

23rd July 2002

Board Paper No. 02/48

Convener of the Audit Committee

Review of System of Internal Control 2001/2002

Recommendation:

Members are asked

- (i) to consider the attached report and to review and evaluate the Board's system of internal control;
- (ii) to report the outcome of this review to the Board on 23rd July 2002, with a recommendation that the Chief Executive should sign the Statement of Internal Control subject to the Statement disclosing the matters identified in the review.

Background

The review by the Audit Committee is intended to provide assurance to the Board that an effective system of internal control is in place and being complied with. It also allows the Chief Executive to sign the Statement of Internal Control which forms part of the Board's annual accounts.

The attached report was discussed as Audit Paper No. 02/15 at the meeting of the Audit Committee Members on 2 July 2002. As a result, a number of changes were agreed which are included in the notes of that meeting and which have been incorporated into the attached report. For ease of reference, the changes made have been highlighted.

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Review of System of Internal Control 2001/2002

1 INTRODUCTION

1.1 Since 1998/99 and in accordance with the Cadbury Report on Corporate Governance, the Chief Executive as Accountable Officer has been required to complete a Statement on Internal Financial Control (SIFC) as part of the Board's Annual Accounts. However since then, best practice in the private sector has developed with the introduction of the London Stock Exchange's "Combined Code" of requirements for listed companies and the publication of "Internal Control: Guidance for Directors on the Combined Code" (the "Turnbull Report") which examined how the requirements of the Combined Code should be implemented. These requirements are

1. The Board should maintain a sound system of internal control to safeguard shareholders' investment and the company's assets;
2. The directors should, at least annually, conduct a review of the effectiveness of the group's system of internal control and should report to shareholders that they have done so. The review should cover all controls, including financial, operational and compliance controls and risk management.
3. Companies which do not have an internal audit function should from time to time review the need for one.

1.2 To reflect developments in the private sector, the Scottish Executive [in HDL (2002) 11] introduced a Statement on Internal Control (SIC) to replace the Statement of Directors' Responsibilities in respect of Internal Financial Control. The scope of the SIC extends beyond financial controls and requires bodies to report upon their risk management and review processes. The guidance issued by the Scottish Executive on the SIC states that the Board is responsible for reviewing the effectiveness of internal control having regard to the assurances obtained from the Audit Committee and any other standing committee which covers internal control e.g. clinical governance or risk management committees. Bodies must declare in the SIC those areas where control arrangements are not fully in place and where further work is required. As Accountable Officer, the Chief Executive is required to complete a SIC for inclusion in the Annual Accounts from 2001/2002.

1.3 This responsibility of the Audit Committee is reflected in its Remit which includes "review of the Board's system of internal control and make recommendations to the Board regarding the Statement of Directors' Responsibilities in respect of Internal Financial Control".

1.4 This report is intended to provide the Audit Committee with evidence of the existence of and compliance with an effective system of internal control during 2001/2002. The Committee is invited to review and evaluate this system of internal control and to report the results to the Board at the meeting on 23 July 2002. The report to the Board should include a recommendation that the Chief Executive should sign the SIC and should indicate which if any weaknesses requires to be disclosed in the SIC.

1.5 The following sources of evidence are presented for consideration.

- Reports by the External Auditors (Section 3)
- Reports by the Internal Auditors (Section 4)
- Assessment against Minimum Financial Control Standards (Section 5)
- Progress on Risk Management (Section 6)
- Annual Review of Corporate Governance (Section 7)
- Annual Fraud Report (Section 8)
- Property Transactions Monitoring (Section 9)
- Clinical Governance (Section 10)

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2 SUMMARY AND CONCLUSION

- 2.1 Members are invited to consider the evidence presented in this report and to evaluate the effectiveness of the Board's system of internal control and to report the results of this evaluation to the Board. The report to the Board should highlight any matters which require to be declared in the SIC which is signed by the Chief Executive and forms part of the Statement of Accounts. It is suggested that the following conclusion should be reported to the Board to allow the Chief Executive to sign the SIC.

