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NHS Dumfries and Galloway

Annual Report to Those Charged with Governance and the Auditor General for Scotland

Year ended 31 March 2016

June 2016

pwc

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The Audit and Risk Committee
NHS Dumfries and Galloway
Crichton Hall
Dumfries
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20 June 2016

Ladies and Gentleman,

We are pleased to enclose our report to the Audit and Risk Committee in respect of our audit for the year ended 31 March 2016. The primary purpose of this report is to communicate the significant findings arising from our audit that we believe are relevant to those charged with governance.

The scope and proposed focus of our audit work was summarised in our audit plan, which we presented to the Audit and Risk Committee in December 2015. We have subsequently reviewed our audit plan and, following an update to our audit methodology, included an additional elevated audit risk in relation to valuation of land and buildings. This change in our risk assessment does not mean that we believe that the risk profile within NHS Dumfries and Galloway has changed; rather it is reflective of a change in our audit methodology. The procedures we have performed in response to our assessment of significant and elevated audit risks are detailed in Section 2.

We have completed the majority of our audit work and expect to be able to issue an unqualified audit opinion on the financial statements on 20 June 2016. At the time of writing, the key outstanding matters relate to subsequent events and audit completion procedures.

We will provide an oral update on these matters at the meeting on 20 June 2016.

We look forward to discussing our report with you on 20 June 2016. Attending the meeting from PwC will be Lindsey Paterson and James Gray.

Yours faithfully

PricewaterhouseCoopers LLP

Contents

Section 1. Executive summary

Introduction

We set out in this report our significant findings from our audit of NHS Dumfries & Galloway ("the Board") for 2015/16, together with those matters which auditing standards require us to report to you as "those charged with governance" of the Board.

We carried out our audit work in line with the 2015/16 audit plan that we presented to you in December 2015. We have subsequently reviewed our audit plan and, following an update to our audit methodology, included an additional elevated audit risk in relation to valuation of land and buildings. This change in our risk assessment does not mean that we believe that the risk profile within NHS Dumfries and Galloway has changed; rather it is reflective of a change in our audit methodology. The procedures we have performed in response to our assessment of significant and elevated audit risks are detailed in Section 2.

Our audit is not designed to identify all matters that may be relevant to you. Accordingly, the audit does not identify all such matters. Communication by auditors of matters arising from the audit of the financial statements or of risks or weaknesses does not absolve management from its responsibility to address the issues raised and to maintain an adequate system of control.

Framework for Our Audit

Our audit is conducted in accordance with Auditing Standards (International Standards on Auditing ('ISAs') (UK and Ireland)) and the Code of Audit Practice ('the Code'), issued by Audit Scotland.

The Code explains how external auditors should carry out their functions under the Public Finance and Accountability (Scotland) Act 2000. The audit of financial statements is covered by engagement and ethical standards issued by the UK Auditing Practices Board (APB), so the Code focuses more on the wider functions of public sector auditors. We have conducted our audit in accordance with the relevant requirements of the Code and International Standards on Auditing.

Respective Responsibilities of Management and Auditors

Management

It is the responsibility of the Board and the Chief Executive, as Accountable Officer, to prepare the financial statements in accordance with the National Health Service (Scotland) Act 1978 and directions made thereunder. This means:

- acting within the law and ensuring the regularity of transactions by putting in place systems of internal control to ensure that financial transactions are in accordance with the appropriate authority;
- maintaining proper accounting records;
- preparing financial statements timeously which give a true and fair view of the financial position of the Board and its expenditure and income for the year ended 31 March 2016; and
- preparing a Performance Report and an Accountability Report.

Auditors' responsibilities

Our responsibilities in accordance with the Code of Audit Practice are to provide you with an audit report stating whether, in our opinion:

- the financial statements give a true and fair view in accordance with the National Health Service (Scotland) Act 1978 and directions made thereunder by the Scottish Ministers of the state of the affairs of the board and its group as at 31 March 2016 and of their net operating cost for the year then ended;

- the financial statements were prepared properly in accordance with relevant legislation, applicable accounting standards and other reporting requirements;
- the information which comprises the annual report included with the financial statements is consistent with the financial statements; and
- in all material respects the expenditure and income in the financial statements were incurred or applied in accordance with any applicable enactments and guidance issued by the Scottish Ministers (the regularity opinion).

We are also required to confirm that the audited element of the Remuneration and Staff Report have been prepared in accordance with the National Health Service (Scotland) Act 1978 and directions made thereunder by the Scottish Ministers.

Financial Statements

As a result of our work, we proposed a number of disclosure adjustments to the draft financial statements. There are no unadjusted material misstatements at the conclusion of our audit and we have completed the majority of our audit work and expect to be able to issue an unqualified audit opinion on 20 June 2016**.**

Financial performance

In the year the Board achieved an overall surplus of £0.06m (2014/15: £2.03m) against its Core Revenue Resource Limit of £299.34m (2014/15: £287.02m).

The Board achieved a breakeven position against its Core Capital Resource Limit of £60.06m (2014/15: £4.32m).

In the year the Board met its Cash Releasing Efficiency Savings (CRES) target of £7.96m and achieved £0.46m productivity savings. 77% of the Board's efficiency savings in 2015/16 were achieved from recurring sources (2014/15: 91%).

Other Matters

Acute Services Redevelopment Project

The project to build the new Dumfries and Galloway Royal Infirmary reached financial close on 11 March 2015 and the project remains on schedule for completion by September 2017. In the current year, the Board has recognised an additional asset under construction and equivalent creditor of £53.98m in relation to the project. This brings the total value of the asset to date on the balance sheet to £81.58m (2014/15: 27.6m).

Valuation of land and buildings

The Board has elected to apply indexation as a valuation base for its land and buildings portfolio for 2015/16. In 2014/15 a full revaluation exercise was performed in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual. This combined use of indexation and full revaluations in intervening years is a permitted valuation base within the Government Financial Reporting Manual (FReM) 2015/16. The indexation process has been conducted applying guidance on appropriate indices from independent valuer, GVA James Barr.

Accounting for revaluations

In the current year the Board recognised an upwards revaluation of £3m as a result of the application of indexation. In our review of the accounting treatment for this revaluation we noted that the Board does not consider the impact of previous downwards revaluations charged to the income and expenditure statement. The 2015/16 FReM requires that downwards revaluations previously taken to the income and expenditure statement should be reversed upon subsequent upwards revaluations. Currently the Board has no process or records in place to ensure this is performed.

Management has undertaken an exercise to quantify the impact of this accounting treatment, going back to when records exist from 2009. This has confirmed that the accounts are free from material misstatement, and management have agreed to implement a process to capture this accounting treatment accurately into the future.

In addition, we also found that the Board does not transfer the realised element of the revaluation reserve annually to the general reserve in accordance with the requirements of the 2015/16 FReM.

Both of these matters have been recorded as control weaknesses and are explained in detail within Section 2.

Enhancements During Leave (EDL)

NHS Circular PCS (AFC) 2008/12 – Changes to the way staff are paid during annual leave was issued in 2008 and highlighted that boards were required to implement the new UK agreement on unsocial hours payments from 1 April 2008. Part of that agreement is that staff must be paid "as if at work" during periods of annual leave, with such payments are referred to as Enhancements During Leave (EDL).

We have gained an understanding of the procedures implemented by the Board to address the requirements of the circular and considered a sample of payments in the year to confirm their accuracy. We found that the processes in place required improvement to ensure the accuracy of payments.

This matter has been recorded as a control weakness and explained in detail within Section 2.

Please note that copies of this report will be sent to the Audit Scotland in accordance with their requirements.

We thank the management and staff of the Board for their co-operation and assistance during the course of our work.

Section 2: Significant audit and accounting matters

We have set out in this section the significant audit and accounting matters arising from our audit.

Matters identified in our audit plan

We have summarised in the table below our response to the significant and elevated risks identified in our audit plan. We have subsequently reviewed our audit plan and, following an update to our audit methodology, included an additional elevated audit risk in relation to valuation of land and buildings. We have included an explanation of this risk and our response in the table below.

