NHS Fife Audit & Risk Committee

Thu 16 June 2022, 14:00 - 16:30

MS Teams

Agenda

14:00 - 14:30
30 min

1. MEMBERS' TRAINING SESSION – THE ANNUAL ACCOUNTS: THE ROLE & FUNCTION OF THE AUDIT & RISK COMMITTEE

Trish Fraser

Slides circulated separately

14:30 - 14:30
0 min

2. Apologies for Absence

Martin Black

14:30 - 14:30
0 min

3. Declaration of Members' Interests

Martin Black

14:30 - 14:30
0 min

4. Minutes of Previous Meeting held on Wednesday 18 May 2022

Enclosed *Martin Black*

Item 04 - Audit & Risk Committee Minutes (unconfirmed) 20220518.pdf (6 pages)

14:30 - 14:40
10 min

5. Matters Arising / Action List

Enclosed *Martin Black*

Item 05 - Audit & Risk Committee Action List - 20220616.pdf (2 pages)

14:40 - 15:25
45 min

6. GOVERNANCE MATTERS

6.1. Annual Review of Code of Corporate Governance

Enclosed *Dr Gillian MacIntosh*

Item 06.1 - SBAR Annual Review of Code of Corporate Governance.pdf (3 pages)
Item 06.1 - Appendix 1 Revised Code of Corporate Governance.pdf (114 pages)

6.2. Committee & Directors' Annual Assurances for 2021/22

Enclosed *Dr Gillian MacIntosh*

Item 06.2 - SBAR Committee & Directors Annual Assurances for 2021-22.pdf (113 pages)

6.3. Audit & Risk Committee Draft Annual Assurance Statement 2021/22

Enclosed *Dr Gillian MacIntosh*

Item 06.3 - SBAR Audit & Risk Committee Draft Annual Assurance Statement 2021-22.pdf (3 pages)
Item 06.3 - Appendix 1 Audit & Risk Committee Draft Annual Assurance Statement 2021-22.pdf (19 pages)

6.4. Draft Letter of Significant Issues of Wider Interest

Enclosed *Kevin Booth*

Item 06.4 - SBAR Draft Letter of Significant Issues of Wider Interest.pdf (3 pages)
Item 06.4 - Appendix 1 Letter dated 24 May 2022 from Director of Health Finance Governance - Richard McCallum.pdf (3 pages)
Item 06.4 - Appendix 2 Draft Response Letter dated 30 May 2022 from Martin Black - Chair of NHS Fife Audit & Risk Committee.pdf (11 pages)

15:25 - 15:40
15 min

7. ANNUAL ACCOUNTS

7.1. Service Auditor Reports on Third Party Services

Enclosed *Kevin Booth*

Item 07.1 - SBAR Service Auditor Reports on Third Party Services.pdf (3 pages)
Item 07.1 - Appendix 1 NSS Practitioner and Counter Fraud Services ISAE 3402 Report 2021-22.pdf (59 pages)
Item 07.1 - Appendix 2 NSS IT Services ISAE 3402 Report 2021-22.pdf (41 pages)
Item 07.1 - Appendix 3 NHS Ayrshire & Arran ISAE 3402 Report 2021-22.pdf (30 pages)

15:40 - 15:55
15 min

8. RISK

8.1. Final Annual Risk Management Report 2021/22

Enclosed *Pauline Cumming*

Item 08.1 - SBAR Final Risk Management Annual Report 2021-22 .pdf (3 pages)
Item 08.1 - Appendix 1 Final Risk Management Annual Report 2021-22.pdf (12 pages)

15:55 - 16:15
20 min

9. GOVERNANCE – INTERNAL AUDIT

9.1. Internal Audit Annual Report 2021/22

Enclosed *Tony Gaskin*

Item 09.1 - SBAR Internal Audit Annual Report 2021-22 .pdf (4 pages)
Item 09.1 - Internal Audit Annual Report 2021-22.pdf (41 pages)

9.2. Annual Internal Audit Plan 2022/23

Enclosed *Tony Gaskin*

Item 09.2 - SBAR Draft Annual Internal Audit Plan 2022-23 .pdf (6 pages)

16:15 - 16:25
10 min

10. FOR ASSURANCE

10.1. Losses & Special Payments Quarter 4

Enclosed *Kevin Booth*

Item 10.1 - SBAR Losses and Special Payments Quarter 4.pdf (3 pages)
Item 10.1 - Appendix 1 Summary of Losses and Special Payments 01.01.22 – 31.03.22.pdf (1 pages)
Item 10.1 - Appendix 2 2021-22 Year End Losses and Special Payments Review.pdf (2 pages)

10.2. Delivery of Annual Workplan

Enclosed *Dr Gillian MacIntosh*

Item 10.2 - Delivery of Annual Workplan.pdf (5 pages)

16:25 - 16:25
0 min

11. ESCALATION OF ISSUES TO NHS FIFE BOARD

11.1. Chair's comments on the Minutes / Any other matters for escalation to NHS Fife Board

Verbal *Martin Black*

16:25 - 16:30
5 min

12. ANY OTHER BUSINESS

16:30 - 16:30
0 min

13. DATE OF NEXT MEETING (ANNUAL ACCOUNTS): FRIDAY 29 JULY 2022 AT 2.30PM VIA MS Teams

MINUTE OF THE AUDIT & RISK COMMITTEE MEETING HELD ON WEDNESDAY 18 MAY 2022 AT 2PM VIA MS TEAMS

Present:
M Black, Non-Executive Member (Chair)
A Grant, Non-Executive Member
A Lawrie, Non-Executive Member
K MacDonald, Non-Executive Member
A Wood, Non-Executive Member

In Attendance:
K Booth, Head of Financial Services & Procurement
A Clyne, Audit Scotland
P Cumming, Risk Manager
T Gaskin, Chief Internal Auditor
B Hudson, Regional Audit Manager
G MacIntosh, Head of Corporate Governance & Board Secretary
M McGurk, Director of Finance & Strategy
C Potter, Chief Executive
H Thomson, Board Committee Support Officer (Minutes)

Chair's Opening Remarks

The Chair welcomed everyone to the meeting

The NHS Fife MS Teams Meeting Protocol was set out and a reminder given that the notes are being recorded with the Echo Pen to aid production of the minutes.

1. Welcome / Apologies for Absence

A Wood was welcomed to her first meeting of the Committee, having agreed to step into the role of member over the next few months whilst the Committee was without a Fife Council representative, to ensure quoracy of meetings. Apologies were received from attendee T Fraser (Audit Scotland).

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minutes of the Previous Meeting held on 17 March 2022

It was agreed to amend the wording under item 6.2, 2nd last paragraph, last sentence to: "Values and having an open and transparent culture will form part of the discussion, with reference also to the Whistleblowing Standards." This clarifies that the Board's discussion on Whistleblowing at its recent Development Session was part of a broader session on values and culture.

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

4. Action List / Matters Arising

The Committee **noted** the updates and also the closed items on the Action List.

5. GOVERNANCE MATTERS

5.1 Draft Governance Statement

The Head of Corporate Governance & Board Secretary advised that the draft Governance Statement is presented to the Committee for comment, and that there is time to incorporate any comments before it is submitted formally as part of the Annual Accounts.

It was reported at the next Committee meeting in June, a training session will be delivered on the Annual Accounts and will include an opportunity to review the Governance Statement in terms of questioning if it reflects the organisation, and that it covers all areas and risks identified appropriately.

The Director of Finance & Strategy reported that the first half of the Governance Statement is largely prescriptive and noted that the Accounting Manual provides direction on the type of information that needs to be included. From the 'Review of Adequacy and Effectiveness' section, there are opportunities to influence and make comment.

A Wood, Non-Executive Director, questioned where the control weakness that have been highlighted through the year's internal audit programme would be reported. The Chief Internal Auditor explained the process of measuring controls and issues and noted that there were no control weaknesses identified thus far that were significant enough to be included as a disclosure in the Governance Statement. The Director of Finance & Strategy added that anything that could materially impact the financial statements would be the type of information disclosed. The Regional Audit Manager added that there are other supporting assurance documents that will be provided to the Committee at future meetings (such as the individual Director's assurance letters), and the Governance Statement was only one aspect of the overall assurance pack. The Chief Executive noted that there are various assurances that come from Directors and cover a variety of points around risk, internal audit recommendations and accountability.

The Committee thanked everyone involved for their hard work in producing the draft Governance Statement.

The Committee **reviewed** the draft Governance Statement.

The Committee **approved** the Governance Statement, subject to any subsequent comments being received.

5.2 Review of Annual Workplan

The Head of Corporate Governance & Board Secretary reported that the Annual Workplan, will be provided to each meeting as a tracked version, detailing which items have been reported on schedule and any deferrals. It was advised that the tracked workplan would be for information and noting at future Committee meetings.

It was agreed to clarify in future iterations of the workplan that the Private Meeting with the Auditors involves both External and Internal Auditors.

Action: Board Committee Support Officer

The Committee **approved** the annual workplan.

5.3 Notification of External Audit Appointment from 2022/2023

The Director of Finance & Strategy reported that Audit Scotland have advised on the new five-year appointments to the external audit positions for all NHSS Boards, and the appointments were outlined. It was noted throughout 2022/2023 there will be a period of engagement to allow the new auditors to familiarise themselves with NHS Fife as an organisation.

The Committee took **assurance** from this appointment process.

5.4 Annual Accounts Preparation Timeline

The Head of Financial Services & Procurement advised that the draft Annual Accounts were submitted to Audit Scotland on 12 May 2022. It was noted the timeline has been reduced compared to last year, and an overview was provided on the timelines, as detailed in the paper.

The Committee took **assurance** from the Annual Accounts Preparation Timeline, commending the work done thus far to meet all deadlines.

6. RISK

6.1 Draft Risk Management Annual Report 2021/2022

The Risk Manager advised that the paper covers the improvement programme of work which commenced in November 2021. It was reported that Internal Audit have provided feedback on the draft report, and an appropriate statement will be added that confirms that "*adequate and effective risk management arrangements have been put in place throughout the year*".

The key points in the report were outlined. A Wood, Non-Executive Member, asked if some particular areas could be more explicit to provide clarity and this was agreed to.

The draft Risk Management Annual Report 2021/2022 will be brought back to the Committee at its next meeting. Comments were welcomed and will be considered for inclusion.

The Committee **considered** and took **assurance** from the content of the draft report.

6.2 Risk Management Improvement Programme – Progress Report

The Risk Manager advised that the paper outlines the current position. It was noted that some aspects of the report are covered within the draft Annual Report and summarises some of the key areas of work being undertaken and work still to be carried out.

The Committee took **assurance** from this update on the programme to refresh and improve the Risk Management Framework.

6.3 Board Assurance Framework (BAF)

The Risk Manager advised that the report reflects the components of the BAFs that have most recently been reported to the Governance Committees. It provides the position on each, the current risk levels relating to those components and summarises where there are particular changes to the respective areas of the BAF and linked risks.

It was advised that work is underway to move some risks from the BAF to the new corporate risk register. It was reported that a risk dashboard is under development and will become a feature of the Integrated Performance & Quality Report (IPQR) going forward.

It was advised that work is underway on the corporate risks related to environmental sustainability, climate change and health equalities, and a progress update will be provided at the next Committee meeting. The last iteration of the BAF in its current format will be presented at the July Governance Committee cycle of meetings.

A Wood, Non-Executive Member, questioned the number of risks remaining high, given that delivery of mitigations is being carried out, particularly for environmental sustainability, and that this needs to be reflected as we move to a corporate risk register. The Director of Finance & Strategy highlighted the challenges in scoring risks and ensuring mitigation impact is consistent with the scoring.

The Chief Internal Auditor advised it is important that target risks have an associated target date at which progress is due to be made.

The Director of Finance & Strategy advised that, going forward there will be two risks for financial sustainability; one that will monitor our in-year position and the creation of an additional corporate level finance risk which describes the level of risk on securing financial sustainability over the medium-term.

The Director of Finance & Strategy reported that work is underway to develop a proposed new risk appetite statement, and this is expected to conclude at the end of June 2022.

The Committee took **assurance** from the BAF and the working being undertaken to improve the risk management framework.

7. GOVERNANCE – INTERNAL AUDIT

7.1 Internal Audit Framework

The Chief Internal Auditor advised that the Internal Audit Framework is presented on a yearly basis to the Audit & Risk Committee and is a requirement of the Audit Standards. The Audit Standards are being reviewed and brought back to the Committee next year.

It was reported there are no significant changes from the previous year. An update will be brought back to the Committee setting out how information is shared between the Fife Integrated Joint Board (IJB) and the Audit & Risk Committee.

A Wood, Non-Executive Director, questioned if the wider governance of the organisation could be made more explicit. The Chief Internal Auditor agreed to widen the narrative and will bring back that extract from the framework to the next Committee meeting.

Action: Chief Internal Auditor

The Committee **approved** the Internal Audit Framework for 2022/23, subject to the change agreed.

7.2 Internal Audit Progress Report 2021/2022

The Regional Audit Manager introduced the report, which details progress made throughout the 2021/2022 plan and the commencement of the 2022/2023 annual plans.

The improvement activities were outlined, and the Regional Audit Manager requested any comments or feedback from Members on the FTF website. The advice and input section of the paper was also outlined.

A Lawrie, Non-Executive Member, questioned how to prevent the incomplete or missing audit information within the progress report from happening in the future. The Regional Audit Manager advised the management response to that section of the report will be presented to the next Clinical Governance Committee, who will take forward issues raised within the B23/22 Resilience Interim Report. The Head of Corporate Governance & Board Secretary noted that bringing back tracked workplans to Committee meetings will support evidencing items that are either deferred or have been removed, improving tracking and oversight more generally.

The Committee **discussed** and took **assurance** on the progress on the delivery of the Internal Audit Plan.

7.3 Draft Annual Internal Audit Plan 2022/2023

The Chief Internal Auditor spoke to the plan and noted that the risk profile is changing given the ongoing context of COVID 19 and through appropriate alignment with the strategic planning process, any new risks will be reflected in the corporate risk register.

A Wood, Non-Executive Member, noted that a number of areas within the non-financial Key Performance Indicators (KPIs) are at the status of red and questioned if a deep-dive into those areas through internal audit would support any improvements in terms of processes and controls. Examples were provided on some of the red status elements, including waiting times and delayed discharge. The Chief Executive advised that, as part of the Annual Delivery Plan, the Scottish Government have requested detail on how

we will address these areas through our strategic planning process. It was also advised there will be more connectivity in terms of our risks, performance and linking into our planning. The Chief Internal Auditor agreed to take forward the examples of the red status elements provided for further discussion and welcomed any other suggestions to take forward for the plan.

The Director of Finance & Strategy noted that, due to the pandemic, the plan appropriately covers the key financial control areas and recognises that, over the coming months, the plan will be further developed and refined. The Chief Internal Auditor noted that addressing sustainability is a key issue and will be built in at every stage.

The Head of Corporate Governance & Board Secretary noted there is an opportunity for the Committee to have sight of the list of areas being reviewed in the Integrated Joint Board (IJB), to help complete the full audit planning picture.

The Chief Internal Auditor thanked the Regional Audit Manager for all the hard work in producing the draft Annual Internal Audit Plan 2022/2023.

The Committee:

- **Approved** the audit plan for 2022/23 (Appendix A) and supported the approach to further developing the Internal Audit Plan for 2022/23 once the Strategic Priorities and Corporate Risk Register are formalised.

8. GOVERNANCE - EXTERNAL AUDIT

8.1 Patients' Private Funds - Audit Planning Memorandum

The Director of Finance & Strategy advised that the external audit planning memorandum on Patients' Private Funds is presented to the Committee for assurance, and the financial statements will be included in the Annual Accounts for review in July 2022.

The Head of Financial Services & Procurement advised that Alan Mitchell, Thomson Cooper, will be attendance at the July 2022 meeting to discuss the completed Patients' Private Funds audit.

The Committee took **assurance** from the Audit Planning Memorandum.

9. ESCALATION OF ISSUES TO NHS FIFE BOARD

There were no issues to highlight to the Board.

10. ANY OTHER BUSINESS

There was no other business.

Date of Next Meeting: Thursday 16 June 2022 at 2pm via MS Teams.

KEY:	Deadline passed / urgent
	In progress / on hold
	Closed

AUDIT & RISK COMMITTEE – ACTION LIST
Meeting Date: Thursday 16 June 2022

NHS Fife

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
1.	16/09/2021	**National Risk Management System**	Exploratory discussions are ongoing at a national level around procurement of risk management systems. Currently, the local preference is for Datix Cloud IQ. The outcome of national discussions is awaited.	**PC**	September 2022	17/03/22 - A business case is being developed in April 2022 for NHS Fife, and the preferred upgrade package is Datix Cloud IQ. An update will be brought back to the Committee on developments as the business case is finalised.	Deadline not reached/ in progress
2.	17/03/2022	**Committee Development Session Topics**	Members and attendees to suggest topics to be covered at a development session, twice a year, to delve deeper into topics relevant to the Committee's remit.	**All**	Dates of Development Sessions to be confirmed	Committee Assurance Principals suggested as a topic, to date. Further suggestions for topics welcomed.	In progress
3.	18/05/22	**Internal Audit Framework**	To widen the narrative around the wider governance of the organisation and bring back that extract from the framework to the next Committee meeting.	**TG**	June 2022	Following change made to the scope section of the Internal Audit Framework: "The scope of Internal Audit within the organisations clinical and non-clinical environment, encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives.	Closed
4.	18/05/2022	**Annual Workplan**	To clarify in future iterations of the workplan that the Private Meeting with the Auditors involves both External and Internal Auditors.	**HT**	May 2022		Closed

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**16 June 2022**
Title:	**Annual Review of Code of Corporate Governance**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Gillian MacIntosh, Board Secretary**

1. Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

- Local policy

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

- Effective

2. Report Summary

2.1 Situation

The Fife NHS Code of Corporate Governance is an all-encompassing suite of documents setting out the Board's Standing Orders, Committee Terms of Reference, Scheme of Delegation, Standing Financial Instructions and Code of Conduct for Board Members. It is therefore important that it remains current and correct.

2.2 Background

An annual review of the Code of Corporate Governance is normally undertaken each spring, with this completed as scheduled in 2021. An in-year update was also considered by the Committee in December 2021, to reflect the addition to the governance structure of the new Public Health & Wellbeing Committee. This version of the Code subsequently received Board approval in January 2022.

In the Committee's workplan, the Code is scheduled for consideration at the May meeting annually. However, there has been a short delay in its tabling this year, to allow for the revised version to include the updated Code of Conduct for Board

Members, which has only been released by Scottish Government and is effective from June 2022.

2.3 Assessment

The version of the Code attached reflects the following:

- tracked changes to each Standing Committee's remit, as discussed and agreed by each Committee following their Terms of Reference review at their March cycle of meetings;
- tracked updates to both the Board's Standing Financial Instructions and Scheme of Delegation, as advised by the Head of Financial Services;
- removal of the previously included appendix on the governance structures in place to account for the South East And Tayside (SEAT) Regional Planning Group (this is no longer in operation in this form); and
- the replacement in its entirety of the previous Code of Conduct for Board Members, to include the new text recently issued by Scottish Government for the immediate adoption by all NHS Boards.

2.3.1 Quality/ Patient Care

Delivering robust governance across the organisation is supportive of enhanced patient care and quality standards.

2.3.2 Workforce

N/A.

2.3.3 Financial

Ensuring appropriate scrutiny of NHS Fife's governance documents, and ensuring these remain up-to-date, is a core part of the Committee's remit.

2.3.4 Risk Assessment/Management

The identification and management of risk is an important factor in the Committee providing appropriate assurance to the NHS Board.

2.3.5 Equality and Diversity, including health inequalities

This paper does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people. Consequently, an EQIA is not required.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

N/A.

2.3.8 Route to the Meeting

This paper has not been considered by any previous group, though its content reflects comments received from colleagues within the Finance Directorate.

2.4 Recommendation

The paper is provided for:

- **Recommending approval to the Board of the updated Code** – subject to members' comments regarding any further amendments necessary

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Revised Code of Corporate Governance

Report Contact
Dr Gillian MacIntosh
Head of Corporate Governance & Board Secretary
gillian.macintosh@nhs.scot

CODE OF CORPORATE GOVERNANCE

FIFE NHS BOARD

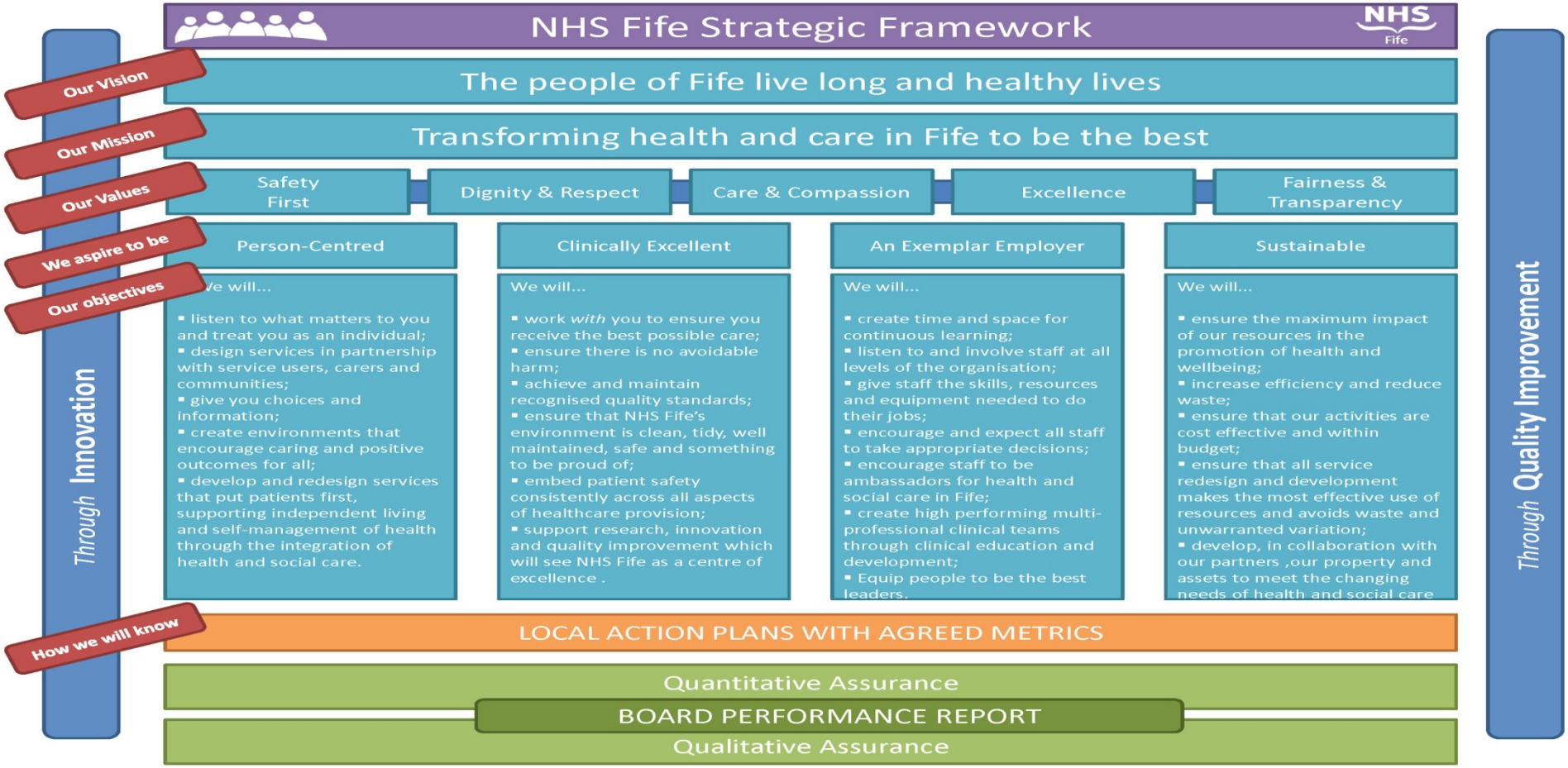
Reviewed by:	Board Secretary
Date of Board Approval:	26 July 2022
Next Review Date:	April 2023

Issue no. 19 – Master

CONTENTS

NHS FIFE
STRATEGIC FRAMEWORK

The Strategic Framework underpins all that NHS Fife as an organisation does. It highlights NHS Fife's key principles and provides a basis for all strategies and plans - each strategy needs to wrap around the principles set out in the framework. The organisation has worked closely with staff to develop the Framework, and it has been endorsed by the NHS Fife Board and staff groups



STANDING ORDERS FOR THE PROCEEDINGS AND BUSINESS OF FIFE NHS BOARD

1 General

1.1 These Standing Orders for regulation of the conduct and proceedings of [Fife] NHS Board, the common name for Fife Health Board, [the Board] and its Committees are made under the terms of The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 (2001 No. 302), as amended up to and including The Health Boards (Membership and Procedure) (Scotland) Amendment Regulations 2016 (2016 No. 3).

Healthcare Improvement Scotland and NHS National Services Scotland are constituted under a different legal basis, and are not subject to the above regulations. Consequently those bodies will have different Standing Orders.

The NHS Scotland Blueprint for Good Governance (issued through DL 2019) 02) has informed these Standing Orders. The Blueprint describes the functions of the Board as:

- Setting the direction, clarifying priorities and defining expectations.
- Holding the executive to account and seeking assurance that the organisation is being effectively managed.
- Managing risks to the quality, delivery and sustainability of services.
- Engaging with stakeholders.
- Influencing the Board's and the organisation's culture.

Further information on the role of the Board, Board members, the Chair, Vice-Chair, and the Chief Executive is available on the NHS Scotland Board Development website.

1.2 The Scottish Ministers shall appoint the members of the Board. The Scottish Ministers shall also attend to any issues relating to the resignation and removal, suspension and disqualification of members in line with the above regulations. Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances.

1.3 Any statutory provision, regulation or direction by Scottish Ministers, shall have precedence if they are in conflict with these Standing Orders.

1.4 Any one or more of these Standing Orders may be varied or revoked at a meeting of the Board by a majority of members present and voting, provided the notice for the meeting at which the proposal is to be considered clearly states the extent of the proposed repeal, addition or amendment. The Board will annually review its Standing Orders.

1.5 Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances. The Scottish Ministers may by determination suspend a

member from taking part in the business (including meetings) of the Board. Paragraph 5.4 sets out when the person presiding at a Board meeting may suspend a Board member for the remainder of a specific Board meeting. The Standards Commission for Scotland can apply sanctions if a Board member is found to have breached the Board Members' Code of Conduct, and those include suspension and disqualification. The regulations (see paragraph 1.1) also set out grounds for why a person may be disqualified from being a member of the Board.

Board Members – Ethical Conduct

1.6 Members have a personal responsibility to comply with the Code of Conduct for Members of Fife Health Board. The Commissioner for Public Standards can investigate complaints about members who are alleged to have breached their Code of Conduct. The Board will have appointed a Standards Officer. This individual is responsible for carrying out the duties of that role, however he or she may delegate the carrying out of associated tasks to other members of staff. The Board's appointed Standards Officer shall ensure that the Board's Register of Interests is maintained. When a member needs to update or amend his or her entry in the Register, he or she must notify the Board's appointed Standards Officer of the need to change the entry within one month after the date the matter required to be registered.

1.7 The Board's appointed Standards Officer shall ensure the Register is available for public inspection at the principal offices of the Board at all reasonable times and will be included on the Board's website.

1.8 Members must always consider the relevance of any interests they may have to any business presented to the Board or one of its committees. Members must observe paragraphs 5.6 - 5.10 of these Standing Orders, and have regard to Section 5 of the Code of Conduct (Declaration of Interests).

1.9 In case of doubt as to whether any interest or matter should be declared, in the interests of transparency, members are advised to make a declaration.

1.10 Members shall make a declaration of any gifts or hospitality received in their capacity as a Board member. Such declarations shall be made to the Board's appointed Standards Officer who shall make them available for public inspection at all reasonable times at the principal offices of the Board and on the Board's website. The Register of Interests includes a section on gifts and hospitality. The Register may include the information on any such declarations, or cross-refer to where the information is published.

1.11 The Board's Secretary shall provide a copy of these Standing Orders to all members of the Board on appointment. A copy shall also be held on the Board's website.

2 Chair

2.1 The Scottish Ministers shall appoint the Chair of the Board.

3 Vice-Chair

3.1 The Chair shall nominate a candidate or candidates for vice-chair to the Cabinet Secretary. The candidate(s) must be a Non-Executive member of the Board. A member who is an employee of a Board is disqualified from being Vice-Chair. The Cabinet Secretary will in turn determine who to appoint based on evidence of effective performance and evidence that the member has the skills, knowledge and experience needed for the position. Following the decision, the Board shall appoint the member as Vice-Chair. Any person so appointed shall, so long as he or she remains a member of the Board, continue in office for such a period as the Board may decide.

3.2 The Vice-Chair may at any time resign from that office by giving notice in writing to the Chair. The process to appoint a replacement Vice-Chair is the process described at paragraph 3.1.

3.3 Where the Chair has died, ceased to hold office, or is unable for a sustained period of time to perform his or her duties due to illness, absence from Scotland or for any other reason, then the Board's Secretary should refer this to the Scottish Government. The Cabinet Secretary will confirm which member may assume the role of interim chair in the period until the appointment of a new chair, or the return of the appointed chair. Where the Chair is absent for a short period due to leave (for whatever reason), the Vice-Chair shall assume the role of the Chair in the conduct of the business of the Board. In either of these circumstances references to the Chair shall, so long as there is no Chair able to perform the duties, be taken to include references to either the interim chair or the Vice-Chair. If the Vice-Chair has been appointed as the Interim Chair, then the process described at paragraph 3.1 will apply to replace the Vice-Chair.

4 Calling and Notice of Board Meetings

4.1 The Chair may call a meeting of the Board at any time and shall call a meeting when required to do so by the Board. The Board shall meet at least six times in the year and will annually approve a forward schedule of meeting dates.

4.2 The Chair will determine the final agenda for all Board meetings. The agenda may include an item for any other business, however this can only be for business which the Board is being informed of for awareness, rather than being asked to make a decision. No business shall be transacted at any meeting of the Board other than that specified in the notice of the meeting except on grounds of urgency.

4.3 Any member may propose an item of business to be included in the agenda of a future Board meeting by submitting a request to the Chair. If the Chair elects to agree to the request, then the Chair may decide whether the item is to be considered at the Board meeting which immediately follows the receipt of the request, or a future Board meeting. The Chair will inform the member which meeting the item will be discussed. If any member has a specific legal duty or responsibility to discharge which requires that member to present a report to the Board, then that report will be included in the agenda.

4.4 In the event that the Chair decides not to include the item of business on the agenda of a Board meeting, then the Chair will inform the member in writing as to the reasons why.

4.5 A Board meeting may be called if one third of the whole number of members signs a requisition for that purpose. The requisition must specify the business proposed to be transacted. The Chair is required to call a meeting within 7 days of receiving the requisition. If the Chair does not do so, or simply refuses to call a meeting, those members who presented the requisition may call a meeting by signing an instruction to approve the notice calling the meeting provided that no business shall be transacted at the meeting other than that specified in the requisition.

4.6 Before each meeting of the Board, a notice of the meeting (in the form of an agenda), specifying the time, place and business proposed to be transacted at it and approved by the Chair, or by a member authorised by the Chair to approve on that person's behalf, shall be circulated to every member so as to be available to them at least three clear days before the meeting. The notice shall be distributed along with any papers for the meeting that are available at that point.

4.7 With regard to calculating clear days for the purpose of notice under 4.6 and 4.9, the period of notice excludes the day the notice is sent out and the day of the meeting itself. Additionally only working days (Monday to Friday) are to be used when calculating clear days; weekend days and public holidays should be excluded.

Example: If a Board is meeting on a Wednesday, the notice and papers for the meeting should be distributed to members no later than the preceding Thursday. The three clear days would be Friday, Monday and Tuesday. If the Monday was a public holiday, then the notice and papers should be distributed no later than the preceding Wednesday.

4.8 Lack of service of the notice on any member shall not affect the validity of a meeting.

4.9 Board meetings shall be held in public. A public notice of the time and place of the meeting shall be provided at least three clear days before the meeting is held. The notice and the meeting papers shall also be placed on the Board's website. The meeting papers will include the minutes of committee meetings which the relevant committee has approved. The exception is that the meeting papers will not include the minutes of the Remuneration Committee. The Board may determine its own approach for committees to inform it of business which has been discussed in committee meetings for which the final minutes are not yet available. For items of business which the Board will consider in private session (see paragraph 5.22), only the Board members will normally receive the meeting papers for those items, unless the person presiding agrees that others may receive them.

4.10 Any individual or group or organisation which wishes to make a deputation to the Board must make an application to the Chair's Office at least 21 working days before the date of the meeting at which the deputation wish to be received. The application will state the subject and the proposed action to be taken.

4.11 Any member may put any relevant question to the deputation, but will not express any opinion on the subject matter until the deputation has withdrawn. If the subject matter relates to an item of business on the agenda, no debate or discussion will take place until the item is considered in the order of business.