Based on this review, the Audit Committee concluded that subject to the two exceptions listed below, the system of internal control complies with the required control standards. It is therefore recommended that the Chief Executive signs the Statement on Internal Control and that the Statement should declare the three exceptions listed below.

1 Risk Strategy

The Board has not yet concluded its arrangements for risk management. The following actions will be taken during 2002 to finalise the risk management arrangements.

1. A Risk Management Strategy and supporting arrangements will be prepared by 30 September 2002 and submitted to the Board for approval in October 2002.
2. All other work necessary to bring the NHS Board into a position where it meets fully the CNORIS Level 1 Standards will be completed and the Board assessed by the Scheme Managers by 30 November 2002.
3. An action plan has been agreed and additional resources have been committed to this task to ensure targets are met.

2 Practitioner Services

Payments for Family Health services are processed by the Practitioner Services Division (PSD) of the Common Services Agency (CSA). The Board has no direct control over this organisation. Our 2000/2001 Statement of Board Members' Responsibility in Respect of the System of Internal Financial Control identified a number of weaknesses in this area. The weaknesses identified related to:

- delays in the processing of Pharmacy payments resulting in prescribing information not being available on a timely basis and contractors being paid on the basis of estimates.
- inadequate process controls and business continuity plans in relation to Pharmacy payment systems
- the absence of a written agreement between PSD and PCTs on the nature and level of Post Payment Verification;
- the absence of a risk assessment exercise for all payment streams; and
- the need for practice visits to be undertaken

With the exception of the issue of Business Continuity Plans, which has been highlighted by the CSA's Service Auditor again, all of these weaknesses have now been addressed. It is however appropriate that we refer to these matters again in the 2001/2002 Statement on Internal Control as the corrective action was not in place throughout the year 2001/2002.

Again, however, a number of concerns have been commented upon in the work of the Service Auditor and the CSA's external auditors, Audit Scotland. Audit Scotland's 2001/2002 review

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indicated that progress had been made in a number of important areas but serious concerns still required to be addressed in relation to:

- Payment Verification of Pharmacy and Ophthalmic payments is not fully in place;
- a number of “high risk” points raised by the Service Auditor including deficiencies in:
 - i) IT disaster recovery and business continuity plans,
 - ii) authorisation of contractor amendments and payment documentation
 - iii) concerns over system access security and change management procedures.
- a comprehensive record was not maintained of the progress that had been made in implementing the 2000/01 Service Auditor recommendations, and therefore there was no clear indication of the extent to which PSD internal controls have improved over the year.

The CSA has agreed to establish a high level Implementation Group to review all issues and approve and monitor a plan of action for progressing action to address the weaknesses effectively and timeously.

The Convener of the Audit Committee has written to the Chief executive of the CSA noting the Committee’s concern and seeking assurance that action is being taken to address the issues

of concern. In addition, the CSA has issued progress reports on the work of the high level Implementation Group.

Audit Committee

Attention is also drawn to the fact that the Audit Committee of NHS Greater Glasgow did not meet during the period 30 September 2001 to 31 March 2002.

1. The unified Board was established on 30 September 2001 and decided on its interim committee arrangements (including the Audit Committee) in December 2001.
2. An attempt was made to convene the inaugural meeting of the Audit Committee on 7 March 2002 but as a quorum could not be achieved, the meeting was deferred to 30 April 2002.
3. At the meeting on 30 April 2002, the modus operandi was agreed including the relationship with the Audit Committees of the NHS Trusts.
4. The Audit Committee of Greater Glasgow Health Board met in May and July 2001. Between July 2001 and April 2002, the Trust Audit Committees continued to meet as normal and to provide oversight of the audit arrangements within each Trust.

(Those sections in the following report which relate to these matters have been highlighted in bold type.)

3 REPORTS BY THE EXTERNAL AUDITORS

3.1 Internal Controls Report

This report gives details of the matters arising from the external audit work done in the period January – March 2002 as part of the statutory audit of the Board annual accounts for 2001/2002. It is presented separately to the Committee as Audit Paper no. 02/15.