Audit risk	Audit response
Risk of Management override of controls – significant risk ISA (UK&I) 240 requires that we plan our audit work to consider the risk of fraud, which is presumed to be a significant risk in any audit. This includes consideration of the risk that management may override controls in order to manipulate the financial statements.	We performed the following procedures: • Tested the appropriateness of journal entries using Computer Assisted Audit Techniques; • Reviewed accounting estimates for bias and evaluated whether circumstances producing any bias represented a risk of material misstatement due to fraud; • Evaluated the business rationale underlying significant transactions; and • Performed 'unpredictable' procedures. We noted no audit adjustments as a result of these procedures. Our unpredictable procedures identified a historic control weakness in relation to enhancements during leave payments, details of this are set out later in this section.
Risk of fraud in revenue and expenditure recognition – significant risk Under ISA (UK&I) 240 there is a (rebuttable) presumption that there are risks of fraud in revenue recognition. There is a risk that the Board could adopt accounting policies or treat income transactions in such a way as to lead to material misstatement in the reported revenue position. We extend this presumption to the recognition of expenditure in the NHS as expenditure is the area where judgements may be needed at the year end.	We obtained an understanding of key revenue and expenditure controls. We evaluated and tested the accounting policy for income and expenditure recognition to ensure that it is consistent with the requirements of the International Financial Reporting Standards (IFRSs), as adopted by the European Union, and as interpreted and adapted by the 2015/16 Government Financial Reporting Manual (FReM). We performed detailed testing of revenue and expenditure transactions, focussing on the areas of greatest risk. We performed a combination of sampling and target testing of revenue and expenditure transactions to ensure that we obtained comfort over the different revenue and expenditure accounts shown within the notes to the accounts. We reviewed significant accounting estimates and judgements for indicators of management bias. We have noted no matters to bring to your attention as a result of our work.

Audit risk	Audit response
Risk of expenditure misclassification – elevated risk The Board has a number of financial targets to meet including: - revenue resource limit - capital resource limit; and - cash. There is a risk that expenditure could be misclassified so as to ensure that the targets above are achieved.	We have performed detailed testing of expenditure transactions and fixed asset additions to determine whether they have been classified appropriately in line with the requirements of the FReM and the Board's accounting policies. We have noted no matters to bring to your attention as a result of our work.
Risk of misstatement on the valuation of the new DGRI asset under construction – elevated risk As the new Dumfries and Galloway Royal Infirmary (DGRI) construction project continues throughout the year, the Board will recognise the completed element of the new build as an asset under construction. This is not a traditional public sector capital build, where staged payments are made upon production of valuation invoices, so there is a risk that the valuation of the asset under construction could be misstated.	We have engaged with management to understand progress on the construction contract. We have reviewed the certification of current costs to date as at the end of March 2016 which the external valuer, MAMG Ltd, have provided to Laing O'Rourke. These costs are in line with the expectations provided in the original financial close model and expected timescales for the construction. We have verified costs incurred to date using third party evidence in the form of a MAMG ltd. certification certificate. We have noted no matters to bring to your attention as a result of our work.
Risk of incorrect accounting treatment for the new Integration Joint Board – elevated risk The Board entered into an Integration Joint Board with Dumfries & Galloway Council for the delivery of the Health and Social Care Integration legislation. These new legal structures and governance arrangements came into place during 2015-16 for the first time, and will therefore be required to be accounted for accurately.	We have considered the financial position of the Integrated Joint Board for 2015/16. We have reviewed management's decision not to consolidate the entity on an equity basis due to materiality. We have noted no matters to bring to your attention as a result of our work.
Wider scope audit risk – financial sustainability – elevated risk There is unprecedented financial pressure on the NHS as a result of ever increasing demand during a period of financial austerity in UK public services. This is leading to Boards across the country finding it increasingly difficult to fill budget gaps through the identification of efficiency savings. As a result there is an increasing risk that financial statements could be manipulated through manual transactions to present compliance with RRL and CRL targets.	We have reviewed management's financial plans going forward to assess their robustness. During the interim visit we understood the 2015-16 financial performance and ensured that our substantive testing programme was delivered to reflect the areas of risk such as cut off, provisions and unrecorded liabilities. We have also considered management's arrangements to manage its future financial position. Our commentary in relation to financial sustainability of the Board is set out in Section 3.

Audit risk	Audit response
Risk of error in valuation of land and buildings – elevated risk Given the significance of the land and buildings balance on the Board's balance sheet, and the judgements and calculations involved in arriving at a valuation figure, we have assessed that there is a risk of error in the process.	We have assessed the valuation base applied to the land and buildings portfolio for compliance with the 2015/16 FReM. We have engaged internal valuation experts to evaluate the indexation indices applied by management. We have re-performed a sample of revaluation transactions to ensure these have been processed accurately and accounted for in accordance with the 2015/16 FReM. We identified two control weaknesses in relation to accounting for revaluations. These are discussed later in this section.

Materiality

We have conducted our work in accordance with the materiality levels detailed below. We have applied a de-minimus level of £250,000 which was agreed with the Audit and Risk Committee upon submission of our annual audit plan.

	£
Overall materiality – This is the amount we have applied in assessing the overall impact on the group financial statements of potential adjustments	**6,820,000**
Performance materiality - We have applied this to direct the amount of work performed over each financial statement line item – for example in calculating sample sizes	**5,115,000**
De-minimus posting level - Under ISA (UK & I) 450, we are required to report to the Audit Committee on all unadjusted misstatements in excess of a 'de-minimus' or 'clearly trifling' amount	**250,000**

We re-assessed materiality once the 2015-16 draft accounts were available to us, and given the difference was less than £1,000 from our initial assessment, we did not update the values set out in the annual audit plan.

Accounting matters

Acute Services Redevelopment Project

The Acute Services Redevelopment Project relates to the construction of a new District General Hospital in Dumfries. This is planned for completion in September 2017 with patients being admitted in December 2017. Financial year 2015/16 constitutes the second year of the construction project and the project is progressing in accordance with planned timescales and budgeted cash-flows.

During the course of the prior year audit, as reported in our annual report to those charged with governance for 2014/15, we reviewed the accounting treatment for the project. This work concluded that the Board had accurately recognised the project as a service concession contract in accordance with IFRIC 12 and the 2014/15 FReM. We have reviewed the accounting treatment against 2015/16 standards and concluded that this treatment remains appropriate.

In the current year, the Board has recognised an additional asset under construction and equivalent creditor of £53.98m to account for the construction progress in the year. This brings the total value of the asset to date on the balance sheet to £81.58m (2014/15: 27.6m).

The current asset value has been determined based on the bidder's financial model as at financial close and confirmed at the 31 March 2016 by MAMG Ltd, external (RICS) valuers, as being the costs associated with the construction project to date. We have inspected the MAMG Ltd. certification for the end of March 2016 and we contacted the company directly to understand their process for arriving at this value. This involved a site visit, review of the construction report and assessing the current costs to date against the original financial close model. We consider that the processes used are reasonable and conclude that the Board has appropriately capitalised a total of £81.58m on its balance sheet as at 31 March 2016.

Valuation of land and buildings

The Board has elected to apply indexation as a valuation base for its land and buildings portfolio for 2015/16. In 2014/15 a full revaluation exercise was performed in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual. This combined use of indexation and full revaluations in intervening years is a permitted valuation base within the Government Financial Reporting Manual (FReM) 2015/16. The indexation process has been conducted applying guidance on appropriate indices from independent valuer, GVA James Barr.

A percentage of 3.5% has been applied to all land and buildings held at depreciated replacement cost, resulting in a net upward revaluation of £3m. Land and buildings held at fair value were allocated an indexation percentage of 0% based on current market conditions.

We have considered the indices applied and sample tested their correct application, we have no matters to bring to the attention to management.

Accounting for revaluations

Our review of the accounting treatment for revaluations confirmed two areas where the Board does not have processes in place to ensure compliance with the 2015/16 FReM:

1. The FReM requires that upon upwards revaluation of an asset, a credit be taken to the income statement to reverse the impact of any previous downward revaluations (less the difference in depreciation since original downward revaluation). The Board has not adopted this practice and instead has credited the full upwards revaluation for 2015/16 to the revaluation reserve. Our review of historic records identified that total amounts which had historically been debited to the income statement since 2009 were under £150,000 and no financial adjustments were proposed. The Board has agreed to adopt the correct practice going forward into 2016/17.

2. There is a further requirement to release the unrealised element of the revaluation reserve to the general fund on an annual basis. This allows the impact of increased depreciation to the income statement from upwards revaluations to be neutralised in the general fund. The Board has not adopted this practice, historically or in the current year. Whilst the error is limited to classification between the revaluation reserve and general fund, it will result in an inability to reduce the balance of the revaluation reserve accurately.

Each of these matters have been raised as audit findings within our action plan set out at Appendix 1. However, the scale of these matters is such that there is no impact upon our audit opinion.

Enhancements During Leave (EDL)

NHS Circular PCS (AFC) 2008/12 – Changes to the way staff are paid during annual leave was issued in 2008 and highlighted that boards were required to implement the new UK agreement on unsocial hours payments from 1 April 2008. Part of that agreement is that staff must be paid "as if at work" during periods of annual leave, with such payments are referred to as Enhancements During Leave (EDL).

Upon receipt of the circular management was proactive in its communication with employees and that the issue has been visible in reporting to the Board and relevant standing committees.