4.12 Any individual or group or organisation which wishes to submit a petition to the Board will deliver the petition to the Chair's Office at least 21 working days before the meeting at which the subject matter may be considered. The Chair will decide whether or not the petition will be discussed at the meeting.

5 Conduct of Meetings

Authority of the Person Presiding at a Board Meeting

5.1 The Chair shall preside at every meeting of the Board. The Vice-Chair shall preside if the Chair is absent. If both the Chair and Vice Chair are absent, the members present at the meeting shall choose a Board member who is not an employee of a Board to preside.

5.2 The duty of the person presiding at a meeting of the Board or one of its committees is to ensure that the Standing Orders or the committee's terms of reference are observed, to preserve order, to ensure fairness between members, and to determine all questions of order and competence. The ruling of the person presiding shall be final and shall not be open to question or discussion.

5.3 The person presiding may direct that the meeting can be conducted in any way that allows members to participate, regardless of where they are physically located, e.g. video-conferencing, teleconferencing. For the avoidance of doubt, those members using such facilities will be regarded as present at the meeting.

5.4 In the event that any member who disregards the authority of the person presiding, obstructs the meeting, or conducts himself/herself inappropriately the person presiding may suspend the member for the remainder of the meeting. If a person so suspended refuses to leave when required by the person presiding to do so, the person presiding will adjourn the meeting in line with paragraph 5.12. For paragraphs 5.5 to 5.20, reference to 'Chair' means the person who is presiding the meeting, as determined by paragraph 5.1.

Quorum

5.5 The Board will be deemed to meet only when there are present, and entitled to vote, a quorum of at least one third of the whole number of members, including at least two members who are not employees of a Board. The quorum for committees will be set out in their terms of reference, however it can never be less than two Board members.

5.6 In determining whether or not a quorum is present the Chair must consider the effect of any declared interests.

5.7 If a member, or an associate of the member, has any pecuniary or other interest, direct or indirect, in any contract, proposed contract or other matter under consideration by the Board or a committee, the member should declare that interest at the start of the meeting. This applies whether or not that interest is already recorded in the Board Members' Register of Interests. Following such a declaration, the member shall be excluded from the Board or committee meeting when the item is under consideration, and should not be counted as participating in that meeting for quorum or voting purposes.

5.8 Paragraph 5.7 will not apply where a member's, or an associate of theirs, interest in any company, body or person is so remote or insignificant that it cannot reasonably be regarded as likely to affect any influence in the consideration or discussion of any question with respect to that contract or matter. In March 2015, the Standards Commission granted a dispensation to NHS Board members who are also voting members of integration joint boards. The effect is that those members do not need to declare as an interest that they are a member of an integration joint board when taking part in discussions of general health & social care issues. However members still have to declare other interests as required by Section 5 of the Board Members' Code of Conduct.

5.9 If a question arises at a Board meeting as to the right of a member to participate in the meeting (or part of the meeting) for voting or quorum purposes, the question may, before the conclusion of the meeting be referred to the Chair. The Chair's ruling in relation to any member other than the Chair is to be final and conclusive. If a question arises with regard to the participation of the Chair in the meeting (or part of the meeting) for voting or quorum purposes, the question is to be decided by the members at that meeting. For this latter purpose, the Chair is not to be counted for quorum or voting purposes.

5.10 Paragraphs 5.6-5.9 shall equally apply to members of any Board committees, whether or not they are also members of the Board, e.g. stakeholder representatives.

5.11 When a quorum is not present, the only actions that can be taken are to either adjourn to another time or abandon the meeting altogether and call another one. The quorum should be monitored throughout the conduct of the meeting in the event that a member leaves during a meeting, with no intention of returning. The Chair may set a time limit to permit the quorum to be achieved before electing to adjourn, abandon or bring a meeting that has started to a close.

Adjournment

5.12 If it is necessary or expedient to do so for any reason (including disorderly conduct or other misbehaviour at a meeting), a meeting may be adjourned to another day, time and place. A meeting of the Board, or of a committee of the

Board, may be adjourned by the Chair until such day, time and place as the Chair may specify.

Business of the Meeting

The Agenda

5.13 If a member wishes to add an item of business which is not in the notice of the meeting, he or she must make a request to the Chair ideally in advance of the day of the meeting and certainly before the start of the meeting. The Chair will determine whether the matter is urgent and accordingly whether it may be discussed at the meeting.

5.14 The Chair may change the running order of items for discussion on the agenda at the meeting. Please also refer to paragraph 4.2.

5.15 For Board meetings only, the Chair may propose within the notice of the meeting "items for approval" and "items for discussion". The items for approval are not discussed at the meeting, but rather the members agree that the content and recommendations of the papers for such items are accepted, and that the minutes of the meeting should reflect this. The Board must approve the proposal as to which items should be in the "items for approval" section of the agenda. Any member (for any reason) may request that any item or items be removed from the "items for approval" section. If such a request is received, the Chair shall either move the item to the "items for discussion" section, or remove it from the agenda altogether.

Decision-Making

5.16 The Chair may invite the lead for any item to introduce the item before inviting contributions from members. Members should indicate to the Chair if they wish to contribute, and the Chair will invite all who do so to contribute in turn. Members are expected to question and challenge proposals constructively and carefully to reach and articulate a considered view on the suitability of proposals.

5.17 The Chair will consider the discussion, and whether or not a consensus has been reached. Where the Chair concludes that consensus has been reached, then the Chair will normally end the discussion of an item by inviting agreement to the outcomes from the discussion and the resulting decisions of the Board.

5.18 As part of the process of stating the resulting decisions of the Board, the Chair may propose an adaptation of what may have been recommended to the Board in the accompanying report, to reflect the outcome of the discussion.

5.19 The Board may reach consensus on an item of business without taking a formal vote, and this will be normally what happens where consensus has been reached.

5.20 Where the Chair concludes that there is not a consensus on the Board's position on the item and/ or what it wishes to do, then the Chair will put the decision to

a vote. If at least two Board members ask for a decision to be put to a vote, then the Chair will do so. Before putting any decision to vote, the Chair will summarise the outcome of the discussion and the proposal(s) for the members to vote on.

5.21 Where a vote is taken, the decision shall be determined by a majority of votes of the members present and voting on the question. In the case of an equality of votes, the Chair shall have a second or casting vote. The Chair may determine the method for taking the vote, which may be by a show of hands, or by ballot, or any other method the Chair determines.

5.22 While the meeting is in public the Board may not exclude members of the public and the press (for the purpose of reporting the proceedings) from attending the meeting.

Board Meeting in Private Session

5.23 The Board may agree to meet in private in order to consider certain items of business. The Board may decide to meet in private on the following grounds:

- The Board is still in the process of developing proposals or its position on certain matters, and needs time for private deliberation.
- The business relates to the commercial interests of any person and confidentiality is required, e.g. when there is an ongoing tendering process or contract negotiation.
- The business necessarily involves reference to personal information, and requires to be discussed in private in order to uphold the Data Protection Principles.
- The Board is otherwise legally obliged to respect the confidentiality of the information being discussed.

5.24 The minutes of the meeting will reflect when the Board has resolved to meet in private.

Minutes

5.25 The names of members present at a meeting of the Board, or of a committee of the Board, shall be recorded in the minute of the meeting. The names of other persons in attendance shall also be recorded.

5.26 The Board's Secretary (or his/her authorised nominee) shall prepare the minutes of meetings of the Board and its committees. The Board or the committee shall review the draft minutes at the following meeting. The person presiding at that meeting shall sign the approved minute.

6 Matters Reserved for the Board

Introduction

6.1 The Scottish Government retains the authority to approve certain items of business. There are other items of the business which can only be approved at an NHS Board meeting, due to either Scottish Government directions or a Board decision in the interests of good governance practice.

6.2 This section summarises the matters reserved to the Board:

a) Standing Orders
b) The establishment and terms of reference of all its committees, and appointment of committee members
c) Organisational Values
d) The strategies for all the functions that it has planning responsibility for, subject to any provisions for major service change which require Ministerial approval.
e) The Annual Operational Plan for submission to the Scottish Government for its approval. (Note: The Board should consider the draft for submission in private session. Once the Scottish Government has approved the Annual Operational Plan, the Board should receive it at a public Board meeting.)
f) Corporate objectives or corporate plans which have been created to implement its agreed strategies.
g) Risk Management Policy.
h) Financial plan for the forthcoming year, and the opening revenue and capital budgets.
i) Standing Financial Instructions and a Scheme of Delegation.
j) Annual accounts and report. (Note: Note: This must be considered when the Board meets in private session. In order to respect Parliamentary Privilege, the Board cannot publish the annual accounts or any information drawn from it before the accounts are laid before the Scottish Parliament. Similarly the Board cannot publish the report of the external auditors of their annual accounts in this period.)
k) Any business case item that is beyond the scope of its delegated financial authority before it is presented to the Scottish Government for approval. The Board shall comply with the Scottish Capital Investment Manual.
l) The Board shall approve the content, format, and frequency of performance reporting to the Board.
m) The appointment of the Board's chief internal auditor. (Note: This applies either when the proposed chief internal auditor will be an employee of the Board, or when the chief internal auditor is engaged through a contract with an external provider. The audit committee should advise the Board on the appointment, and the Board may delegate to the audit committee oversight of the process which leads to a recommendation for appointment.)
n) The contribution to Community Planning Partnerships through the associated improvement plans.
o) Health & Safety Policy
p) Arrangements for the approval of all other policies.
q) The system for responding to any civil actions raised against the Board.
r) The system for responding to any occasion where the Board is being investigated and / or prosecuted for a criminal or regulatory offence.

6.3 The Board may be required by law or Scottish Government direction to approve certain items of business, e.g. the integration schemes for a local authority area.

6.4 The Board itself may resolve that other items of business be presented to it for approval.

7 Delegation of Authority by the Board

7.1 Except for the Matters Reserved for the Board, the Board may delegate authority to act on its behalf to committees, individual Board members, or other Board employees. In practice this is achieved primarily through the Board's approval of the Standing Financial Instructions and the Scheme of Delegation.

7.2 The Board may delegate responsibility for certain matters to the Chair for action. In such circumstances, the Chair should inform the Board of any decision or action subsequently taken on these matters.

7.3 The Board and its officers must comply with the NHS Scotland Property Transactions Handbook, and this is cross-referenced in the Scheme of Delegation.

7.4 The Board may, from time to time, request reports on any matter or may decide to reserve any particular decision for itself. The Board may withdraw any previous act of delegation to allow this.

8 Execution of Documents

8.1 Where a document requires to be authenticated under legislation or rule of law relating to the authentication of documents under the Law of Scotland, or where a document is otherwise required to be authenticated on behalf of the Board, it shall be signed by an executive member of the Board or any person duly authorised to sign under the Scheme of Delegation in accordance with the Requirements of Writing (Scotland) Act 1995. Before authenticating any document the person authenticating the document shall satisfy themselves that all necessary approvals in terms of the Board's procedures have been satisfied. A document executed by the Board in accordance with this paragraph shall be self-proving for the purposes of the Requirements of Writing (Scotland) Act 1995.

8.2 Scottish Ministers shall direct which officers of the Board can sign on their behalf in relation to the acquisition, management and disposal of land.

8.3 Any authorisation to sign documents granted to an officer of the Board shall terminate upon that person ceasing (for whatever reason) from being an employee of the Board, without further intimation or action by the Board.

9 Committees

9.1 Subject to any direction issued by Scottish Ministers, the Board shall appoint such committees (and sub-committees) as it thinks fit. NHS Scotland Board

Development website will identify the committees which the Board must establish.

9.2 The Board shall appoint the chairs of all committees. The Board shall approve the terms of reference and membership of the committees. The Board shall review these as and when required, and shall review the terms within 2 years of their approval if there has not been a review.

9.3 The Board shall appoint committee members to fill any vacancy in the membership as and when required. If a committee is required by regulation to be constituted with a particular membership, then the regulation must be followed

9.4 Provided there is no Scottish Government instruction to the contrary, any Non-Executive Board member may replace a Committee member who is also a Non-Executive Board member, if such a replacement is necessary to achieve the quorum of the committee.

9.5 The Board's Standing Orders relating to the calling and notice of Board meetings, conduct of meetings, and conduct of Board members shall also be applied to committee meetings where the committee's membership consist of or include all the Board members. Where the committee's members includes some of the Board's members, the committee's meetings shall not be held in public and the associated committee papers shall not be placed on the Board's website, unless the Board specifically elects otherwise. Generally Board members who are not members of a committee may attend a committee meeting and have access to the meeting papers. However if the committee elects to consider certain items as restricted business, then the meeting papers for those items will normally only be provided to members of that committee. The person presiding the committee meeting may agree to share the meeting papers for restricted business papers with others.

9.6 The Board shall approve a calendar of meeting dates for its committees. The committee chair may call a meeting any time, and shall call a meeting when requested to do so by the Board.

9.7 The Board may authorise committees to co-opt members for a period up to one year, subject to the approval of both the Board and the Accountable Officer. A committee may decide this is necessary to enhance the knowledge, skills and experience within its membership to address a particular element of the committee's business. A co-opted member is one who is not a member of Fife NHS Board and is not to be counted when determining the committee's quorum.

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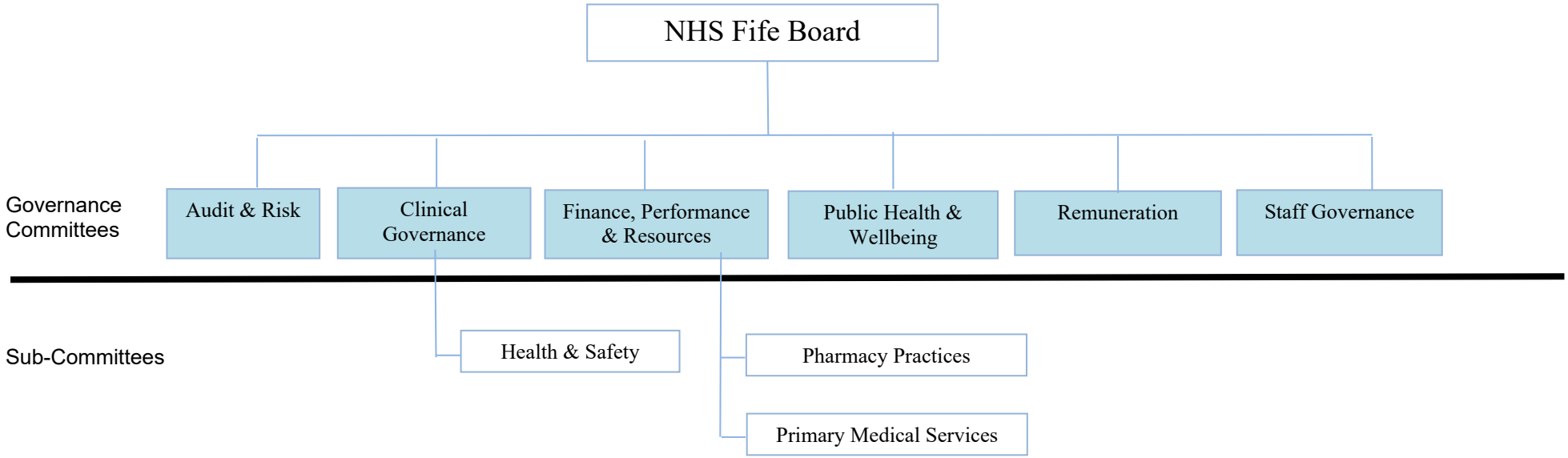
NHS Fife

NHS FIFE BOARD COMMITTEE STRUCTURE



TERMS OF REFERENCE FOR BOARD COMMITTEES

AUDIT AND RISK COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: 26 July 2022 ~~25 May 2021~~

1. PURPOSE

1.1 To provide the Board with the assurance that the activities of Fife NHS Board are within the law and regulations governing the NHS in Scotland and that an effective system of internal control is maintained. The duties of the Audit and Risk Committee shall be in accordance with the Scottish Government Audit & Assurance Handbook, dated April 2018.

2. COMPOSITION

2.1 The membership of the Audit and Risk Committee will be:

- Five Non-Executive or Stakeholder members of Fife NHS Board (one of whom will be the Chair). (A Stakeholder member is appointed to the Board from Fife Council or by virtue of holding the Chair of the Area Partnership Forum or the Area Clinical Forum).

2.2 The Chair of Fife NHS Board cannot be a member of the Committee.

2.3 In order to avoid any potential conflict of interest, the Chair of the Audit and Risk Committee shall not be the Chair of any other governance Committee of the Board.

2.4 Officers of the Board will be expected to attend meetings of the Committee when issues within their responsibility are being considered by the Committee. In addition, the Committee Chair will agree with the Executive Lead Officer to the Committee which Directors and other Senior Staff should attend meetings, routinely or otherwise. The following will normally be routinely invited to attend Committee meetings:

- Chief Executive
- Director of Finance & Strategy (who is also Executive Lead for Risk Management)
- Chief Internal Auditor or representative
- Statutory External Auditor
- Head of Financial Services & Procurement
- Risk Manager
- Board Secretary

2.5 The Director of Finance & Strategy shall serve as the Lead Executive Officer to the Committee.

2.6 The Board shall ensure that the Committee's membership has an adequate range of skills and experience that will allow it to effectively discharge its responsibilities. With regard to the Committee's responsibilities for financial reporting, the Board shall ensure that at least one member can engage

competently with financial management and reporting in the organisation, and associated assurances.

3. QUORUM

3.1 No business shall be transacted at a meeting of the Committee unless at least three Non-Executive or Stakeholder members are present. There may be occasions when due to the unavailability of the above Non-Executive members, the Chair will ask other Non-Executive members to act as members of the committee so that quorum is achieved. This will be drawn to the attention of the Board.

4. MEETINGS

4.1 The Committee shall meet as necessary to fulfil its remit but not less than four times a year.

4.2 The Chair of Fife NHS Board shall appoint a Chair who shall preside at meetings of the Committee. If the Chair is absent from any meeting of the Committee, members shall elect from amongst themselves one of the other Committee members to chair the meeting.

4.3 The agenda and supporting papers will be sent out at least five clear days before the meeting.

4.4 If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee and, if relevant, the External Auditor and/or Chief Internal Auditor.

4.5 If required, the Chairperson of the Audit and Risk Committee may meet individually with the Chief Internal Auditor, the External Auditor and the Accountable Officer.

5. REMIT

5.1 The main objective of the Audit and Risk Committee is to support the Accountable Officer and Fife NHS Board in meeting their assurance needs. This includes:

- Helping the Accountable Officer and Fife NHS Board formulate their assurance needs, via the creation and operation of a well-designed assurance framework, with regard to risk management, governance and internal control;

- Reviewing and challenging constructively the assurances that have been provided as to whether their scope meets the needs of the Accountable Officer and Fife Health Board;

- Reviewing the reliability and integrity of those assurances, i.e. considering whether they are founded on reliable evidence, and that the conclusions are reasonable in the context of that evidence;

- Drawing attention to weaknesses in systems of risk management, governance and internal control, and making suggestions as to how those weaknesses can be addressed;

- Commissioning future assurance work for areas that are not being subjected to significant review

- Seeking assurance that previously identified areas of weakness are being remedied.

The Committee has no executive authority, and is not charged with making or endorsing any decisions. The only exception to this principle is the approval of the Board's accounting policies and audit plans. The Committee exists to advise the Board or Accountable Officer who, in turn, makes the decision.

5.2 The Committee will keep under review and report to Fife NHS Board on the following:

Internal Control and Corporate Governance

5.3 To evaluate the framework of internal control and corporate governance comprising the following components, as recommended by the Turnbull Report:

- control environment;
- risk management;
- information and communication;
- control procedures;
- monitoring and corrective action.

5.4 To review the system of internal financial control, which includes:

- the safeguarding of assets against unauthorised use and disposition;
- the maintenance of proper accounting records and the reliability of financial information used within the organisation or for publication.

5.5 To ensure that the activities of Fife NHS Board are within the law and regulations governing the NHS.

5.6 To monitor performance and best value by reviewing the economy, efficiency and effectiveness of operations.

5.7 To review the disclosures included in the Governance Statement on behalf of the Board. In considering the disclosures, the Committee will review as necessary and seek confirmation on the information provided to the Chief Executive in support of the Governance Statement including the following:

- Annual Statements of Assurance from the main Governance Committees and the conclusions of the other sub-Committees, confirming whether they have fulfilled their remit and that there are adequate and effective internal controls operating within their particular area of operation;

- Annual Statement of Assurance from the Integration Joint Board, confirming all aspects of clinical, financial and staff governance have been fulfilled, with appropriate and adequate controls and risk management in place;

- Details from the Chief Executive on the operation of the framework in place to ensure that they discharge their responsibilities as Accountable Officer as set out in the Accountable Officer Memorandum;

- Confirmation from Executive Directors that there are no known control issues nor breaches of Standing Orders/Standing Financial Instructions other than any disclosed within the Governance Statement;

- Summaries of any relevant significant reports by Healthcare Improvement Scotland (HIS) or other external review bodies.

5.8 To present an annual statement of assurance on the above to the Board, to support the NHS Fife Chief Executive's Governance Statement.

Internal Audit

5.9 To review and approve the Internal Audit Strategic and Annual Plans having assessed the appropriateness to give reasonable assurance on the whole of risk control and governance.

5.10 To monitor audit progress and review audit reports.

5.11 To monitor the management action taken in response to the audit recommendations through an appropriate follow-up mechanism.

5.12 To consider the Chief Internal Auditor's annual report and assurance statement.

5.13 To approve the Fife Integration Joint Board Internal Audit Output Sharing Protocol.

5.14 To review the operational effectiveness of Internal Audit by considering the audit standards, resources, staffing, technical competency and performance measures.

5.15 To ensure that there is direct contact between the Audit and Risk Committee and Internal Audit and that the opportunity is given for discussions with the Chief Internal Auditor at least once per year (scheduled within the timetable of business) and, as required, without the presence of the Executive Directors.

5.16 To review the terms of reference and appointment of the Internal Auditors and to examine any reason for the resignation of the Auditors or early termination of contract/service level agreement.

External Audit

5.16 To note the appointment of the Statutory Auditor and to approve the appointment and remuneration of the External Auditors for the NHS Fife Annual Accounts and the NHS Fife Patients' Funds Accountsand Endowment Funds.

5.17 To review the Audit Strategy and Plan, including the Best Value and Performance Audits programme.

5.18 To consider all statutory audit material, in particular:

- Audit Reports;
- Annual Reports;
- Management Letters

relating to the certification of Fife NHS Board's Annual Accounts and Annual Patients' Funds Accounts.

5.19 To monitor management action taken in response to all External Audit recommendations, including Best Value and Performance Audit Reports.

5.20 To hold meetings with the Statutory Auditor at least once per year and as required, without the presence of the Executive Directors.

5.21 To review the extent of co-operation between External and Internal Audit.

5.22 To appraise annually the performance of the Statutory and External Auditors and to examine any reason for the resignation or dismissal of the External Auditors.

Risk Management

5.23 The Committee has no executive authority, and has no role in the executive decision-making in relation to the management of risk. The Committee is charged with ensuring that there is an appropriate publicised Risk Management Framework with all roles identified and fulfilled. THowever the Committee shall seek specific assurance that:

- There is an effective comprehensive risk management system in place to identify, assess, mitigateanage and monitor risks at all levels of the organisation;

- There is appropriate ownership of risk in the organisation, and that there is an effective culture of risk management;

- The Board has clearly defined its risk appetite (i.e. the level of risk that the Board is prepared to accept, tolerate, or treatbe exposed to at any time), and that the executive's approach to risk management is consistent with that appetite;

- A robust and effective Board Assurance Framework is in place.

5.24 In order to discharge its advisory role to the Board and Accountable Officer, and to inform its assessment on the state of corporate governance, internal control and risk management, the Committee shall:

- Receive and review a quarterly report summarising any significant changes to the Board's Corporate Risk Register, and what plans are in place to mitigate~~anage~~ them;
- Assess whether the Corporate Risk Register is an appropriate reflection of the key risks to the Board, so as to advise the Board;
- Consider the impact of changes to the risk register on the assurance needs of the Board and the Accountable Officer, and communicate any issues when required;
- Receive and review a quarterly update on the Board Assurance Framework;
- Assess whether the linkages between the Corporate Risk Register and the Board Assurance Framework are robust and enable the Board to identify gaps in control and assurance;
- ~~Reflect on the assurances that have been received to date, and identify whether entries on the Board's risk management system requires to be updated;~~
- Receive an annual report on risk management, confirming whether or not there have been adequate and effective risk management arrangements throughout the year, and highlighting any material areas of risk;
- The Committee shall seek assurance on the overall system of risk management for all risks and risks pertinent to its core functions.
- The Committee may also elect to request information on risks held on any risk registers within the organisation.

Standing Orders and Standing Financial Instructions

5.25 To review annually the Standing Orders and associated appendices of Fife NHS Board and advise the Board of any amendments required.

5.26 To examine the circumstances associated with any occasion when Standing Orders of Fife NHS Board have been waived or suspended.

Annual Accounts

5.27 To review and recommend approval of draft Fife NHS Board Annual Accounts and Patient Funds Accounts to the Board.

5.28 To review the draft Annual Report and ~~Financial~~Performance Review of Fife NHS Board ~~as found~~ within ~~the Directors Report incorporated within~~ the Annual Accounts.

5.29 To review annually (and recommend Board approval ofe any changes in) the accounting policies of Fife NHS Board.

5.30 To review schedules of losses and compensation payments where the amounts exceed the delegated authority of the Board prior to being referred to the Scottish Government for approval.

Other Matters

5.31 The Committee has a duty to review its own performance, effectiveness, including its running costs, and terms of reference on an annual basis.

5.32 The Committee has a duty to keep up-to-date by having mechanisms to ensure topical legal and regulatory requirements are brought to Members' attention.

5.33 The Committee shall review the arrangements for employees raising concerns, in confidence, about possible wrongdoing impropriety in financial management or reporting or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow-up action.

5.34 The Committee shall review regular reports on Fraud and potential Frauds as presented by the Fraud Liaison Officer (FLO).

5.35 The Chairperson of the Committee will submit an Annual Report of the work of the Committee to the Board following consideration by the Audit and Risk Committee in Juneannually.

5.36 The Chairperson of the Committee should be available at Fife NHS Board meetings to answer questions about theits work of the Committee.

5.37 The Committee shall preparedraw up and approve, before the start of each financial year, an Annual Workplan for the Committee's planned work during the forthcoming year.

5.38 The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

5.39 The Committee shall seek assurance that the Board has systems of control to ensure that it discharges its responsibilities under the Freedom of Information (Scotland) Act 2002.

5.40 The Committee shall review the Board's arrangements to prevent bribery and corruption within its activities. This includes the systems to support Board members' compliance with the NHS Fife Board Code of Conduct (Ethical Standards in Public Life Act 2000), the systems to promote the required standards of business conduct for all employees and the Boards procedure to prevent Bribery (Bribery Act 2000).

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference, and in doing so, is authorised to seek any information it requires from any employee or external experts.

6.2 In order to fulfil its remit, the Audit and Risk Committee may obtain whatever professional advice it requires, and may require Directors or other officers of the Board to attend meetings.

6.3 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of external advisors~~outsiders~~ with relevant experience and expertise if it considers this necessary.

6.4 The Committee's authority is included in the Board's Scheme of Delegation and is set out in the Purpose and Remit of the Committee.

7. REPORTING ARRANGEMENTS

7.1 The Audit and Risk Committee reports directly to the Fife NHS Board on its work. Minutes of the Committee are presented to the Board by the Committee Chairperson, who provides a report, on an exception basis, on any particular issues which the Committee wishes to draw to the Board's attention.

7.2 The Audit and Risk Committee will advise the Scottish Parliament Public Audit Committee of any matters of significant interest as required by the Scottish Public Finance Manual.

CLINICAL GOVERNANCE COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: 26 July 2022 ~~25 May 2021~~

1. PURPOSE

1.1 To oversee clinical governance mechanisms in NHS Fife.

1.2 To observe and check the clinical governance activity being delivered within NHS Fife and provide assurance to the Board that the mechanisms, activity and planning are acceptable.

1.3 To oversee the clinical governance and risk management activities in relation to the ~~development and~~ delivery of the existing Clinical Strategy.

~~1.3~~1.4 To evaluate agreed actions relevant to clinical governance in the implementation of the developing Population Health & Wellbeing Strategy, including assessing the quality and safety aspects of new and innovative ways of working.

~~1.4~~1.5 To assure the Board that appropriate clinical governance mechanisms and structures are in place for clinical governance to be supported effectively throughout the whole of Fife NHS Board's responsibilities~~, including health improvement activities~~.

~~1.5~~1.6 To assure the Board that the Clinical and Care Governance Arrangements in the Integration Joint Board are working effectively.

~~1.6~~1.7 To escalate any issues to the NHS Fife Board, if serious concerns are identified about the quality and safety of care in the services across NHS Fife, including the services devolved to the Integration Joint Board.

2. COMPOSITION

2.1 The membership of the Clinical Governance Committee will be:

- Six Non-Executive or Stakeholder members of the Board (one of whom will be the Chair). (A Stakeholder member is appointed to the Board from Fife Council or by virtue of holding the Chair of the Area Partnership Forum or the Area Clinical Forum)
- Chief Executive
- Medical Director
- Nurse Director
- Director of Public Health
- One Staff Side representative of NHS Fife Area Partnership Forum
- One Representative from Area Clinical Forum
- One Patient Representative

2.2 Officers of the Board will be expected to attend meetings of the Committee when issues within their responsibility are being considered by the Committee.

In addition, the Committee Chair will agree with the Lead Officer to the Committee which other Senior Staff should attend meetings, routinely or otherwise. The following will normally be routinely invited to attend Committee meetings:

- Director of Acute Services
- Director of Finance & Strategy
- Director of Health & Social Care
- Director of Pharmacy & Medicines
- Associate Director, Digital & Information
- Associate Medical Director, Acute Services Division
- Associate Medical Director, Fife Health & Social Care Partnership
- Associate Medical Director, Women & Children's Services
- Associate Director~~Head~~ of Quality & Clinical Governance
- Board Secretary

2.3 The Medical Director shall serve as the lead officer to the Committee.

3. QUORUM

3.1 No business shall be transacted at a meeting of the Committee unless at least three Non-Executive members or Stakeholder members are present. There may be occasions when due to the unavailability of the above Non- Executive members, the Chair will ask other Non-Executive members to act as members of the Committee so that quorum is achieved. This will be drawn to the attention of the Board.

4. MEETINGS

4.1 The Committee shall meet as necessary to fulfil its remit but not less than six times a year.

4.2 The Chair of Fife NHS Board shall appoint a Chair who shall preside at meetings of the Committee. If the Chair is absent from any meeting of the Committee, members shall elect from amongst themselves one of the other Committee members to chair the meeting.

4.3 The agenda and supporting papers will be sent out at least five clear days before the meeting.

5. REMIT

5.1 The remit of the Clinical Governance Committee is to:

- monitor progress on the ~~health status targets~~quality and safety performance indicators set by the Board.

- provide oversight of the implementation of the Clinical Strategy and review its impact, in line with the NHS Fife Strategic Framework and the Care and Clinical Governance Framework~~Strategy~~.

- ensure appropriate alignment and clinical governance oversight with the emerging Programmes reporting through the Portfolio Board;

- receive the minutes of meetings of:
  - Acute Services Division Clinical Governance Committee
  - Area Clinical Forum
  - Area Drug & Therapeutics Committee
  - Area Radiation Protection Committee
  - Digital & Information Board
  - Fife Research Committee
  - Health & Safety Sub Committee
  - H&SCP Clinical & Care Governance Committee
  - ~~H&SCP Integration Joint Board~~
  - Infection Control Committee
  - Information Governance & Security Steering Group
  - ~~Integrated Transformation Board~~
  - ~~Public Health Assurance Committee~~
  - NHS Fife Clinical Governance Steering Group
  - NHS Fife Resilience Forum

- The Committee will produce an Annual Report incorporating a Statement of Assurance for submission to the Board, via the Audit and Risk Committee. The proposed Annual Report will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit and Risk Committee in June.

- Receive updates on and oversee the progress on the recommendations from relevant external reports of reviews of all healthcare organisations, including clinical governance reports and recommendations from relevant regulatory bodies which may include Healthcare Improvement Scotland (HIS) reviews and visits.

- Issues arising from these Committees will be brought to the attention of the Chair of the Clinical Governance Committee for further consideration as required.

- To provide assurance to Fife NHS Board about the quality of services within NHS Fife.

- To undertake an annual self-assessment of the Committee's work and effectiveness.

- The Committee shall review regularly the sections of the NHS Fife Integrated Performance & Quality Report relevant to the Committee's responsibility.

5.2 The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

5.3 The Committee shall draw up and approve, before the start of each financial year, an Annual Workplan for the Committee's planned work during the forthcoming year.

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference, and in so doing, is authorised to seek any information it requires from any employee.

6.2 In order to fulfil its remit, the Clinical Governance Committee may obtain whatever professional advice it requires, and require Directors or other officers of the Board to attend meetings.

7. REPORTING ARRANGEMENTS

7.1 The Clinical Governance Committee reports directly to Fife NHS Board. Minutes of the Committee are presented to the Board by the Committee Chair, who provides a report, on an exception basis, on any particular issues which the Committee wishes to draw to the Board's attention.