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The reports makes eight recommendations of which three are deemed to be high priority, one medium and four as low priority. The three high priority recommendations relate to

1. The need to convene a meeting of the Audit Committee. (A meeting has since been convened on 30 April 2002).
2. The arrangements for discussion by Board Members of more detailed financial information. (This matter will be considered as part of the review of governance arrangements in September.)
3. The need for a formal risk management strategy (see section 6 of this report).

3.2 Follow Up of 2000/2001 Recommendations

This report was presented to the Audit Committee on 30 April 2002 (Audit Paper no. 02/7) and set out the results of the external auditors follow up work in respect of all external audit recommendations made in respect of the 2000/2001 audit. Of the eight recommendations agreed with management, three had been fully implemented while five had been partially implemented at the time of the audit visit. The implementation dates were confirmed for the five recommendations not yet fully implemented.

3.3 Report to Audit Committee

This report is presented separately to the Audit Committee as Audit Paper no. 02/16. This indicates that that the external auditors have formed the following opinions.

The audit opinion on whether the annual accounts prepared by the Board present a true and fair view of the state of affairs of the Board at 31 March 2002 is unqualified.

The auditors are also required to express a regularity opinion on whether in all material respects the income and expenditure shown in the accounts has been applied in accordance with applicable enactments and guidance issued by Scottish Ministers. This opinion is qualified due to the limitations in scope of the post payment verification procedures in respect of primary care practitioners. This qualification is technical in nature; while the auditors' concerns relate to matters reported in the Board's accounts, the Board has no direct influence or control over the post payment verification process as this is carried out by the Common Services Agency on behalf of the Primary Care Trust. (Further details of this matter are given in section 3.5 of this report.)

3.4 Private Meeting with Members

In accordance with its Remit and in line with the recommended best practice, the Committee met to meet with the External Auditors at the meeting on 2 July 2002 without officers of the Board being present.

3.5 Report by the External Auditors of the Common Services Agency

Payments for Family Health services are processed by the Practitioner Services Division (PSD) of the Common Services Agency (CSA). The Board has no direct control over this organisation. Our 2000/2001 Statement of Board Members' Responsibility in Respect of the System off Internal Financial Control identified a number of weaknesses in this area. The weaknesses identified related to:

- **delays in the processing of Pharmacy payments resulting in prescribing information not being available on a timely basis and contractors being paid on the basis of estimates.**
- **inadequate process controls and business continuity plans in relation to Pharmacy payment systems**
- **the absence of a written agreement between PSD and PCTs on the nature and level of Post Payment Verification;**

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- the absence of a risk assessment exercise for all payment streams; and
- the need for practice visits to be undertaken

With the exception of the issue of Business Continuity Plans, which has been highlighted by the CSA's Service Auditor again, all of these weaknesses have now been addressed. It is however appropriate that we refer to these matters again in the 2001/2002 Statement on Internal Control as the corrective action was not in place throughout the year 2001/2002.

Again, however, a number of concerns have been commented upon in the work of the Service Auditor and the CSA's external auditors, Audit Scotland. Audit Scotland's 2001/2002 review indicated that progress had been made in a number of important areas but serious concerns still required to be addressed in relation to:

- Payment Verification of Pharmacy and Ophthalmic payments is not fully in place;
- a number of "high risk" points raised by the Service Auditor including deficiencies in:
 - iv) IT disaster recovery and business continuity plans,
 - v) authorisation of contractor amendments and payment documentation
 - vi) concerns over system access security and change management procedures.
- a comprehensive record was not maintained of the progress that had been made in implementing the 2000/01 Service Auditor recommendations, and therefore there was no clear indication of the extent to which PSD internal controls have improved over the year.

The CSA has agreed to establish a high level Implementation Group to review all issues and approve and monitor a plan of action for progressing action to address the weaknesses effectively and timeously.

The Convener of the Audit Committee has written to the Chief Executive of the CSA noting the Committee's concern and seeking assurance that action is being taken to address the issues of concern. In addition, the CSA has issued progress reports on the work of the high level Implementation Group.