The Board has fully acknowledged the requirements of the circular and implemented a system of shadow shifts on SSTS (the rostering system) whereby each manager estimates normal work patterns and enters a shadow shift for the period of annual leave to reflect this. Discussions with both management and line managers confirmed that this approach is not based on historic data, but rather line manager judgement, and therefore includes an element of estimation in the amounts paid.

We performed a review over one department within the Board to consider payments made versus payments due based on historic working patterns. On an individual basis, we performed a detailed analysis on three employees and inspected the weekly time sheets for each employee over a historical 13 week period, as this is the current minimum period of time managers must assess for each individual member of staff. The data accurately showed the total unsocial hours worked during each week and then analysed the normal work pattern of each employee before each instance of annual leave was taken. The results of the analysis are summarised below:

Table 1: Testing of EDL hours due compared to hours paid

Employee	Difference between hours due and hours paid - Saturday	Difference between hours due and hours paid - Sunday	Difference between hours due and hours paid - Night
Employee No.1	14.5 (Overpayment)	-17.2 (Underpayment)	0.6 (Overpayment)
Employee No.2	8.4 (Overpayment)	11.2 (Overpayment)	4.2 (Overpayment)
Employee No.3	22.9 (Overpayment)	-16.6 (Underpayment)	39 (Overpayment)

The variances above reflect the fact that currently line managers estimate and book unsocial hours during annual leave based on judgement rather than formal analysis of prior period work pattern.

Overall we have concluded that the processes adopted to implement the requirements of the circular mean that amounts paid are based upon an element of estimation rather than using actual working pattern data. As part of the audit, we re-performed the calculation of EDL payments due based upon actual data, rather than estimated data and found a number of differences as shown above. However, the differences identified are not material to the financial statements.

We further note that from July 2016 SSTS will have the functionality to automatically calculate enhancements due based on historic working patterns for each employee and look back over a full 52 week period, rather than using a 13 week period. It is expected that this will resolve the inaccuracies caused by the current process.

This matter has been raised as an audit finding within our action plan set out at Appendix 1.

Related party transactions

The Board has a process in place to understand the interests of its Executive and Non-executive Board members, which has been devised to meet the requirements of the Board's own internal governance processes and mitigate conflicts of interest. This process is also used as the mechanism to identify and record related party transactions in accordance with IAS 24.

Whilst the register of interest process has been recognised as good practice within the sector, it is not directly aligned to the accounting requirements for related parties, nor the timescales for the annual accounts process. Specifically the forms used to gather interests are not clearly aligned to the requirements of IAS 24 and therefore do not easily facilitate identification of related parties for accounting purposes.

This matter has been raised as an audit finding within our action plan set out at Appendix 1.

General ledger

In accordance with ISA (UK&I) 240 (revised): *The Auditor's responsibilities relating to fraud in an audit of financial statements,* an auditor is required to test the appropriateness of journal entries recorded in the general ledger and other adjustments made in the preparation of the financial statements.

For our journals testing in 2015/16 with have used a data auditing package, 'Halo', which is an application that analyses and assures data using a suite of algorithms. We have used this software to focus our journals testing on the arears of greatest risk and through this process we have identified some key trends in the Board's use of journal entries.

We performed detailed analysis on the Board's journals and identified that a total of 84,021 were posted in the year. Of these 9,733 (12%) were under £10 and the split of manual to automated journals for the year was 98% to 2%.

Journal and line item totals (Year on Year)	**2015/16**	**2014/15**
Total number of journals posted	84,021	87,973
Average lines per manual journal	7.1	11.92

The table above demonstrates that there has been a reduction in the number of journals posted by the Board compared to the previous financial year. The table below sets out further information obtained from our current year HALO output which we analysed and discussed with management.

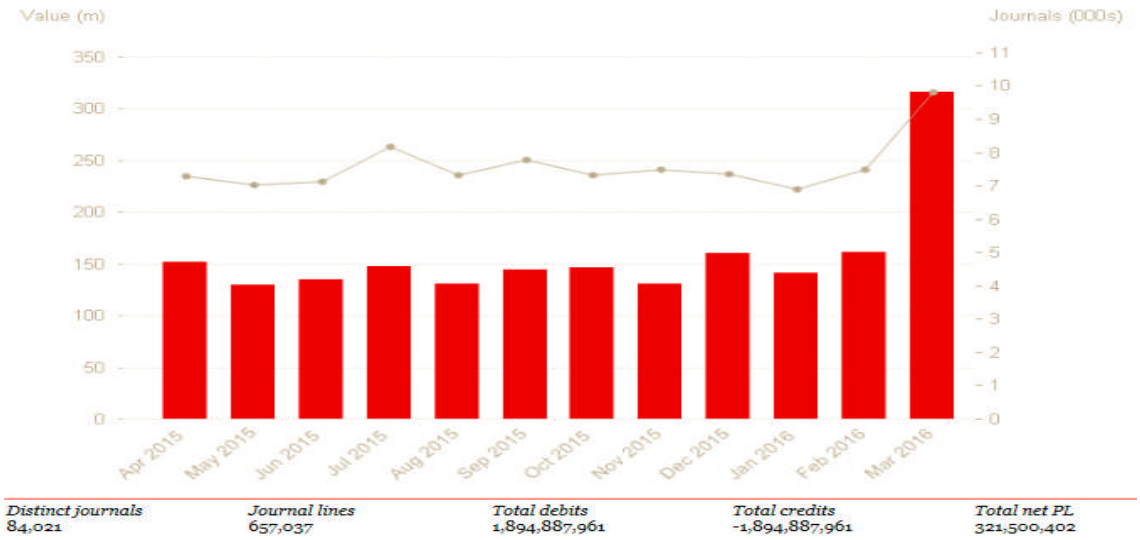
Journal detail	**2015/16**
Number of users posting journals	41 users
Journals under £10	9,733
Number of users posting journals under £10	7 users
Percentage of manual journals posted	98%

The number of journals with a value of under £10 is in our experience high and represents a potential area where the Board can look to drive efficiencies perhaps through the use of weekly rather than daily postings.

Our work included a check to ensure that senior finance management did not post any journals. No exceptions were identified from our work, which was in line with our expectations of the role of management within the finance department.

The graph below shows the distribution of journals throughout the year which demonstrates that there is a steady posting of journals until the final month for year-end adjustments which are posted by the finance department.

Figure 1: Journal totals in 2015/16



The key financial control identified in relation to manual journals is that the finance team performs a spot check of 10% of all journals retrospectively to confirm legitimacy and accuracy. The reason for the 10% spot check is due to the volume of manual journals processed and striking the balance between mitigation of risk and use of resource.

Whilst it is agreed that a secondary review process cannot be undertaken across the full manual journals population, management would benefit from using a risk based approach to direct their review to journals which presented the highest risk of material misstatement in the financial statements.

This matter has been raised as an audit finding within our action plan set out at Appendix 1.

Misstatements and significant audit adjustments

We report to you all misstatements that we have found during the course of our audit, other than those of a trivial nature, which have not been corrected by management in the financial statements. There are no uncorrected misstatements arising from our audit to report to you.

The only corrected adjustments to the accounts were of a minor nature.

Qualitative aspects of accounting practices

Financial statement disclosures

In October 2015 Audit Scotland published a follow up to its 2014/15 publication *Improving the quality of NHS annual report and accounts*. This comprised a follow up review of the recommendations made in the original publication and concluded there have been significant improvements in the presentation of NHS Board accounts in 2014/15.

We have once again considered the key issues raised in the original publication and ensured that the Board has addressed these in the presentation of their annual report and accounts document.

We have also reviewed, and tested, the material disclosures in the financial statements. We identified no significant issues as part of this work.

Governance Statement

The Financial Reporting Manual requires Chief Executives to sign a Governance Statement which covers all aspect of control including financial, operational, compliance and risk.

We reviewed the governance statement and considered the following:

- Compliance with the required elements of the pro-forma statement developed by SGHSCD; and
- Consistency with the remainder of information presented within the annual accounts and our overarching understanding of the entity.

Based on our normal audit procedures, we do not disagree with the disclosures contained in the Statement.

Performance Report and Accountability Report

The NHS Accounts Manual reflects requirements set out in the 2015/16 FReM. The most significant change is that, in accordance with chapter 5.1 of the FReM, Boards are now required to prepare an annual report which comprises the following:

- A Performance Report;
- An Accountability Report (including the Corporate Governance Report); and
- The financial statements.

This replaces the previous requirement to prepare Directors' and Strategic Reports. Based on our normal audit procedures, we believe these have been presented appropriately within the 2015/16 Annual Report and Accounts.