7.2 Each Committee of the Board will scrutinise relevant risks on the Corporate Risk Register on a bi-monthly basis.

7.3 Each Committee of the Board will scrutinise the Board Assurance Framework risk(s) aligned to it on a bi-monthly basis.

FINANCE, PERFORMANCE AND RESOURCES COMMITTEE CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: 26 July 2022~~25 May 2021~~

1. PURPOSE

1.1 The purpose of the Committee is to keep under review the financial position and performance against key non-financial targets of the Board, and to ensure that suitable arrangements are in place to secure economy, efficiency and effectiveness in the use of all resources, and that the arrangements are working effectively.

1.2 To consider, review and take assurance from agreed actions relevant to financial sustainability in the implementation of the developing Population Health & Wellbeing Strategy, including assessing the financial and performance aspects of new and innovative ways of working.

2. COMPOSITION

2.1 The membership of the Finance, Performance and Resources Committee will be:

- Six Non-Executive or Stakeholder members of the Board (one of whom will be the Chair). (A Stakeholder member is appointed to the Board from Fife Council or by virtue of holding the Chair of the Area Partnership Forum or the Area Clinical Forum)
- Chief Executive
- Director of Finance & Strategy
- Medical Director
- Director of Public Health
- Director of Nursing

2.2 The Chair of the Audit and Risk Committee will not be a member of the Finance, Performance and Resources Committee.

2.3 Officers of the Board will be expected to attend meetings of the Committee when issues within their responsibility are being considered by the Committee. In addition, the Committee Chair will agree with the Lead Officer to the Committee which other Senior Staff should attend meetings, routinely or otherwise. The following will normally be routinely invited to attend Committee meetings:

- Director of Acute Services
- Director of Property & Asset Management
- Director of Health & Social Care
- Director of Pharmacy & Medicines
- Board Secretary

2.4 The Director of Finance & Strategy shall serve as the Lead Executive Officer to the Committee.

3. QUORUM

3.1 No business shall be transacted at a meeting of the Committee unless at least three Non-Executive members or Stakeholder members are present. There may be occasions when due to the unavailability of the above Non-Executive members, the Chair will ask other Non-Executive members to act as members of the committee so that the quorum is achieved. This will be drawn to the attention of the Board.

4. MEETINGS

4.1 The Committee shall meet as necessary to fulfil its remit but not less than four times per year.

4.2 The Chair of Fife NHS Board shall appoint a Chair who shall preside at meetings of the Committee. If the Chair is absent from any meeting of the Committee, members shall elect from amongst themselves one of the other Committee members to chair the meeting.

4.3 The agenda and supporting papers will be sent out at least five clear days before the meeting.

5. REMIT

5.1 The Committee shall have accountability to the Board for ensuring that the financial position of the Board is soundly based, having regard to:

- compliance with statutory financial requirements and achievement of financial targets;
- such financial monitoring and reporting arrangements as may be specified from time-to-time by Scottish Government Health & Social Care Directorates and/or the Board;
- the impact of planned future policies and known or foreseeable future developments on the financial position;
- undertake an annual self-assessment of the Committee's work and effectiveness; and
- review regularly the sections of the NHS Fife Integrated Performance & Quality Report relevant to the Committee's responsibility.

<u>Arrangements for Securing Value for Money</u>

5.2 The Committee shall keep under review arrangements for securing economy, efficiency and effectiveness in the use of resources. These arrangements will include procedures for (a) planning, appraisal, control, accountability and evaluation of the use of resources, and for (b) reporting and reviewing performance and managing performance issues as they arise in a timely and effective manner. In particular, the Committee will review action (proposed or underway) to ensure that the Board achieves financial balance in line with statutory requirements.

Allocation and Use of Resources

5.3 The Committee has key responsibilities for:

- reviewing the development of the Board's Financial Strategy in support of the Annual Operational / Remobilisation Plan, and recommending approval to the Board;
- reviewing all resource allocation proposals outwith authority delegated by the Board and make recommendations to the Board thereon;
- monitoring the use of all resources available to the Board; and
- reviewing all matters relating to Best Value.

5.4 Specifically, the Committee is charged with recommending to the Board annual revenue and capital budgets and financial plans consistent with its statutory financial responsibilities. It shall also have responsibility for the oversight of the Board's Capital Programme (including individual Business Cases for Capital Investment) and the review of the Property Strategy (including the acquisition and disposal of property), and for making recommendations to the Board as appropriate on any issue within its terms of reference.

5.5 The Committee will receive minutes from the Pharmacy Practices Committee and the Primary Medical Services Committee. Issues arising from these Committees will be brought to the attention of the Chair of the Finance, Performance and Resources Committee for further consideration as required.

5.6 The Committee will produce an Annual Report incorporating a Statement of Assurance for submission to the Board, via the Audit and Risk Committee. The proposed Annual Report will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit and Risk Committee in June.

5.7 The Annual Report will include the Committee's assessment and conclusions on its effectiveness over the financial year in question.

5.8 The Committee shall draw up and approve, before the start of each financial year, an Annual Workplan for the Committee's planned work during the forthcoming year.

5.9 The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference, and in so doing, is authorised to seek any information it requires from any employee.

6.2 In order to fulfil its remit, the Finance, Performance and Resources Committee may obtain whatever professional advice it requires, and require Directors or other officers of the Board to attend meetings.

6.3 The authority of the Committee is included in the Board's Scheme of Delegation, as set out in the Purpose and Remit of the Committee.

7. REPORTING ARRANGEMENTS

7.1 The Finance, Performance and Resources Committee reports directly to Fife NHS Board on its work. Minutes of the Committee are presented to the Board by the Committee Chair, who provides a report, on an exception basis, on any particular issues which the Committee wishes to draw to the Board's attention.

7.2 Each Committee of the Board will scrutinise relevant risks on the Corporate Risk Register on a bi-monthly basis.

7.3 Each Committee of the Board will scrutinise the Board Assurance Framework risk(s) aligned to it on a bi-monthly basis.

PUBLIC HEALTH & WELLBEING COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: 26 July 2022~~30 November 2021~~

1. PURPOSE

1.1 To assure Fife NHS Board that NHS Fife is fully engaged in supporting wider population health and wellbeing for the local population, including overseeing the implementation of the population health and wellbeing actions defined in the Board's strategic plans and ensuring effective contribution to population health and wellbeing related activities.

1.2 To exercise scrutiny and challenge over the delivery performance of a range of services for which NHS Fife is accountable to Scottish Ministers.

1.3 To strengthen collaboration, build momentum, enable ownership and demonstrate leadership across all current partnerships and networks in Fife (particularly Fife Partnership Board), to address health inequalities and improve the wider determinants of health for our population.

1.4 To assure the Board that appropriate mechanisms and structures are in place for public health and wellbeing activities to be supported effectively throughout the whole of Fife NHS Board's responsibilities, including services delivered by partners, to reflect NHS Fife's ambition to be an anchor institution within its population area.

2. COMPOSITION

2.1 The membership of the Public Health & Wellbeing Committee will be:

- The Chair of the Board (who will act as Chair of the Committee)
- Three Non-Executive members of the Board
- Employee Director
- Chief Executive
- Director of Finance & Strategy
- Director of Nursing
- Director of Public Health
- Medical Director

2.2 Officers of the Board will be expected to attend meetings of the Committee when issues within their responsibility are being considered by the Committee. In addition, the Committee Chair will agree with the lead Executive officer to the Committee which other Senior Staff should attend meetings, routinely or otherwise. The following will normally be routinely invited to attend Committee meetings:

- Director of Health & Social Care
- Associate Director, Planning & Performance
- Board Secretary

2.3 The Director of Public Health shall serve as the lead Executive officer to the Committee.

3. QUORUM

3.1 No business shall be transacted at a meeting of the Committee unless at least three members are present, two of whom should be Non-Executive members of the Board. There may be occasions when due to the unavailability of the above Non-Executive members, the Chair will ask other Non-Executive members to act as members of the Committee so that quorum is achieved. This will be drawn to the attention of the Board.

4. MEETINGS

4.1 The Committee shall meet ~~initially on a monthly basis.~~as necessary to fulfil its remit but not less than six times per year.

4.2 The Chair of Fife NHS Board shall preside at meetings of the Committee. If the Chair is absent from any meeting of the Committee, members shall elect from amongst themselves one of the other Non-Executive Committee members to chair the meeting.

4.3 The agenda and supporting papers will be sent out at least five clear days before the meeting.

5. REMIT

5.1 The remit of the Public Health & Wellbeing Committee is:

- To agree key areas of focus within the public health priorities that will be taken forward every year, oversee the agreed population health activities, ensure equity in provision and access to services, and provide assurance thereon to Fife NHS Board.
- To ensure that a strategic plan is formulated that reflects public health and wellbeing needs and priorities for the population serviced by NHS Fife in line with the priorities of the national care and wellbeing programmes.
- To monitor strategy implementation through regular progress reports and review of intermediate measures and long-term outcomes.
- To receive assurance that the risks relating to primary care and community services are addressed in line with the directions set and that robust mitigating actions are in place to address any areas of concern or where performance is not in line with national standards or targets.
- To support the work of the Anchor Institute Programme Board and ~~Population Health and Wellbeing~~ Portfolio Board and receive updates on progress and outcomes.
- To support the work of the Primary Care Governance & Oversight Group, in its development of the Primary Care Strategy.
- To support the ambitions set out in the Plan for Fife (Community Planning Partnership) through collaboration on agreed areas of influence.

- To undertake scrutiny of individual topics / projects / work-streams to promote the health of the population in Fife, including NHS Fife staff, with particular emphasis on prevention and addressing health inequalities.
- To ensure appropriate linkages to other key work of the Board, such as the development of new services, workstreams and delivery plans.
- To undertake an annual self-assessment of the Committee's work and effectiveness.

5.2 The Committee shall review regularly the sections of the NHS Fife Integrated Performance & Quality Report relevant to the Committee's areas of responsibility.

5.3 The Committee will produce an Annual Report incorporating a Statement of Assurance for submission to the Board, via the Audit and Risk Committee. The proposed Annual Report will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit and Risk Committee in June.

5.4 The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

5.5 The Committee shall draw up and approve, before the start of each financial year, an Annual Workplan for the Committee's planned work during the forthcoming year.

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference, and in so doing, is authorised to seek any information it requires from any employee.

6.2 In order to fulfil its remit, the Public Health & Wellbeing Committee may obtain whatever professional advice it requires, and require Directors or other officers of the Board to attend meetings.

7. REPORTING ARRANGEMENTS

7.1 The Public Health & Wellbeing Committee reports directly to Fife NHS Board. Minutes of the Committee are presented to the Board by the Committee Chair, who provides a report, on an exception basis, on any particular issues which the Committee wishes to draw to the Board's attention.

7.2 Each Committee of the Board will scrutinise relevant risks on the Corporate Risk Register on a bi-monthly basis.

7.3 Each Committee of the Board will scrutinise the Board Assurance Framework risk(s) aligned to it on a bi-monthly basis.

REMUNERATION COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: 26 July 2022 ~~25 May 2021~~

1. PURPOSE

1.1 To consider and agree performance objectives and performance appraisals for staff in the Executive cohort and to oversee performance arrangements for designated senior managers.

1.2 To direct the appointment process for the Chief Executive and Executive ~~Members of the Board~~Directors.

2. COMPOSITION

2.1 The membership of the Remuneration Committee will be:

- Fife NHS Board Chairperson
- Two Non-Executive Board members
- ~~Chief Executive~~
- Employee Director

2.2 The Director of Workforce shall act as Lead Executive Officer for the Committee.

2.3 The NHS Fife Chief Executive will leave the meeting when there is any discussion with regard to their own performance. The Director of Workforce will leave the meeting when there is any discussion with regard to their own performance.

3. QUORUM

3.1 Meetings will be quorate when at least three members are present, at least two of whom are Non-Executive members.

4 MEETINGS

4.1 The Committee shall meet as necessary, but not less than three times a year.

4.2 The Fife NHS Board Chairperson will chair the Committee. If the Chairperson is absent from the meeting, one of the other Non-Executive members will chair the meeting.

4.3 The agenda and supporting papers for each meeting will be sent out at least five clear days before the meeting.

4.4 The full minutes will be circulated to all Committee members. Minutes edited to remove all personal details will be circulated to the Board.

5 REMIT

5.1 The remit of the Remuneration Committee is to consider:

- job descriptions for the Executive cohort;
- other terms of employment which are not under Ministerial direction;
- to hear and determine appeals against the decisions of the Consultant Discretionary Awards Panel. The Remuneration Committee can make decisions regarding Discretionary Points in exceptional circumstances;
- agree performance objectives and appraisals directly for the Executive cohort only, and oversee arrangements for designated senior managers;
- redundancy, early retiral or termination arrangement in respect of all staff in situations where there is a financial impact upon the Board (this excludes early retiral on grounds of ill health) and approve these or refer to the Board as it sees fit.

5.2 The Committee will produce an Annual Report incorporating a Statement of Assurance for submission to the Board, via the Audit & Risk Committee. The proposed Annual Report will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the Committee by the end of May each year for presentation to the Audit & Risk Committee in June.

5.3 The Committee shall draw up and approve, before the start of each financial year, an Annual Workplan for the Committee's planned work during the forthcoming year.

5.4 The Committee will undertake an annual self-assessment of its work and effectiveness.

5.5 The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference, and in so doing, is authorised to seek any information it requires from any employee.

6.2 In order to fulfil its remit, the Remuneration Committee may obtain whatever professional advice it requires, and require Directors or other officers of the Board to attend meetings.

6.3 Delegated authority is detailed in the Board's Standing Orders and Standing Financial Instructions and is set out in the Purpose and Remit of the Committee.

7. REPORTING ARRANGEMENTS

7.1 The Remuneration Committee reports directly to the Fife NHS Board on its work. Minutes of the Committee, edited to remove all personal details, are presented to the Board by the Committee Chairperson, who provides a report, on an exception basis, on any particular issues which the Committee wishes to draw to the Board's attention.

STAFF GOVERNANCE COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: 26 July 2022~~25 May 2021~~

1. PURPOSE

1.1 The purpose of the Staff Governance Committee is to support the development of a culture within the health system where the delivery of the highest standard possible of staff management is understood to be the responsibility of everyone working within the system, and is built upon partnership and collaboration, and within the direction provided by the Staff Governance Standard.

1.2 To assure the Board that the staff governance arrangements in the Integration Joint Board are working effectively.

1.3 To escalate any issues to the NHS Fife Board if serious concerns are identified regarding staff governance issues within ~~the~~ services, including those devolved to the Integration Joint Board.

~~1.3~~1.4 To evaluate agreed plans that have relevance to staff governance matters in the development and implementation of the Population Health & Wellbeing Strategy.

2. COMPOSITION

2.1 The membership of the Staff Governance Committee will be:

- Four Non-Executive members, one of whom will be the Chair of the Committee.
- Employee Director ~~(as a Stakeholder member of the Board by virtue of holding the Chair of the Area Partnership Forum)~~
- Chief Executive
- Director of Nursing
- Staff Side Chairs of the Local Partnership Forums, or their nominated deputy

2.2 Each member shall give notification if they are unable to attend a meeting. For Non-Executive members, they shall notify the Chair, who may ask other Non-Executive members to act as members of the Committee to achieve a quorum. For Staff Side Chairs of the Local Partnership Forums, they will notify the Lead Officer, confirming their nominated deputy. This will be reported to the Chair.

2.3 Officers of the Board will be expected to attend meetings of the Committee when issues within their responsibility are being considered by the Committee. In addition, the Committee Chair will agree with the Lead Officer to the Committee which other Senior Staff should attend meetings, routinely or otherwise. The following will normally be routinely invited to attend Committee meetings:

- Director of Workforce
- Director of Acute Services

- Director of Health & Social Care
- Board Secretary
- Deputy Director of Workforce and Heads of Service, Workforce Directorate

2.4 The Director of Workforce will act as Lead Executive Officer to the Committee.

3. QUORUM

3.1 No business shall be transacted at a meeting of the Committee unless:

- at least three members are present, at least two of whom should be Non-Executive members of the Board.
- at least one of the Staff Side Chairs of the Local Partnership Forums or their nominated deputy is present.

There may be occasions when due to unavailability of the above Non-Executive members the Chair will ask other Non-Executive members to act as members of the Committee so that quorum is achieved. Similarly, there may be occasions due to unavailability a Staff Side Chair of the Local Partnership Forums shall confirm the nominated deputy who will attend meetings in their absence. This will be reported to the Chair. This information will be drawn to the attention of the Board.

4. MEETINGS

4.1 The Staff Governance Committee shall meet as necessary to fulfil its purpose but not less than four times a year.

4.2 The Chair of Fife NHS Board shall appoint a Chair who shall preside at meetings of the Committee. If the Chair is absent from any meeting of the Committee, members shall elect from amongst themselves one of the other Committee members to chair the meeting.

4.3 The agenda and supporting papers will be sent out at least five clear days before the meeting.

5. REMIT

5.1 The remit of the Staff Governance Committee is to:

- Consider NHS Fife's performance in relation to its achievements of effective Staff Governance and its compliance with the Staff Governance Standard;

- Review action taken on recommendations made by the Committee, NHS Boards, or the Scottish Ministers on Staff Governance matters;

- Give assurance to the Board on the operation of Staff Governance systems within NHS Fife, identifying progress, issues and actions being taken, where appropriate;

- Support the operation of the Area Partnership Forum and the Local Partnership Forums in their Staff Governance monitoring role and the appropriate flow of information to facilitate this;

- Encourage the further development of mechanisms for engaging effectively with all members of staff within the NHS in Fife;

- Contribute to the development of the Annual Operational Plan, in particular but not exclusively, around issues affecting staff;

- Support the continued development of personal appraisal professional learning and performance;

- Review regularly the sections of the NHS Fife Integrated Performance & Quality Report relevant to the Committee's responsibility;

- Undertake an annual self-assessment of the Committee's work and effectiveness.

5.2 The Committee is also required to carry out a review of its function and activities and to provide an Annual Report incorporating a Statement of Assurance. This will be submitted to the Board via the Audit and Risk Committee. The proposed Annual Report will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit and Risk Committee in June.

5.3 The Committee shall draw up and approve, before the start of each financial year, an Annual Workplan for the Committee's planned work during the forthcoming year.

5.4 The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference, and in so doing, is authorised to seek any information it requires from any employee.

6.2 In order to fulfil its remit, the Staff Governance Committee may obtain whatever professional advice it requires, and require Directors or other officers of the Board to attend meetings.

6.3 Delegated authority is detailed in the Board's Standing Orders, as set out in the Purpose and Remit of the Committee.

7. REPORTING ARRANGEMENTS

7.1 The Staff Governance Committee reports directly to Fife NHS Board on its work. Minutes of the Committee are presented to the Board by the Committee Chair, who provides a report, on an exception basis, on any particular issues which the Committee wishes to draw to the Board's attention.

7.2 Each Committee of the Board will scrutinise relevant risks on the Corporate Risk Register on a bi-monthly basis.

7.3 Each Committee of the Board will scrutinise the Board Assurance Framework risk(s) aligned to it on a bi-monthly basis.

STANDING FINANCIAL INSTRUCTIONS

INDEX

1. INTRODUCTION

1.1 Standing Financial Instructions (SFIs) are issued in accordance with the financial directions made under the provisions of the NHS (Financial Provisions) (Scotland) Regulations 1974, and all other enabling powers, for the regulation of the conduct of the Board, its members, officers and agents in relation to all financial matters. These SFIs form part of the Standing Orders and should be used along with the Standing Orders and Scheme of Delegation.

1.2 **Terminology**

Any expression to which a meaning is given in the Health Service Acts, Scottish Statutory Instrument number 302 (2001) which brought NHS Boards into being, or in the financial regulations made under the Acts shall have the same meaning in these Instructions; and:

(a) "NHS Fife" means all elements of the NHS under the auspices of Fife Health Board.
(b) "Board" and "Health Board" mean Fife NHS Board, the common name of Fife Health Board.
(c) "Budget" means a resource expressed in financial terms and set by the Board for the purposes of carrying out for a specified period any or all functions of the Health Board.
(d) "Chief Executive" means the Chief Officer of the Health Board.
(e) "Director of Finance" means the Chief Financial Officer of the Health Board.
(f) "Budget Holder" means any individual with delegated authority to manage finances (Income and/or expenditure) for a specific area of the Board.

1.3 All staff individually and collectively are responsible for the security of the property of the Board, for avoiding loss, for economy and efficiency in the use of the resources and for conforming with the requirements of the Code of Corporate Governance, including Standing Orders, Standing Financial Instructions and Financial Operating Procedures.

1.4 The Director of Finance, on behalf of the Chief Executive, shall be responsible for supervising the implementation of the Board's Standing Financial Instructions and Financial Operating Procedures and for co-ordinating any action necessary to further these as agreed by the Chief Executive. The Director of Finance shall review these at least every three years and be accountable to the Board for these duties.

1.5 Wherever the title, Chief Executive, Director of Finance, or other nominated officer is used in these Instructions, it shall be deemed to include such other staff who have been duly authorised to represent them.

1.6 All relevant employees and agents shall be provided with a copy of these SFIs and are required to complete a form stating that these Instructions have been read and understood and that the individual will comply with the Instructions. They must also sign for any amendments.

1.7 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting.

1.8 Failure to comply with Standing Financial Instructions is a disciplinary matter, which could result in dismissal.

1.9 The Standing Financial Instructions along with the Scheme of Delegation and Financial Operating Procedures provide details of delegated financial responsibility and authority.

2. KEY RESPONSIBILITIES FOR FINANCIAL GOVERNANCE

The Board and Audit and Risk Committee

2.1 The Board shall approve these SFIs and Scheme of Delegation

2.2 The Board shall ensure and be assured that the SFIs and Scheme of Delegation are complied with at all times.

2.3 The Board shall agree the terms of reference of the Audit and Risk Committee, which must conform with extant Scottish Government Instruction and other guidance on good practice.

2.4 The Board shall perform its functions within the total funds allocated by the Scottish Government.

The Chief Executive (Accountable officer)

2.5 The Chief Executive as Accountable Officer for the organisation is ultimately responsible for ensuring that the Board meets its obligations to perform its functions within the allocated financial resources. The Director of Finance is responsible for providing a sound financial framework that assists the Chief Executive when fulfilling these commitments.

2.6 The Board shall delegate executive responsibility for the performance of its functions to the Chief Executive. Board Members shall exercise financial supervision and control by requiring the submission and approval of budgets within approved allocations, by defining and approving essential features of the arrangements in respect of important procedures and financial systems, including the need to obtain value for money, and by defining specific responsibilities placed on individuals.

2.7 It shall be the duty of the Chief Executive to ensure that existing staff and all new employees and agents are notified of their responsibilities within these Instructions.

The Director of Finance

2.8 Without prejudice to any other functions of employees of the Board, the duties of the Director of Finance shall include the provision of financial advice to the Board and its employees, the design, implementation and supervision of systems of financial control and preparation and maintenance of such accounts, certificates, estimates, records and reports as the Board may require for the purpose of carrying out its statutory duties.

2.9 The Director of Finance shall keep records of the Board's transactions sufficient to disclose with reasonable accuracy at any time the financial position of the Board.

2.10 The Director of Finance shall require any individual who carries out a financial function to discharge his/her duties in a manner, and keep any records in a form, that shall be to the satisfaction of the Director of Finance.

2.11 The Director of Finance shall prepare, document and maintain detailed financial procedures and systems incorporating the principles of separation of duties and internal checks to supplement these Standing Financial Instructions.

2.12 The Director of Finance shall be responsible for setting the Board's accounting policies, consistent with the Scottish Government and Treasury guidance and generally accepted accounting practice.

2.13 The Director of Finance will either undertake the role of Fraud Liaison Officer or nominate another senior manager to the role, to work with Counter Fraud Services and co-ordinate the reporting of Fraud and Thefts.

2.14 The Director of Finance is entitled without necessarily giving prior notice to require and receive:-

- access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- access at all reasonable times to any land, premises or employee of the health board;
- the production of any cash, stores or other property of the health board under an employee's control; and
- explanations concerning any matter under investigation.

All Directors and Employees

2.15 All directors and employees, individually and working together, are responsible for:

- Keeping the property of the Board secure, and to apply appropriate routine security practices as may be determined by the Board. This includes:-

  a. ensuring that the assets within their area of responsibility are included within the appropriate asset register (see Section 7);

  b. ensuring that asset records/registers are kept up-to-date;

  c. performing verification exercises to confirm the existence and condition of the assets, and the completeness of the appropriate asset register; and

  d. following any prescribed procedures to notify the organisation of any theft, loss or damage to assets.

- Avoiding loss;

- Securing Best Value in the use of resources; and

- Following these SFIs and any other policy or procedure that the Board may approve.

2.16 All budget holders shall ensure that:-

- Information is provided to the Director of Finance to enable budgets to be compiled;

- Budgets are only used for their stated purpose; and

- Budgets are never exceeded.

2.17 When a budget holder expects his expenditure will exceed his/her delegated budget, they must secure an increased budget, or seek explicit approval to overspend before doing so.

2.18 All NHS staff who commit NHS resources directly or indirectly must be impartial and honest in their conduct of business and all employees must remain beyond suspicion.

2.19 All employees shall observe the requirements of MEL (1994) 48, which sets out the Code of Conduct for all NHS staff. There are 3 crucial public service values which underpin the work of the health service:-

Conduct
There should be an absolute standard of honesty and integrity which should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers; in the use of information acquired in the course of NHS duties; in dealing with the assets of the NHS.

Accountability
Everything done by those who work in the NHS must be able to stand the test of parliamentary and public scrutiny, judgements on propriety and professional codes of conduct.

Openness
The Board should be open about its activities and plans so as to promote confidence between the component parts of NHS Fife, other health organisations and its staff, patients and the public.

2.20 All employees shall:-

- Ensure that the interest of patients remain paramount at all times;
- Be impartial and honest in the conduct of their official business;
- Use the public funds entrusted to them to the best advantage of the service, always ensuring value for money; and
- Demonstrate appropriate ethical standards of personal conduct.

2.21 Furthermore all employees shall not:-

- Abuse their official position for the personal gain or to the benefit of their family or friends;
- Undertake outside employment that could compromise their NHS duties; and
- Seek to advantage or further their private business or interest in the course of their official duties.

2.22 The Director of Finance shall publish supplementary guidance and procedures in the form of Financial Operating Procedures to ensure that the above principles are understood and applied in practice.

2.23 The Chief Executive shall establish procedures for voicing complaints or concerns about misadministration, breaches of the standards of conduct, suspicions of criminal behaviour (e.g. theft, fraud, bribery) and other concerns of an ethical nature.

2.24 All employees must protect themselves and the Board from any allegations of impropriety by seeking advice from their line manager, or from the appropriate contact point, whenever there is any doubt as to the interpretation of these standards.

3. AUDIT

Audit and Risk Committee

3.1 In accordance with Standing Orders the Board shall formally establish an Audit and Risk Committee, with clearly defined terms of reference.

3.2 Where the Audit and Risk Committee feels there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the Chairperson of the Audit and Risk Committee should raise the matter at a full meeting of the Board. In considering whether to do so, the Committee must be mindful of the arrangements with NHS Counter Fraud Services (CFS) and the role of the Fraud Liaison Officer (FLO). Exceptionally, the matter may need to be referred to the Scottish Government Health & Social Care Directorates (SGHSCD).

3.3 It is the responsibility of the Audit and Risk Committee to ensure an effective internal audit service is provided and this will be largely influenced by the professional judgement of the Director of Finance.

Director of Finance

3.4 The Director of Finance is responsible for:

a. Ensuring there are arrangements to measure, evaluate and report on the effectiveness of internal control and efficient use of resources, including the establishment of a professional internal audit function headed by a Chief Internal Auditor;

b. Ensuring that Internal Audit is adequate and meets the mandatory NHS internal audit standards;

c. Taking appropriate steps, in line with SGHSCD guidance, to involve CFS and/or the Police in cases of actual or suspected fraud, misappropriation, and other irregularities;

d. Ensuring that the Chief Internal Auditor prepares the following risk based plans for approval by the Audit and Risk Committee:

- Strategic audit plan covering the coming four years,
- A detailed annual plan for the coming year.

e. Ensuring that an annual internal audit report is prepared by the Chief Internal Auditor, in accordance with the timetable laid down by the Audit and Risk Committee, for the consideration of the Audit and Risk Committee and the Board.

The report should include:

- A clear statement on the adequacy and effectiveness of internal control;

- Main internal control issues and audit findings during the year;
- Extent of audit cover achieved against the plan for the year.

f. Progress on the implementation of internal audit recommendations including submission to the Audit and Risk Committee.

3.5 The Director of Finance shall refer audit reports to the appropriate officers designated by the Chief Executive and failure to take any necessary remedial action within a reasonable period shall be reported to the Chief Executive.

Internal Audit

3.6 Internal Audit shall adopt the Public Sector Internal Audit Standards (PSIAS), which are mandatory and which define internal audit as "an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes."

Minor deviations from the PSIAS should be reported to the Audit and Risk Committee. More significant deviations should be considered for inclusion in the Annual Governance Statement.

3.7 Internal Audit activity must evaluate and contribute to the improvement of governance, risk management and control processes using a systematic and disciplined approach. Internal Audit activity and scope is fully defined within the Audit plan, approved by the Audit & Risk Committee.

3.8 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance, as the FLO (unless delegated to another senior officer), must be notified immediately, and before any detailed investigation is undertaken.

3.9 The Chief Internal Auditor (or Counter Fraud Services staff, acting on the Director of Finance's behalf on any matters related to the investigation of fraud) is entitled without necessarily giving prior notice to require and receive:

(a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature (in which case he shall have a duty to safeguard that confidentiality), within the confines of the data protection act.

(b) Access at all reasonable times to any land, premises or employees of the Board;

(c) The production or identification by any employee of any cash, stores or other property of the Board under an employee's control; and

(d) Explanations concerning any matter under investigation.

3.10 The Chief Internal Auditor, or appointed representative, will normally attend Audit and Risk Committee meetings; and has a right of access to all Audit Committee members, the Chairperson and Chief Executive of the Board.

3.11 The Chief Internal Auditor shall be accountable to the Director of Finance. The reporting and follow-up systems for internal audit shall be agreed between the Director of Finance, the Audit and Risk Committee and Chief Internal Auditor. The agreement shall comply with the guidance on reporting contained in Government Internal Audit Standards.

External Audit

3.12 The External Auditor is concerned with providing an independent assurance of the Board's financial stewardship including value for money, probity, material accuracy, compliance with guidelines and accepted accounting practice for NHS accounts. Responsibility for securing the audit of the Board rests with Audit Scotland. The appointed External Auditor's statutory duties are contained in the Public Finance and Accountability (Scotland) Act 2000 which supersedes the Local Government (Scotland) Act 1973 (Part VII) as amended by the National Health Services and Community Care Act 1990.

3.13 The appointed auditor has a general duty to satisfy him/herself that:

(a) The Board's accounts have been properly prepared in accordance with the Direction of the Scottish Ministers to comply with the accounting principles and disclosure requirements of the edition of the Government Financial Reporting Manual (FReM) which is in force for the year for which the statement of accounts are prepared;

(b) Proper accounting practices have been observed in the preparation of the accounts;

(c) The Board has made proper arrangements for securing economy, efficiency and effectiveness in the use of its resources.

3.14 In addition to these responsibilities, Audit Scotland's Code of Audit Practice requires the appointed auditor to consider:

(a) Whether the statement of accounts presents a true and fair~~ly the~~ financial position of the Board;

(b) The Board's main financial systems;

(c) The arrangements in place at the Board for the prevention and detection of fraud and corruption;

(d) Aspects of the performance of particular services and activities;

(e) The Board's management arrangements to secure economy, efficiency and effectiveness in the use of resources.

3.15 The Board's Audit and Risk Committee provides a forum through which Non-Executive Members can secure an independent view of any major activity within the appointed auditor's remit. The Audit and Risk Committee has a responsibility to ensure that the Board receives a cost-effective audit service and that co-operation with Board senior managers and Internal Audit is appropriate.

3.16 The External Auditor, or appointed representative, will normally attend Audit and Risk Committee meetings; and has a right of access to all Audit and Risk Committee members, the Chairperson and Chief Executive of the Board.

4. FINANCIAL MANAGEMENT

This section applies to both revenue and capital budgets.

Planning

4.1 The Scottish Government has set the following financial targets for all boards:-

- To operate within the revenue resource limit.
- To operate within the capital resource limit.
- To operate within the cash requirement.

4.2 The Chief Executive shall produce an Annual Operational Plan. The Chief Executive shall submit a Plan for approval by the Board that takes into account financial targets and forecast limits of available resources. The Annual Operational Plan shall contain:-

- a statement of the significant assumptions within the Plan; and
- details of major changes in workload, delivery of services or resources required to achieve the plan.

4.3 Before the financial year begins, the Director of Finance shall prepare and present a financial plan to the Board. The report shall:-

- show the total allocations received from the Scottish Government and their proposed uses, including any sums to be held in reserve;
- be consistent with the Annual Operational Plan;
- be consistent with the Board's financial targets;
- identify potential risks;

- identify funding and expenditure that is of a recurring nature; and

- identify funding and expenditure that is of a non-recurring nature.