4 REPORTS BY THE INTERNAL AUDITORS

4.1 Annual Report 2002

The Internal Audit Annual Report is presented separately to the Committee (Audit Paper No. 02/13) and includes the following Annual Statement.

"On the basis of work undertaken in the year ended 31 March 2002 we consider that the Board generally has an adequate framework of control over the systems we examined as summarised in the Appendix to this report (subject to implementation of the recommendations which have been agreed with management). In providing such an opinion we would draw your attention to our summary findings as presented in our individual reports issued throughout the year."

4.2 Assignment Reports 2001/2002

Five assignments were concluded by 31 March 2002. Of the four to which grades could be awarded, two attracted "A" gradings (controls satisfactory with no system weaknesses) and two attracted "B" gradings (adequate controls in place with recommendations made to improve efficiency and effectiveness). A total of 20 recommendations were made and none of these was identified as "priority one" (major issue requiring the attention of senior

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management and the Audit Committee). Further details can be found in the Internal Audit Annual Report presented to this meeting of the Committee (Audit Paper no. 02/13).

4.3 Risk Assessment and Audit Plans

The internal audit plan continues to be based on formal risk assessment. An audit needs assessment was concluded in 1997 following detailed discussions with management and Members. This resulted in a risk and complexity matrix which summarised the risks surrounding each of the Board's main areas of activity. This Matrix has been amended on an ongoing basis to form the basis of the internal audit plans. A detailed series of workshops will be held during 2002 as part of the risk management process which will also inform the audit planning process.

4.4 Private Meeting with Members

In accordance with its Remit and in line with the recommended best practice, the Committee met with the Internal Auditors on 2 July 2002 without officers of the Board being present.

5 ASSESSMENT AGAINST FINANCIAL CONTROL STANDARDS

- 5.1 To complement the introduction of the statement of Directors' Responsibilities in respect of Internal Financial Control in 1998/99, the Scottish Executive issued a set of defined Minimum Financial Control Standards. HDL (2002) 11 introduced the Statement of Internal Control from 2001/2002 and confirmed that these Minimum Financial Control Standards should still be used when assessing financial controls. The Board's system of internal financial control has been assessed against these standards with the detailed results set out in Appendix 1.
- 5.2 **This assessment highlighted that the need to complete the arrangements for risk management required to be declared in the SIC.**

6 PROGRESS ON RISK MANAGEMENT

- 6.1 **During 2001, work continued towards achieving the level 1 standards of the Clinical Negligence and Other Risk Indemnity Scheme (CNORIS). There are ten individual standards to be achieved in order to comply with level 1 of CNORIS. Difficulties in allocating the appropriate resources to this task meant that the intended deadline for achieving the level 1 standards of 31 December 2001 was not achieved. As a result, the Board does not have a finalised risk strategy or a formal risk management process in place. This fact should be declared in the SIC.**
- 6.2 **Resources have now been identified to complete the work required to achieve the level 1 standards of CNORIS and a target date of November 2002 has been set for assessment.**
- 1. A Risk Management Strategy and supporting arrangements will be prepared by 30 September 2002 and submitted to the Board for approval in October 2002.**
 - 2. All other work necessary to bring the NHS Board into a position where it meets fully the CNORIS Level 1 Standards will be completed and the Board assessed by the Scheme Managers by 30 November 2002.**
 - 3. An action plan has been agreed and additional resources have been committed to this task to ensure targets are met.**

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Evidence is required to demonstrate that bodies have met each of the prescribed criteria in respect of each of the ten standards. Appendix 2 provides details of the progress made towards meeting these criteria.

- 6.3 The possibility of pooling resources to achieve a Glasgow wide approach to risk management is being explored by the Directors of Finance.

7 ANNUAL REVIEW OF CORPORATE GOVERNANCE

- 7.1 The Board's arrangements for corporate governance are set out in the following documents which are subject to annual review by the Board.