Dumfries and Galloway Integrated Joint Board

Financial year 2015/16 represented the shadow year for the Dumfries and Galloway Integrated Joint Board (IJB). During the shadow period, the IJB incurred some running costs although not operational until 1 April 2016. For 2015/16 the NHS Accounts Manual sets out the requirement for Boards to consolidate the IJB on an equity basis. On the basis of materiality, the Board has assessed that there is no need to consolidate the IJB in the current year. This is assessment is supported by the level of expenditure set out below:

Table 2: Breakdown of IJB expenditure in 2015/16

50% of Executive's time allocated to IJB Nov 15-March 16	24,028
Audit Fee	5,000
Total IJB expenditure in 2015/16	**29,028**

The level of activity and number of financial entries within the IJB is expected to increase significantly for 2016/17 in comparison to the figures shown in the table above and will mean that consolidation will be required.

Section 3. Financial performance

Financial targets

The Scottish Government Health and Social Care Directorate set three financial targets for the Board on an annual basis. These targets are:

- Revenue Resource Limit – a resource limit for ongoing operations;
- Capital Resource Limit – a resource budget for net capital investment; and
- Cash requirement – a financing requirement to fund the cash consequences of the ongoing operations and net capital investment.

The Board's performance against its three financial targets for financial year 2015/16 is set out below:

Table 3: Financial targets summary 2015/16

	Limit as agreed by SGHSCD £ million	Actual Outturn £ million	Underspend/ (Overspend) £ million
Revenue Resource Limit (RRL)			
Core	299.39	299.33	0.06
Non-core	7.11	7.11	-
TOTAL	**306.49**	**306.43**	**0.06**
Capital Resource Limit (CRL)			
Core	60.08	60.06	0.02
Non-core	-	-	-
TOTAL	**60.08**	**60.06**	**0.02**
Cash Requirement			
Cash Requirement	**317.77**	**317.77**	-

The Board's underspend of £2.03m against its Core Revenue Resource Limit of £287.02m in 2014/15 has been utilised by the Board in 2015/16 as part of the overall financial plan for 16/17.

The Board's capital resource limit in 2015/16 has been utilised primarily on two large projects; the new Acute Services Redevelopment project discussed in Section 2 above (£53.86m) and the development of the new Women & Children's Hub (£2.9m).

Budgetary control

In order to support the balance between achieving targets in year and longer term financial planning it is vital that Board has in place a sound system of financial planning and budgetary control. Each month management accounts monitor budgeted spend versus actual to identify any large variances to the budgets set at the beginning of the year. Any large variances are discussed with the Director of Finance at the end of each month.

The annual budget setting process takes place in consultation with Directorates based on indicative allocations from the Scottish Government. The Board has assigned budget holders for all departments and prepares monthly budget reporting packs for each which are discussed at meetings between Finance and the Directorates. Progress against budget is reported as a standing item to the Board and the Performance Committee.

In relation to attainment of efficiency savings, opportunities are explored via the Efficiency Group which is chaired jointly by the Director of Finance and Chief Operating Officer. The group is attended by General Managers and other key stakeholders, including partnership representation to explore new and innovative areas for efficient ways of working. Monthly budget scrutiny meetings between the Chief Operating Officer, Director of Finance and General Managers are also used to drive the focus on savings.

It is our view that the budgetary control arrangements in place are effective and have supported the Board to deliver break even budgets until now, and should continue to do so into the future.

Efficiency savings

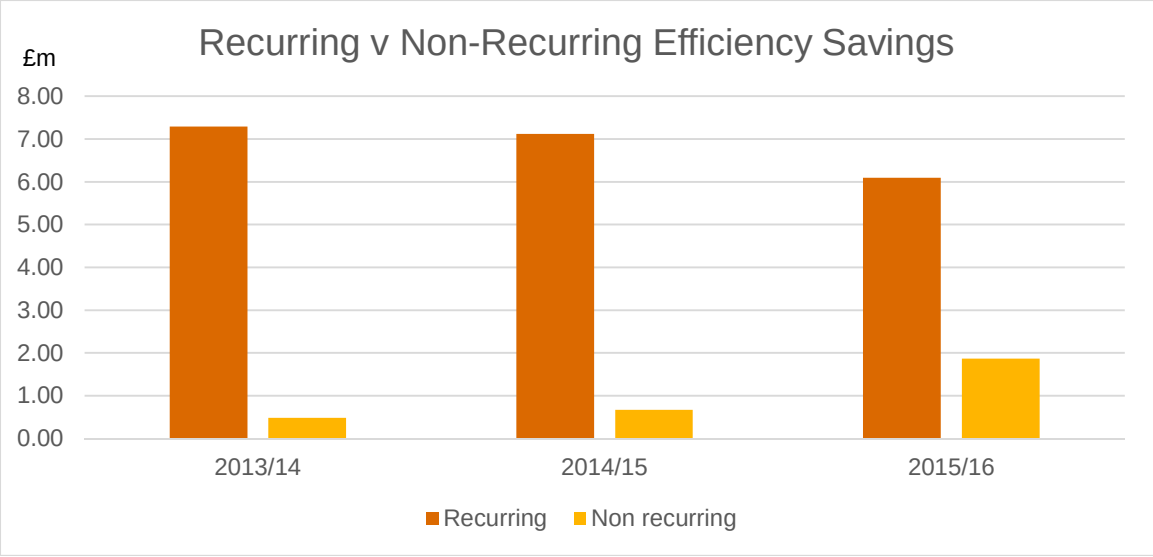
The Board has achieved £7.96m of efficiency savings in 2015/16, meeting its target for the NHS Scotland Efficient Government savings target. This is split between £7.5m cash releasing efficiencies and £0.46m productivity savings. The sources through which the Board has achieved these efficiencies are set out below:

Table 4: Efficiency savings 2015/16

Source	Savings £ million	% of total
Service Productivity	2.771	34.8%
Drugs & Prescribing	1.250	15.7%
Procurement	0.608	7.6%
Workforce	2.770	34.8%
Other sources	0.561	7.0%
Total reported	**7.960**	**100%**

The graph below displays the recurring and non-recurring efficiency savings over the past three years and the Board's forecast efficiency savings for 2016/17.

Figure 2: Breakdown of Recurring v Non- Recurring Efficiency Savings



The Board's financial plan identifies a requirement to deliver £12.7m savings for 2016/17 on a recurring basis to remain in recurring financial balance. Over the past three years there has been an increase in the proportion of its savings which are non-recurring in nature. However, as at June 2016 only £5.6m of total planned recurring savings have been identified for 2016/17. A further £5.7m of savings have been identified from non-recurring sources and the remainder of required savings is unidentified at present. It has been assumed by the Board that the unidentified balance of £1.4m will be delivered recurrently with the focus remaining on the recurring gap of £5.7m through the development of savings schemes which will increase the recurring savings plans.

Financial sustainability

In recent years NHS Boards in Scotland have faced significant challenges in delivering healthcare services amidst continued financial pressures. Audit Scotland's publication '*NHS in Scotland 2014/15*' recognises the difficulties caused by the focus on meeting annual targets and the extent to which this focus can hinder the longer term financial planning process. The overarching recommendation for NHS Boards is in relation to a strengthened approach to long term financial planning, considering in detail the resources required to implement service changes.

In light of this, financial sustainability has become a key matter for consideration by Boards and it is vital that consideration of longer term financial plans has taken place.

2016/17 financial plan

NHS Dumfries and Galloway's Financial Plan for 2016/17 highlights the following key areas of income and expenditure, recurring and non-recurring:

Table 5: 2016/17 Financial Plan

NHS Dumfries & Galloway	2016/17 Projected £ million
Recurring income	310.97
Recurring expenditure	323.73
Recurring savings	7.01
Underlying recurring (deficit)/surplus	(5.75)
Non-recurring income	28.31
Non-recurring expenditure	28.31
Non-recurring savings	5.75
Non-recurring (deficit)/surplus	5.75
Overall Financial (deficit)/surplus	-
Recurring surplus as percentage of recurring income	0.0%

The requirement for a significant amount of non-recurring resource arises from the increasing need each year to sustain medical staffing cover with locum and agency workers. The Board is treating this cost pressure as non-recurring to reflect the fact that using medical locums and agency workers is not a sustainable staffing model and it is therefore supplementing budgets on a non-recurring basis. The Board is in the process of reviewing medical models and rotas on an individual service by service basis in order to agree and finalise staffing plans on an ongoing basis.

The Board's 2016/17 plan also makes use of non-recurring resources to relieve other costs pressures, including achieving access targets, continued funding of roles across the organisation which are reliant on non-recurring funding and increasing activity in certain departments (most notably laboratories and theatres).

The planned projected savings to deliver a balanced budget in 2016/17 include the following:

1. ***High Value Drugs***

A project is ongoing to consult with local GPs in order to understand prescribing practices and identify lower cost replacements for expensive drugs. Plans are in place to implement workshops to allow GPs to link up and share practices with a view to achieving efficiencies across the Board.