4.4 The Health Board shall approve the financial plan for the forthcoming financial year.

4.5 The Director of Finance shall continuously review the financial plan, to ensure that it meets the Board's requirements and the delivery of financial targets.

4.6 The Director of Finance shall regularly update the Board on significant changes to the allocations and their uses.

4.7 The Director of Finance shall keep the Chief Executive and the Board informed of the financial consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

4.8 The Director of Finance shall establish the systems for identifying and approving how the Board's capital allocation will be used, consisting of proposals for individual schemes, major equipment, IT developments, backlog maintenance, statutory compliance works and minor scheme provision. The approval of business cases shall be as described in the Scheme of Delegation.

4.9 The Director of Finance shall release capital funds allowing for project start dates and phasing.

Budgetary Control

4.10 The Board shall approve the opening budgets for each financial year on an annual basis.

4.11 The Chief Executive shall delegate the responsibility for budgetary control to designated budget holders. The Scheme of Delegation sets out the delegated authorities to take decisions and approve expenditure for certain posts.

4.12 Employees shall only act on their delegated authority when there is an approved budget in place to fund the decisions they make.

4.13 Delegation of budgetary responsibility shall be in writing and be accompanied by a clear definition of:-

- the amount of the budget;

- the purpose(s) of each budget heading;

- what is expected to be delivered with the budget in terms of organisational performance; and

- how the budget holder will report and account for his or her budgetary performance.

4.14 The Chief Executive may agree a virement procedure that would allow budget holders to transfer resources from one budget heading to another. The Board shall set the virement limits for the Chief Executive and the Chief Executive shall ensure these are not exceeded

4.15 If the budget holder does not require the full amount of the budget delegated to him for the stated purpose (s), and virement is not exercised, then the amount not required shall revert back to the Chief Executive.

4.16 The Director of Finance shall devise and maintain systems of budgetary control. These will include:-

- monthly financial reports to the Board in a form approved by the Board containing:-

  a. net expenditure of the Board for the financial year to date; and

  b. a forecast of the Board's expected net expenditure for the remainder of the year on a monthly basis from (at the latest) the month 6 position onwards.

  c. capital project spend and projected outturn against plan;

  d. explanations of any material variances from plan and/or emerging trends;

  e. details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

- the issue of timely, accurate and comprehensible advice and financial reports to each holder of a budget, including those responsible for capital schemes, covering the areas for which they are responsible;

- investigation and reporting of variances from agreed budgets;

- monitoring of management action to correct variances and/or emerging adverse trends; and

- ensuring that adequate training is delivered on an on-going basis to budget holders.

Monitoring

4.17 The Director of Finance shall provide monthly reports in the form requested by the Cabinet Secretary showing the charge against the Board's resource limits on the last day of each month.

5. ANNUAL ACCOUNTS AND REPORTS

5.1 The Director of Finance, on behalf of the Board, shall prepare, certify and submit audited Annual Accounts to the SGHSCD in respect of each financial year in such a form as the SGHSCD may direct.

5.2 The Director of Finance will ensure that the Annual Accounts and financial returns are prepared in accordance with the guidance issued in the Government Financial Reporting Manual (FReM), detailing the accounts and returns to be prepared, the accounting standards to be adopted and the timetable for submission to the SGHSCD.

5.3 The Audit and Risk Committee will ensure that the Annual Accounts are reviewed and submitted to the Board for formal approval and the Chief Executive will ensure that they are recorded as having been so presented. The Annual Accounts will be subject to statutory audit by the external auditor appointed by Audit Scotland.

5.4 The Director of Finance shall prepare a Financial Statement for inclusion in the Board's Annual Report, in accordance with relevant guidelines, for submission to Board members and others who need to be aware of the Board's financial performance.

5.5 The Board shall publish an Annual Report, in accordance with the Scottish Government's guidelines on local accountability requirements.

6. BANKING AND CASH HANDLING

6.1 The Director of Finance shall manage the Board's banking arrangements and advise the Board on the provision of banking services and operation of accounts. This advice shall take into account guidance/Directions issued from time to time by the Scottish Government.

6.2 The Director of Finance shall ensure that the banking arrangements operate in accordance with the Scottish Government banking contract and Government Banking Service (GBS) and the Scottish Public Finance Manual.

6.3 The Board shall approve the banking arrangements. No employee may open a bank account for the Board's activities or in the Board's name, unless the Board has given explicit approval.

6.4 The Director of Finance shall:-

- Establish separate bank accounts for non-exchequer funds;
- Establish a separate bank account for all capital building projects where the budget is over £2m. This account will be used solely to process payments to Preferred Supply Chain Partners (PSCP);

- Ensure payments made from bank or GBS accounts do not exceed the amount credited to the account, except where arrangements have been made;

- Ensure money drawn from the Scottish Government against the Cash Requirement is required for approved expenditure only, and is drawn down only at the time of need;

- Promptly bank all monies received intact. Expenditure shall not be made from cash received that has not been banked, except under exceptional arrangements approved by the Director of Finance; and

- Report to the Board all arrangements made with the Board's bankers for accounts to be overdrawn.

6.5 The Director of Finance shall prepare detailed instructions on the operation of bank and GBS accounts, which must include:-

- The conditions under which each bank and GBS account is to be operated;

- Ensuring that the GBS account is used as the principal banker and that the amount of cleared funds held at any time within exchequer commercial bank accounts is limited to a maximum of £50,000 (of cleared funds). The bank account for capital building projects will only hold funds transferred from the GBS principal account to the value of the certified payment due at that time;

- The limit to be applied to any overdraft;

- Those authorised to sign cheques or other orders drawn on the Board's accounts; and

- The required controls for any system of electronic payment.

6.6 The Director of Finance shall:-

- Approve the stationery for officially acknowledging or recording monies received or receivable, and keep this secure;

- Provide adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

- Approve procedures for handling cash and negotiable securities on behalf of the Board.

6.7 Money in the custody of the Board shall not under any circumstances be used for the encashment of private cheques.

6.8 The holders of safe keys shall not accept unofficial funds for depositing in their safes other than in exceptional circumstances. Such deposits must be in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Board is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Board from responsibility for any loss.

7. SECURITY OF ASSETS

7.1 Overall responsibility for the security of the Board's assets rests with the Board's Chief Executive. All members and employees have a responsibility for the security of property of the Board and it shall be an added responsibility of senior staff in all disciplines to apply appropriate routine security practices in relation to NHS property. Any significant breach of agreed security practice should be reported to the Chief Executive.

7.2 Wherever practicable, items of equipment shall be marked as property of Fife NHS Board.

7.3 The Chief Executive shall define the items of equipment to be controlled, and officers designated by the Chief Executive shall maintain an up-to-date register of those items. This shall include separate records for equipment on loan from suppliers, and lease agreements in respect of assets held under a finance lease and capitalised.

7.4 The Director of Finance shall approve the form of register and the method of updating which shall incorporate all requirements extant for capital assets.

7.5 Additions to the fixed asset register must be added to the records based on the documented cost of the asset at the time of acquisition.

7.6 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorised documentation.

7.7 The value of each asset where applicable shall be indexed to current values and depreciated using methods and rates as suggested in the Capital Accounting Manual and notified by the SGHSCD.

7.8 Revaluation of land and buildings will be provided by the Board's recommended Valuation Agent on a rolling annual programme designed to ensure that all such assets are revalued once every five years. Some assets can be revalued more than once in the five years if there has been material work done to the asset.

7.9 Annual indexation for land and buildings not included in the revaluation exercise in any given year will be provided by the Board's recommended Valuation Agent.

7.10 Any damage to the Board's premises, vehicles and equipment, or any loss of equipment or supplies shall be reported by staff in accordance with the procedure for reporting losses.

8. PAY

Remuneration Committee

8.1 The Board shall approve the terms of reference for the Remuneration Committee, in line with any extant guidance or requirements.

8.2 The Board shall remunerate the Chair and other Non-Executive directors in accordance with instructions issued by Scottish Government

Processes

8.3 The Chief Executive shall establish a system of delegated budgetary authority within which budget holders shall be responsible for the engagement of staff within the limits of their approved budget.

8.4 All time-records, payroll timesheets and other pay records and notifications shall be in a form approved by the Director of Finance and shall be authorised and submitted in accordance with his/her instructions. This also includes the payment of expenses and additions to pay whether via e-Expenses, SSTS or other arrangements, including manual systems.

8.5 The Director of Finance shall be responsible for ensuring that rates of pay and relevant conditions are applied in accordance with current agreements. The Chief Executive, or the Board in appropriate circumstances, shall be responsible for the final determination of pay. There will be no variation to agreed terms and conditions without the prior approval of the Director of Human Resources and Director of Finance. The Director of Finance shall determine the dates on which the payment of salary and wages are to be made. These may vary due to special circumstances (e.g. Christmas and other Public Holidays). Payments to an individual shall not be made in advance of normal pay, except:

a. To cover a period of authorised leave, involving absence on the normal pay day; or

b. As authorised by the Chief Executive and Director of Finance to meet special circumstances, and limited to the net pay due at the time of payment.

8.6 Wherever possible, officers should not compile their own payroll input. Where it is unavoidable that the compiler of the payroll input is included on that input, then the entry in respect of the compiler must be supported by evidence that it has been checked and found to be appropriate by another officer holding a higher position.

8.7 Under no circumstance should officers authorise/approve their own payroll input or expenses.

8.8 All employees shall be paid by bank credit transfer unless otherwise agreed by the Director of Finance.

8.9 The Board shall delegate responsibility to the Director of Workforce for ensuring that all employees are issued with a contract of employment in a form approved by the Board and which complies with employment legislation and any extant NHS policies.

9. NON PAY

Tendering, Contracting and Purchasing Procedures

9.1 The Director of Finance shall prepare detailed procedural instructions on the obtaining of goods, services and works, incorporating thresholds set by the Board. The current Authorisation Limits are set out in Scheme of Delegation and the Financial Operating Procedures.

9.2 The Chief Executive shall designate a senior officer as the lead senior officer for procurement, and this person shall oversee the procurement of goods and services, to ensure there is an adequate approval of suppliers and their supplies based on cost and quality.

9.3 NSS National Procurement shall undertake procurement activity on a national basis on behalf of boards (including NHS Fife), and the Board shall implement these nationally negotiated contracts where possible.

9.4 The Board shall operate within the processes established for the procurement of publicly funded construction work.

9.5 The Board shall comply with Public Contracts (Scotland) Regulations 2012 (and any subsequent relevant legislation) for any procurement it undertakes directly.

9.6 The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

9.7 All other aspects of procurement activity must follow the requirements of the Standing Orders and SFIs. Any decision to depart from the requirements of this section must have the approval of NHS Fife Board.

9.8 The Director of Finance shall:-

- Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained in accordance with the Public Contracts (Scotland) Regulations, as issued annually through Scottish Statutory Instrument.

- Ensure the preparation of comprehensive procedures for all aspects of procurement activity.

9.9 The following basic principles shall be generally applied:-

- Procurement activity satisfies all legal requirements;
- Adequate contracts are in place with approved suppliers for the supply of approved products and services;
- Segregation of duties is applied throughout the process;
- Adequate approval mechanisms are in place before orders are raised;
- All deliveries are checked for completeness and accuracy, and confirmed before approval to pay is made; and
- All payments made are in accordance with previously agreed terms, and what the Board has actually received.

9.10 Limits of Authorisation of Orders

(a) Up to £100,000

- All Corporate Directors, Director of Acute Services and the Director of Health & Social Care can on their own authority commit expenditure up to £100,000 provided this is within the budgets for which they have responsibility.
- All other orders with a value up to £100,000 are subject to a scheme of delegation to Designated Ordering Officers with assigned limits. This scheme is detailed in the Financial Operating Procedures

(b) £100,000 to £1,000,000

All orders between £100,000 and £1,000,000 submitted by any authorised officer must be countersigned by the Board Chief Executive, Director of Acute Services, Director of Health & Social Care (or a designated deputy for them), or Director of Finance.

(c) Above £1,000,000 and less than £2,000,000

All orders above £1,000,000 and less than £2,000,000 must be authorised by the Board Chief Executive and the Director of Finance, subject to the expenditure having been approved by the Board as part of a capital or revenue plan.

(d) The placing of annual orders and the acceptance of all annual contracts over £2,000,000 and less than £5,000,000, whether capital or revenue, is reserved to the Board and must be authorised by the Board Chief Executive and Director of Finance. If above £5,000,000 then prior approval needs to be sought from the Scottish Government.

9.11 For all orders raised between £2,500 and £10,000 there is a requirement for the ordering officer to obtain two written quotations. Orders over £10,000 and up to £25,000 should ensure 3 tendered quotes are received subject to the Board's tendering procedures.

In the following exceptional circumstances, except in cases where Public Sector Procurement Regulations must be adhered to~~except in cases where EU Directives must be adhered to~~, the Director of Finance and Chief Executive, as specified in the Scheme of Delegation, can approve the waiving of the above requirements. Where goods and services are supplied on this basis and the value exceeds £2,500, a "Waiver of Competitive Tender/Quotation" may be granted by completing a Single Source Justification form for approval by the appropriate director and the Head of Procurement. Where the purchase of equipment is valued in excess of £5,000 and where the purchase of other goods and services on this basis exceeds £10,000, the completed Single Source Justification Form shall be endorsed by the Director of Finance and Chief Executive and submitted to the Audit and Risk Committee.

At least one of the following conditions must be outlined in the Single Source Justification Form:

1. where the repair of a particular item of equipment can only be carried out by the manufacturer;
2. where the supply is for goods or services of a special nature or character in respect of which it is not possible or desirable to obtain competitive quotations or tenders;
3. a contractors special knowledge is required;
4. where the number of potential suppliers is limited, and it is not possible to invite the required number of quotations or tenders, or where the required number do not respond to an invitation to tender or quotation to comply with these SFIs;
5. where, on the grounds of urgency, or in an emergency, it is necessary that an essential service is maintained or where a delay in carrying out repairs would result in further expense to NHS Fife.

In the case of 1, 2, 3, and 4 above, the Single Source Justification~~Waiver of Competitive Tender/Quotation~~ Form must be completed in advance of the order being placed, but may be completed retrospectively in the case of 5.

The Head of Procurement will maintain a record of all such exceptions.

Where additional works, services or supplies have become necessary and a change of supplier/contractor would not be practicable (for economic, technical or interoperability reasons) or would involve substantial inconvenience and/or duplication of cost, an existing contractor may be asked to undertake additional works providing the additional works do not exceed 50% of the original contract value and are provided at a value for money cost which should normally be at an equivalent or improved rate to the original contract.

When goods or services are being procured for which quotations or tenders are not required and for which no contract exists, it will be necessary to demonstrate that value for money is being obtained. Written notes/documentation to support the case, signed by the responsible Budget Holder, must be retained for audit inspection.

Further detail on the ordering of goods and services and relevant documentation are set out in the Financial Operating Procedures.

The use of supplies within the Office of Government (OGC) framework agreements may negate the need for three competitive tenders. The use of this route must always be recorded. In all instances, Public Sector Procurement Regulations must be followed~~In all instances, the regulations in respect of Official Journal of the European Union (OJEU) must be followed~~.

9.12 No order shall be issued for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive from the overall financial resources available to the Board.

9.13 Orders shall not be placed in a manner devised to avoid the financial thresholds specified by the Board within the Scheme of Delegation.

9.14 All procurement on behalf of the Board must be made on an official order on the e-Procurement system (PECOS).

9.15 The Board shall not make payments in advance of need. However payment in advance of the receipt of goods or services is permitted in accordance with the SPFM and where approved by the lead senior officer for procurement who shall be a member of the Finance Directorate Senior Team. Examples of such instances are:-

- Items such as conferences, courses and travel, foreign currency transactions, where payment is to be made at the time of booking.
- Where payment in advance of complete delivery is a legal or contractual requirement, e.g. maintenance contracts, utilities, rates.
- Where payment in advance is necessary to support the provision of services/delivery of a project by external providers (e.g. grants to local authorities or voluntary bodies.)

9.16 Purchases from petty cash shall be undertaken in accordance with procedures stipulated by the Director of Finance in the Financial Operating Procedures.

Commissioning of Patient Services

9.17 The Director of Finance, jointly with the Director of Acute Services or Director of Health & Social Care will ensure service agreements are in place with other healthcare providers for the delivery of patient services, ensuring the appropriate financial details are contained and clarity on reporting of performance, quality and safety issues.

9.18 The Director of Finance shall be responsible for maintaining a system for the payment of invoices in respect of patient services in accordance with agreed terms and national guidance and shall ensure that adequate financial systems are in place to monitor and control these.

Payment of Accounts and Expense Claims

9.19 The Director of Finance shall be responsible for the prompt payment of all accounts and expense claims. The Director of Finance shall publish the Board's performance in achieving the prompt payment targets in accordance with specified terms and national guidance.

9.20 The Director of Finance shall be responsible for designing and maintaining a system for the verification, recording and payment of all amounts payable by the Board. The system shall provide for authorisation by agreed delegated officers, a timetable and system for the payment of accounts and instruction to staff regarding handling, checking and payment of accounts and claims.

9.21 The Director of Finance shall ensure that payments for goods and services are made only after goods and services are received. Prepayments will be permitted in exceptional circumstances and with the prior approval of the Director of Finance

Additional Matters for Capital Expenditure

Overall Arrangements for the Approval of the Capital Plan

9.22 The Board shall follow any extant national instructions on the approval of capital expenditure, such as the Scottish Capital Investment Manual. The authorisation process shall be described in the Scheme of Delegation.

9.23 The Chief Executive shall ensure that:-

- there is an adequate appraisal and approval process in place for determining capital expenditure priorities within the Property Strategy and the effect of each proposal upon business plans;
- all stages of capital schemes are managed, and are delivered on time and to cost;
- capital investment is not undertaken without confirmation that the necessary capital funding and approvals are in place; and
- all revenue consequences from the scheme, including capital charges, are recognised, and the source of funding is identified in financial plans.

Implementing the Capital Programme

9.24 For every major capital expenditure proposal the Chief Executive shall ensure:-

- that a business case as required by the Scottish Capital Investment Manual (SCIM) is produced setting out:-
    a. an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and

b. appropriate project management and control arrangements; and

- that the Director of Finance has assessed the costs and revenue consequences detailed in the business case.

9.25 The approval of a business case and inclusion in the Board's capital plan shall not constitute approval of the individual elements of expenditure on any scheme. The Chief Executive shall issue to the manager responsible for any scheme:-

- specific authority to commit expenditure; and
- following the required approval of the business case, authority to proceed to tender.

9.26 The Scheme of Delegation shall stipulate where delegated authority lies for:-

- approval to accept a successful tender; and
- where Frameworks Scotland applies, authority to agree risks and timelines associated with a project in order to arrive at a target price.

9.27 The Director of Finance shall issue procedures governing the financial management of capital investment projects (e.g. including variations to contract, application of Frameworks Scotland) and valuation for accounting purposes.

Public Private Partnerships and other Non-Exchequer Funding

9.28 When the Board proposes to use finance which is to be provided other than through its capital allocations, the following procedures shall apply:-

- The Director of Finance shall demonstrate that the use of public private partnerships represents value for money and genuinely transfers significant risk to the private sector.
- Where the sum involved exceeds the Board's delegated limits, the business case must be referred to the Scottish Government for approval or treated as per current guidelines.
- Board must specifically agree the proposal.
- The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

Disposals of Assets

9.29 The Director of Finance shall issue procedures for the disposal of assets including condemnations. All disposals shall be in accordance with MEL(1996)7: Sale of surplus and obsolete goods and equipment.

9.30 There is a requirement to achieve Best Value for money when disposing of assets belonging to the Health Board. A competitive process should normally be undertaken.

9.31 When it is decided to dispose of a Health Board asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

9.32 All unserviceable articles shall be:-

- Condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance.

- Recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

Capital Accounting

9.33 The Director of Finance shall be notified when capital assets are sold, scrapped, lost or otherwise disposed of, and what the disposal proceeds were. The value of the assets shall be removed from the accounting records. Each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

9.34 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

9.35 The value of each asset shall be indexed and depreciated in accordance with methods specified by the Capital Accounting Manual.

9.36 The Director of Finance shall calculate capital charges, which will be charged against the Board's revenue resource limit.

10. PRIMARY CARE CONTRACTORS

10.1 In these SFIs and all other Board documentation, Primary Care contractor means:-

- an independent provider of healthcare who is registered to provide general dental, medical, ophthalmic or pharmaceutical services under the National Health Service in the United Kingdom (UK); or

- an employee of an National Health Service organisation in the UK who is registered to provide general dental, medical, ophthalmic or pharmaceutical services under the National Health Service in the UK.

10.2 The Primary Care Manager shall devise and implement systems to control the registers of those who are entitled to provide general dental, medical, ophthalmic or pharmaceutical services under the National Health Service in Fife. Systems shall include criteria for entry to and deletions from the registers.

10.3 The Director of Finance shall agree the Service Level Agreement (s) with NHS National Services Scotland for:-

- the development, documentation and maintenance of systems for the verification, recording and receipt of NHS income collected by or on behalf of primary care contractors; and

- the development, documentation and maintenance of systems for the verification, recording and payment of NHS expenditure incurred by or on behalf of primary care contractors.

10.4 The agreements at paragraph F10.3 shall comply with guidance issued from time to time by the Scottish Government. In particular they shall take account of any national systems for the processing of income and expenditure associated with primary care contractors.

10.5 The Director of Finance shall ensure that all transactions conducted for or on behalf of primary care contractors by the Board shall be subject to these SFIs.

11. INCOME AND SCOTTISH GOVERNMENT ALLOCATIONS

11.1 The Director of Finance shall be responsible for designing and maintaining systems for the proper recording and collection of all monies due.

11.2 The Director of Finance shall take appropriate recovery action on all outstanding debts and shall establish procedures for the write-off of debts after all reasonable steps have been taken to secure payment.

11.3 The Director of Finance is responsible for ensuring the prompt banking of all monies received.

11.4 In relation to business development/income generation schemes, the Director of Finance shall ensure that there are systems in place to identify and control all costs and revenues attributed to each scheme.

11.5 The Director of Finance shall approve all fees and charges other than those determined by the Scottish Government or by Statute.

11.6 Scottish Government letters that change funding allocations must be signed by two members of the Finance Directorate Senior Team to evidence their review of the aggregate allocation received.

12. FINANCIAL MANAGEMENT SYSTEM

12.1 The Director of Finance shall have~~carry prime~~ responsibility for the accuracy and security of the computerised financial data of the Board and shall devise

and implement any necessary procedures to protect the Board and individuals from inappropriate use or misuse of any financial and other information held on computer files for which he is responsible, after taking account of all relevant legislation and guidance

12.2 The Director of Finance shall ensure that contracts for computer services for financial applications with another Board or any other agency shall clearly define the responsibility of all the parties for the security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage.

12.3 The Director of Finance shall ensure that adequate data controls exist to provide for security of financial applications during data processing, including the use of any external agency arrangements.

12.4 The Director of Finance shall satisfy her/himself that such computer audit checks as s/he may consider necessary are being carried out.

12.5 The Director of Finance shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and are thoroughly tested prior to implementation.

12.6 Where another health organisation or any other agency provides a financial system service to the Board, the Director of Finance shall periodically seek assurances, through Audit where appropriate, that adequate controls are in operation and that disaster recovery arrangements are robust.

13. CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

13.1 Any employee or agent discovering or suspecting a loss of any kind shall forthwith inform his head of department, who shall immediately inform the Chief Executive and the Director of Finance. Where a criminal offence is suspected, the Director of Finance shall follow the Anti-Theft, Fraud, and Corruption Policy, as set out in the Financial Operating Procedures.

13.2 The Director of Finance shall notify the Audit and Risk Committee and Counter Fraud Services of all actual or suspected frauds. See 13.10 below.

13.3 In all instances where there is any suspicion of fraud then the guidance contained within NHS Circular, HDL (2005) 5: “Tackling Fraud in Scotland – Joint Action Programme. Financial Control : Procedures where criminal offences are suspected” must be followed. The Board’s Fraud Liaison Officer (FLO) must be notified immediately of all cases of fraud or suspected fraud.

13.4 The Director of Finance shall issue procedures on the recording of and accounting for Losses and special payments to meet the requirements of the Scottish Public Finance Manual. These procedures shall include the steps to be taken where the loss may have been caused by a criminal act.

13.5 The Scheme of Delegation shall describe the process for the approval of the write-off of losses and making of special payments

13.6 The Director of Finance shall maintain a Losses and Special Payments Register in which details of all losses shall be recorded as they are known~~Category 1 and Category 2 losses shall be recorded as they are known. Category 3 losses may be recorded in summary form~~. Write-off action shall be recorded against each entry in the Register.

13.7 No special payments exceeding the delegated limits shall be made without prior approval by the SGHSCD.

13.8 The Director of Finance shall be authorised to take any necessary steps to safeguard the Board's interest in bankruptcies and company liquidations.

13.9 The Director of Finance is required to produce a report on Condemnations, Losses and Special Payments, where the delegated limits have been exceeded and SGHSCD approval has been requested, to the Audit and Risk Committee.

13.10 The Bribery Act came into force in 2010; it aims to tackle bribery and corruption in both the private and public sectors. The Act is fully endorsed by Fife NHS Board. NHS Fife conducts its contracting and procurement practices with integrity, transparency and fairness and has a zero tolerance policy on bribery or any kind of fraud. There are robust controls in place to help deter, detect and deal with it. These controls are regularly reviewed in line with the Standing Financial Instructions and feedback is provided to the Audit & Risk Committee. Procurement actively engage with NHS Scotland Counter Fraud Services to ensure that our team is fully trained on spotting potential signs of fraud and knowing how to report suspected fraud. Anys ~~an~~ existing or potential contractor to NHS Fife is ~~, you are~~ required to understand that it may be a criminal offence under the Bribery Act 2010, punishable by imprisonment, to promise, give or offer any gift, consideration, financial or other advantage whatsoever as an inducement or reward to any officer of a public body and that such action may result in the Board excluding the organisation from the selected list of Potential Bidders, and potentially from all future public procurements. It is therefore vital that staff, contractors and agents understand what is expected of them and their duties to disclose and deal with any instances they find.

14. RISK MANAGEMENT

14.1 The Chief Executive shall ensure that the Board has a programme of risk management, which will be approved and monitored by the Board and which complies with the Standards issued by NHS Health Improvement Scotland.

14.2 The programme of risk management shall include:

a. A process for identifying and quantifying risks and potential liabilities, including the establishment and maintenance of a Risk Register;

b. Engendering among all levels of staff a positive attitude towards the control of risk;

c. Management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover and decisions on the acceptable level of retained risk;

d. Contingency plans to offset the impact of adverse events;

e. Audit arrangements including internal audit, clinical audit and health and safety review;

f. Arrangements to review the risk management programme.

g. A review by each Governance Committee of relevant risks pertaining to their business.

The existence, integration and evaluation of the above elements will provide a basis for the Audit and Risk Committee to make a statement on the overall effectiveness of Internal Control and Corporate Governance to the Board.

14.3 The programme of risk management will be underpinned by a Board Assurance Framework, approved, and reviewed annually by the NHS Board.

15. RETENTION OF DOCUMENTS

15.1 The Chief Executive shall be responsible for maintaining archives for all documents in accordance with the NHS Code of Practice on Records Management.

15.2 The documents held in archives shall be capable of retrieval by authorised persons.

15.3 Documents held under the Code shall only be destroyed at the express instigation of the Chief Executive, and records shall be maintained of documents so destroyed.

16. PATIENTS' PROPERTY AND FUNDS

16.1 The Board has a responsibility to provide safe custody, for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

16.2 The Chief Executive shall be responsible for ensuring that patients or their guardians, as appropriate, are informed before, or at their admission, by: -

- Notices and information booklets
- Hospitals' admission documentation and property records, and
- The oral advice of administrative and nursing staff responsible for admissions, that the Board will not accept responsibility or liability for patients' monies and personal property brought into Board premises unless it is handed in for safe custody and a copy of an official patient property record is obtained as a receipt.

16.3 The Director of Finance shall provide detailed written instructions on the collection, custody, investment, recording, safekeeping and disposal of patients'

property (including instructions on the disposal of the property of deceased patients and patients transferred to other premises), for all staff whose duty it is to administer, in any way, the property of the patients.

16.4 Bank accounts for patients' monies shall be operated under arrangements agreed by the Director of Finance.

16.5 A patients' property record, in a form determined by the Director of Finance, shall be completed.

16.6 The Director of Finance is responsible for providing detailed instructions on the Board's responsibility as per the Adults with Incapacity (Scotland) Act 2000 and the updated Part 5 in CEL11(2008) Code of Practice. These instructions are contained within the Financial Operating Procedures.

16.7 The Director of Finance shall prepare an abstract of receipts and payments of patients private funds in the form laid down by Scottish Government.

17. STORES

17.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use), should be:-

- Kept to a minimum;
- Subject to annual stocktake; and
- Valued at the lower of cost and net realisable value.

17.2 Subject to the responsibility of the Director of Finance for the systems of control, the control of stores throughout the organisation shall be the responsibility of the relevant managers. The day-to-day management may be delegated to departmental officers and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance.

17.3 The responsibility for security arrangements, and the custody of keys for all stores locations, shall be clearly defined in writing by the manager responsible for the stores and agreed with the Director of Finance. Wherever practicable, stock items, which do not belong to the Board, shall be clearly identified.

17.4 All stores records shall be in such form and shall comply with such system of control and procedures as the Director of Finance shall approve.

17.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year. The physical check shall involve at least one officer other than the Storekeeper, and the Director of Finance and Internal & External Audit shall be notified and may attend, or be represented, at their discretion. The stocktaking records shall be numerically controlled and signed by the officers undertaking the check. Any surplus or deficiency revealed on stocktaking shall be reported immediately to the Director of Finance, and he may investigate as necessary. Known losses of

stock items not on stores control shall be reported to the Assistant Director of Finance.

17.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

17.7 Instructions for stock take and the basis for valuation will be issued ~~at least once a year~~ by the Director of Finance if required.

18. AUTHORISATION LIMITS

18.1 The purpose of Standing Financial Instructions is to ensure adequate controls exist for the committing and payment of funds on behalf of NHS Fife. The main principles applied in determining authorisation limits are those of devolved accountability and responsibility. The rules for financial delegation to all levels of management within the Board's established policies and priorities are set out in the Scheme of Delegation and Financial Operating Procedures

18.2 Areas covered by the Scheme of Delegation include:

- Limitation and Authority to vire budgets between one budget heading and another.
- Limitation of level of Authority for the placing of orders or committing resources
- Limitation as to the level of authority to approve receipt of orders, expenses, travel claims, payment of invoices, write off of losses.

19. ENDOWMENT FUNDS

19.1 The Standing Financial Instructions deal with matters related to exchequer income and expenditure for NHS Fife. Whilst Endowment Funds fall outwith the scope of core exchequer funds, it is important that all relevant employees and agents are aware of the arrangements for the financial responsibility and authority for such funds.

19.2 Endowment Funds and are those held in trust for purposes relating to the National Health Service, either by the Board or Special Trustees appointed by the Scottish Ministers or by other persons.

19.3 Members of the Fife Health Board become Trustees of the Board's Endowment Funds (Fife Health Charity). The responsibilities as Trustees are discharged separately from the responsibilities as members of the Board.

19.4 The Director of Finance shall prepare detailed procedural instructions covering the receiving, recording, investment and accounting for Endowment Funds.

19.5 Through the Board's Scheme of Delegation, authority will be given by the Trustees to allow for the day to day management of the funds within specified limits.

19.6 The Authorisation Limits are set out in the Scheme of Delegation and the Financial Operating Procedures.

19.7 The Director of Finance shall prepare annual accounts for the funds held in trust, to be audited independently and presented annually to the Board of Ttrustees.

FIFE NHS BOARD
SCHEME OF DELEGATION

1. Introduction

Board's Responsibility

The Standing Orders for the proceedings and Business of the Fife NHS Board include a section on Matters Reserved for the Board (Section 6). This section of the Standing Orders summarises all matters where decision making is reserved to the Board.

The subsequent section (Section 7) within the Standing Orders, identifies that other "matters" may be delegated to Committees or individuals to act on behalf of the Board.

The following appendix sets out:

- Committees' delegated responsibility on behalf of the Board
- Matters delegated to individuals

2. Committees' Delegated Responsibility on behalf of the Board

2.1 Audit & Risk Committee	
Responsible Director for this Section	Director of Finance

Role and Remit	• Supporting the Accountable Officer and Fife NHS Board formulate their assurance needs with regard to risk management, governance and internal control;
	
	• Drawing attention to weaknesses in systems of risk management, governance and internal control;
	
	Internal Control and Corporate Governance
	
	• To evaluate the framework of internal control and corporate governance comprising the following components, as recommended by the Turnbull Report:
	
	  • control environment;
	  • risk management;
	  • information and communication;
	  • control procedures;
	  • monitoring and corrective action.
	