- Declarations of Interest by Members
- Standing Orders for the Proceedings and Business of the Board
- Decisions Reserved for the Board and Remit of Committees
- Scheme of Delegation
- Standing Financial Instructions
- Diary of Corporate Governance Events
- Fraud and Corruption Response Plan
- Guidance to Support Standards of Business Conduct

Following the review in April 2001, the Board considered and approved interim governance and committee arrangements in October 2001 to reflect the transition to NHS Greater Glasgow. The review for 2002 was deferred until September to allow the newly formed committees the opportunity to develop into their new roles and responsibilities before evaluating the new arrangements.

- 7.2 **The Audit Committee of NHS Greater Glasgow did not meet during the period 30 September 2001 to 31 March 2002. This matter should be declared in the SIC.**

1. **The unified Board was established on 30 September 2001 and decided on its interim committee arrangements (including the Audit Committee) in December 2001.**
2. **An attempt was made to convene the inaugural meeting of the Audit Committee on 7 March 2002 but as a quorum could not be achieved, the meeting was deferred to 30 April 2002.**
3. **At the meeting on 30 April 2002, the modus operandi was agreed including the relationship with the Audit Committees of the NHS Trusts.**
4. **Between July 2001 and April 2002, the Trust Audit Committees continued to meet as normal and to provide oversight of the audit arrangements within each Trust.**
5. **The Committee will now meet on a regular basis, at least four times a year in accordance with its Remit.**

8 ANNUAL FRAUD REPORT 2001/2002

- 8.1 The Board's Fraud and Corruption Response Plan was approved by the Board in April 1998 and requires an annual report to be made to the Audit Committee on the level of suspected and detected fraud and corruption within the Board and the arrangements in place for their prevention and detection. The Annual Fraud Report for 2001/2002 is the subject of a separate report to the Committee (Audit Paper no. 02/18) and intimates that no new cases of fraud had arisen during 2001/2002.

- 8.2 The report also compares the Board's anti-fraud policies and procedures against a checklist

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published by the Audit Commission for England and Wales which was produced to enable organisations to assess the effectiveness of their arrangements in this respect. This comparison indicated that the Board's anti-fraud arrangements were satisfactory during 2001/2002. In their Internal Controls Report (Audit Paper no.02/15), the Board's external auditors reported that no significant issues were noted in the course of their review of the Board's arrangements for the prevention and detection of fraud.

- 8.3 In addition, the Board's Fraud and Corruption Response Plan requires that a register of fraud be maintained and that the Audit Committee receives regular reports on additions to this register and on the progress of each case of fraud or suspected fraud.

9 PROPERTY TRANSACTIONS MONITORING 2001/2002

- 9.1 The NHS Scotland Property Transactions Handbook set out the detailed and rigorous procedures which all NHS bodies in Scotland must follow when conducting any transaction involving property. The Handbook requires post transaction monitoring to be an integral part of the internal audit programme with the internal auditor reporting the results of the monitoring to the Audit Committee which in turn reports to the Board. If approved by both the Audit Committee and the Board, the monitoring report is submitted to the Scottish Executive.
- 9.2 During 2001/2002, only one property transaction was concluded. The premises occupied by the Health Promotion Store at 8 Houston Place, Glasgow were sub leased from a company (the mid landlord) who in turn leased the property from the owner (the head landlord). During 2001, it was discovered that the mid landlord had been placed in liquidation which led to the head lease being terminated. This in turn led to the automatic termination of the sub lease.
- 9.3 The Health Promotion Store serves a wide range of clients across Glasgow and the current premises had been chosen because of their central location and ease of access. The preferred option therefore was to remain in those premises and negotiations for a new lease commenced with the head landlord. These negotiations were difficult but with the assistance of the Board's Property Adviser and the Central Legal Office, terms and conditions were agreed which were favourable to the Board.
- 9.4 The Board's Property Adviser is currently concluding the documents required by the Property Transactions Handbook. These will be passed to the Internal Auditors to allow them to review the transaction and report to the next meeting of the Audit Committee in September 2002 in accordance with the revised reporting timetable issued by the Scottish Executive.