2. ***Management of Repeat Prescriptions***

The Board has recommended that patients with repeat prescriptions are communicated with to ensure they still require their repeat prescriptions and that these are not being collected by patients each month without the need for them. This practice is expected to reduce prescribing costs over the course of 2016/17. The total target of prescribing efficiencies for the coming year is set out as follows:

Table 6: Prescribing efficiency savings 2016/16

	Proposed Board Target	Realistic Saving Identified	Gap
2016/17 Prescribing Efficiencies Total	**2,500,000**	**2,011,000**	**(489,000)**

There is still a large variance of £489,000 which has been identified in the table above against the proposed Board prescribing efficiencies target. The Board will devise a strategy in the coming months on how to reduce this gap over the course of 2016/17.

3. ***Service Transformation***

This project aims to reduce the requirement to utilise the services of other Scottish NHS Boards to treat patients from NHS Dumfries and Galloway. Such treatment costs cannot be controlled by the Board and travel costs are also incurred. A key element of this project will encompass expanding the capacity for more complex treatments within DGRI.

4. ***Medical Locums***

The use of medical locums continues to be a significant cost pressure for the Board. In order to manage this risk, the organisation is considering following a managed service contract model for the supply of medical locums which is already used by a number of other Scottish Health Boards. There is evidence that this model, where supply risk is transferred to the private sector, can result in savings for the Board.

Financial Planning: 2016/17 and beyond

The Board has developed a five year financial plan to 2019/20 (submitted as part of the LDP) which forecasts a break even position in each year. NHS Dumfries & Galloway has a requirement to deliver efficiency savings of 3% of its of baseline allocation each year in order to meet the Scottish Government 3% efficiency target. This target has been increased to 4.7% for 2016/17. However the Board has identified in its 5 year plan commentary that savings targets are becoming increasingly challenging to meet each year and that it will be difficult to continue to achieve this level in the coming years. In setting its five year plan, the Board considers the following to be the areas of greatest financial uncertainty:

Table 7: Areas for financial uncertainty/risk

Risk	Impact
Allocation Uplift	The 2016/17 uplift of 1.7% has been confirmed by Scottish Government to date. The five year plan assumes a 1.8% uplift over years 2-5, where uncertainty over this rate presents a risk.
CRES delivery	Future attainment of a 3% efficiency savings target will become increasingly challenging, particularly on a recurring basis. Please see commentary below the 2016/17 financial plan above where efficiency saving plans have been outlined.
Prescribing (General)	The on-going financial risk associated with new drugs and increasing growth (taking into account national indicators and local knowledge) remains a significant risk particularly in relation to new drugs that will be approved by the Scottish Medical Consortium. It is our understanding that it is the increased cost of drugs which was a key factor in the Board achieving a near break-even position compared with a surplus in prior years.
Prescribing (new medicines fund)	An assessment has been undertaken within the plan to incorporate estimates of likely growth of drugs in this area. It is assumed that these will be matched with funding within the five year plan.
Workforce/Recruitment	Whilst £4m non-recurring funding was assigned in 2015/16 on a non-recurring basis, this is not a sustainable model over the medium/longer term.
Health and Social Care Integration	A significant level of system risk remains. This will only be resolved once the Integrated Joint Board is fully operational and the new management structure appointed. This has been fully established on 1st April 2016 and poses a risk to the Board in ensuring it can appropriately identify costs relating to the IJB and account for these correctly.
DGRI Maintenance	The backlog maintenance at DGRI will continue to require expenditure over the period that the hospital remains operational. Funding for backlog maintenance is restricted and investment will require to be prioritised.
Externals	The Board has seen a substantial increase in the level of activity undertaken outwith Board boundaries. Whilst financial provision has been made in the plan, changes relating to service redesign in preparation for the hew hospital opening, has increased costs significantly.

It is clear from our review of the 5-year financial plan that significant effort and consideration has been put into this exercise. We agree with the financial risks that have been identified, and we noted that there is an underlying recurring surplus, which is balanced against a projected non-recurring deficit to deliver a break-even position in each of the next 5 financial years.

Whilst this is an informative report for the Board, we think it could be strengthened through the inclusion of some sensitivity analysis to quantify the size of the financial risks included in the table above. For example, there is an assumption that Agenda for Change staff will be restricted to a 1% pay award over the period of the plan,

which is in line with the current government policy. However, if this policy were to change to 2% per annum it would represent a recurring cost pressure of over £2m per year and has a cumulative effect which compounds the cost pressure in future years.

We also noted that the Board has a contingency reserve of £2m to manage in-year pressures and will act as a buffer to manage the realisation of financial risks.

The Board's main capital commitment over the coming years will continue to be the Acute Services Redevelopment Project. The Board has included the requirement to draw down on the monies banked with Scottish Government in its five year plan to fund the expected double running costs across the new hospital and existing DGRI.

In conclusion the Board appears to have a robust financial plan which sets out how a break-even position can be achieved during these difficult financial years.

Section 4. Governance and internal control

Governance structure

There has been no change to the Board's governance structure in the year. The Board continues to be supported by the following standing committees:

Healthcare Governance Committee – responsible for providing assurance to the Board that appropriate systems and structures are in place to effectively manage clinical care and healthcare services.

Person Centred Health and Care Committee - provides assurance to the Board on implementation of the national Person Centred Health and Care Programme locally within Dumfries and Galloway.

Audit and Risk Committee – responsible for oversight of internal and external audit, internal governance, risk and fraud.

Performance Committee - provides a monitoring function for financial and non-financial areas within the Health Board to aim to achieve the performance targets which have been set both locally and on a national level.

Staff Governance Committee **-** monitors and reviews objectives to improve the standards of Staff Governance in the light of national and local priorities together with the results of the Staff Survey and the Staff Governance Action Plan.

The terms of reference for all Committees including the core function and membership were reviewed during the year following the appointment of new Non Executive Board members and the Board also approved revised Standing Financial Instructions during 2015/16. The Board and its Standing Committees continue to demonstrate that they have clearly defined and documented roles and responsibilities, as evidenced through our review of Board and other committee minutes, as well as attendance at Audit and Risk Committee meetings.

In addition, the Board has completed the NHS Scotland Board Diagnostic (self-assessment) Diagnostic Toolkit to demonstrate compliance with the UK Corporate Governance Code. The completed questionnaire was agreed by the Board, with the results being used to develop the work that will be taken forward in 2016/17 as part of the agreed framework for the joint executive and non-executive leadership development programme. The Board has also undertaken its own internal review of its governance arrangements and committees in April 2016.

In accordance with legislation, an Integrated Joint Board was formally established during 2015/16 between the Board and Dumfries & Galloway Council with the approval of the Integration Scheme by Scottish Ministers. This formally established the partnership and organisational arrangements with the Local Authority, with the scope of services delegated to IJB including Adult Social Care Services and all operational health services including Acute Services. In addition the Boards well developed community planning processes enable it to work effectively with the local authority and the voluntary sector and other public sector partners. We have reviewed the Integration Scheme and confirmed that adequate financial governance provisions were made to ensure that public funds can be accounted for appropriately.

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We have reviewed the Governance Statement in the annual accounts, which based on our knowledge of the Board, is a fair reflection of the governance arrangements in operation during 2015/16. Further, the Board's self-assessment of the effectiveness of those governance arrangements is not inconsistent with the findings from our audit work.

System of internal control

The Chief Executive Officer in conjunction with management is responsible for developing and implementing systems of internal financial control and having in place proper arrangements to monitor their adequacy and effectiveness in practice.

We review these arrangements for the purposes of our audit of the financial statements and for our review of the annual governance statement and report to you any significant deficiencies in internal control that we find during our audit.

The Board also has a dedicated internal audit department which adds an extra layer of assurance to the Board's system of internal controls. Please see Internal Audit section below for further details.

We have set out all control matters noted during the course of the audit, and referred to throughout this document, in an action plan with Appendix 1.

We have also performed follow up procedures over prior year audit recommendations, the results of which are set out at Appendix 2. We have concluded that all but one prior year recommendations have been fully implemented.

Based on our work performed we consider the systems of internal control to be appropriate.

Risk management

NHS Dumfries and Galloway has a risk management strategy in place and has produced an annual risk report for 2015-16. During the year the Board formalised the role of the Risk Executive Group, setting this out in a terms of reference covering:

- Agreeing the Risk Management strategy of the Board;
- Overseeing and directing the Risk Management agenda;
- Overseeing and providing assurance to the Audit and Risk Committee of the effectiveness of risk management arrangements;
- Providing direction and guidance to the Risk Management Network, Management Boards and the General Managers Group;
- Ensuring that Risk Management is integral to all business decision making, planning, performance reporting and delivery processes;
- Setting a model for agreeing and monitoring risk appetite which reports into the Audit and Risk Committee; and
- Responsibility for the review and monitoring of the Corporate Risk Register and any escalated/uncontrolled risks from directorates.