	• To review the system of internal financial control, which includes:
	
	  • the safeguarding of assets against unauthorised use and disposition;
	
	  • the maintenance of proper accounting records and the reliability of financial information used within the organisation or for publication.
	
	• To ensure that the activities of Fife NHS Board are within the law and regulations governing the NHS.
	
	• To review the disclosures included in the Governance Statement on behalf of the Board.
	
	• To present an annual statement of assurance on the above to the Board, to support the NHS Fife Chief Executive's Governance Statement.

	Internal Audit
	
	• To review and approve the Internal Audit Strategic and Annual Plans.
	
	• To monitor audit progress and review audit reports.
	
	• To monitor the management action taken in response to the audit recommendations through an appropriate follow-up mechanism.
	
	• To consider the Chief Internal Auditor's annual report and assurance statement.
	
	• To review the operational effectiveness of Internal Audit by considering the audit standards, resources, staffing, technical competency and performance measures.
	
	External Audit
	
	• To note the appointment of the Statutory Auditor and to approve the appointment and remuneration of the External Auditors for Patients' Funds ~~and Endowment Funds~~.
	
	• To review the Audit Strategy and Plan, including the Best Value and Performance Audits programme.
	
	• To consider all statutory audit material, in particular:-
	
	  • Audit Reports;
	  • Annual Reports;
	  • Management Letters
	
	  relating to the certification of Fife NHS Boards Annual Accounts, Annual Patients' Private Funds Accounts.
	
	Risk Management
	
	The Committee shall seek assurance that**:**
	
	• There is a comprehensive risk management system in place to identify, assess, manage and monitor risks at all levels of the organisation.
	
	• There is appropriate ownership of risk in the organisation, and that there is an effective culture of risk management
	
	• The Board has clearly defined its risk appetite (i.e. the level of risk that the Board is prepared to accept, tolerate, or be exposed to at any time), and that the executive's approach to risk management is consistent with that appetite.

	• The Committee will also receive and review a report summarising any significant changes to the Board's Board Assurance Framework, and what plans are in place to manage them. The Committee may also elect to occasionally request information on significant risks held on any risk registers held in the organisation. • Assess whether the Board Assurance Framework is an appropriate reflection of the key risks to the Board, so as to advise the Board. • Receive an annual report on risk management, confirming whether or not there have been adequate and effective risk management arrangements throughout the year, and highlighting any material areas of risk. **Standing Orders and Standing Financial Instructions** • To review the model Standing Orders for Boards as issued by NHS Scotland, and associated appendices of Fife NHS Board, and advise the Board of any amendments required. • To examine the circumstances associated with any occasion when Standing Orders of Fife NHS Board have been waived or suspended. **Annual Accounts** • To review and recommend approval of draft Fife NHS Board Annual Accounts to the Board. • To review the draft Annual Report and Financial Review of Fife NHS Board as found within the Directors Report incorporated within the Annual Accounts. • To review annually (and approve any changes in) the accounting policies of Fife NHS Board. • To review schedules of losses and compensation payments where the amounts exceed the delegated authority of the Board prior to being referred to the Scottish Government for approval. **Other Matters** • The Committee shall review the arrangements for employees raising concerns, in confidence, about possible wrongdoing in financial reporting or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow-up action.

	• The Committee shall review regular reports on Fraud and potential Frauds and have oversight of the Board's compliance towards the Counter Fraud Standards. • The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements". • The Committee shall seek assurance that the Board has systems of control to ensure that it discharges its responsibilities under the Freedom of Information (Scotland) Act 2002. • The Committee shall review the Board's arrangements to prevent bribery and corruption within its activities. This includes the systems to support Board members' compliance with the NHS Fife Board Code of Conduct (Ethical Standards in Public Life Act 2000), the systems to promote the required standards of business conduct for all employees and the Boards procedure to prevent Bribery (Bribery Act 2000).

2.2 Clinical Governance Committee	
Responsible Director for this Section	Medical Director
Sub-Committees	• Health & Safety
Role and Remit	• To monitor progress on the health status targets set by the Board. • The Committee will produce an Annual Statement of Assurance for submission to the Board, via the Audit & Risk Committee. The proposed Annual Statement will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit and Risk Committee in June. • To capture and record all issues and risks on an operational risk register to be monitored through the Committee, and where appropriate these should be escalated to the Board for consideration in addition to the corporate risk register until mitigated to a tolerable level. • To receive updates on and oversee the progress on the recommendations from relevant external reports of reviews of all healthcare organisations including clinical governance reports and recommendations from relevant regulatory bodies which may include Healthcare Improvement Scotland (HIS) reviews and visits. • To provide assurance to Fife NHS Board about the quality of services within NHS Fife. • The Committee shall review regularly the sections of the NHS Fife Integrated Performance & Quality Report relevant to the Committee's responsibility. • To undertake an annual self-assessment of the Committee's work and effectiveness. • The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

2.3 Finance, Performance and Resources Committee	
Responsible Director for this Section	Director of Finance
Sub-Committees	• Pharmacy Practices • Primary Medical Services
Role and Remit	• The Committee shall have accountability to the Board for ensuring that the financial position of the Board is soundly based, having regard to: • compliance with statutory financial requirements and achievement of financial targets; • such financial monitoring and reporting arrangements as may be specified from time-to-time by SGHSCD and/or the Board; • levels of balances and reserves; • the impact of planned future policies and known or foreseeable future developments on the financial position; • undertake an annual self-assessment of the Committee's work and effectiveness; and • review regularly the sections of the NHS Fife Integrated Performance & Quality Report relevant to the Committee's responsibility. **Arrangements for Securing Value for Money** • The Committee shall keep under review arrangements for securing economy, efficiency and effectiveness in the use of resources. These arrangements will include procedures for (a) planning, appraisal, and control, accountability and evaluation of the use of resources, and for (b) reporting and reviewing performance and managing performance issues as they arise in a timely and effective manner. In particular, the Committee will review action (proposed or underway) to ensure that the Board achieves financial balance in line with statutory requirements. **Allocation and Use of Resources** The Committee has key responsibilities for: • reviewing the development of the Board's Financial Strategy in support of the Annual Operational Plan, and recommending approval to the Board; • reviewing all resource allocation proposals outwith authority delegated by the Board and make recommendations to the Board thereon; and

	• monitoring the use of all resources available to the Board. • Specifically, the Committee is charged with recommending to the Board annual revenue and capital budgets and financial plans consistent with its statutory financial responsibilities. It shall also have responsibility for the oversight of the Board's Capital Programme (including individual Business Cases for Capital Investment) and the review of the Property Strategy (including the acquisition and disposal of property), and for making recommendations to the Board as appropriate on any issue within its terms of reference; • The Committee will produce an Annual Statement of Assurance for submission to the Board, via the Audit and Risk Committee. The proposed Annual Statement will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit and Risk Committee in June; and • The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

2.4 Public Health & Wellbeing Committee	
Responsible Director for this Section	Director of Public Health
Role and Remit	The remit of the Public Health & Wellbeing Committee is: • To agree key areas of focus within the public health priorities that will be taken forward every year, oversee the agreed population health activities, ensure equity in provision and access to services, and provide assurance thereon to Fife NHS Board. • To ensure that a strategic plan is formulated that reflects public health and wellbeing needs and priorities for the population serviced by NHS Fife in line with the priorities of the national care and wellbeing programmes. • To monitor strategy implementation through regular progress reports and review of intermediate measures and long-term outcomes. • To receive assurance that the risks relating to primary care and community services are addressed in line with the directions set and that robust mitigating actions are in place to address any areas of concern or where performance is not in line with national standards or targets. • To support the work of the Anchor Institute Programme Board and Population Health and Wellbeing Portfolio Board and receive updates on progress and outcomes. • To support the ambitions set out in the Plan for Fife (Community Planning Partnership) through collaboration on agreed areas of influence. • To undertake scrutiny of individual topics / projects / work-streams to promote the health of the population in Fife, including NHS Fife staff, with particular emphasis on prevention and addressing health inequalities. • To ensure appropriate linkages to other key work of the Board, such as the development of new services, workstreams and delivery plans.

	• To undertake an annual self-assessment of the Committee's work and effectiveness. • The Committee will produce an Annual Report incorporating a Statement of Assurance for submission to the Board, via the Audit & Risk Committee. The proposed Annual Report will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the Committee by the end of May each year for presentation to the Audit & Risk Committee in June. • The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

2.5 Remuneration Committee	
Responsible Director for this Section	Director of Workforce

Role and Remit	• The remit of the Remuneration Committee is to consider:
	  • job descriptions for the Executive cohort;
	  • other terms of employment which are not under Ministerial direction;
	  • to hear and determine appeals against the decisions of the Consultant Discretionary Awards Panel. The Remuneration Committee can make decisions regarding Discretionary Points in exceptional circumstances;
	  • agree performance objectives and appraisals directly for the Executive cohort only, and oversee arrangements for designated senior managers;
	  • redundancy, early retiral or termination arrangement in respect of all staff in situations where there is a financial impact upon the Board (this excludes early retiral on grounds of ill health) and approve these or refer to the Board as it sees fit; and
	  • undertake an annual self-assessment of the Committee's work and effectiveness.
	• The Committee will produce an Annual Report incorporating a Statement of Assurance for submission to the Board, via the Audit & Risk Committee. The proposed Annual Report will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the Committee by the end of May each year for presentation to the Audit & Risk Committee in June.
	• The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

2.6 Staff Governance Committee	
Responsible Director for this Section	Director of Workforce

Role and Remit	• The remit of the Staff Governance Committee is to:
	  • consider NHS Fife's performance in relation to its achievements of effective Staff Governance and its compliance with the Staff Governance Standard;
	  • review action taken on recommendations made by the Committee, NHS Boards, or the Scottish Ministers on Staff Governance matters;
	  • give assurance to the Board on the operation of Staff Governance systems within NHS Fife, identifying progress, issues and actions being taken, where appropriate;
	  • support the operation of the Area Partnership Forum and the Local Partnership Forums in their Staff Governance monitoring role and the appropriate flow of information to facilitate this;
	  • encourage the further development of mechanisms for engaging effectively with all members of staff within the NHS in Fife;
	  • contribute to the development of the Annual Operational Plan, in particular but not exclusively, around issues affecting staff;
	  • support the continued development of personal appraisal professional learning and performance;
	  • review regularly the sections of the NHS Fife Integrated Performance & Quality Report relevant to the Committee's responsibility; and
	  • undertake an annual self-assessment of the Committee's work and effectiveness.
	• The Committee is also required to carry out a review of its function and activities and to provide an Annual Statement of Assurance. This will be submitted to the Board via the Audit and Risk Committee. The proposed Annual Statement

	will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit and Risk Committee in June. • The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

3. Matters Delegated to Individuals

3.1 Matters Delegated to the Chief Executive	
	General Provisions In the context of the Board's principal role to protect and improve the health of Fife residents, the Chief Executive as Accountable Officer shall have delegated authority and responsibility to secure the economical, efficient and effective operation and management of Fife NHS Board and to safeguard its assets: • in accordance with the statutory requirements and responsibilities laid upon the Chief Executive as Accountable Officer for Fife NHS Board; • in accordance with direction from the Scottish Government Health and Social Care Directorates; • in accordance with the current policies of and decisions made by the Board; • within the limits of the resources available, subject to the approval of the Board; • and in accordance with the Code of Corporate Governance as detailed in Standing Orders and Standing Financial Instructions. The Chief Executive is authorised to take such measures as may be required in emergency situations, subject to advising, where possible, the Chairperson and the Vice-Chairperson of the Board, and the relevant Standing Committee Chairperson. Such measures, that might normally be outwith the scope of the authority delegated by the Board or its Standing Committees to the Chief Executive, shall be reported to the Board or appropriate Standing Committee as soon as possible thereafter. The Chief Executive is authorised to give a direction in special circumstances that any officer shall not exercise a delegated function subject to reporting on the terms of the direction to the next meeting of the appropriate Committee. **Finance** Resources shall be used only for the purpose for which they are allocated, unless otherwise approved by the Chief Executive, after taking account of the advice of the Director of Finance. The Chief Executive acting together with the Director of Finance has delegated authority to approve the transfer of funds between budget heads, including transfers from reserves and balances, up to a maximum of £2,000,000 in any one instance.

	The Chief Executive shall report to the Finance, Performance and Resources Committee those instances where this authority is exercised and/or the change in use of the funds relates to matters of public interest. The Chief Executive may, acting together with the Director of Finance, and having taken all reasonable action to pursue recovery, approve the writing-off of losses, subject to the financial limits and categorisation of losses laid down from time to time by the Scottish Government Health and Social Care Directorates. **Legal Matters** The Chief Executive is authorised to institute, defend or appear in any legal proceedings or any inquiry, including proceedings before any statutory tribunal, board or authority, and following consideration of the advice of the Central Legal Office of the National Services Scotland (NSS), to appoint or consult with Counsel where it is considered expedient to do so, for the promotion or protection of the Board's interests. In circumstances where a claim against the Board is settled by a decision of a Court, and the decision is not subject to appeal, the Chief Executive shall implement the decision of the relevant Court on behalf of the Board. In circumstances where the advice of the Central Legal Office is to reach an out-of-court settlement, the Chief Executive may, acting together with the Director of Finance, settle claims against the Board, subject to a report thereafter being submitted to the Finance, Performance and Resources Committee. The Chief Executive, acting together with the Director of Finance, may make ex gratia payments subject to the limits laid down from time to time by the Scottish Government Health & Social Care Directorates. The arrangements for signing of documents in respect of matters covered by the Property Transactions Manual shall be in accordance with the direction of Scottish Ministers. The Chief Executive and the Director of Finance are currently authorised to sign such documentation on behalf of the Board and Scottish Ministers. The Chief Executive shall have responsibility for the safe keeping of the Board's Seal, and together with the Chairperson or other nominated Non-Executive Member of the Board, shall have responsibility for the application of the Seal on behalf of the Board.

	Procurement of Supplies and Services The Chief Executive shall have responsibility for nominating officers or agents to act on behalf of the Board, for specifying, and issuing documentation associated with invitations to tender, and for receiving and opening of tenders. Where post tender negotiations are required, the Chief Executive shall nominate in writing, officers and/or agents to act on behalf of the Board. The Chief Executive, acting together with the Director of Finance, has authority to approve on behalf of the Board the acceptance of tenders, submitted in accordance with the Board's Standing Orders, up to an annual value of £2,000,000, within the limits of previously approved Revenue and Capital Budgets, where the most economically advantageous tender is to be accepted. The Chief Executive through the Director of Finance shall produce a listing, including specimen signatures, of those officers or agents to whom they have given delegated authority to sign official orders on behalf of the Board. **Human Resources** The Chief Executive may, after consultation and agreement with the Director of Workforce, and the relevant Director, amend staffing establishments in respect of the number and grading of posts. In so doing, the Director of Finance must have been consulted, and have confirmed that the cost of the amended establishment can be contained within the relevant limit approved by the Board for the current and subsequent financial years. Any amendment must also be in accordance with the policies and arrangements relating to workforce planning, approved by the Board or Staff Governance Committee. The Chief Executive has delegated authority from Fife NHS Board to approve the establishment of salaried dentist posts within NHS Fife, within the systematic approach as laid down by the Scottish Government Health & Social Care Directorates Circular No PCA(D)(2005)3. The Chief Executive may attend and may authorise any member of staff to attend within and outwith the United Kingdom conferences, courses or meetings of relevant professional bodies and associations, provided that:

	• attendance is relevant to the duties or professional development of such member of staff; and • appropriate allowance has been made within approved budgets; or • external reimbursement of costs is to be made to the Board. • Under the terms of the public sector reform act the Chief Executive is required to keep a register of all such approvals. The Chief Executive may, in accordance with the Board's agreed Employee Conduct Policy, take disciplinary action, in respect of members of staff, including dismissal where appropriate. The Chief Executive shall have overall responsibility for ensuring that the Board complies with Health and Safety legislation, and for ensuring the effective implementation of the Board's policies in this regard. The Chief Executive may, following consultation and agreement with the Director of Workforce and the Director of Finance approve payment of honoraria to any employee. The Chief Executive may, in consultation with the Director of Workforce and Director of Finance, approve applications to leave the employment of the Board on grounds of early retirement by any employee provided the terms and conditions relating to the early retirement are in accordance with the relevant Board policy. All such applications and outcomes will be reported to the Remuneration Committee. **Patients' Property** The Chief Executive shall have overall responsibility for ensuring that the Board complies with legislation in respect of patients' property. The term 'property' shall mean all assets other than land and building. (e.g. furniture, pictures, jewellery, bank accounts, shares, cash.)

3.2 Matters Delegated to the Director of Finance	
	Authority is delegated to the Director of Finance to take the necessary measures as undernoted, in order to assist the Board and the Chief Executive in fulfilling their corporate responsibilities: **Accountable Officer** The Director of Finance has a general duty to assist the Chief Executive in fulfilling their responsibilities as the Accountable Officer of the Board. **Financial Statements** The Director of Finance is empowered to take all steps necessary to assist the Board to: • Act within the law and ensure the regularity of transactions by putting in place systems of internal control to ensure that financial transactions are in accordance with the appropriate authority; • Maintain proper accounting records; and • Prepare and submit for External Audit timeous financial statements which give a true and fair view of the financial position of the Board and its income and expenditure for the period in question. **Corporate Governance and Management** The Director of Finance is authorised to put in place proper arrangements to ensure that the financial position of the Board is soundly based by ensuring that the Board, its Committees, and supporting management groupings receive appropriate, accurate and timely information and advice with regard to: • The development of financial plans, budgets and projections; • Compliance with statutory financial requirements and achievement of financial targets; • The impact of planned future policies and known or foreseeable developments on the Board's financial position. The Director of Finance is empowered to take steps to ensure that proper arrangements are in place for: • Developing, promoting and monitoring compliance with Standing Orders and Standing Financial Instructions, and appropriate guidance on standards of business conduct;

	• Developing and implementing systems of internal control, including systems of financial, operational and compliance controls and risk management; • Developing and implementing strategies for the prevention and detection of fraud and irregularity; • Internal Audit. **Performance Management** The Director of Finance is authorised to assist the Chief Executive to ensure that suitable arrangements are in place to secure economy, efficiency, and effectiveness in the use of resources and that they are working effectively. These arrangements include procedures: • for planning, appraisal, authorisation and control, accountability and evaluation of the use of resources; • to ensure that performance targets and required outcomes are met and achieved. **Banking** The Director of Finance is authorised to oversee the Board's arrangements in respect of accounts held in the name of the Board with the appointed Government Banking Services ~~Paymaster General Office~~ and the commercial bankers duly appointed by the Board. The Director of Finance will be responsible for ensuring that the appointed Government Banking Services~~Paymaster General's Office~~ and the commercial bankers are advised in writing of amendments to the panel of nominated authorised signatories. **Tax** The Director of Finance shall have delegated authority as lead officer for Tax matters, in relation to the management of taxes as they affect NHS Fife's financial affairs. This includes but is not limited to final determination in cases of off payroll working, application of the Construction Industry Scheme regulations, VAT etc. **Patients' Property** The Director of Finance shall have delegated authority to ensure that detailed operating procedures in relation to the management of the property of patients (including the opening of bank accounts where appropriate) are compiled for use by staff involved in the management of patients' property and financial affairs, in line with the terms of the Adults with Incapacity (Scotland) Act 2000.

3.3 Matters Delegated to Other Senior Officers of the Board	
	Director of Acute Services and Director of Health and Social Care
	General Provisions The Director of Acute Services/Director of Health and Social Care shall have delegated authority and responsibility from the Board Chief Executive to secure the economical, efficient and effective operation and management of their services: • in accordance with the current policies and decisions made by the Board; • within the limits of the resources made available to the Division/IJB; • in accordance with the Code of Corporate Governance as detailed in the Board's Standing Orders and Standing Financial Instructions. The Director of Acute Services and Director of Health and Social Care have a general duty to assist the Chief Executive in fulfilling their responsibilities as the Accountable Officer of the Board. The Director of Acute Services and Director of Health and Social Care are authorised to take such measures as may be required in emergency situations, subject to advising, where possible, the Chairperson or the Vice-Chairperson of the Board, the Chief Executive and where appropriate the relevant Standing Committee Chairperson. Such measures, that might normally be outwith the scope of the authority delegated by the Board or its Standing Committees to the Chief Executive, shall be reported to the Board or appropriate Standing Committee as soon as possible thereafter. The Director of Acute Services and Director of Health and Social Care are authorised to give a direction in special circumstances that any officer within their area shall not exercise a delegated function subject to reporting on the terms of the direction to the next meeting of the Board. **Finance** Resources shall be used only for the purpose for which they are allocated, unless otherwise approved by the Director of Acute Services and Director of Health and Social Care, after taking account of the advice of the Deputy Director of Finance. The Director of Acute Services and Director of Health and Social Care acting

	together with the Deputy Director of Finance have delegated authority to approve the transfer of funds between budget heads, up to a maximum of £500,000 in any one instance. Those instances where this authority is exercised and/or the change in use of the funds relates to matters of public interest shall be notified to the Finance, Performance and Resources Committee. **Legal Matters** The Director of Acute Services and Director of Health and Social Care are authorised to institute, defend or appear in any legal proceedings or any inquiry, (including proceedings before any statutory tribunal, board or authority) in respect of their service areas, and following consideration of the advice of the Central Legal Office of the National Services Scotland and in consultation with the Chief Executive, to appoint or consult with Counsel where it is considered expedient to do so, for the promotion or protection of the Board's interests. **Procurement of Supplies and Services** The Director of Acute Services and Director of Health and Social Care shall have responsibility for nominating officers or agents to act on behalf of the Board, for specifying, and issuing documentation associated with invitations to tender, and for receiving and opening of tenders. The Director of Acute Services and Director of Health and Social Care shall work with the Deputy Director of Finance and the Director of Finance to produce a listing, including specimen signatures, of those officers or agents to whom he has given delegated authority to sign official orders on behalf of the Board within their areas of responsibility. **Human Resources** The Director of Acute Services and Director of Health and Social Care may, after consultation and agreement with Human Resources, amend staffing establishments in respect of the number and grading of posts. In so doing, the Deputy Director of Finance, must have been consulted, and have confirmed that the cost of the amended establishment can be contained within the relevant limit approved for the current and subsequent financial years. Any amendment must also be in accordance with the policies and arrangements relating to workforce planning, approved by the Board or the Staff Governance Committee. The Director of Acute Services and Director of Health and Social Care may, in accordance with the Board's agreed Employee

	Conduct Policy, take disciplinary action in respect of members of staff, including dismissal where appropriate. **Patients' Property** The Director of Acute Services and Director of Health and Social Care shall have overall responsibility for ensuring compliance with legislation in respect of patient's property and that effective and efficient management arrangements are in place.
	3.4 Champion Roles The following roles are filled by Non-Executive Board members. • Counter Fraud Services Champion • Digital Champion • Equality & Diversity Champion • Safety & Cleanliness Champion • Whistle Blowing Champion (appointed nationally)

Code of Conduct for Members of Fife NHS Board

CONTENTS

SECTION 1: INTRODUCTION TO THE CODE OF CONDUCT

1.1 This Code has been issued by the Scottish Ministers, with the approval of the Scottish Parliament, as required by the Ethical Standards in Public Life etc. (Scotland) Act 2000 (the "Act").

1.2 The purpose of the Code is to set out the conduct expected of those who serve on the boards of public bodies in Scotland.

1.3 The Code has been developed in line with the nine key principles of public life in Scotland. The principles are listed in Section 2 and set out how the provisions of the Code should be interpreted and applied in practice.

My Responsibilities

1.4 I understand that the public has a high expectation of those who serve on the boards of public bodies and the way in which they should conduct themselves in undertaking their duties. I will always seek to meet those expectations by ensuring that I conduct myself in accordance with the Code.

1.5 I will comply with the substantive provisions of this Code, being sections 3 to 6 inclusive, in all situations and at all times where I am acting as a board member of my public body, have referred to myself as a board member or could objectively be considered to be acting as a board member.

1.6 I will comply with the substantive provisions of this Code, being sections 3 to 6 inclusive, in all my dealings with the public, employees and fellow board members, whether formal or informal.

1.7 I understand that it is my personal responsibility to be familiar with the provisions of this Code and that I must also comply with the law and my public body's rules, standing orders and regulations. I will also ensure that I am familiar with any guidance or advice notes issued by the Standards Commission for Scotland ("Standards Commission") and my public body, and endeavour to take part in any training offered on the Code.

1.8 I will not, at any time, advocate or encourage any action contrary to this Code.

1.9 I understand that no written information, whether in the Code itself or the associated Guidance or Advice Notes issued by the Standards Commission, can provide for all circumstances. If I am uncertain about how the Code applies, I will seek advice from the Standards Officer of my public body, failing whom the Chair or Chief Executive of my public body. I note that I may also choose to seek external legal advice on how to interpret the provisions of the Code.

Enforcement

1.10 Part 2 of the Act sets out the provisions for dealing with alleged breaches of the Code, including the sanctions that can be applied if the Standards

Commission finds that there has been a breach of the Code. More information on how complaints are dealt with and the sanctions available can be found at Annex A.

SECTION 2: KEY PRINCIPLES OF THE CODE OF CONDUCT

2.1 The Code has been based on the following key principles of public life. I will behave in accordance with these principles and understand that they should be used for guidance and interpreting the provisions in the Code.

2.2 I note that a breach of one or more of the key principles does not in itself amount to a breach of the Code. I note that, for a breach of the Code to be found, there must also be a contravention of one or more of the provisions in sections 3 to 6 inclusive of the Code.

The key principles are:

Duty
I have a duty to uphold the law and act in accordance with the law and the public trust placed in me. I have a duty to act in the interests of the public body of which I am a member and in accordance with the core functions and duties of that body.

Selflessness
I have a duty to take decisions solely in terms of public interest. I must not act in order to gain financial or other material benefit for myself, family or friends.

Integrity
I must not place myself under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence me in the performance of my duties.

Objectivity
I must make decisions solely on merit and in a way that is consistent with the functions of my public body when carrying out public business including making appointments, awarding contracts or recommending individuals for rewards and benefits.

Accountability and Stewardship
I am accountable to the public for my decisions and actions. I have a duty to consider issues on their merits, taking account of the views of others and I must ensure that my public body uses its resources prudently and in accordance with the law.

Openness
I have a duty to be as open as possible about my decisions and actions, giving reasons for my decisions and restricting information only when the wider public interest clearly demands.

Honesty
I have a duty to act honestly. I must declare any private interests relating to my public duties and take steps to resolve any conflicts arising in a way that protects the public

interest.

Leadership
I have a duty to promote and support these principles by leadership and example, and to maintain and strengthen the public's trust and confidence in the integrity of my public body and its members in conducting public business.

Respect
I must respect all other board members and all employees of my public body and the role they play, treating them with courtesy at all times. Similarly, I must respect members of the public when performing my duties as a board member.

SECTION 3: GENERAL CONDUCT

Respect and Courtesy

3.1 I will treat everyone with courtesy and respect. This includes in person, in writing, at meetings, when I am online and when I am using social media.

3.2 I will not discriminate unlawfully on the basis of race, age, sex, sexual orientation, gender reassignment, disability, religion or belief, marital status or pregnancy/maternity; I will advance equality of opportunity and seek to foster good relations between different people.

3.3 I will not engage in any conduct that could amount to bullying or harassment (which includes sexual harassment). I accept that such conduct is completely unacceptable and will be considered to be a breach of this Code.

3.4 I accept that disrespect, bullying and harassment can be:

a) a one-off incident,
b) part of a cumulative course of conduct; or
c) a pattern of behaviour.

3.5 I understand that how, and in what context, I exhibit certain behaviours can be as important as what I communicate, given that disrespect, bullying and harassment can be physical, verbal and non-verbal conduct.

3.6 I accept that it is my responsibility to understand what constitutes bullying and harassment and I will utilise resources, including the Standards Commission's guidance and advice notes, my public body's policies and training material (where appropriate) to ensure that my knowledge and understanding is up to date.

3.7 Except where it is written into my role as Board member, and / or at the invitation of the Chief Executive, I will not become involved in operational management of my public body. I acknowledge and understand that operational management is the responsibility of the Chief Executive and Executive Team.

3.8 I will not undermine any individual employee or group of employees, or raise concerns about their performance, conduct or capability in public. I will raise any concerns I have on such matters in private with senior management as appropriate.

3.9 I will not take, or seek to take, unfair advantage of my position in my dealings with employees of my public body or bring any undue influence to bear on employees to take a certain action. I will not ask or direct employees to do something which I know, or should reasonably know, could compromise them or prevent them from undertaking their duties properly and appropriately.

3.10 I will respect and comply with rulings from the Chair during meetings of:

a) my public body, its committees; and
b) any outside organisations that I have been appointed or nominated to by my public body or on which I represent my public body.

3.11 I will respect the principle of collective decision-making and corporate responsibility. This means that once the Board has made a decision, I will support that decision, even if I did not agree with it or vote for it.

Remuneration, Allowances and Expenses

3.12 I will comply with the rules, and the policies of my public body, on the payment of remuneration, allowances and expenses.

Gifts and Hospitality

3.13 I understand that I may be offered gifts (including money raised via crowdfunding or sponsorship), hospitality, material benefits or services ("gift or hospitality") that may be reasonably regarded by a member of the public with knowledge of the relevant facts as placing me under an improper obligation or being capable of influencing my judgement.

3.14 I will never **ask for** or **seek** any gift or hospitality.

3.15 I will refuse any gift or hospitality, unless it is:

a) a minor item or token of modest intrinsic value offered on an infrequent basis;
b) a gift being offered to my public body;
c) hospitality which would reasonably be associated with my duties as a board member; or
d) hospitality which has been approved in advance by my public body.

3.16 I will consider whether there could be a reasonable perception that any gift or hospitality received by a person or body connected to me could or would influence my judgement.

3.17 I will not allow the promise of money or other financial advantage to induce me to act improperly in my role as a board member. I accept that the money or advantage (including any gift or hospitality) does not have to be given to me directly. The offer of monies or advantages to others, including community groups, may amount to bribery, if the intention is to induce me to improperly perform a function.

3.18 I will never accept any gift or hospitality from any individual or applicant who is awaiting a decision from, or seeking to do business with, my public body.

3.19 If I consider that declining an offer of a gift would cause offence, I will accept it and hand it over to my public body at the earliest possible opportunity and ask for it to be registered.

3.20 I will promptly advise my public body's Standards Officer if I am offered (but refuse) any gift or hospitality of any significant value and / or if I am offered any gift or hospitality from the same source on a repeated basis, so that my public body can monitor this.

3.21 I will familiarise myself with the terms of the Bribery Act 2010, which provides for offences of bribing another person and offences relating to being bribed.

Confidentiality

3.22 I will not disclose confidential information or information which should reasonably be regarded as being of a confidential or private nature, without the express consent of a person or body authorised to give such consent, or unless required to do so by law. I note that if I cannot obtain such express consent, I should assume it is not given.

3.23 I accept that confidential information can include discussions, documents, and information which is not yet public or never intended to be public, and information deemed confidential by statute.

3.24 I will only use confidential information to undertake my duties as a board member. I will not use it in any way for personal advantage or to discredit my public body (even if my personal view is that the information should be publicly available).

3.25 I note that these confidentiality requirements do not apply to protected whistleblowing disclosures made to the prescribed persons and bodies as identified in statute.

Use of Public Body Resources

3.26 I will only use my public body's resources, including employee assistance, facilities, stationery and IT equipment, for carrying out duties on behalf of the public body, in accordance with its relevant policies.

3.27 I will not use, or in any way enable others to use, my public body's resources:

a) imprudently (without thinking about the implications or consequences);
b) unlawfully;
c) for any political activities or matters relating to these; or
d) improperly.

Dealing with my Public Body and Preferential Treatment

3.28 I will not use, or attempt to use, my position or influence as a board member to:

a) improperly confer on or secure for myself, or others, an advantage;
b) avoid a disadvantage for myself, or create a disadvantage for others or
c) improperly seek preferential treatment or access for myself or others.

3.29 I will avoid any action which could lead members of the public to believe that preferential treatment or access is being sought.

3.30 I will advise employees of any connection, as defined at Section 5, I may have to a matter, when seeking information or advice or responding to a request for information or advice from them.

Appointments to Outside Organisations

3.31 If I am appointed, or nominated by my public body, as a member of another body or organisation, I will abide by the rules of conduct and will act in the best interests of that body or organisation while acting as a member of it. I will also continue to observe the rules of this Code when carrying out the duties of that body or organisation.

3.32 I accept that if I am a director or trustee (or equivalent) of a company or a charity, I will be responsible for identifying, and taking advice on, any conflicts of interest that may arise between the company or charity and my public body.

SECTION 4: REGISTRATION OF INTERESTS

4.1 The following paragraphs set out what I have to register when I am appointed and whenever my circumstances change. The register covers my current term of appointment.

4.2 I understand that regulations made by the Scottish Ministers describe the detail and timescale for registering interests; including a requirement that a board member must register their registrable interests within one month of becoming a board member, and register any changes to those interests within one month of those changes having occurred.

4.3 The interests which I am required to register are those set out in the following paragraphs. Other than as required by paragraph 4.23, I understand it is not necessary to register the interests of my spouse or cohabitee.