10 CLINICAL GOVERNANCE

- 10.1 Following the first meeting of the Committee there was concern expressed about its composition and remit – this was mainly around the Committee's wish that Executive Directors were not full members of the Committee and its modus operandi needed to reflect the existence of the four Trust Clinical Governance Committees.

A short life working group was established to consider these matters and its recommendations were submitted to the NHS Board in May 2002. These recommendations were accepted by the Board. They saw a split in the remit of the Committee recognising its NHS Greater Glasgow-wide responsibilities and the responsibilities for the NHS Board's clinical staff.

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On the first point the Committee shall systematically review the scope and performance of the Trust clinical governance processes and shall, where appropriate, examine certain aspects of these by taking evidence from the Trusts.

The Committee shall ensure that the clinical professions:-

1. engage in effective professional practice;
2. operate so as to support the delivery of high quality care for the population of the Board's area – best met through systematic review of clinical practice;
3. review practice in a systematic manner across Greater Glasgow and identify area-wide issues and consider differences in practice and reasons for such differences;
4. engage in continued professional development.

The Committee will also, in conjunction with the Trust Clinical Governance Committees, identify and monitor issues of common concern for the purpose of setting priorities to be addressed on an area-wide basis.

In relation to its responsibilities for the NHS Board staff, it shall oversee the preparation of broadly based performance plans for Board's clinical staff and critically review activity against these plans on an annual basis.

The Committee will report to the NHS Board through the submission of its minutes to the Board and reporting any areas which it believes should be brought to the NHS Board's attention. An Annual Report will also be submitted in April 2003.

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APPENDIX 1

Required Standard	GGNHSB
1 The Control Environment	Documents marked (*) are included in the Annual Review of Corporate Governance presented to the Board in April each year. All changes to these documents are approved by the Board as part of the Annual Review. (See paragraph 5.1.)
1.1 Standing Orders are in place.	Actioned * but will be updated in September 2002
1.2 Standing Financial Instructions are in place.	Actioned *
1.3 A scheme of reservation and delegation is in place.	Actioned *
1.4 Responsibilities of the Accounting Officer are defined.	Actioned. The responsibilities of the Accounting Officer are defined in the Appointed Officer Memorandum from the Management Executive.
1.5 Standards of Business Conduct for NHS Boards and staff are in place	Actioned. The Standards of Business Conduct for NHS Boards and Staff which are contained in MEL (1994) 80 are incorporated into the contract of employment of each Director and employee. In addition, supplementary guidance to support these Standards has been issued to assist staff.
1.6 A Fraud and Corruption Policy and Response Plan is in place.	Actioned * The Fraud and Corruption Response Plan includes the Board's Fraud and Corruption Policy and is included in the Annual Review of Corporate Governance. Guidance has been issued to staff on the

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		implementation of the Response Plan. In addition, an annual fraud report is produced which includes an assessment of the arrangements to prevent and detect fraud.
1.7	An Audit Committee is in place.	Actioned. The Audit Committee consists of five Non-Executive Directors and the Chairmen of the Trust Audit Committees.
	Required Standard	GGNHSB
		The Remit of the Committee is included in the Annual Review of Corporate Governance.
1.8	A Remuneration Committee is in place.	Actioned. Currently the Remuneration Committee is a sub committee of the Board and membership consists of the Chairman, five Non-executive Directors and the Employee Director. The Remit is considered as part of the Annual Review of Corporate Governance.
1.9	There is an Internal Audit Function in accordance with the NHS Internal Audit Standards.	Actioned. Internal audit services are provided under contract by a firm of Chartered Accountants. The contract requires the contractor to comply with the NHS Internal Audit Standards.
1.10	A performance management system has been established for all staff with financial responsibility which ensures that individual's objectives flow from the organisation's objectives.	Actioned. A performance management system for all staff on executive pay grades is operated in accordance with the guidance issued by the Management Executive. Under this system, each individual's objectives cascade down from the Board's objectives. A development scheme which incorporates a system of objective setting and performance appraisal applies to staff who are not on General and Senior Managers' pay.
2	Identification and Evaluation of Risks and Control Objectives	
2.1	There is an annually produced Local Health Plan which includes financial and other performance targets.	Actioned. The Local Health Plan is presented to the Board annually for approval and includes financial and non-financial targets (e.g.