All directorates within the Board maintain a risk register which is scrutinised by the relevant management team as well as being monitored in departmental performance reviews. Relevant sections of the risk register are reviewed periodically by each standing committee. The corporate risk register is a standing item of the Audit and Risk Committee agenda.

A Risk Management Annual Report is presented to the Audit and Risk Committee annually to ensure that all aspects of risk are considered at a strategic level and in order to drive plans for the current financial year and beyond for the Board to implement measures to mitigate risk where possible.

We have inspected meeting minutes evidencing that the Risk Executive Group report into the Audit and Risk Committee at each meeting since they were set up in 2015/16. There is now far more awareness of incidents within the Board as there is a clear system and process in place for people to raise concerns or highlight incidents which can then be discussed at the Audit and Risk Committee if appropriate. We noted that feedback from individuals and teams collated by the group improved throughout the year but there remains further work to be done to address the key challenge of communication (of known or potential risk areas) within the Board. However, a process is in place where each directorate has a risk facilitator and staff can also use their line manager or supervisor to sound these concerns before being raised at regular Risk Executive Committee meetings.

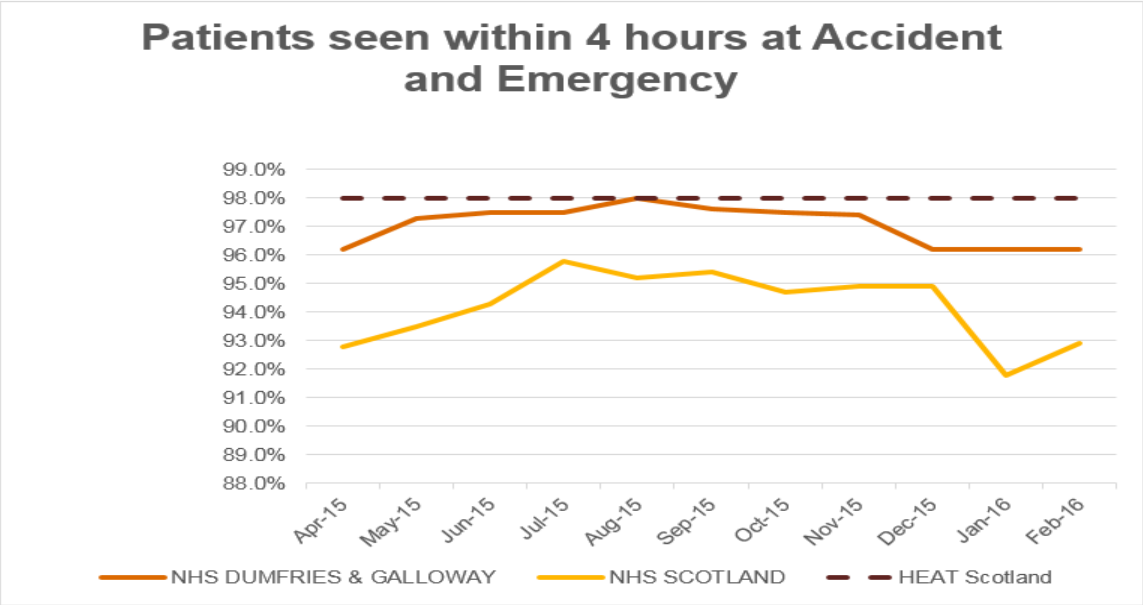
The Board recognises that risk management in the NHS is changing and requires to adapt. The review and development of risk management arrangements in year has continued to improve the Board's overall assurance arrangements for risk.

Performance management

Accident and Emergency Waiting Times

NHS Scotland's national target is that 98% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment. During the period April 2015 – March 2016, NHS Dumfries and Galloway has seen the percentage of patients seen within 4 hours of arrival fluctuate between 98.0% and 96.2%. As Figure 1 illustrates below, this is above the overall NHS Scotland position but still not above the national target:

Figure 3: A&E Waiting Times



The Board's Local Unscheduled Care Action Plan (LUCAP) contains many key actions to support the achievement of the 4 hour target. These include:

- Developing the primary care and community response to prevent admission to/ attendance at A&E;
- Continued management of hospital inpatients and patient flow; and
- Providing safe and effective care at the front door of the hospital 24/7 (primarily through increasing the number of middle grade staff with the Emergency Department).

Delayed Discharges

From April 2013 onwards, no patient should wait more than 28 days to be discharged from hospital into a more appropriate care setting after being recognised as fit for discharge. This was reduced to a maximum of 14 days from April 2015 and remained at this level for 2015/16. Table 8 below shows that in the past four quarters the NHS Dumfries & Galloway has failed to achieve the 14 day discharge target:

Table 8: Total number of delayed discharges

	Apr 15	Jul 15	Oct 15	Jan 16
Total Delays beyond 14 days	**7**	**6**	**22**	**10**

Delayed discharges are discussed on a monthly basis at the Primary and Community Care Management Board chaired by the Chief Operating Officer and attended by key stakeholders who influence delayed discharge performance. Key priority actions of this group include:

- Commencement of a weekly discharge meeting with senior social workers, nurse managers and locality managers to discuss individual delayed discharges;
- Work to improve patient flow in the DGRI and cottage hospitals including review of the admission, transfer and discharge policy, trialling 7 day discharges, promoting criteria led discharge and through the introduction of patient flow coordinators; and
- Escalation of capacity issues in relation to care packages on a weekly basis.

Local Delivery Plan standards

The Scottish Government Health and Social Care Directorates requires NHS Boards to prepare Local Delivery Plans (LDPs) on an annual basis. The LDPs set performance indicators and standards which have replace the system of HEAT Targets for 2015/16.

The table below sets outs the board's performance against the LDP standards, which we are not required to audit:

Table 9: Summary of LDP Standards performance

LDP Standard	Status	Period	Actual	Status
1. Detect Cancer Early	To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 29%.	Q4 2015-16	26%	Target not met (29%)
2. Cancer Waiting Times (31 days)	95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95% of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral.	Feb 2016 (Source: LDP Summary Dashboard)	100%	Target met (95%)
3. Cancer Waiting Times (62 days)	95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95% of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral.	Feb 2016 (Source: LDP Summary Dashboard)	95%	Target met (96%)
4. Dementia Post Diagnostic Support	People newly diagnosed with dementia will have a minimum of 1 years post-diagnostic support. (No data available for monitoring purposes)	Q4 2015-16	N/A	N/A
5. Treatment Time Guarantee	100% of patients to wait no longer than 12 weeks from the patient agreeing treatment with the hospital to treatment for inpatient or daycase treatment	Q3 2015-16 (Source: Scotland Performs website)	98%	Target not met (100%)
6. Early Access to Antenatal Care	At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation. The stretch target for NHS Dumfries and Galloway is 83.5%.	Q4 2015-16	81.7%	Lowest Quintile, stretch target not met
7. IVF Treatment Times	Eligible patients will commence IVF treatment within 12 months by 31 March 2015	Q3 2015-16 (Source: LDP Summary Dashboard)	90%	Target Met (100%)
8. 18 Weeks Referral to Treatment	90% of planned / elective patients to commence treatment within 18 weeks of referral	Jan 2016 (Source: LDP Summary Dashboard)	90.4%	Target met (90%)
9. 12 Weeks First Outpatient Appointment	No patient will wait longer than 12 weeks from referral (all sources) to a first outpatient appointment (measured on month end Census).	Dec 2015 (Source: LDP Summary Dashboard)	93.9%	Target not met (95%)

LDP Standard	Status	Period	Actual	Status
10. Clostridium difficile infections	NHS Boards' rate of Clostridium difficile infections in patients aged 15 and over is 0.32 cases or less per 1000 total occupied bed days	2015 Calendar year (Source: Scotland Performs website)	0.32	Target not met (0.37)
11. CAMHS Waiting Times	90% of young people to commence treatment for specialist Child and Adolescent Mental Health services within 18 weeks of referral	Q3 2015-16 (Source: LDP Summary Dashboard)	99%	Target met (90%)
12. Psychological Therapies Waiting Times	90% of patients to commence Psychological Therapy based treatment within 18 weeks of referral	Q3 2015-16 (Source: LDP Summary Dashboard)	66.4%	Target not met (90%)
13. MRSA/MSSA Bacteraemias	NHS Boards' staphylococcus aureus bacteraemia (including MRSA) cases are 0.24 or less per 1,000 acute occupied bed days	2015 Calendar year (Source: Scotland Performs website)	0.24	Target met (0.24)
14. Drug and Alcohol Treatment: Referral to Treatment	90% of clients will wait no longer that 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.	Q3 2015-16 (Source: LDP Summary Dashboard)	92.1%	Target met (90%)
15. Alcohol Brief Interventions	Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings.	Apr-Dec 2015 (Source: Local Management Information)	1168	Target not met (1743 for 2015/16)
16. Smoking Cessation, most deprived	Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas	Apr-Sep 2015 (Source: LDP Summary Dashboard)	101	Target not met (207 (for 2015/16)
17. 48hr access GP Practice Team	48 Hour access or advance booking to an appropriate member of the GP team (90%)	2013-14 (Source: LDP Summary Dashboard)	95.4%	Target met (90%)
18. Sickness Absence Rate	NHS boards to achieve a sickness absence rate of 4% or less	2015 Cal yr (Source: Local Management Information)	4.95%	Target not met (4%)