Category One: Remuneration

4.4 I will register any work for which I receive, or expect to receive, payment. I have a registrable interest where I receive remuneration by virtue of being:

a) employed;
b) self-employed;
c) the holder of an office;
d) a director of an undertaking;
e) a partner in a firm;
f) appointed or nominated by my public body to another body; or
g) engaged in a trade, profession or vocation or any other work.

4.5 I understand that in relation to 4.4 above, the amount of remuneration does not require to be registered. I understand that any remuneration received as a board member of this specific public body does not have to be registered.

4.6 I understand that if a position is not remunerated it does not need to be registered under this category. However, unremunerated directorships may need to be registered under Category Two, "Other Roles".

4.7 I must register any allowances I receive in relation to membership of any organisation under Category One.

4.8 When registering employment as an employee, I must give the full name of the employer, the nature of its business, and the nature of the post I hold in the organisation.

4.9 When registering remuneration from the categories listed in paragraph 4.4 (b) to (g) above, I must provide the full name and give details of the nature of the business, organisation, undertaking, partnership or other body, as appropriate. I recognise that some other employments may be incompatible with my role as board member of my public body in terms of paragraph 6.8 of this Code.

4.10 Where I otherwise undertake a trade, profession or vocation, or any other work, the detail to be given is the nature of the work and how often it is undertaken.

4.11 When registering a directorship, it is necessary to provide the registered name and registered number of the undertaking in which the directorship is held and provide information about the nature of its business.

4.12 I understand that registration of a pension is not required as this falls outside the scope of the category.

Category Two: Other Roles

4.13 I will register any unremunerated directorships where the body in question is

a subsidiary or parent company of an undertaking in which I hold a remunerated directorship.

4.14 I will register the registered name and registered number of the subsidiary or parent company or other undertaking and the nature of its business, and its relationship to the company or other undertaking in which I am a director and from which I receive remuneration.

Category Three: Contracts

4.15 I have a registerable interest where I (or a firm in which I am a partner, or an undertaking in which I am a director or in which I have shares of a value as described in paragraph 4.20 below) have made a contract with my public body:

a) under which goods or services are to be provided, or works are to be executed; and
b) which has not been fully discharged.

4.16 I will register a description of the contract, including its duration, but excluding the value.

Category Four: Election Expenses

4.17 If I have been elected to my public body, then I will register a description of, and statement of, any assistance towards election expenses relating to election to my public body.

Category Five: Houses, Land and Buildings

4.18 I have a registrable interest where I own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of my public body.

4.19 I accept that, when deciding whether or not I need to register any interest I have in houses, land or buildings, the test to be applied is whether a member of the public, with knowledge of the relevant facts, would reasonably regard the interest as being so significant that it could potentially affect my responsibilities to my public body and to the public, or could influence my actions, speeches or decision-making.

Category Six: Interest in Shares and Securities

4.20 I have a registerable interest where:

a) I own or have an interest in more than 1% of the issued share capital of the company or other body; or
b) Where, at the relevant date, the market value of any shares and securities (in any one specific company or body) that I own or have an

interest in is greater than £25,000.

Category Seven: Gifts and Hospitality

4.21 I understand the requirements of paragraphs 3.13 to 3.21 regarding gifts and hospitality. As I will not accept any gifts or hospitality, other than under the limited circumstances allowed, I understand there is no longer the need to register any.

Category Eight: Non–Financial Interests

4.22 I may also have other interests and I understand it is equally important that relevant interests such as membership or holding office in other public bodies, companies, clubs, societies and organisations such as trades unions and voluntary organisations, are registered and described. In this context, I understand non-financial interests are those which members of the public with knowledge of the relevant facts might reasonably think could influence my actions, speeches, votes or decision-making in my public body (this includes its Committees and memberships of other organisations to which I have been appointed or nominated by my public body).

Category Nine: Close Family Members

4.23 I will register the interests of any close family member who has transactions with my public body or is likely to have transactions or do business with it.

SECTION 5: DECLARATION OF INTERESTS

Stage 1: Connection

5.1 For each particular matter I am involved in as a board member, I will first consider whether I have a connection to that matter.

5.2 I understand that a connection is any link between the matter being considered and me, or a person or body I am associated with. This could be a family relationship or a social or professional contact.

5.3 A connection includes anything that I have registered as an interest.

5.4 A connection does not include being a member of a body to which I have been appointed or nominated by my public body as a representative of my public body or of which I am a member by reason of, or in implementation of, a statutory provision, unless:

a) The matter being considered by my public body is quasi-judicial or regulatory; or
b) I have a personal conflict by reason of my actions, my connections or my legal obligations.

Stage 2: Interest

5.5 I understand my connection is an interest that requires to be declared where the objective test is met – that is where a member of the public with knowledge of the relevant facts would reasonably regard my connection to a particular matter as being so significant that it would be considered as being likely to influence the discussion or decision-making.

Stage 3: Participation

5.6 I will declare my interest as early as possible in meetings. I will not remain in the meeting nor participate in any way in those parts of meetings where I have declared an interest.

5.7 I will consider whether it is appropriate for transparency reasons to state publicly where I have a connection, which I do not consider amounts to an interest.

5.8 I note that I can apply to the Standards Commission and ask it to grant a dispensation to allow me to take part in the discussion and decision-making on a matter where I would otherwise have to declare an interest and withdraw (as a result of having a connection to the matter that would fall within the objective test). I note that such an application must be made in advance of any meetings where the dispensation is sought and that I cannot take part in any discussion or decision-making on the matter in question unless, and until, the application is granted.

5.9 I note that public confidence in a public body is damaged by the perception that decisions taken by that body are substantially influenced by factors other than the public interest. I will not accept a role or appointment if doing so means I will have to declare interests frequently at meetings in respect of my role as a board member. Similarly, if any appointment or nomination to another body would give rise to objective concern because of my existing personal involvement or affiliations, I will not accept the appointment or nomination.

SECTION 6: LOBBYING AND ACCESS

6.1 I understand that a wide range of people will seek access to me as a board member and will try to lobby me, including individuals, organisations and companies. I must distinguish between:

a) any role I have in dealing with enquiries from the public;
b) any community engagement where I am working with individuals and organisations to encourage their participation and involvement, and;
c) lobbying, which is where I am approached by any individual or organisation who is seeking to influence me for financial gain or advantage, particularly those who are seeking to do business with my public body (for example contracts/procurement).

6.2 In deciding whether, and if so how, to respond to such lobbying, I will always have regard to the objective test, which is whether a member of the public, with knowledge of the relevant facts, would reasonably regard my conduct as being likely to influence my, or my public body's, decision-making role.

6.3 I will not, in relation to contact with any person or organisation that lobbies, do anything which contravenes this Code or any other relevant rule of my public body or any statutory provision.

6.4 I will not, in relation to contact with any person or organisation that lobbies, act in any way which could bring discredit upon my public body.

6.5 If I have concerns about the approach or methods used by any person or organisation in their contacts with me, I will seek the guidance of the Chair, Chief Executive or Standards Officer of my public body.

6.6 The public must be assured that no person or organisation will gain better access to, or treatment by, me as a result of employing a company or individual to lobby on a fee basis on their behalf. I will not, therefore, offer or accord any preferential access or treatment to those lobbying on a fee basis on behalf of clients compared with that which I accord any other person or organisation who lobbies or approaches me. I will ensure that those lobbying on a fee basis on behalf of clients are not given to understand that preferential access or treatment, compared to that accorded to any other person or organisation, might be forthcoming.

6.7 Before taking any action as a result of being lobbied, I will seek to satisfy myself about the identity of the person or organisation that is lobbying and the motive for lobbying. I understand I may choose to act in response to a person or organisation lobbying on a fee basis on behalf of clients but it is important that I understand the basis on which I am being lobbied in order to ensure that any action taken in connection with the lobbyist complies with the standards set out in this Code and the Lobbying (Scotland) Act 2016.

6.8 I will not accept any paid work:

a) which would involve me lobbying on behalf of any person or organisation or any clients of a person or organisation.

b) to provide services as a strategist, adviser or consultant, for example, advising on how to influence my public body and its members. This does not prohibit me from being remunerated for activity which may arise because of, or relate to, membership of my public body, such as journalism or broadcasting, or involvement in representative or presentational work, such as participation in delegations, conferences or other events.

ANNEX A: BREACHES OF THE CODE

Introduction

1. The Ethical Standards in Public Life etc. (Scotland) Act 2000 ("the Act") provided for a framework to encourage and, where necessary, enforce high ethical standards in public life.

2. The Act provided for the introduction of new codes of conduct for local authority councillors and members of relevant public bodies, imposing on councils and relevant public bodies a duty to help their members comply with the relevant code.

3. The Act and the subsequent Scottish Parliamentary Commissions and Commissioners etc. Act 2010 established the Standards Commission for Scotland ("Standards Commission") and the post of Commissioner for Ethical Standards in Public Life in Scotland ("ESC").

4. The Standards Commission and ESC are separate and independent, each with distinct functions. Complaints of breaches of a public body's Code of Conduct are investigated by the ESC and adjudicated upon by the Standards Commission.

5. The first Model Code of Conduct came into force in 2002. The Code has since been reviewed and re-issued in 2014. The 2021 Code has been issued by the Scottish Ministers following consultation, and with the approval of the Scottish Parliament, as required by the Act.

Investigation of Complaints

6. The ESC is responsible for investigating complaints about members of devolved public bodies. It is not, however, mandatory to report a complaint about a potential breach of the Code to the ESC. It may be more appropriate in some circumstances for attempts to be made to resolve the matter informally at a local level.

7. On conclusion of the investigation, the ESC will send a report to the Standards Commission.

Hearings

8. On receipt of a report from the ESC, the Standards Commission can choose to:

   - Do nothing;
   - Direct the ESC to carry out further investigations; or
   - Hold a Hearing.

9. Hearings are held (usually in public) to determine whether the member concerned has breached their public body's Code of Conduct. The Hearing

Panel comprises of three members of the Standards Commission. The ESC will present evidence and/or make submissions at the Hearing about the investigation and any conclusions as to whether the member has contravened the Code. The member is entitled to attend or be represented at the Hearing and can also present evidence and make submissions. Both parties can call witnesses. Once it has heard all the evidence and submissions, the Hearing Panel will make a determination about whether or not it is satisfied, on the balance of probabilities, that there has been a contravention of the Code by the member. If the Hearing Panel decides that a member has breached their public body's Code, it is obliged to impose a sanction.

Sanctions

10. The sanctions that can be imposed following a finding of a breach of the Code are as follows:

- **Censure**: A censure is a formal record of the Standards Commission's severe and public disapproval of the member concerned.
- **Suspension**: This can be a full or partial suspension (for up to one year). A full suspension means that the member is suspended from attending all meetings of the public body. Partial suspension means that the member is suspended from attending some of the meetings of the public body. The Commission can direct that any remuneration or allowance the member receives as a result of their membership of the public body be reduced or not paid during a period of suspension.
- **Disqualification**: Disqualification means that the member is removed from membership of the body and disqualified (for a period not exceeding five years), from membership of the body. Where a member is also a member of another devolved public body (as defined in the Act), the Commission may also remove or disqualify that person in respect of that membership. Full details of the sanctions are set out in section 19 of the Act.

Interim Suspensions

11. Section 21 of the Act provides the Standards Commission with the power to impose an interim suspension on a member on receipt of an interim report from the ESC about an ongoing investigation. In making a decision about whether or not to impose an interim suspension, a Panel comprising of three Members of the Standards Commission will review the interim report and any representations received from the member and will consider whether it is satisfied:

- That the further conduct of the ESC's investigation is likely to be prejudiced if such an action is not taken (for example if there are concerns that the member may try to interfere with evidence or witnesses); or
- That it is otherwise in the public interest to take such a measure. A policy outlining how the Standards Commission makes any decision under Section 21 and the procedures it will follow in doing so, should any such a report be received from the ESC can be found here.

12. The decision to impose an interim suspension is not, and should not be seen as, a finding on the merits of any complaint or the validity of any allegations against a member of a devolved public body, nor should it be viewed as a disciplinary measure.

ANNEX B: DEFINITIONS

“Bullying” is inappropriate and unwelcome behaviour which is offensive and intimidating, and which makes an individual or group feel undermined, humiliated or insulted.

"Chair" includes Board Convener or any other individual discharging a similar function to that of a Chair or Convener under alternative decision-making structures.

“Code” is the code of conduct for members of your devolved public body, which is based on the Model Code of Conduct for members of devolved public bodies in Scotland.

"Cohabitee" includes any person who is living with you in a relationship similar to that of a partner, civil partner, or spouse.

“Confidential Information” includes:
- any information passed on to the public body by a Government department (even if it is not clearly marked as confidential) which does not allow the disclosure of that information to the public;
- information of which the law prohibits disclosure (under statute or by the order of a Court);
- any legal advice provided to the public body; or
- any other information which would reasonably be considered a breach of confidence should it be made public.

"Election expenses" means expenses incurred, whether before, during or after the election, on account of, or in respect of, the conduct or management of the election.

“Employee” includes individuals employed:
- directly by the public body;
- as contractors by the public body, or
- by a contractor to work on the public body’s premises.

“Gifts” a gift can include any item or service received free of charge, or which may be offered or promised at a discounted rate or on terms not available to the general public. Gifts include benefits such as relief from indebtedness, loan concessions, or provision of property, services or facilities at a cost below that generally charged to members of the public. It can also include gifts received directly or gifts received by any company in which the recipient holds a controlling interest in, or by a partnership of which the recipient is a partner.

“Harassment” is any unwelcome behaviour or conduct which makes someone feel offended, humiliated, intimidated, frightened and / or uncomfortable. Harassment can be experienced directly or indirectly and can occur as an isolated incident or as a course of persistent behaviour.

"Hospitality" includes the offer or promise of food, drink, accommodation, entertainment or the opportunity to attend any cultural or sporting event on terms not available to the general public.

"Relevant Date" Where a board member had an interest in shares at the date on which the member was appointed as a member, the relevant date is – (a) that date; and (b) the 5th April immediately following that date and in each succeeding year, where the interest is retained on that 5th April.

"Public body" means a devolved public body listed in Schedule 3 of the Ethical Standards in Public Life etc. (Scotland) Act 2000, as amended.

"Remuneration" includes any salary, wage, share of profits, fee, other monetary benefit or benefit in kind.

"Securities" a security is a certificate or other financial instrument that has monetary value and can be traded. Securities includes equity and debt securities, such as stocks bonds and debentures.

"Undertaking" means:

a) a body corporate or partnership; or
b) an unincorporated association carrying on a trade or business, with or without a view to a profit.

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**16 June 2022**
Title:	**Committee & Directors' Annual Assurances for 2021/22**
Responsible Executive:	**Respective Executive Directors**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

- Legal requirement
- Local policy

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

- Effective

2 Report summary

2.1 Situation

The purpose of this report is to present the Annual Assurance Statements for each standing Committee of the Board and the individual Executive Director assurance letters for consideration by the Audit & Risk Committee as part of the overall annual accounts and assurance process for 2021/22. The assurance statement produced by the IJB's Chief Internal Auditor is not yet available and has not been considered as yet by the IJB's Audit & Risk Committee. This will follow separately to the Committee at its July meeting.

2.2 Background

The Code of Corporate Governance requires all standing committees of the NHS Board to provide an Annual Report (Assurance Statement). As part of this Assurance Statement, each Committee must demonstrate that it is fulfilling its remit, implementing its work plan and ensuring the timely presentation of its minutes to the Board. These reports are designed to provide assurance that there are adequate and effective governance arrangements in place. Each Committee must identify any significant control weaknesses or issues at the year-end which it considers should be disclosed in the Governance Statement and should specifically record and provide assurance that the Committee has carried out the annual self- assessment of its effectiveness.

Separately, each Executive Director is asked to complete to the Chief Executive a letter at year-end to give individual assurance, for the respective areas under each Executive Director, that there are no control weaknesses that should otherwise be disclosed in the annual accounts.

2.3 Assessment

The Annual Assurance Statements for the Clinical Governance Committee, Finance, Performance & Resources Committee, Public Health & Wellbeing Committee, Remuneration Committee and Staff Governance Committee are attached for consideration by members of the Audit & Risk Committee. Each has been discussed and approved by the respective Committee at their May 2022 cycle of meetings. A final appendix gives the collated responses from the Executive Directors on their areas of responsibility.

2.3.1 Quality/ Patient Care

Delivering robust governance across the organisation is supportive of enhanced patient care and quality standards.

2.3.2 Workforce

N/A.

2.3.3 Financial

The production and review of year-end assurance statements are a key part of the financial year-end process.

2.3.4 Risk Assessment/Management

The identification and management of risk is an important factor in providing appropriate assurance to the NHS Board.

2.3.5 Equality and Diversity, including health inequalities

This paper does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people. Consequently, an EQIA is not required.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

N/A.

2.3.8 Route to the Meeting

This respective assurance statements have been considered and approved by each Committee at the meetings below:

- Clinical Governance Committee, 29 April 2022

- Finance, Performance & Resource Committee, 10 May 2022
- Public Health & Wellbeing Committee, 16 May 2022
- Remuneration Committee, 17 May 2022
- Staff Governance Committee, 12 May 2022

The collated pack of Executive Directors' letters have been reviewed by Internal Audit as part of their year-end work.

2.4 Recommendation

The paper is provided for:

- **Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix No.1 – Standing Committee Annual Statements of Assurance
- Appendix No.2 – Executive Directors' Annual Letters of Assurance

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ANNUAL STATEMENT OF ASSURANCE FOR NHS FIFE CLINICAL GOVERNANCE COMMITTEE 2021/22

1. Purpose

1.1 To provide the Board with the assurance that appropriate clinical governance mechanisms and structures are in place for clinical governance to be supported effectively throughout the whole of Fife NHS Board's responsibilities.

2. Membership

2.1 During the financial year to 31 March 2022, membership of the Clinical Governance Committee comprised: -

Christina Cooper	Chair / Non-Executive Member
Martin Black	Non-Executive Member
Sinead Braiden	Non-Executive Member
Wilma Brown	Area Partnership Forum Representative (to July 2021)
Simon Fevre	Area Partnership Forum Representative (from July 2021)
Cllr David Graham	Non-Executive Member
Rona Laing	Non-Executive Member
Aileen Lawrie	Area Clinical Forum Representative
Dr Christopher McKenna	Medical Director
Dona Milne	Director of Public Health (to May 2021)
Dr Joy Tomlinson	Director of Public Health (from May 2021)
Janette Owens	Director of Nursing
Carol Potter	Chief Executive
Margaret Wells	Non-Executive Member (to July 2021)
Arlene Wood	Non-Executive Member (from September 2021)

2.2 The Committee may invite individuals to attend the Committee meetings for particular agenda items, but the Director of Acute Services, Director of Finance & Strategy, Director of Health & Social Care, Director of Pharmacy & Medicines, Associate Medical Director (Acute Services Division), Associate Medical Director (Fife Health & Social Care Partnership), Associate Director, Digital & Information, Associate Director of Quality and Clinical Governance and Board Secretary will normally be in attendance at Committee meetings. Other attendees, deputies and guests are recorded in the individual minutes of each Committee meeting.

2.3 The Clinical Governance Committee's remit permits a Patient Representative to be a member of the Committee. This post has been vacant in the reporting year, whilst an ongoing review is undertaken of the function and appointment route of this role.

3. Meetings

3.1 The Committee met on seven occasions during the financial year to 31 March 2022, on the undernoted dates:

- 30 April 2021
- 7 July 2021
- 2 September 2021 (held as an extraordinary meeting)

- 17 September 2021
- 3 November 2021
- 13 January 2022
- 10 March 2022

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 The business of the Committee during the year continues to have been impacted greatly by the need for NHS Fife as a whole to address the ongoing challenges of the global Coronavirus pandemic. The Committee Chair has liaised closely with the Medical Director, as lead Executive Officer, and the Director of Nursing to identify what business must be considered by the Committee and what must be prioritised in agenda planning. In the period covered by this report, some routine business has been suspended or deferred, with the occasional meeting running with a prioritised agenda. This has maximised the time available for management and operational staff to deal with the significant challenges of addressing Covid-surge-related demand within clinical services, and, at the same time, allowed the Board to appropriately discharge its governance responsibilities. The Committee's workplan has been regularly reviewed to ensure that specific items related to Covid-19 have been covered appropriately and that the required assurances could be provided to the Board as part of the year-end process.

4.2 In October 2021, the Board established a new Public Health & Wellbeing Committee, which has taken under its remit some public health-related areas previously covered by the Clinical Governance Committee. A review of workplans and terms of reference of Committee's with overlapping agenda topics has attempted to limit any duplication in reporting and enhance clarity about roles and responsibilities. This remains, however, at the time of writing a work-in-progress, as the new Public Health & Wellbeing Committee evolves and develops, and this gives the Clinical Governance Committee an opportunity for more focused agendas and enhanced scrutiny on the key aspects of business aligned to its specific remit.

4.3 The Clinical Governance Committee's first meeting of the 2021-22 reporting year took place in April 2021, with updates given to members on the Covid vaccination programme, including future delivery models and associated governance structure for the immunisation programme. The Committee were assured of the Board's above-average progress in delivery of vaccines to the eligible population, the workforce in place to support the programme, and the inclusivity initiatives being undertaken to reach disadvantaged groups. At the same meeting, members also received up-to-date information on the expansion of Covid-19 testing, particularly asymptomatic testing within the community and the dedicated sites being established to support that across Fife. Given the complexity of the message around testing and isolation for positive cases, the Committee welcomed the clear and practical communications being issued to support the local population.

4.4 Further updates on both testing and vaccine delivery were presented to the Committee at its July 2021 meeting, noting the expansion of both and the transition from a Covid-focused programme to a revised Flu Vaccination & Covid Vaccination (FVCV) programme, beginning in the autumn of 2021. Comprehensive assurance was provided that the Board was actively planning for what would be its biggest immunisation programme to date, and that lessons learned from earlier stages of the vaccination delivery would mitigate any foreseen risks, particularly around the use once again of the national scheduling tool. A new governance and assurance structure has been developed to meet the increasing demands and expectations of all childhood and adult immunisation programmes in Fife, ensuring that the Board has in place

the necessary workforce and logistical expertise, as Covid-related work increasingly transitions into business-as-usual activity.

4.5 The Committee held an Extraordinary Meeting in September 2021 to scrutinise the expanded Winter immunisation programme, covering the planning for delivering both seasonal flu and Covid booster vaccinations. Detail was provided on the governance structures in place (including the appointment of a dedicated Immunisation Programme Director) and the supporting workstreams covering logistics (such as clinic venues and scheduling), workforce and models of care. Members took assurance from the progress made in planning for such a large-scale endeavour. Members also discussed issues ranging from the availability of vaccine, the prioritisation of cohorts, the governance, risk and project management arrangements for the roll-out of the programme, planning for venues, scheduling and appointing mechanisms, and the workforce and financial implications. Also considered at the special meeting was the enhanced Fife Immunisation Strategic Framework for 2021-24, which set out plans for all immunisation programmes for vaccine-preventable disease to be delivered over the period. It was noted that lessons learned from the issues encountered with the 2020-21 Seasonal Flu programme had indicated that improvements in the leadership, management and governance of immunisation programmes were required. The Framework therefore provides the foundation for an integrated strategic approach for planning and delivery of immunisation-related activities, including those related to Covid, clarifying the roles and overlapping responsibilities between the Board, the IJB and the Health & Social Care Partnership. Members greatly welcomed the Framework, recognising this provided helpful clarification and direction over what remains a complex and high-profile programme of work.

4.6 In September 2021, further updates on Covid-related activity were given, with this meeting coinciding with a sharp increase in positive infections within Fife and, as a result, the number of tests being carried out. Assurances were provided on the Board's capacity to manage the high demand, along with efforts being made to minimise staff absence and ensure test sites (both fixed and mobile) were easily accessible to the entire Fife population. The upsurge in cases caused significant pressure on clinical services, with increased Acute admissions and subsequent pressure on flow across the overall system. The Committee took assurance from the selective pausing of elective procedures and outpatient activity, which took due account of clinical prioritisation and planning, to address ongoing high levels of activity.

4.7 Further and ongoing updates on Covid-19 activity, in addition to the roll-out of the Flu Vaccination & Covid Vaccination programme, have been given to members at Committee meetings held over the Winter period, where activity has fluctuated, due to the impact of the Omicron wave of infections and reduction of social distancing prevention measures. The progress of the Seasonal Flu and Covid booster campaign has been actively scrutinised, with assurances given around planning, infrastructure and staffing over what has been a period of extremely high activity. A briefing on the Board's response to 'long' or post-Covid syndrome, which is being led by a specific Oversight Group, was given in March 2022. The long-term effects of Covid can vary widely, with enduring impact on both physical and mental health, and the Committee were assured that a range of support measures were being put in place to support individuals who continue to experience after-effects of the illness.

4.8 The January 2022 meeting of the Committee was prioritised to focus on Covid-related business or items otherwise requiring approval, given the critical pressure then apparent on operational staff and Executive Directors. The Committee were apprised of developments to the testing and tracing programme, including funding for the contact workforce and the introduction of antiviral / immune moderated treatment for the most vulnerable via a dedicated Covid-19 Outpatient Assessment (COPA) unit situated at the Victoria Hospital. It was noted that the success of the Covid booster immunisation programme had had a positive impact on reducing the number of individuals requiring hospital treatment due to Covid, but that there remained

serious pressure on care homes and wards due to the levels of infection, impacting on discharge and flow. The FVCV work had been especially challenging over a busy festive period, though nevertheless the Board exceeded the Scottish Government target for vaccines to be delivered under the 'Boosted by the Bells' campaign. Outreach work had also continued, to mitigate any inequalities and to ensure the vaccine is available to all. The Committee continued to take assurance from this important work, noting the exceptional efforts of all involved in the Winter immunisation activities. The strong performance of the Board when compared with other nationally has given the appropriate assurance that the planning and implementation of such a large-scale programme has taken due cognisance of the lessons learned from the 2020 review of Seasonal Flu immunisation and improvement made in immunisation governance, in addition to benefitting from the expertise, dedication and knowledge of staff from across a range of services.

4.9 The Committee has received regular updates on the initial development stages of the Board's new Population Health & Wellbeing Strategy, which will inform planning for the next five to ten years. Development of the individual workstreams are being taken forward through a Portfolio approach involving all members of the Executive Directors' Group. Overall, the workstreams will be linked to the five national care programmes that have been initiated by the Scottish Government. Early engagement has taken place with key stakeholders and members of the public, and updates have been given to the Committee thereon. The Public Health & Wellbeing Committee is the lead Committee for the development of the new Strategy, though the Clinical Governance Committee will continue to have a specific role in the scrutiny and assurance of developments with a defined clinical governance-related impact.

4.10 A draft of the Joint Remobilisation Plan (RMP4), outlining the planning for addressing the backlog of planned care activity following the initial phase of the Covid pandemic, has been reviewed by the Committee and its input welcomed. The Plan detailed the adopted methodology around the planning for resumption of normal services, based around a 'Respond, Recover and Renew' approach, building on earlier iterations of the Plan approved by Scottish Government. For 2021-22, the Winter Plan has been encompassed within the Remobilisation Plan, and this has taken account of the context of levels of demand and staff workforce capacity. A progress update on deliverables has been considered by the Committee at its January 2022 meeting.

4.11 During the pandemic, strategic decisions have been made in relation to both the configuration of services and on which services could reasonably be provided. Changes to service provision have been risk assessed and the Committee has recognised that some patients may be affected by these decisions. As such, any consequences that resulted would not be considered avoidable, given that this was based on the strategic decision to prioritise services to address the pandemic. Importantly, actions to mitigate identified risks were implemented at all opportunity. The Committee considers that the local response to the pandemic was appropriate, considered and aligned to Scottish Government direction. Throughout the pandemic thus far, urgent services such as cancer services and urgent care have been prioritised. Data on Hospital Standardised Mortality Ratios (HSMR) has been considered in regular reporting via the IPQR. Members have noted the data and taken assurance, following discussion about the significance and interpretation of the data within the pandemic period. A further report is expected to be tabled for a future meeting, which will include information from national data collected by Public Health Scotland on HSMR. The governance route for changing or stopping services has been carefully scrutinised through the pandemic response structures of Bronze, Silver and Gold Command groups. Critically, clinical teams and leaders have been central to decision-making, to ensure that any potential harm resulting from cessation or service change was appropriately mitigated. Examples of mitigation include the nationally-agreed surgical prioritisation framework, use of 'Near Me' for the continuance of remote appointments, and outpatient prioritisation. The dynamic nature of the pandemic and

the evolving understanding of the virus has necessitated a continual review of changes, which have been considered through the command structures described and also discussed by the Committee during the year. As services continue to remobilise and recover, the Clinical Governance Committee will continue to offer oversight, to provide assurance in relation to the recovery of services and planning for tackling increased waiting lists. It has also been decided that the risk to patient safety due to increased waiting times will be captured in a revised Quality & Safety Board Assurance Framework submission.

4.12 An update by the Medical Director on the Redesign of Urgent Care, including the governance structure for undertaking this work, was delivered to members in November 2021, with a further report tabled in March 2022. Details on the design and operation of the Flow & Navigation Hub within the Urgent Care Service was outlined, following Scottish Government guidance for all Boards to establish a local hub to ensure patients are directed to the appropriate point of care. This continues to operate successfully, helping ensure Accident & Emergency attendances are managed and patients are directed to the right forms of support for their own individual needs. A new funding stream, Interface Care, helps support the ambulatory options available to patients, to help reduce the length of stay in hospital for certain conditions and to maximise the use of services such as Hospital@Home. The Committee has received subsequent updates on the impact of the changes on the Emergency Department, including measures in place aimed at reducing the pressure at the front door by redirecting patients to more suitable services, and members have gained full assurance that the Board is addressing the national requirements in this area.

4.13 In September 2021, an assurance report on the benefits and enhancements to the patient experience by the introduction of robotic-assisted surgery was considered by the Committee, outlining the potential transformative nature of this initiative on a number of complex surgical procedures.

4.14 In November 2021, the Committee received a detailed update on this risks around the Primary Care Improvement Plan Memorandum of Understanding 2, focusing on those related to delivery, finance and workforce. Members recognised this was a significant workstream, which would be challenging to deliver in time for the nationally-set deadlines. General Practices remain under pressure due to levels of demand and the need to maintain Covid-distancing measures, thus reducing face-to-face contact with patients. Close working is needed with contractors, including pharmacies, in order to achieve the Plan's ambitions and this will be the subject of future reports to the Committee.

4.15 The Committee carefully scrutinises at each meeting key indicators in areas such as performance in relation to falls, pressure ulcers, complaints and the number of Adverse Events, via the Integrated Performance & Quality Report (IPQR). Specific scrutiny has been given in recent meetings to the increased rate of in-patient falls, which has been attributed to the footprint alteration and staffing changes in the hospital due to the pandemic, and the Committee has received detail on how this will be addressed. A detailed report and presentation on reducing incidents of harm from pressure ulcers, catheter-associated urinary tract infections and E Coli Bacterium has also been scrutinised by the Committee, to address concerns where targets have deteriorated. It has been agreed that a specific Committee Development Session be held in the current year to have a deep-dive into this area, to enhance members' knowledge of this area.

4.16 Stand-alone updates on complaints performance have also been discussed at the Committee, noting the backdrop of a backlog of cases built up during the pandemic and a related increase in complaints as treatment delays have multiplied due to pauses in outpatient and elective surgery appointments. Recovery performance has been variable, with the need to pause some complaint activity at times of extreme pressure, exacerbated also by the issue of staff shortage

within the Patient Relations team. Enhancements in reporting to the Committee have been introduced, to provide more meaningful data around patient feedback and experience and analysis / learning from themes and trends, to be progressed by a new Organisational Learning Group. A full-scale review of the IPQR is presently underway, following the Board's Active Governance session held in November 2021, and this will reach its conclusion shortly.

4.17 The Committee noted that robust action plans were developed following Health Improvement Scotland (HIS) Healthcare Associated Infection (HAI) inspection visits to Glenrothes Hospital (7-8 July 2020) and to Adamson Hospital (28 October 2020), with members receiving an update on progress in addressing actions of these inspections at their April 2021 meeting. The Glenrothes Hospital Inspection resulted in the identification of four areas of good practice (particularly around hospital cleanliness and infection control support) and five requirements in areas to be improved (the majority related to improved documentation to ensure that people's health and wellbeing were being supported and safeguarded during the pandemic). The Adamson Hospital Inspection highlighted three areas of good practice (including robust standards of hospital cleanliness and thorough completion of assessment such falls, oral care and pressure ulcers prevention) and eight requirements to be followed up. Six requirements related to improved documentation to ensure that people's health and wellbeing were being supported and safeguarded during the pandemic and two requirements were in relation to infection control practices supporting a safe environment for patients and staff. At their April 2021 meeting, the Committee were pleased to note that the action plan in relation to the Glenrothes Hospital inspection has been fully completed, and that for Adamson Hospital was awaiting final HIS sign-off. In September 2021, the Committee noted that a Covid-focused HIS inspection of the Victoria Hospital, undertaken in May 2021, had concluded with largely positive findings and a number of good practice areas identified. Two minor requirements for improvements were identified and these had been quickly addressed.