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waiting lists).

- 2.2 A Risk Management Strategy is in place which includes an assessment of financial risks and the setting of control objectives. **While all required action was taken to assess and address risk, this was not carried out in the context of a formal Risk Management Strategy.**

The Board is working towards achieving compliance with the CNORIS (Clinical

Required Standard

GGNHSB

Negligence and Other Risk Indemnity Scheme) during 2002. Progress towards achieving the CNORIS standards is set out in section 6 and Appendix 2.

It is therefore recommended that the absence of a finalised Risk Management Strategy be reported in the Statement of Internal Control.

3 Information and Communication

- 3.1 Systems are in place which produce reliable information and proper accounting records. Actioned

Established systems and processes were in place for all the Board's key financial activities:- payroll, creditors' payments, maintenance of the general ledger and endowments funds.

- 3.2 There is an Information Systems Security Policy in place. Actioned

The Information Systems Security Policy is issued to all staff on appointment.

- 3.3 There is an IM & T Strategy in place which covers the Finance Directorate and all significant financial systems. Actioned

The Board has developed a Greater Glasgow information strategy.

- 3.4 There is a comprehensive budgetary control system in place. Actioned

The system of budgetary control is operated includes reporting mechanism to allow budget holders to control expenditure.

4 Control Processes

- 4.1 Procedure notes are in place for all significant and fundamental financial systems. Actioned

All significant and fundamental financial systems are covered by a combination of Standing Financial Instructions, procedure notes and manuals.

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4.2	There is a mechanism in place to control the acquisition, use, disposal and safeguarding of assets.	Actioned. Standing Financial Instructions specify the processes to be followed to acquire, use, dispose of and safeguard assets. These processes reflect the contents of the NHS Property Transactions Handbook, the Capital Asset Accounting Manual and the NHS Security Manual.
	Required Standard	GGNHSB
4.3	There are clearly defined capital and investment control guidelines and formal capital project management disciplines in place.	Actioned SFIs set out the controls which apply to capital expenditure and other investment. These controls include the requirement to comply with the Scottish Capital Investment Manual.
4.4	There are controls in place to ensure compliance with laws and regulations that have significant financial implications.	Actioned SFIs and other governance documents are reviewed on an on-going basis to ensure continued compliance with the law and other regulations.
4.5	There are arrangements in place to ensure that resources are used effectively, efficiently and economically.	Actioned The Board's governance arrangements have been established to ensure that value for money is achieved in all aspects of the Board's operations. These arrangements include: <ul style="list-style-type: none">• Regular review of corporate governance to ensure continued compliance with policy;• Target setting in the Local Health Plan;• Performance management and oversight by the Remuneration Committee. In addition, SFIs place an over-arching obligation on all Directors and employees to secure value for money in all their activities and operations. The SFIs and procedure notes for each specific activity set out the detailed processes by which value for money can be achieved.

5 Monitoring and Corrective Action

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| 5.1 | The Board regularly receives and reviews financial and performance reports. | Actioned.

Financial monitoring reports are presented regularly to the NHS Board.

Reports on non-financial performance are presented to the NHS Board (e.g. waiting lists, complaints). |
| Required Standard | | GGNHSB |
| 5.2 | The Audit Committee reviews and monitors internal financial control and the implementation of agreed control improvements. | Actioned.

The Audit Committee receives regular progress reports from the Internal Auditors which set out the findings and recommendations from the audit work carried out. Follow up reviews are carried out to ensure that recommendations are implemented as agreed and the results of these are reported to the Audit Committee.