LDP Standard	Status	Period	Actual	Status
19. Accident and Emergency Waiting Times	4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%)	Feb 2016 (Source: LDP Summary Dashboard)	95.10%	Target not met (98%)
20. Financial Performance	Operate within agreed revenue resource limit; capital resource limit; and meet cash requirement	1 April 2015 – 31 March 2016	**Revenue** £306m **Capital** £60m **Cash** £318m	Target met £306m £60m £318m

In summary of the 20 LDP standards set for 2015/16:

- 9 have been met
- 10 have not been met
- 1 had no data available

Internal Audit

The Board has a dedicated internal audit function. The department undertook multiple internal audit reviews during the year, with a focus on monitoring the design and operating effectiveness of internal controls for both financial and non-financial areas.

The reviews to be carried out during the year are detailed in the internal audit plan which is set at the beginning of each financial year and is in line with the audit strategy, both presented to and approved by the Audit and Risk Committee.

Each internal review carried out during the year will result in the compilation of a report which details the nature, work and findings of the review. Each report will be given an assurance level and where relevant recommendations will be made. Assurances range from Comprehensive - Significant - Moderate - Limited (poorest and requires full reporting to Audit and Risk Committee).

Furthermore, where relevant, follow up work will be carried out in subsequent years by the Internal Audit team to ensure that recommendations made have been actioned.

We have reviewed selected reports from the Board's internal audit function and used these to understand and evaluate the control environment of the Board and to focus our audit on particular areas of risk.

Based on audit work performed we consider the Internal Audit function within the Board to be appropriate for the needs of the Board.

Health and social care integration

The Public Bodies (Joint Working) (Scotland) Act 2014 was passed in April 2014 as part of the Scottish Government's agenda to drive improvement in the provision of health and social care services. The Act details the integration models available to Health Boards and Local Authorities in developing their integration strategy

as well as required documentation and timescales for delivery of integration schemes. The vision for Dumfries and Galloway is to share the job of making the community the best place to live active, safe and healthy lives by promoting independence, choice and control.

Dumfries and Galloway Council, on the 26 June 2014, and NHS Dumfries and Galloway, on the 4 August 2014, agreed to adopt the body corporate model allowed by the legislation and, therefore, to establish an interim Integrated Joint Board (IJB).

The IJB has the responsibility for the strategic planning of the functions delegated to it and for ensuring the delivery of its functions through the locally agreed operational arrangements set out within the Scheme. The members of the IJB consist of: 10 voting members (5 representatives each from the Council and NHS Dumfries and Galloway). At the first meeting of the IJB on 5 November 2015 the following appointments were made:

- Chair
- Vice Chair
- Chief Officer
- Chief Finance Officer

The IJB is responsible for the development and implementation of a number of key documents including:

- Health and social care strategic plan
- Strategic needs assessment
- Locality plans
- Financial plan
- Equality outcomes framework
- Complaints handling framework
- Performance management framework
- Workforce plan
- Clinical and care governance framework
- Participation and engagement strategy
- Risk strategy
- Statement of consultation

All of these documents were presented to the IJB at its second meeting on 17 March 2016 for consideration and approval to be in place for 1 April 2016.

As noted above, the Integration Joint Board (IJB) has formal delegated authority from 1st April 2016 and the suite of measures and performance indicators contained within the Local Delivery Plan will be used in conjunction with a range of other indicators produced by the IJB to measure whole system performance over the coming year.

During 2016/17, the partnership will develop implementation plans for the four local delivery plans, which will set out how they will achieve the 9 national health and well-being outcomes, utilising the core suite of 23 indicators alongside a range of local and national performance indicators.

Delegated Functions

Functions that were required to be transferred to the IJB by NHS Dumfries and Galloway are set out in The Public Bodes (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014. In addition to the prescribed functions, NHS Dumfries and Galloway has also opted to include the entirety of its Acute Services. This approach was agreed jointly to allow flexibility, full accountability and joint planning across the entire health service functions, and also take advantage of the coterminous boundaries of the two organisations.

The following services have been transferred from NHS Dumfries and Galloway:

- Acute and Diagnostic
- Primary Care and Community
- Mental Health
- Women and Children
- Estates and Facilities

This reflects the entirety of operational health services currently managed by the Chief Operating Officer in Health and extends beyond the requirements of the legislation.

Other matters

Compensation and Confidentiality Agreements

In the year, the Board committed to pay two exit packages with a total value of £317,324. Both payments were redundancy payments as defined in Section 16 of the NHS terms and conditions of service handbook. We reviewed the approval process for each settlement and confirmed that all had been appropriately approved and are compliant with the relevant legislation.

No confidentiality clauses were entered into during the 2015-16 financial year.

Table 10: Exit packages

Employee number	Role	Total years of service	Total redundancy payment
1	Medical Director/ Consultant	23	315,324
2	Nurse	2	2,000

Medical workforce

Medical workforce shortages across the health sector in Scotland are leading to an increased use of medical locums which is having a significant impact on the costs associated with staffing certain specialties. During 2015/16 NHS Dumfries and Galloway spent £11.354m on the use of medical locums, with the greatest spend across the following five specialties:

Table 11: Areas of medical locum spend

Specialty	2015/16 Spend
DGRI Radiography	1,467,000
General Medicine	916,000
Ophthalmology	656,000
Urology	633,000
General Surgery	629,000

Spending on medical locums has increased over the past five years as illustrated in Table 10:

Table 10: Medical Locum Spend over the past 5 years

	2011/12 £ million	*2012/13 £ million*	*2013/14 £ million*	*2014/15 £ million*	*2015/16 £ million*
Locum Spend (£ million)	**4.929**	**6.003**	**7.112**	**10.165**	**11.354**

This is a recurring issue faced by NHS Dumfries and Galloway caused by a shortage of permanent medical staff who are willing to move to the area. This has resulted in the significant increase in the costs to the Board associated with medical locums.

In response to the increased reliance on medical locums the Board has undertaken the following key actions to stabilise the spend in 2015/16:

- Holding collaborative talks with other NHS bodies to explore the ways in which the Boards can work together to make services sustainable or more attractive to potential candidates (for example, consultants spending 1-2 sessions a week doing specialised work in larger centres).
- Developing proposals for shared posts e.g. a Consultant Community Care of the Elderly post to work across both the Galloway Community Hospital, and Girvan Hospital, with costs and support being shared between NHS Dumfries & Galloway and NHS Ayrshire & Arran.
- Development of a medical recruitment website which promotes the Board and the local area with the aim of attracting consultants who prefer a smaller hospital and who like the challenges of more generalist work along with an opportunity to develop a special area of interest.
- Advertising through the British Medical Journal.
- Dedicating resource to oversee medical recruitment and provision of a tailored recruitment service for potential candidates including early engagement with candidates, offering of hospital walk rounds and the opportunity to meet senior management and assistance to candidate's spouses in sourcing employment in the local area.
- Promoting free accommodation for junior doctors during their training months.

The Board also has recruitment challenges within General Practice. This reflects a national shortfall in the number of younger doctors wanting to go into General Practice, and, within the Board, a large cohort of doctors who are approaching retirement age.

Section 5. Fraud

International Standards on Auditing (UK&I) state that we, as auditors, are responsible for obtaining reasonable assurance that the financial statements taken as a whole are free from material misstatement, whether caused by fraud or error. The respective responsibilities of auditors and management are summarised below:

Auditors' responsibility

Our objectives are:

- to identify and assess the risks of material misstatement of the financial statements due to fraud;
- to obtain sufficient appropriate audit evidence regarding the assessed risks of material misstatement due to fraud, through designing and implementing appropriate responses; and
- to respond appropriately to fraud or suspected fraud identified during the audit.

Management's responsibility

Management's responsibilities in relation to fraud are:

- to design and implement programmes and controls to prevent, deter and detect fraud;
- to ensure that the entity's culture and environment promote ethical behaviour; and
- to perform a risk assessment that specifically includes the risk of fraud addressing incentives and pressures, opportunities, and attitudes and rationalisation.