4.18 The Committee has discussed planning for the Winter Period (as part of the Board's Joint Remobilisation Plan) and reflected on Winter performance via a report on the 2020/21 period. It was recognised that, particularly with Covid activity ongoing, planning for pressures and surges was, in essence, a year-round activity, which goes beyond the actual Winter season. Services have been recovering as well as remobilising, and close working relationships particularly with colleagues in the Health & Social Care Partnership have helped to managed delay and flow, with varying results across the year.

4.19 The Committee has received updates throughout the year on the new requirements of various legislative initiatives, including, in April 2021, dedicated reports on the Board's preparedness for the introduction of recent guidance on donation and pre-death procedures for organ and tissue donation (effective March 2021) and also new guidelines on the self-referral to forensic medical services for adults, children and young people who have experienced rape, sexual assault or sexual abuse (effective April 2022). In relation to the latter, the Committee were assured that the Board's facilities and services are trauma-informed, holistic and person-centred, whilst fully integrated with cross-sector partners. An update was provided in November 2021 on the National Hub for Reviewing and Learning from the Deaths of Children and Young People, which will be supported locally by the establishment of a Child and Young Persons' Governance Group, reporting henceforth annually into the Committee. Via these reports, the Committee took assurance that the relevant services were fully prepared for the impact of these legislative changes, ensuring that patients and service users would receive the highest standards of care required.

4.20 Reports to the Committee have further detailed the revised model for participation and patient engagement put in place to support any service developments or change, such as the remodelling work undertaken in the reporting year around access to Urgent Care. The newly established Participation & Engagement Advisory Group (PEAG) has been highlighted as a

potential model for other Boards to follow, as detailed in an update to the Committee in April 2021. The Committee noted the linkage of this work to newly released guidance and statutory duties on 'Planning with People: Community Engagement and Participation Guidance for NHS Boards, IJBs and Local Authorities' for healthcare services, with both workstreams being taken forward across relevant partners in tandem. In July 2021, the Committee received a further updated on patient feedback on the early stages of Urgent Care redesign activities, noting the steps being taken to address some concerns raised in the consultation exercise, to ensure no specific groups were being disadvantaged by the change to the process. Members welcomed this person-centred focus and reflection on the national service changes being introduced for unscheduled care pathways.

4.21 In July 2021, members considered a proposal for Fife to develop and implement a new East Region Formulary, which aims to reduce variation between local Health Boards and therefore unwarranted variation in the medications prescribed to patients, with uniformity of choice for clinicians. The governance structure to be adopted (with a direct reporting line into the Clinical Governance Committee) was also described. Members supported the programme of work. Also at the July 2021 meeting, an update was given to members on an ongoing incident relating to the National Cervical Screening Programme, where an issue had been identified where some patients had been mis-coded, with the potential for the causation of harm. Assurance was given that locally in Fife clinicians were actively reviewing cases, to identify with urgency any patients thought to be affected. In March 2022, the Committee reviewed NHS Fife's response to a Scottish Government request for information, following the publication of the findings of the independent review of Paediatric Audiology Services in NHS Lothian, which identified a number of failings in timely patient care. The Committee gained assurance that NHS Fife was actively reviewing the learning from the Lothian review, to ensure early diagnosis and the best possible outcomes for new-borns with potential hearing impairment.

4.22 The Committee, along with others of the Board, considered the revised Fife Integration Scheme, recommending the revisions made to the Board, thus enabling its submission to Scottish Government for formal approval. The revised Scheme has enhanced clarity around the responsibilities and accountabilities of NHS Fife, Fife Council and Fife Integration Joint Board for clinical and care governance and the professional roles held by the Executive Nurse Director, the Executive Medical Director and the Chief Social Work Officer. The formal sign-off by Scottish Government was achieved in March 2022.

4.23 Annual reports were received on the subjects of the work of the Clinical Advisory Panel; Adult Support & Protection; Fife Child Protection (including an in-year update in July 2021, with a particular focus on the possibly of hidden harm due to the pandemic); Health Promoting Health Service; Immunisation; Nursing, Midwifery & Allied Health Professionals' Assurance Framework; Medical Education; Medical Appraisal & Revalidation; Prevention & Control of Infection; Occupational Staff & Wellbeing Service; Organisational Duty of Candour; Research & Development Strategy & Annual Review; Safer Management of Controlled Drugs; Volunteering; and any relevant Internal Audit reports that fall under the Committee's remit, such as those on Digital & Information Governance arrangements and Manual Handling Training. The findings of the Internal Audit report on the Clinical Governance Strategy & Assurance has also been reviewed in depth, helping provide the background to a refreshed framework and delivery plan, due for finalisation in summer 2022. The Committee has also reviewed the clinical governance-related recommendations of the Annual Internal Audit Report for 2020-21. The findings of a recent interim Internal Audit report on resilience has been reviewed and assurance taken that a new Head of Resilience is progressing areas of focussed work around emergency planning, resilience guidance documents and Business Continuity Planning across the organisation, thereby addressing the audit points raised in the report.

4.24 The Committee has received minutes and assurance reports from its three sub-groups, namely the Digital & Information Board, Health & Safety Sub-Committee, and the Information Governance & Security Steering Group, detailing their business during the reporting year. Updates to Terms of Reference and workplans for these groups have also been considered when necessary. As agreed previously, guidance and a template for the format of sub-groups annual assurance statements has been created for the groups to follow, to improve the consistency and content of information provided, and the annual reports of each of the groups have been reviewed at the Committee's April 2022 meeting.

4.25 In reference to the Health & Safety Sub-Committee, whilst Covid has dominated their proceedings, the policy and procedure reviews scheduled for this year have been completed. In November 2020, NHS Fife received a Covid Management 'spot check' visit to the Victoria Hospital site from Health & Safety Executive (HSE) inspectors. The visit resulted in a 'Notice of Contravention' being issued to the organisation with a requirement for actions to be taken around the areas of physical distancing (especially in rest/break areas), records management and training with regard to face fit testing and fit testers, and concerns with changing and locker facilities. Following action to address these recommendations, final confirmation was given in September 2021 that the Notice of Contravention had formally been closed by the HSE. The Sub-Committee have continued to ensure that the Board is meeting all guidance issued around Covid, to ensure the highest levels of protection for staff and patients. Other workstreams considered by the Sub-Committee include oversight of outstanding internal audit points around Manual Handling and Sharps Management and the ongoing recruitment for a new Health & Safety Manager, following the current incumbent's secondment to the Infection Prevention & Control Team. Since the report's production, recruitment for the Health & Safety Manager has successfully concluded, with an anticipated start date of August 2022. In relation to Sharps Management, the Sharps Strategy Group is now scheduled to meet bi-monthly, with enhanced formality in the minuting of its meetings and agendas focused on staff training, risks and procurement.

4.26 The Digital & Information Board has continued to develop the governance, process and controls necessary to assure the organisation about the consideration and delivery of the Digital & Information Strategy and associated delivery plan. Specifically, this relates to ensuring progress is made with delivering the strategic ambition, relating to year three of NHS Fife's Digital and Information Strategy (2019-2024), and ensuring the maintenance and improvement in performance across Digital & Information technical and operational teams. This work has included consideration of a number of significant and outstanding Internal Audit findings given in previous reports, as well as the action points from previous NIS audits. During the pandemic period, there has been unprecedented change in the areas of digital adoption, for staff, patients and the public in general. This has influenced initiatives such as the national appointment system for Covid vaccinations and the further roll-out and adoption of 'Near Me' virtual appointments. The learning from the pandemic period in particular has highlighted the importance of addressing digital inclusion and inequalities, in addition to maximising digital solutions to tackle the resultant backlog of routine healthcare activities.

4.27 Via a number of updates throughout the year, the Committee were assured that Digital & Information colleagues will take due account of recent learning as the Board continues to deliver the key ambitions of the Digital & Information Strategy, noting that these will be scrutinised and prioritised in accordance with the individual programmes and workstreams of the new organisational strategy. The Digital & Information Board will continue to assess the impact on fixed resource levels across Digital teams, who are now required to run an operate the additional digital capabilities introduced. A revised engagement model has been established, which ensures the correct level of clinical and leadership engagement with digital developments, including the prioritisation of projects reflecting clinical effectiveness and safety issues, to help manage excess demand. The removal of legacy and unsecured systems

remains an area of priority, given the high rating of the cyber-security threat level for the public sector that was evident throughout 2021-22. The annual Assurance Statement of the Digital & Information Board provides further detail on the Group's activities and will be considered by the Committee at its May 2022 meeting.

4.28 In relation to specific Digital enhancements, the Committee has received updates on the hospital electronic prescribing and medicines administration system (HEPMA) being introduced in Fife. Contractual negotiations did not proceed as planned, which has delayed the project considerably from its original due date. However, the Committee received assurance that the transformational benefits of the introduction of HEPMA remain undiminished and a new procurement process has begun to move this work forward.

4.29 The Clinical Governance Committee has also considered updates from the Information Governance & Security Steering Group, which has been restructured and refocused on priorities and areas of greatest risk. The Group has reviewed reports detailing the current baseline of performance and controls within the remit of the Information Governance & Security activities, recognising that whilst compliance and assurance in some areas is effective, in others improvement in data availability and reporting is necessary to ensure the confidentiality, availability and integrity of patient, corporate and staff information. The Group have adopted a set of performance measures and a workplan has been introduced, with projects and deliverables associated across outcomes per quarter. This, in turn, brings assurance to support a strong baseline of performance in the area of Information Governance & Security, with improvement against key controls to better measure performance. Throughout the year, the Group were presented with a consistent summary risk profile by risk rating and information relating to the improvement or deterioration of risk during the period. Visualisation of the risk profile, which averaged 26 in number over the year, supported the critique and assurance the Group were able to offer. Internal Audit have now reduced the level of risk associated with Information Governance & Security compliance and there are no issues identified that require disclosure within the Governance Statement, which is testament to improvements made, including in the Group's reporting to the Clinical Governance Committee and the Executive Directors' Group.

4.30 An annual statement of assurance has also been received and considered from the Clinical & Care Governance Committee of the Integration Joint Board, detailing how Clinical & Care Governance mechanisms are in place within all Divisions of the Fife Health & Social Care Partnership and that systems exist to make these effective throughout their areas of responsibility.

4.31 Minutes of Clinical Governance Committee meetings have been subsequently approved by the Committee and presented to Fife NHS Board. The Board also receives a verbal update at each meeting from the Chair, highlighting any key issues discussed by the Committee at its preceding meeting. The Committee maintains a rolling action log to record and manage actions agreed from each meeting, and reviews progress against deadline dates at subsequent meetings. The format of the action log has been enhanced, to provide greater clarity on priority actions and their due dates.

5. Best Value

5.1 Since 2013/14 the Board has been required to provide overt assurance on Best Value. A revised Best Value Framework was considered and agreed by the NHS Board in January 2018. Appendix 2 provides evidence of where and when the Committee considered the relevant characteristics during 2021/22.

6. Risk Management

6.1 In line with the Board's agreed risk management arrangements, NHS Fife Clinical Governance Committee, as a governance committee of the Board, has considered risk through a range of reports and scrutiny, including oversight on the detail of the Board Assurance Framework (BAF) in the areas of Quality & Safety, Strategic Planning and Digital & Information. Progress and appropriate actions were noted. In addition, many of the Committee's requested reports in relation to Covid have been commissioned on a risk-based approach, to focus members' attention on areas that were central to the Board's priorities around care, service delivery and vaccination during peaks of activity during the pandemic.

6.2 During the year, in relation to Quality & Safety, the Committee has specifically considered the overall component of this BAF, along with linked operational risks. In July 2021, it was agreed that a larger scale review of the Board's risk management processes were required, to ensure that each Committee had a realistic and dynamic understanding of the risks relevant to their particular remits. Members supported the planned programme of improvement work going forward with the Board Assurance Framework (this work is planned to conclude in summer 2022). In November 2021, the Committee reviewed revised wording for the Quality & Safety risk, to ensure this was an accurate reflection of what the risk profile is presently. Additionally, it has been agreed that the active consideration of patient safety deteriorating due to increased waiting times will be reflected in the updated Quality & Safety BAF. Further work has been undertaken to review whether the linked risks and descriptions within the BAF are appropriately strategic, with the proposed removal of those deemed operationally. An additional update on these enhancements was provided to the Committee at its March 2022 meeting. This work will proceed in tandem with the organisation risk management review being led at Board-level.

6.3 The Committee recognised that further work is required around the reporting of risks related to transformation programmes, noting that the ongoing strategy review will bring an overall focus and direction to a number of hitherto individual strands of work. In relation to the Strategic Planning BAF, the core risk has been reviewed to clearly reference the development and the delivery of the Population Health & Wellbeing Strategy and to focus this at a more strategic level. New wording was agreed for this particular risk, which highlights the key role of the Board's governance committees in shaping and influencing strategy development, and thus scrutinising progress delivery once a new strategy has been agreed. Updates have been given to the Committee on the Strategic Planning & Resource Allocation process for 2022-23, now in its second year of operation, which has linkages to the overall Remobilisation / annual financial and workforce planning and definition of Corporate Objectives. It is considered that this focus will improve the overall lines of reporting and assurance to the Committee over the forthcoming year.

6.4 In relation to Digital & Information risks, the alignment of risks to the two revised governance groups (the Digital & Information Board and the Information & Security Steering Group) has been progressed. Colleagues have worked closely with the Risk Manager and Internal Auditors to pilot a revised BAF for this area, to reflect core operational, strategic and information security risks critical to the organisation and enhanced framing within the overall Digital Strategy. A number of risks have heightened during the year, including those related to the overall cyber threat landscape and the potential for financial costs to increase due to the new nationally negotiated licensing deal for software. It has been recognised that financial prioritisation has to take place, to address those areas that are essential to support the Digital & Information Strategy.

7. Self-Assessment

7.1 The Committee has undertaken a self-assessment of its own effectiveness, utilising a revised questionnaire considered and approved by the Committee Chair. Attendees were also invited

to participate in this exercise, which was carried out via an easily-accessible online portal. A report summarising the findings of the survey was considered and approved by the Committee at its March 2022 meeting, and action points are being taken forward at both Committee and Board level.

8. Conclusion

8.1 As current Chair of the Clinical Governance Committee, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place throughout NHS Fife during the year.

8.2 I can confirm that that there were no significant control weaknesses or issues at the year-end which the Committee considers should be disclosed in the Governance Statement, as they may have impacted financially or otherwise in the year or thereafter.

8.3 I would pay tribute to the dedication and commitment of fellow members of the Committee and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings of the Committee, particularly in another most challenging year, set against the ongoing backdrop of the Coronavirus pandemic. All Committee members and I continue to be astounded and humbled by the efforts made by NHS Fife and Fife Health & Social Care staff at what continues to be a difficult period of exceptional demand on our Acute and community services. We all remain in their debt.

Signed: Christina Cooper Date: 29 April 2022

Christina Cooper, Chair
On behalf of the Clinical Governance Committee

Appendix 1 – Attendance Schedule
Appendix 2 – Best Value

APPENDIX 1

NHS Fife Clinical Governance Committee Attendance Record
1 April 2021 to 31 March 2022

	30.04.21	07.07.21	02.09.21	17.09.21	03.11.21	13.01.22	10.03.22
Members							
C Cooper, Non-Executive Member **(Chair)**	P	P	P	P	P	P	P
M Black, Non-Executive Member	P	P	P	P	P	P	P
S Braiden, Non-Executive Member	P	P	P	P	P	P	P
W Brown, Area Partnership Forum Representative	X						
S Fevre, Area Partnership Forum Representative		P	P	P	P	X	P
Cllr D Graham, Stakeholder Member, Fife Council	P	P	P	P	X	X	X
R Laing, Non-Executive Member	X	P	P	X	P	P	P
A Lawrie, Area Clinical Forum Representative	X	P	X	P	P	X	X
C McKenna, Medical Director **(Exec Lead)**	P	P	X	P	P	P	P
D Milne, Director of Public Health	P						
J Owens, Director of Nursing	P	P	P	P	P	P	P
C Potter, Chief Executive	X	P	P	P	P	X	P
J Tomlinson, Director of Public Health		P	P	P	P	P	P Item 1 – 8.1
M Wells, Non-Executive Member	P	P					
A Wood, Non-Executive Member					P	P	P
In Attendance							
H Bett, Senior Manager Children's Services Project	P Item 9.2						P Item 8.6
N Beveridge, Head of Nursing	P						
S Blair, Consultant in Occupational Medicine							P Item 10.2
L Campbell, Associate Director of Nursing	X	P	P	X	P	P	X
N Connor, Director of H&SC	X	P	X	x	P	P	X
L Cooper, Immunisation Programme Director			P		P Item 5.2		
G Couser, Associate Director of Quality & Clinical Governance	P	P	X	P	P	P	P

APPENDIX 1

	30.04.21	07.07.21	02.09.21	17.09.21	03.11.21	13.01.22	10.03.22
B Davis, Head of Primary & Preventative Care			P				
E Curnock, Deputy Director of Public Health		P					
C Dobson, Director of Acute Services	P	P	P	x	P	P	x
L Douglas, Director of Workforce			P				
F Forrest, Interim Deputy Director of Pharmacy							P
S Fraser, Associate Director of Planning & Performance	P	P	P	x		P	
S Garden, Director of Pharmacy & Medicines (to March 2022)	P	x	P	P	P	x	
A Graham, Director of Digital & Information	x	P	P	P	P	x	P
B Hannan, Director of Pharmacy & Medicines (from March 2022)		P				P	x
H Hellewell, Associate Medical Director, H&SCP	P	P	x	P	x	x	x
G MacIntosh, Head of Corporate Governance & Board Secretary	P	P	P	P	P	P	P
N McCormick, Director of Property & Asset Management			P	P		P	
M McGurk, Director of Finance & Strategy	x	P	x	P	P	P	P
A McKay, Deputy Chief Operating Officer				P			P
F McKay, Divisional General Manager				P			
M Michie, Deputy Director of Finance & Strategy			P				
J Morrice, AMD, Women & Children Services	P	x	x	x	P	x	x
E Muir, Clinical Effectiveness Co-ordinator	P	P	x	P	P	x	P
M Wood, Interim Associate Medical Director for Surgery, Medicine & Diagnostics						P	P

Best Value Framework

Vision and Leadership

A Best Value organisation will have in place a clear vision and strategic direction for what it will do to contribute to the delivery of improved outcomes for Scotland's people, making Scotland a better place to live and a more prosperous and successful country. The strategy will display a clear sense of purpose and place and be effectively communicated to all staff and stakeholders. The strategy will show a clear direction of travel and will be led by Senior Staff in an open and inclusive leadership approach, underpinned by clear plans and strategies (aligned to resources) which reflect a commitment to continuous improvement.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
The strategic plan is translated into annual operational plans with meaningful, achievable actions and outcomes and clear responsibility for action.	Winter Plan Capacity Plan	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **CLINICAL GOVERNANCE COMMITTEE** **BOARD**	Annual Bi-monthly Bi-monthly	Winter Plan review NHS Fife Clinical Governance Workplan is approved annually and kept up-to-date on a rolling basis Minutes from Linked Committees e.g. · NHS Fife Area Drugs & Therapeutics Committee · Acute Services Division, Clinical Governance Committee · NHS Fife Infection Control Committee · NHS Fife H&SCP Care & Clinical Governance Committee NHS Fife Integrated Performance & Quality Report is considered at every meeting

GOVERNANCE AND ACCOUNTABILITY

The "Governance and Accountability" theme focuses on how a Best Value organisation achieves effective governance arrangements, which help support Executive and Non-Executive leadership decision-making, provide suitable assurances to stakeholders on how all available resources are being used in delivering outcomes and give accessible explanation of the activities of the organisation and the outcomes delivered.

OVERVIEW

A Best Value organisation will be able to demonstrate structures, policies and leadership behaviours which support the application of good standards of governance and accountability in how the organisation is improving efficiency, focusing on priorities and achieving value for money in delivering its outcomes. These good standards will be reflected in clear roles, responsibilities and relationships within the organisation. Good governance arrangements will provide the supporting framework for the overall delivery of Best Value and will ensure openness and transparency. Public reporting should show the impact of the organisations activities, with clear links between the activities and what outcomes are being delivered to customers and stakeholders. Good governance provides an assurance that the organisation has a suitable focus on continuous improvement and quality. Out with the organisation, good governance will show itself through an organisational commitment to public performance reporting about the quality of activities being delivered and commitments for future delivery.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Board and Committee decision-making processes are open and transparent.	Board meetings are held in open session and minutes are publicly available. Committee papers and minutes are publicly available	**BOARD** **COMMITTEES**	Ongoing	Strategy updates considered regularly Via the NHS Fife website
Board and Committee decision-making processes are based on evidence that can show clear links between activities and outcomes	Reports for decision to be considered by Board and Committees should clearly describe the evidence underpinning the proposed decision.	**BOARD** **COMMITTEES**	Ongoing	SBAR reports EQIA section on all reports

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
NHS Fife has developed and implemented an effective and accessible complaints system in line with Scottish Public Services Ombudsman guidance.	Complaints system in place and regular complaints monitoring.	**CLINICAL GOVERNANCE COMMTTEE**	Ongoing Bi-monthly	Single complaints process across Fife health & social care system NHS Fife Integrated Performance & Quality Report is discussed at every meeting. Complaints are monitored through the report.
NHS Fife can demonstrate that it has clear mechanisms for receiving feedback from service users and responds positively to issues raised.	Annual feedback Individual feedback	**CLINICAL GOVERNANCE COMMITTEE**	Ongoing Bi-monthly	Update on Participation & Engagement processes and groups undertaken during the reporting year. NHS Fife Integrated Performance & Quality Report is discussed at every meeting. Complaints are monitored through the report.

USE OF RESOURCES

The "Use of Resources" theme focuses on how a Best Value organisation ensures that it makes effective, risk-aware and evidence-based decisions on the use of all of its resources.

OVERVIEW

A Best Value organisation will show that it is conscious of being publicly funded in everything it does. The organisation will be able to show how its effective management of all resources (including staff, assets, information and communications technology (ICT), procurement and knowledge) is contributing to delivery of specific outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
There is a robust information governance framework in place that ensures proper recording and transparency of all NHS Fife's activities.	Information & Security Governance Steering Group Annual Report Digital & Information Board Annual Report Digital & Information Board minutes	**CLINICAL GOVERNANCE COMMITTEE**	Annual	Minutes and Annual Report considered, in addition to related Internal Audit reports. Reporting format and content has been enhanced in current year.
NHS Fife understands and exploits the value of the data and information it holds.	Remobilisation Plan Integrated Performance & Quality Report	**BOARD** **COMMITTEES**	Annual Bi-monthly	Integrated Performance & Quality Report considered at every meeting Particular review of performance in relation to pressure ulcers, falls, catheter infections and E Coli undertaken in current year

PERFORMANCE MANAGEMENT

The "Performance Management" theme focuses on how a Best Value organisation embeds a culture and supporting processes which ensures that it has a clear and accurate understanding of how all parts of the organisation are performing and that, based on this knowledge, it takes action that leads to demonstrable continuous improvement in performance and outcomes.

OVERVIEW

A Best Value organisation will ensure that robust arrangements are in place to monitor the achievement of outcomes (possibly delivered across multiple partnerships) as well as reporting on specific activities and projects. It will use intelligence to make open and transparent decisions within a culture which is action and improvement oriented and manages risk. The organisation will provide a clear line of sight from individual actions through to the National Outcomes and the National Performance Framework. The measures used to manage and report on performance will also enable the organisation to provide assurances on quality and link this to continuous improvement and the delivery of efficient and effective outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Performance is systematically measured across all key areas of activity and associated reporting provides an understanding of whether the organisation is on track to achieve its short and long-term strategic, operational and quality objectives	Integrated Performance & Quality Report encompassing all aspects of operational performance, Annual Operational Plan targets / measures, and financial, clinical and staff governance metrics. The Board delegates to Committees the scrutiny of performance Board receives full Integrated Performance & Quality Report and notification of any issues for escalation from Committees.	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report considered at every meeting Minutes from Linked Committees e.g. · Area Drugs & Therapeutics Committee · Acute Services Division, Clinical Governance Committee · Digital & Information Board · Infection Control Committee · Information Governance & Security Steering Group
The Board and its Committees approve the format and content of the performance reports they receive	The Board / Committees review the Integrated Performance & Quality Report and agree the measures.	**COMMITTEES** **BOARD**	Annual	Integrated Performance & Quality Report considered at every meetings. Review of format and content is being undertaken in reporting year.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Reports are honest and balanced and subject to proportionate and appropriate scrutiny and challenge from the Board and its Committees.	Committee Minutes show scrutiny and challenge when performance is poor as well as good; with escalation of issues to the Board as required	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report considered at every meetings Minutes of Linked Committees are reported at every meeting, with improved process for escalation of issues.
The Board has received assurance on the accuracy of data used for performance monitoring.	Performance reporting information uses validated data.	**COMMITTEES** **BOARD**	Every meeting Annual	Integrated Performance & Quality Report considered at every meeting The Committee commissions further reports on any areas of concern, e.g. as with complaints, adverse events.
NHS Fife's performance management system is effective in addressing areas of underperformance, identifying the scope for improvement, agreeing remedial action, sharing good practice and monitoring implementation.	Encompassed within the Integrated Performance & Quality Report	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report considered at every meeting Minutes of Linked Committees · Area Clinical Forum · Acute Services Division, Clinical Governance Committee · Area Drugs & Therapeutics Committee

CROSS-CUTTING THEME – EQUALITY

The "Equality" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded an equalities focus which will secure continuous improvement in delivering equality.

OVERVIEW

Equality is integral to all our work as demonstrated by its positioning as a cross-cutting theme. Public Bodies have a range of legal duties and responsibilities with regard to equality. A Best Value organisation will demonstrate that consideration of equality issues is embedded in its vision and strategic direction and throughout all of its work.

The equality impact of policies and practices delivered through partnerships should always be considered. A focus on setting equality outcomes at the individual Public Body level will also encourage equality to be considered at the partnership level.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
NHS Fife meets the requirements of equality legislation.		**BOARD** **COMMITTEES**	Ongoing	Strategy updates regularly considered, along with People with Planning updates in current year All strategies have a completed EQIA
The Board and senior managers understand the diversity of their customers and stakeholders.	Equality Impact Assessments are reported to the Board and Committees as required and identify the diverse range of stakeholders.	**BOARD** **COMMITTEES**	Ongoing	Strategy updates regularly considered Vaccination programme updates have this as a central point of reporting All strategies have a completed EQIA
NHS Fife's policies, functions and service planning overtly consider the different	In accordance with the Equality and Impact Assessment Policy, Impact Assessments consider the current and future needs and	**BOARD** **COMMITTEES**	Ongoing	All NHS Fife policies have a EQIA completed and approved. The EQIA is published alongside the policy

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
current and future needs and access requirements of groups within the community.	access requirements of the groups within the community.			when uploaded onto the website
Wherever relevant, NHS Fife collects information and data on the impact of policies, services and functions on different equality groups to help inform future decisions.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments will collect this information to inform future decisions.	**BOARD** **COMMITTEES**	Ongoing	Update on Participation & Engagement processes and groups undertaken during the reporting year, which encompassed effectiveness of engagement with key groups of users

ANNUAL STATEMENT OF ASSURANCE FOR THE FINANCE, PERFORMANCE & RESOURCES COMMITTEE 2021/22

1. Purpose of Committee

1.1 The purpose of the Committee is to keep under review the financial position and performance against key non-financial targets of the Board, and to ensure that suitable arrangements are in place to secure economy, efficiency and effectiveness in the use of all resources, and that these arrangements are working effectively.

2. Membership of Committee

2.1 During the financial year to 31 March 2022, membership of the Finance, Performance & Resources Committee comprised:

Rona Laing	Chair / Non-Executive Member
Wilma Brown	Non-Executive Stakeholder Member
Eugene Clarke	Non-Executive Member (to July 2021)
Alastair Grant	Non-Executive Member (from September 2021)
Aileen Lawrie	Area Clinical Forum Representative
Mansoor Mahmood	Non-Executive Member (from September 2021)
Margo McGurk	Director of Finance & Strategy
Dona Milne	Director of Public Health (to May 2021)
Alistair Morris	Non-Executive Member
Dr Chris McKenna	Medical Director
Janette Owens	Director of Nursing
Carol Potter	Chief Executive
Joy Tomlinson	Director of Public Health (from May 2021)

2.2 The Committee may invite individuals to attend the Committee meetings for particular agenda items, but the Director of Acute Services, Director of Health & Social Care, Director of Property & Asset Management, Director of Pharmacy & Medicines and Board Secretary will normally be in attendance at Committee meetings. Other attendees, deputies and guests are recorded in the individual minutes of each Committee meeting.

3. Meetings

3.1 The Committee met on six occasions during the financial year to 31 March 2022, on the undernoted dates:

- 11 May 2021
- 13 July 2021

- 7 September 2021
- 9 November 2021
- 11 January 2022
- 15 March 2022

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 The business of the Committee during the year continues to have been impacted greatly by the need for NHS Fife as a whole to address the ongoing challenges of the global Covid pandemic. The Committee Chair has liaised closely with the Director of Finance & Strategy, as lead Executive Officer, to identify what business must be considered by the Committee and what must be prioritised in agenda planning. In the period covered by this report, some routine business has been suspended or deferred, with the occasional meeting running with a prioritised agenda. This has maximised the time available for management and operational staff to deal with the significant challenges of addressing Covid-surge-related demand within clinical services, and, at the same time, allowed the Board to appropriately discharge its governance responsibilities. The Committee workplan has been regularly reviewed to ensure that new items related to Covid have been covered appropriately and that the required assurances could be provided to the Board throughout the year and as part of the year-end process.

4.2 In October 2021, the Board established a new Public Health & Wellbeing Committee, which has taken under its remit some areas previously covered by the Finance, Performance & Resources Committee (chiefly scrutiny over mental health performance delivery in Child & Adolescent Mental Health Services (CAMHS) and Psychological Therapies (PT)). A review of workplans and terms of reference has attempted to limit any duplication in reporting and enhance clarity on roles and responsibilities. This remains, however, a work-in-progress, as the new Committee develops, and gives the Finance, Performance & Resources Committee an opportunity for more focused agendas and enhanced scrutiny on the key aspects of business aligned to its specific remit.

4.3 At each meeting the Finance, Performance & Resources Committee considers the most up-to-date financial position for the year for both revenue and capital expenditure. This function is of central importance, as the Committee provides detailed scrutiny of the ongoing financial position and on aspects of operational performance across NHS Fife activities, including those delegated to the Integration Joint Board. Considerable time was spent in meetings discussing and reviewing the financial pressures facing the Board, the delivery of in-year savings and consideration of the financial consequences, particularly of Covid. Updates on the predicted year-end position were presented and discussed by members.

4.4 The Finance, Performance & Resources Committee's first meeting of the 2021/22 reporting year took place in May 2021. An update on the budget setting process for 2021/22 was given, including its relationship with the Strategic Planning & Resource Allocation process (SPRA), then in its initial phase of operation.

4.5 In January 2022, the Committee gained assurance from a detailed report proposing the creation of a dedicated Financial Improvement & Sustainability Programme, building on the solid foundation provided by the first two years of the SPRA. Members noted that NHS Fife are committed to delivering a cost improvement programme that has capacity to deliver substantial cost reduction benefits. It was noted that, moving forward, there may require to be two risks reported on the Financial Sustainability Board Assurance Framework. One would relate to in-year financial performance and the other would be a risk on financial improvement and sustainability for the medium-term. This will be discussed and reviewed appropriately by the Committee in the year ahead.

4.6 The Committee has received updates on financial planning in light of the Covid response, with further iterations of the Board's Remobilisation Plan prepared and submitted to members, prior to seeking Scottish Government agreement on its content. In May 2021, the Committee considered in Private Session comments received from the Scottish Government on the Board's Remobilisation Plan 3, noting the requirement for further discussion on the management of legacy savings from 2020/21. In September 2021, an update on the next iteration of the Remobilisation Plan (RMP4) was given, which also encompassed the annual Winter Plan actions. An action tracker, outlining key actions and progress on deliverables, has helped support the delivery of the Plan and scrutiny of its achievements against target dates.

4.7 Updates have been given to the Committee on the Strategic Planning & Resource Allocation process for 2022-23, now in its second year of operation, which has generated key content to support the Remobilisation Plan for 2022/23, financial and workforce plans and the Corporate Objectives for the year. It is considered that this focus will improve the overall lines of reporting and assurance to the Committee over the forthcoming year. Ongoing reports have been provided on the Strategy Development work, including details on the proposed engagement approach and the development of the Population Health Needs Assessment, which will create the baseline for the new strategy. Development of the individual workstreams are being taken forward through a Portfolio approach involving all members of the Executive Directors' Group. Overall, the workstreams will be linked to the five national care programmes that have been initiated by the Scottish Government. Early engagement has taken place with key stakeholders and members of the public, and updates have been given to the Committee thereon. The Public Health & Wellbeing Committee is the lead Committee for the development of the new Strategy, though the Finance, Performance & Resources Committee will continue to have a specific role in the scrutiny and assurance of the financial plan.