The External Auditors also report to the Audit Committee on the implementation of previous recommendations. |
| 5.3 | Policies, procedures and control frameworks are regularly assessed to ensure they remain in line with current guidance and best practice. | Actioned

SFIs and other governance arrangements are reviewed continuously whenever changes are made to the law or other regulations. Changes in financial procedures are presented to the Audit Committee for approval. |

Alan Lindsay
Head of Control & Support Systems
25 June 2002

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APPENDIX 2

Standard	Supporting Evidence	Status
1 Risk Strategy	Organisation meeting minutes Risk Management Strategy Report & accounts Job descriptions Organisation chart	Available Drafted Available Check content of key individuals especially DoF Available
2 Risk Management Process	Risk Management Strategy Risk Identification and Recording Procedure Risk Assessment, Policy and Procedures Risk Register Risk action plans and follow up Risk Management Group minutes Monitoring and review procedure Evidence of monitoring and review Organisational reports & distribution arrangements Unified Board minutes Consultation with stakeholders minutes & reports Patient surveys Business cases Organisational chart Job descriptions	Drafted To be actioned To be actioned To be actioned To be actioned To be actioned Scope to improve Scope to improve Check distribution of all reports, minutes etc Available Available Available Available Available Available but content to be checked.
3 Governance & Risk Management System	Risk Management Strategy Terms of Reference for Committees Organisation chart Meeting minutes Risk Management Group initiatives Risk Management Sub Group minutes Local work instructions Risk action plan and follow up	Drafted Available Available Available To be actioned To be actioned Partly in place To be actioned

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	Risk Management Group Minutes	To be actioned
4	Incident Reporting	
	Incident reporting policy/precedes	Available
	Incident reporting form & guidelines for completion	Available but guidelines to be checked.
	Incident investigation reports	Available
	Incident statistics & analysis (incl. RIDDOR requirements)	Available
	Risk Management Group Minutes	To be actioned
	Copies of relevant reports to external bodies	Available
	Induction training programme(s)	Available
	Sample completed IR forms (anonymised for purposes of assessment)	Available
5	Incident Management	
	Significant incident policy	Revise
	Incident reporting (IR) protocol and guidance for completing IR form	Update guidance
	Distribution arrangements for policies	In place
6	Dealing with Complaints	
	Copy of complaints policy	Available
	Complaints Register	Available
	Organisation reports	Available
	Evidence that the Chief Executive responds in writing to all written complaints	Available
	Performance against NHS guidelines	Available
7	Operational Risk	
	Risk Management Strategy	Drafted
	Communication Strategy	To be drafted
	HDL/Legislation/Regulation distribution channels	In place but check
	ACOP/Guidance Note distribution channels	In place but check
	Action plan on "Towards A Safer Healthier Workplace"	In progress
8	Standards, Use, Storage and Retrieval of Records	
	Policy on non-clinical record keeping	Available
	Guidance on records management	To be produced to reflect current consultative draft
	Documents outlining the role and responsibilities of the Caldicott Guardian	Available
	Liaison between the Caldicott Guardian, Data Protection Adviser and records managers	Possible need for sub-committee
	Training records	Available
	Audit proformas, reports and action plans	Available
	Standing Financial Orders	Being revised
9	Monitoring and Review of Performance Management	

Embargoed Until Meeting

Review of System of Internal Control 2001/2002

Indicators	PAF
Evidence of usage at all levels	To be checked
Internal audit reports	Available
Health & Safety Committee minutes	Available
Risk Management Committee minutes	To be actioned
Audit Committee minutes	Available
Internal audit statement to Chief Executive	Available
Clinical Governance Committee minutes	Available
Action plans and follow up	Available
Performance monitoring reports	To be checked
Specific project plans	To be checked
Action plan on "Towards a Safer Healthier Workplace"	In progress
Action plan on "Learning Together"	In progress

10 Human Resources, Initial/Continuing Staff Competence

Action plan on "Towards a Safer Healthier Workplace"	In progress
Action plan on "Learning Together"	Available
General induction programme	Available
Local induction checklist and procedures	Available
Temporary staff induction procedures and documentation	Available
Recruitment and selection policy and procedure	Available
Induction/refresher attendance and follow-up records	Available but follow up being developed.

Alan Lindsay
Head of Control & Support Systems
25 June 2002