National Fraud Initiative (NFI)

The Board participates in the National Fraud Initiative (NFI). The Board has identified 203 recommended matches and 4,293 other matches for the 2015/16 year. As at 25/02/2016 when we assessed progress in relation to NFI, 199 (98%) of 203 "recommended matches" had been investigated, with the remaining four in progress. The percentage of matches investigated has increased by 2% from the Board's position in June 2015. In accordance with our responsibilities as your appointed auditor, we have completed the NFI questionnaire and noted the following key outcomes:

- The Board has adequate arrangements in place for the submission of NFI data and investigation of matches through the Fraud Liaison Officer;
- There is sufficient reporting of the NFI process and outcomes to the Audit and Risk committee; and
- The Board has not identified any fraudulent or irregular transactions to date from the investigation of matches.

Prevention and detection of fraud and corruption

Based on audit work performed we consider that the controls in place to prevent and detect fraud or corruption to be suitable for the operations of the Board. The Board has in place an appropriate code of conduct, fraud response plan and whistleblowing policy. The Board has in place a fraud policy and action plan in place which aims to promote reporting and identification of fraud among the Board's staff.

Fraud reports are routinely presented to the Audit and Risk Committee. This includes progress against the fraud action plan as well as any national developments released by Counter Fraud Services as noted above.

Based on audit work performed we consider that the controls in place to prevent and detect fraud or corruption to be suitable for the operations of the Board.

Section 6. Independence

Independence and objectivity

There are no matters which we perceive may impact our independence and objectivity of the audit team

Independence conclusion

At the date of this plan we confirm that in our professional judgement, we are independent accountants with respect to the Board, within the meaning of UK regulatory and professional requirements and that the objectivity of the audit team is not impaired.

Appendix 1. 2015/16 Action Plan

Finding	Management response
1. Accounting treatment for revaluation of fixed assets **Audit finding:** It was confirmed that currently no consideration is taken to recognise any amounts in the operating cost statement (when reversing a previous downward valuation) and there is also no transfer is made each year from the revaluation reserve into the general reserve in line with the capital accounting manual: 4.13.2 A surplus arising on the revaluation of an asset will be credited to the reserve, **unless it reverses a previous revaluation loss which was debited to the operating cost statement in a previous financial period**, when (after adjusting for subsequent depreciation) it **should be credited to the operating cost statement**. 4.13.4 Each year, the realised element of the reserve (i.e. an amount equal to the excess of the actual depreciation over depreciation based on historical cost) **should be transferred from the reserve to the general fund.** **Recommendation:** It is recommended to investigate the Fixed Asset Register (CARS system) and historic records to ensure that the above requirements of the capital accounting manual are complied with. CARS should also be updated or a process implemented to assist in future calculations relating to revaluations and also for transfers to the General Fund each year.	Noted, this will be reviewed to ensure than a process is put in place for the year ahead. **Target date:** May 2017

Finding	Management response
2. Enhancements During Leave (EDL) **Audit finding:** The processes adopted to implement the requirements of the circular mean that amounts paid are based upon an element of estimation rather than using actual working pattern data. As part of the audit, we re-performed the calculation of EDL payments due based upon actual data, rather than estimated data and found a number of differences **Recommendation:** We recommend that the Board formalises a process to investigate historic EDL payments to staff and monitor future amounts for reasonableness and accuracy which are calculated by the line managers.	Noted, the transfer to the automated system within SSTS will improve this moving forward. A Short Life Working group will be set up to review the historic position as necessary. **Target date:** May 2017
3. Related Parties process for identifying transactions throughout the year **Audit finding:** Whilst the register of interest process has been recognised as good practice within the sector, it is not directly aligned to the accounting requirements for related parties, nor the timescales for the annual accounts process. Specifically the forms used to gather interests are not clearly aligned to the requirements of IAS 24 and therefore do not easily facilitate identification of related parties for accounting purposes. **Recommendation:** We recommend that the Board formalises a process to identify related parties in accordance with IAS 24 which is aligned with the required timescales for annual accounts.	Noted, Deputy Director of Finance and Corporate Business Manager will incorporate two processes into one. **Target date:** May 2017

Finding	Management response
4. Review of high risk journals **Audit finding:** The key financial control identified in relation to manual journals is that the Finance Team performs a spot check of 10% of all journals retrospectively to confirm legitimacy and accuracy. The reason for the 10% spot check is due to the volume of manual journals processed and striking the balance between mitigation of risk and use of resource. Whilst it is agreed that a secondary review process cannot be undertaken across the full manual journals population, management would benefit from using a risk based approach to direct their review to journals which presented the highest risk of material misstatement in the financial statements. **Recommendation:** We recommend that the Board formalises a process to review all journals over a certain monetary amount, or on a risk based basis (i.e. all credits posted against expenditure account codes).	The output of HALO review work will be used to determine a new model for authorising journals within the Board. **Target date:** May 2017

Appendix 2. Follow up of prior year recommendations

Finding	2015/16 Updated Position
1. Risk Executive Group **Audit finding:** During the year the Board strengthened its risk management arrangements with the formation of the Risk Executive Group. Whilst there has been discussion of the proposed remit of the Group, a formal terms of reference has yet to be developed. **Recommendation:** We recommend that the Board formalises the remit of the Group through a Terms of Reference.	A terms of reference document for the Risk Executive Group was prepared and presented to the Audit and Risk Committee meeting in September 2016. **Complete.**
2. Completion of staff engagement forms **Audit finding:** A staff engagement form is used as the basis for adding new employees to the payroll and should be signed by both the employee and the line manager. In 7 out of 20 new starts tested, payroll processed an engagement form that was not signed by the employee. In 1 of these 7 instances, the engagement form was also authorised by the line manager. For each of these 7 instances, we undertook additional procedures such as review of employment contracts or agreeing the employee to the staff database on the intranet to confirm that the staff members were genuine employees of the Board. We also noted that 4 of the 7 staff engagement forms had later been signed by the employee and were held locally by line managers. **Recommendation:** Payroll staff should be reminded that a new start on the payroll system should not be processed without a completed staff engagement form signed by both the employee and signed by an authorised signatory. Only in exceptional circumstances, to be defined by Management, will an engagement form be processed which has not been signed by the employee. However, in these instances, the employee must have provided Payroll with a signed bank mandate form.	Staff were reminded in November 2015 that a signed staff engagement form must be in place prior to entry of a new start on to the payroll system. Our detailed testing of payroll starters for 2015/16 noted five of 21 instances in which a new start was processed with an engagement form that was not signed by the employee. All exceptions took place prior to November 2015 after which we noted no exceptions. **Complete.**

Finding	2015/16 Updated Position
3. Authorised signatories on SSTS **Audit finding:** A member of staff should only be added to the SSTS system as an authoriser of staff hours by Payroll after Finance has received an approved request. We noted 1 instance from a sample of 25 excess hours payments where a member of staff had authorised excess hours on SSTS but was not listed on the Board's authorised signatory list to do so. We were able to confirm that the authorised signatory listing is up to date; however, there have been no checks to ensure that authorisers on SSTS remain appropriate. **Recommendation:** A reconciliation of the SSTS authorisers within the system and those detailed in the Board's authorised signatory listing should take place to ensure that there are no discrepancies between the two. This reconciliation should occur periodically.	Management confirmed that a reconciliation was not performed in 2015/16. Review controls are in place for adding and removing employees onto SSTS as authoriser role as well as adding them onto the Board's authorised signatory list. However as no annual reconciliation is performed, there is a risk that an employee remains an authorised individual when they no longer should have this level of authority. PwC confirmed with management that a formal reconciliation should be performed periodically and that this recommendation be implemented for 2016/17. **Open** **Revised target date:** May 2017

Finding	2015/16 Updated Position
4. SSTS roster locations for authorisation **Audit finding:** We sampled 25 payments made to individuals working above their contracted hours and noted that in 2 of these instances (relating to bank and ad hoc staff), no approval for these additional hours worked was required. This was a result of these roster locations (individual payroll cost centres) not being set up on SSTS to require these hours to be authorised before payment. We noted that, going forward, any new roster locations being set up by payroll will require authorisation of all hours worked (including normal and excess hours). However, payroll has not yet undertaken an exercise to ensure that all existing roster locations also meet this requirement. Without authorisation procedures in place, payments could be made for hours not worked. This is particularly true in relation to ad hoc/ bank hours where there it may not be possible to identify payments which are not genuine due to their unpredictable payment pattern. **Recommendation:** All existing roster locations will be reviewed to ensure that all hours worked require a level of authorisation prior to payments being made.	We sampled 25 payments made to individuals working above their contracted hours and found no exceptions in the current year. All roster locations have been reviewed an authorisation is now undertaken at both a local level and within the payroll team. **Complete.**