4.8 The draft Corporate Objectives 2021/22 were presented to the Committee in July 2021. The report described what NHS Fife aims to achieve in-year, in tandem with a looking-back review of Directors' Objectives for 2020/21. Each objective has been carefully refined, with details on what Directors are leading on or supporting more generally. The objectives are framed under the four key strategic priorities of the Board and reference the ongoing Strategy Development work being undertaken in this reporting year. The Committee were pleased to endorse the Corporative Objectives for onward submission to the Board for formal approval.

4.9 The Committee scrutinised operational performance at each meeting through review of the Integrated Performance & Quality Report (IPQR), specifically those measures that fall within its own remit (performance updates related to CAMHS and Psychological Therapies have transitioned to come under the responsibility of the new Public Health & Wellbeing Committee over the year). The impact of coronavirus on traditional key performance measures monitored by the Committee was significant, particularly in relation to Treatment Times Guarantee measures, numbers of new referrals and diagnostic performance. In general, the plans to tackle the resultant backlog from the pause of services during the height of the pandemic remains a significant focus of the Committee going forward. Demand for services has continued to exceed expectation for much of the year, leading to significant pressures particularly at the front-door of the Emergency Department. Spikes in Covid-related infection have continued to negatively impact upon the delay position and discharge / flow, with the Committee receiving a specific paper on this issue at its September 2021 meeting. Scrutiny of the actions underway to improve the situation was undertaken, with members noting the negative impact on whole-system care, quality and workforce in consequence of the delay position.

4.10 The Committee discussed planning for the Winter Period (as part of the Board's Remobilisation Plan) and reflected on Winter performance via a report on the 2020/21 period. It was recognised that, particularly with Covid activity ongoing, planning for pressures and surges was, in essence, a year-round activity, which goes beyond the actual Winter season. Services have been recovering as well as remobilising, and close working relationships (particularly with colleagues in the Health & Social Care Partnership) have helped to manage delay and flow, with varying results across the

year. It has been important for the Board continuously review proposals to mitigate capacity issues, to ensure that pressures 365 days per year are accounted for in overall planning. Activity levels have at some periods been unrelenting, and the Committee were fully apprised of the impact this had on the variability of performance overall, particularly around key targets such as A&E attendances. Clinical prioritisation, however, ensures that the most urgent cases continue to receive timely treatment. In March 2022, members were pleased to note the introduction of a new Operational Pressures Escalation Levels (OPEL) process, which is helping manage day-to-day pressures, with clear triggers for action and escalation.

4.11 At the Committee's July 2021 meeting, members received an update on the Smoke-Free Environmental Strategy, which closed an action on the Committee rolling action list in reference originally to work to support smoking cessation at the Stratheden Intensive Psychiatric Care Unit (IPCU).

4.12 The Committee has considered updates around the status of General Policies & Procedures, noting that the introduction of a new post-holder in the Corporate Governance support team has led to considerable work being undertaken to improve the follow-up processes and guidance available to staff. The format and content of the report to the Committee has also been enhanced to provide clearer detail and assurance around areas that require further follow-up work. Members have previously been supportive of efforts to move to a more streamlined review process, utilising electronic software solutions where appropriate, and this remains under review with an option appraisal process underway by Clinical Governance colleagues. Dedicated staff resource secured to assist with the general administration and review of General Policies is expected to improve the situation in the long term with the backlog of overdue reviews and the Committee will receive ongoing updates on this, for assurance.

4.13 The Committee considered progress in relation to the following capital schemes:

- Fife Orthopaedic National Treatment Centre
- Hospital Electronic Prescribing & Medicines Administration (HEPMA)
- Kincardine & Lochgelly Health Centres
- Robotic Assisted Surgery

4.14 Ongoing quarterly updates were provided to members on the progress with the Elective Orthopaedic Centre construction project. A report from NHS Scotland Assure was considered in May 2021, which reviewed the delivery, quality and sustainability of the build and assessed the capability and capacity of the Board to deliver the project on time and on budget. Two risks identified in the report were discussed and assurance provided that both had the required mitigation in place. The NHS Scotland Assure review process is intended to support local work by providing a central bank of knowledge and intelligence to support boards deliver large-scale capital projects. Members were pleased to note its findings and took assurance from the proposed governance routes set out to close the residual actions arising from the report. In July 2021, an update on build progress was given, outlining a number of developing issues on construction material availability and associated price increases, which were being actively managed by the Project Board. Further information was given on work ongoing with Fife Health Charity to enhance the patient and staff areas and deliver supplementary audio visual capability within theatres. The Committee also took assurance from the dedicated workforce strategy within the programme to ensure availability of appropriately-trained staff by its opening. In November 2021, further detail was given on workforce planning and also the service model being designed for the new centre, and in March 2022 members received information on recruitment of posts and the financial implications and additional Scottish Government funding required to support an increase in planned workforce for the Centre.

4.15 At the Committee's March 2022 meeting, members received a report detailing significant contractual issues with the HEPMA contract award and the eventual ceasing of negotiation with the preferred supplier in January 2022. It was noted that a full re-procurement exercise will now be required. The Committee noted their disappointment that the original procurement process could not be concluded successfully, but recognised that this was a late decision on a major contractual

term by the preferred supplier. The Committee took assurance that lessons learned throughout the original negotiations will help assist the revised procurement stage for a replacement supplier.

4.16 Updates on the Outline Business Case for the new Kincardine & Lochgelly Health & Wellbeing Centres were delivered to the Committee at its 2021/22 meetings. Consultation with local stakeholders and design of the replacement Health Centres progressed throughout the year and, in July 2021, the Committee received a detailed update on progress in creating the Outline Business Case. Communication with local communities was noted as being critical, with the creation of a number of 'personas' to help support delivery of the project aims.

4.17 In March 2021, the Committee supported the initial Business Case for the purchase of a surgical robot. The Business Case was updated and reviewed by the Committee in May 2021, with a final Business Case following in July 2021. Members recognised the significant capital funding received to support the procurement of a surgical robot was an important development in enhancing surgery in Fife and driving forward innovation. Detail was provided on how Acute Services would manage the revenue costs of this programme within the directorate. The launch of this service will deliver clinical benefits to patients and be an important driver in attracting highly skilled staff to work in Fife, and these benefits were warmly welcomed by members.

4.18 The Committee also considered and endorsed the Capital Formula Allocation for 2021/22, which provided budget distributions from the core capital allocation of £7.2m. Detail was provided on the individual projects and business cases being supported. In September 2021, a specific report on the work of the Fife Capital Investment Group (FCIG) was considered, with discussion on the risk mitigation processes in place to help lessen supply chain-related shortages. At the same meeting, a detailed report on the Quarter 1 Financial Review 2021/22 was discussed with members, with focus on the risk of unachieved (and legacy) savings, the pressures in respect of Service Level Agreements and the longer term-impact of Covid on the Board financial position. Committee members recognised that delivery of savings in-year, when the workforce remains under significant pressure, is very challenging and were assured that the review process outlined viable medium-term cash reduction plans, to help the Board achieve recurring financial balance in the next three years. In November 2021, the Annual Report of FCIG was reviewed and an update received on the targeted spend of the full capital allocation by the end of March 2022. It was recognised that the spend achieved in 2021/22 supported the largest capital programme in NHS Fife for a number of years, and Finance and Property and Assets colleagues were congratulated on their efforts.

4.19 The annual Public Private Partnership (PPP) Monitoring Report for 2020/21, covering the sites of St Andrews Community Hospital and Phase 3 of the Victoria Hospital in Kirkcaldy, was considered by the Committee in November 2021, with members gaining assurance from the positive audit opinion detailed therein. Members reviewed the interim Property & Asset Management Strategy (PAMS) update for 2020 at its March 2021 meeting, with a further update on the preparation of the full strategy given in July, prior to the final document coming forward to the November 2021 meeting. It was recognised that the PAMS document is an important supporting framework to the development of the organisation strategy, describing how the NHS Fife estate will help deliver and support its ambitions. The current iteration, considered by the Committee in November 2021, gave a local focus to the work underway in NHS Fife related to Anchor Institution ambitions, plus further detail on our plans to improve Environmental Sustainability though our work on zero carbon initiatives, enhancing green spaces and embracing bio-diversity. Members noted that NHS Fife has a large estate footprint and diverse asset base, with considerable potential for this to be better exploited in the future. Another learning point to be captured further in future planning is the impact of remote working, which has increased greatly in the pandemic, and has consequences for how we best use our estate and existing buildings going forward. Members greatly welcomed the report's enhancements, noting its strategic focus across the wider organisation has direct relevance to the work underway in developing a new organisational strategy to help serve our local communities.

4.20 In July 2021, the Committee considered a report on the Transfer of Third-Party Leases from GP practices, to help support GP sustainability. The Committee took assurance on the interim arrangements being put in place for the first two premises and the discussions ongoing to help support the policy changes overall. In September 2021, members reviewed a paper outlining the ongoing Primary Care Premises Review, which will help support the delivery of the new General Medical Services Memorandum of Agreement (GMS MoU2). This workstream is also of critical importance to the development of the organisational strategy, to help alleviate pressures within GP practices and to ensure that local services appropriately address local needs. Members supported this approach, which is an important cornerstone of the work being undertaken to review the NHS Fife property and asset needs and requirements over the longer term.

4.21 The Committee has received a briefing on the Board's participation in the Non-Domestic Energy Efficiency Framework (NDEE), which aims to support public sector bodies to decarbonise and use less energy. Members noted the Board had been successful in its bid for funding to support low energy initiatives, which will have a positive impact on financial savings and help improve carbon off-setting performance. In March 2022, a further update was given, with members welcoming the significant grant received by NHS Fife to support greater energy efficiency across the estate.

4.22 The Committee received initial updates on a Community Asset Transfer (CAT) request, submitted under the Community Empowerment Act 2015, by a charity body seeking a long-term lease of mainly agricultural land adjacent to the Stratheden Hospital site. Members agreed to a short-life working group being established to formally evaluate the request and its supporting business case against the defined criteria described in the legislation, with a recommendation on the proposal expected in May 2022. A scoring matrix was developed to enable the proposal to be appraised against key indicators.

4.23 In November 2020, the Committee originally considered the South East Payroll Consortium Business Case, which has also been considered by the Staff Governance Committee. The proposal outlines the ambition to build a single employer, with multiple bases, to ensure the resilience of payroll on a regional basis in the future, given long-standing capacity challenges across boards. Members supported the proposal in principle, noting the criticality of the service to the Health Board, but recommended discussions take place about a more phased approach than the draft timeline suggested. A further update was given in January 2022, where an addendum to the original Business Case was given to address previously submitted feedback, particularly around the staff TUPE process and phasing of the implementation. Given that staffing levels in the local payroll team continue to represent a significant risk to the organisation, and also recognising the criticality of the function, members welcomed the resilience the consortium approach would provide. The Committee supported the implementation of the regional solution as soon as practically possible.

4.24 In March 2022, the Committee considered and endorsed the Annual Procurement Report, which sets out compliance with national standards in relation to procurement.

4.25 The Committee considered the revised Fife Integration Scheme. The Committee took assurance from and endorsed the revisions particularly within the finance section. The formal sign-off by Scottish Government was achieved in March 2022. The Committee has also considered further guidance on the IJB's increasing use of Directions at its meeting in November 2021, which indicates how Directions to NHS Fife will be issued, responded to and monitored on a performance-related basis. Members noted the helpful clarity that Directions provide and agreed that the Committee will receive such instructions from the IJB as required.

4.26 The Committee considered internal audit reports relevant to its remit and the actions required thereunder, which are monitored for completion by the Audit & Risk Committee. Also considered in July 2021 was an internal audit report on Financial Process Compliance, with the auditors' findings discussed and noted. Members noted that there had been no requirements to revise any internal control mechanism across the Board during Covid, and that commendation had been given

to work undertaken to redistribute staff to ensure procurement-related work and securing PPE were prioritised at key stages of the pandemic. The Annual Internal Audit report was considered in November 2021, with members noting the positive comments from the auditors on the SPRA and strategy development process. In addition, in July 2021, the Committee received the annual report on the Laboratories Managed Service Contract, focused on the performance against contract.

4.27 An updated draft of the Board's Model Publication Scheme, required under Freedom of Information legislation, was also considered and approved at the Committee's meeting in July, noting its relevance to ensuring improved FOI performance more generally.

4.28 Minutes of Committee meetings have been approved by the Committee and presented to Fife NHS Board. The Board also receives a verbal update at each meeting from the Chair, highlighting any key issues discussed by the Committee at its preceding meeting. The Committee maintains a rolling action log to record and manage actions agreed from each meeting, and reviews progress against deadline dates at subsequent meetings. The format of the action log has been enhanced, to provide greater clarity on priority actions and their due dates.

5. Outcomes

5.1 The Committee has, through its scrutiny and monitoring of regular finance reports and other one-off reports, been able to assure the Board that NHS Fife:

- complied with statutory financial requirements and achieved its financial targets for the financial year 2021/22;
- met specific reporting timetables to both the Board and the Scottish Government Health & Social Care Directorates;
- exceeded the in-year efficiency saving target, though this required Scottish Government support for the historical underlying target associated with a recurring overspend in Acute services; and
- has taken account of planned future policies and known or foreseeable future developments in the financial planning process.

6 Best Value

6.1 The introduction of both the SPRA process in 2020/21 and the Financial Improvement & Sustainability Programme in 2021/22 build on the aims of the previous organisational Best Value Framework (2018). Their combined impact facilitates a more effective triangulation of workforce, operational and financial planning, which supports the promotion and delivery of best value across all of our resource allocation. The Committee supported both these initiatives and throughout 2021/22 received progress reports and plans for consideration. The Committee were able to take ongoing assurance that the organisation had the plans and processes in place to promote and deliver best value.

6.2 Appendix 2 provides evidence of where and when the Committee considered the relevant best value characteristics during 2021/22.

7 Risk Management

7.1 In line with the Board's agreed risk management arrangements, the Committee considered risk through a range of reports and scrutiny, including oversight on the detail of the Board Assurance Frameworks (BAF) covering Financial Sustainability, Strategic Planning and Environmental Sustainability. Progress and appropriate actions were noted. The Committee monitored and took assurance from the BAF reporting on Financial Sustainability throughout the year and particularly the additional costs and funding associated with the Covid response and the delivery of in-year and historical efficiency savings.

7.2 In the current year, the complexity of financial reporting remained high, as a result of maintaining the core and Covid financial monitoring and reporting arrangements. The Committee has maintained an appropriate focus on these risks in its discussions, in addition to its regular scrutiny of the Financial Sustainability BAF and the tracking of the high risks identified therein.

7.3 The Committee closely monitored the position in relation to Financial Sustainability, noting in May 2021 that, due to achieving full funding for the Covid position and a break-even position for Year End 2020/21, the risk for this BAF would be amended to moderate (down from the previous high rating). In the longer term, members noted that receiving the required level of Covid-related funding and delivering the required level of previously unachieved savings on a recurring basis was an important driver for maintenance of the risk at this lower level. Discussions with Scottish Government in relation to the lack of NRAC parity have been carried out, in the context of achieving financial balance for this reporting year. The Board has received non-repayable financial support from Scottish Government to enable a break-even position to be achieved at this year's financial Year End. This has reduced financial sustainability risk levels, though the Committee recognise the pressure of reducing the recurrent financial gap and the requirement to deliver on cost improvements in the medium to longer term. Moving forward, the Board will need to deliver on transformation, as we move beyond the current pandemic landscape.

7.4 In relation to the Strategic Planning BAF, the Committee took assurance from and endorsed the core risk description change to clearly reference the development and the delivery of the Population Health & Wellbeing Strategy and to focus this at a more strategic level. New wording was agreed for this particular risk, which highlights the key role of the Board's governance committees in shaping and influencing strategy development, and thus scrutinising progress delivery once a new strategy has been agreed. The Committee welcomed the investment made in enhancing the Board's Programme Management Office (PMO), which will provide valuable resource to drive forward individual strategy workstreams and help support efficiencies in services going forward.

7.5 The Committee took assurance from and closely monitored progress in mitigating a range of environmental and estate sustainability risks, noting that two of the three residual operational risks in this area require the completion of the Elective Orthopaedic Centre to be achieved before these can be closed (both relate to activity currently being undertaken in the Phase 2 Tower Block at VHK and require the move of all non-ambulatory patients from this location). Enhancing fire safety training has reduced and mitigated this risk until the new orthopaedic wards are opened. The remaining risk, in relation to the replacement of flexible hoses by the PFI contractor, is being addressed by an ongoing programme of work covered by a lifecycle contract.

8 Self-Assessment

8.1 The Committee has undertaken a self-assessment of its own effectiveness, utilising a revised questionnaire considered and approved by the Committee Chair. Attendees were also invited to participate in this exercise, which was carried out via an easily-accessible online portal. A report summarising the findings of the survey was considered and approved by the Committee at its March 2022 meeting, and action points are being taken forward at both Committee and Board level.

9. Conclusion

9.1 As Chair of the Finance, Performance and Resources Committee at 31 March 2022, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year, I can confirm that adequate financial planning and monitoring and governance arrangements were in place throughout NHS Fife during the year, including scrutiny of all aspects of non-financial performance metrics, noting the particular impact of Covid upon the indicators generally.

9.2 I would pay tribute to the dedication and commitment of fellow members of the Committee and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings of the Committee, particularly in this most challenging of years, set against the backdrop of the Coronavirus pandemic.

Signed:  Date: 10 May 2022

Rona Laing, Chair
On behalf of the Finance, Performance and Resources Committee

Appendix 1 – Attendance Schedule
Appendix 2 – Best Value

APPENDIX 1

FINANCE, PERFORMANCE AND RESOURCES COMMITTEE
ATTENDANCE SCHEDULE 2021/22

Members	11/05/21	13/07/21	07/09/21	09/11/21	11/01/22	15/03/22
R Laing, Non-Executive Member **(Chair)**	ü	ü	ü	ü	ü	ü
W Brown, Non-Executive Member	x	x	ü	ü	ü	ü
E Clarke, Non-Executive Member	ü	ü				
A Grant, Non-Executive Member				ü	ü	x
A Lawrie, Area Clinical Forum Representative	ü	ü	ü	ü	x	x
M Mahmood, Non-Executive Director				ü	ü	x
A Morris, Non-Executive Member	ü	ü	ü	ü	ü	ü
J Owens, Stakeholder Member	ü	ü	ü	ü	ü	ü
C Potter, Chief Executive	ü	ü	x	ü	ü	ü
M McGurk, Director of Finance & Strategy **(Exec Lead)**	ü	ü	ü	x	ü	ü
C McKenna, Medical Director	x	ü	x	ü	ü	x
D Milne, Director of Public Health	ü					
J Tomlinson, Director of Public Health		ü	ü	ü	ü	ü
In attendance						
K Booth, Head of Financial Services & Procurement					ü	ü
N Connor, Director of H&SC	ü	ü	ü	ü	ü	ü
C Dobson, Director of Acute Services	ü	X	ü	ü	ü	x
S Fraser, Associate Director of Planning & Performance				ü		
S Garden, Director of Pharmacy & Medicines (to March 2022)	ü	ü	ü	ü	ü	
B Hannan, Director of Pharmacy & Medicines (from March 2022)						x
G MacIntosh, Head of Corporate Services & Board Secretary	ü	ü	ü	ü	ü	ü
A MacKay, Deputy Chief Operating Officer		ü				
N McCormick, Director of Property & Asset Management	ü	ü		ü	ü	ü
M Michie, Deputy Director of Finance		ü observing	ü	ü	ü	ü
R Robertson, Deputy Director of Finance	ü	ü				
A Graham, Associate Director of Digital & Information						ü

BEST VALUE FRAMEWORK

Vision and Leadership

A Best Value organisation will have in place a clear vision and strategic direction for what it will do to contribute to the delivery of improved outcomes for Scotland's people, making Scotland a better place to live and a more prosperous and successful country. The strategy will display a clear sense of purpose and place and be effectively communicated to all staff and stakeholders. The strategy will show a clear direction of travel and will be led by Senior Staff in an open and inclusive leadership approach, underpinned by clear plans and strategies (aligned to resources) which reflect a commitment to continuous improvement.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Resources required to achieve the strategic plan and operational plans e.g. finance, staff, asset base are identified and additional / changed resource requirements identified.	Financial Plan Workforce Plan Property & Asset Management Strategy	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **STAFF GOVERNANCE COMMITTEE** **BOARD**	Annual Annual Annual Bi-annual Bi-monthly	Annual Operational / Remobilisation Plan Financial Plan Workforce Plan Property & Asset Management Strategy Integrated Performance & Quality Report
The strategic plan is translated into annual operational plans with meaningful, achievable actions and outcomes and clear responsibility for action.	Winter Plan Capacity Plan	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **CLINICAL GOVERNANCE COMMITTEE** **BOARD**	Annual Bi-monthly Bi-monthly	Winter Plan Minutes of Committees Integrated Performance & Quality Report

GOVERNANCE AND ACCOUNTABILITY

The "Governance and Accountability" theme focuses on how a Best Value organisation achieves effective governance arrangements, which help support Executive and Non-Executive leadership decision-making, provide suitable assurances to stakeholders on how all available resources are being used in delivering outcomes and give accessible explanation of the activities of the organisation and the outcomes delivered.

OVERVIEW

A Best Value organisation will be able to demonstrate structures, policies and leadership behaviours which support the application of good standards of governance and accountability in how the organisation is improving efficiency, focusing on priorities and achieving value for money in delivering its outcomes. These good standards will be reflected in clear roles, responsibilities and relationships within the organisation. Good governance arrangements will provide the supporting framework for the overall delivery of Best Value and will ensure open-ness and transparency. Public reporting should show the impact of the organisation's activities, with clear links between the activities and what outcomes are being delivered to customers and stakeholders. Good governance provides an assurance that the organisation has a suitable focus on continuous improvement and quality. Outwith the organisation, good governance will show itself through an organisational commitment to public performance reporting about the quality of activities being delivered and commitments for future delivery.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Board and Committee decision-making processes are open and transparent.	Board meetings are held in open session and minutes are publicly available. Committee papers and minutes are publicly available	**BOARD** **COMMITTEES**	On going	NHS Fife website

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Board and Committee decision-making processes are based on evidence that can show clear links between activities and outcomes	Reports for decision to be considered by Board and Committees should clearly describe the evidence underpinning the proposed decision.	**BOARD** **COMMITTEES**	Ongoing	SBAR reports EQIA section on all reports
NHS Fife conducts rigorous review and option appraisal processes of any developments.	Business cases	**BOARD** **FINANCE, PERFORMANCE & RESOURCES COMMITTEE**	Ongoing	Business Cases

USE OF RESOURCES

The "Use of Resources" theme focuses on how a Best Value organisation ensures that it makes effective, risk-aware and evidence-based decisions on the use of all of its resources.

OVERVIEW

A Best Value organisation will show that it is conscious of being publicly funded in everything it does. The organisation will be able to show how its effective management of all resources (including staff, assets, information and communications technology (ICT), procurement and knowledge) is contributing to delivery of specific outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
NHS Fife understands and measures and reports on the relationship between cost, quality and outcomes.	Reporting on financial position in parallel with operational performance and other key targets	**BOARD** **FINANCE, PERFORMANCE & RESOURCES COMMITTEE**	Bi-monthly	Integrated Performance & Quality Report
The organisation has a comprehensive programme to evaluate and assess opportunities for efficiency savings and service improvements including comparison with similar organisations.	National Benchmarking undertaken through Corporate Finance Network. Local benchmarking with similar sized organisation undertaken where information available. Participation in National Shared Services Programme Systematic review of activity / performance data through use of Discovery tool	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **BOARD**	Annual Bi-monthly Ongoing	Financial Plan Integrated Performance & Quality Report Financial overview presentations

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Organisational budgets and other resources are allocated and regularly monitored.	Annual Operational / Remobilisation Plan Integrated Performance & Quality Report	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE**	Bi-monthly	Integrated Performance & Quality Report SPRA Process
NHS Fife has a strategy for procurement and the management of contracts (and contractors) which complies with the SPFM and demonstrates appropriate competitive practice.	Code of Corporate Governance Financial Operating Procedures	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE**	Reviewed annually	Code of Corporate Governance Financial Operating Procedures Procurement Annual Report
NHS Fife understands and exploits the value of the data and information it holds.	Annual Operational / Remobilisation Plan Integrated Performance & Quality Report	**BOARD** **COMMITTEES**	Annual Bi-monthly	Annual Operational / Remobilisation Plan Integrated Performance & Quality Report

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Fixed assets including land, property, ICT, equipment and vehicles are managed efficiently and effectively and are aligned appropriately to organisational strategies.	Property and Asset Management Strategy	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE**	Bi-annual Ongoing Bi-monthly Monthly	Property and Asset Management Strategy Report on asset disposals Integrated Performance & Quality Report Minutes of NHS Fife Capital Investment Group

PERFORMANCE MANAGEMENT

The "Performance Management" theme focuses on how a Best Value organisation embeds a culture and supporting processes which ensures that it has a clear and accurate understanding of how all parts of the organisation are performing and that, based on this knowledge, it takes action that leads to demonstrable continuous improvement in performance and outcomes.

OVERVIEW

A Best Value organisation will ensure that robust arrangements are in place to monitor the achievement of outcomes (possibly delivered across multiple partnerships) as well as reporting on specific activities and projects. It will use intelligence to make open and transparent decisions within a culture which is action and improvement oriented and manages risk. The organisation will provide a clear line of sight from individual actions through to the National Outcomes and the National Performance Framework. The measures used to manage and report on performance will also enable the organisation to provide assurances on quality and link this to continuous improvement and the delivery of efficient and effective outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Performance is systematically measured across all key areas of activity and associated reporting provides an understanding of whether the organisation is on track to achieve its short and long-term strategic, operational and quality objectives	Integrated Performance & Quality Report encompassing all aspects of operational performance, AOP targets / measures, and financial, clinical and staff governance metrics. The Board delegates to Committees the scrutiny of performance Board receives full Integrated Performance & Quality Report and notification of any issues for escalation from Committees.	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Code of Corporate Governance Minutes of Committees

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REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
The Board and its Committees approve the format and content of the performance reports they receive	The Board / Committees review the Integrated Performance & Quality Report and agree the measures.	**COMMITTEES** **BOARD**	Annual	Integrated Performance & Quality Report
Reports are honest and balanced and subject to proportionate and appropriate scrutiny and challenge from the Board and its Committees.	Committee Minutes show scrutiny and challenge when performance is poor as well as good; with escalation of issues to the Board as required	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Minutes of Committees
The Board has received assurance on the accuracy of data used for performance monitoring.	Performance reporting information uses validated data.	**COMMITTEES** **BOARD**	Every meeting Annual	Integrated Performance & Quality Report Annual Accounts including External Audit report

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife's performance management system is effective in addressing areas of underperformance, identifying the scope for improvement, agreeing remedial action, sharing good practice and monitoring implementation.	Encompassed within the Integrated Performance & Quality Report	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Minutes of Committees

CROSS-CUTTING THEME – SUSTAINABILITY

The "Sustainability" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded a sustainable development focus in its work.

OVERVIEW

The goal of Sustainable Development is to enable all people throughout the world to satisfy their basic needs and enjoy a better quality of life without compromising the quality of life of future generations. Sustainability is integral to an overall Best Value approach and an obligation to act in a way which it considers is most sustainable is one of the three public bodies' duties set out in section 44 of the Climate Change (Scotland) Act 2009. The duty to act sustainably placed upon Public Bodies by the Climate Change Act will require Public Bodies to routinely balance their decisions and consider the wide range of impacts of their actions, beyond reduction of greenhouse gas emissions and over both the short and the long term.

The concept of sustainability is one which is still evolving. However, five broad principles of sustainability have been identified as:

- promoting good governance;
- living within environmental limits;
- achieving a sustainable economy;
- ensuring a stronger healthier society; and
- using sound science responsibly.

Individual Public Bodies may wish to consider comparisons within the wider public sector, rather than within their usual public sector "family". This will assist them in getting an accurate gauge of their true scale and level of influence, as well as a more accurate assessment of the potential impact of any decisions they choose to make.

A Best Value organisation will demonstrate an effective use of resources in the short-term and an informed prioritisation of the use of resources in the longer-term in order to bring about sustainable development. Public bodies should also prepare for future changes as a result of emissions that have already taken place. Public Bodies will need to ensure that they are resilient enough to continue to deliver the public services on which we all rely.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
NHS Fife can demonstrate that it respects the limits of the planet's environment, resources and biodiversity in order to improve the environment and ensure that the natural resources	Sustainability and Environmental report incorporated in the Annual Accounts process.	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **BOARD**	Annual	Annual Accounts

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
needed for life are unimpaired and remain so for future generations.				Climate Change Template

APPENDIX 2

CROSS-CUTTING THEME – EQUALITY

The "Equality" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded an equalities focus which will secure continuous improvement in delivering equality.

OVERVIEW

Equality is integral to all our work as demonstrated by its positioning as a cross-cutting theme. Public Bodies have a range of legal duties and responsibilities with regard to equality. A Best Value organisation will demonstrate that consideration of equality issues is embedded in its vision and strategic direction and throughout all of its work.

The equality impact of policies and practices delivered through partnerships should always be considered. A focus on setting equality outcomes at the individual Public Body level will also encourage equality to be considered at the partnership level.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE:**
NHS Fife meets the requirements of equality legislation.		**BOARD** **COMMITTEES**	Ongoing	EQIA section on all reports
The Board and senior managers understand the diversity of their customers and stakeholders.	Equality Impact Assessments are reported to the Board and Committees as required and identify the diverse range of stakeholders.	**BOARD** **COMMITTEES**	Ongoing	EQIA section on all reports

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
NHS Fife's policies, functions and service planning overtly consider the different current and future needs and access requirements of groups within the community.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments consider the current and future needs and access requirements of the groups within the community.	**BOARD** **COMMITTEES**	Ongoing	Development of new Strategy EQIA section on reports
Wherever relevant, NHS Fife collects information and data on the impact of policies, services and functions on different equality groups to help inform future decisions.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments will collect this information to inform future decisions.	**BOARD** **COMMITTEES**	Ongoing	EQIA section on reports

ANNUAL STATEMENT OF ASSURANCE FOR NHS FIFE PUBLIC HEALTH & WELLBEING COMMITTEE 2021/22

1. Purpose

To provide the Board with assurance that NHS Fife is fully engaged in supporting wider population health and wellbeing for the local population, including overseeing the implementation of the population health and wellbeing actions defined in the Board's strategic plans and ensuring effective contribution to population health and wellbeing related activities.

2. Membership

2.1 From its establishment in October 2021 and during the remainder of financial year to 31 March 2022, membership of the Population Health & Wellbeing Committee comprised: -

Tricia Marwick	Committee Chair / Chair of the Board
Martin Black	Non-Executive Member
Christina Cooper	Non-Executive Member
Rona Laing	Non-Executive Member
Margo McGurk	Director of Finance & Strategy
Dr Christopher McKenna	Medical Director
Janette Owens	Director of Nursing
Carol Potter	Chief Executive
Dr Joy Tomlinson	Director of Public Health

2.2 The Committee may invite individuals to attend the Committee meetings for particular agenda items, but the Director of Health & Social Care, Associate Director of Planning & Performance and Board Secretary will normally be in attendance at Committee meetings. Other attendees, deputies and guests are recorded in the individual minutes of each Committee meeting.

3. Meetings

3.1 Following its establishment in October 2021, the Committee met on four occasions during the financial year to 31 March 2022, on the undernoted dates:

- 15 October 2021
- 15 November 2021
- 10 January 2022
- 8 March 2022

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 In July 2021, the Board approved a proposal to establish a new Standing governance committee of the Board. The principle behind the establishment of the Public Health & Wellbeing Committee has been to give greater focus in the Board governance structure to wellbeing and preventative / proactive care (in line with Scottish Government's direction of travel) and to consider placement of the public health aspects currently within the remit of the Clinical Governance Committee and Finance, Performance & Resources Committee, to allow for enhanced input by the Board. In establishing the committee, it was agreed the first

meeting thereof would be an opportunity for members to directly discuss and agree the proposed Terms of Reference for the group, for formal approval of the Board thereafter.

4.2 The Committee met for its first meeting on 15 October 2021, with the sole agenda item being a draft remit for members to discuss. The remit has been influenced by Public Health Scotland's areas of focus and the Public Health Priorities for Scotland, including those around Covid. It also seeks to bring together into the one committee scrutiny of performance-related measures related to the planning and delivery of delegated services for which the Integration Joint Board sets the overall strategic direction. Prior to the Committee's meeting, discussion on the draft took place with the Chair, Vice-Chair and Chief Executive, with earlier input by the Directors of Health & Social Care and Public Health respectively. Members actively discussed the tabled draft and made a number of amendments, prior to a final version being agreed for the Board's endorsement at its November 2021 meeting.

4.3 On completion of the Committee's Terms of Reference, a comprehensive review of its workplan has also taken place, to help define the cycle of business that will be considered by the Committee annually. As part of this exercise, a parallel review of both Clinical Governance and Finance, Performance & Resources remits and workplans have been completed, to limit the potential for any unnecessary duplication of effort and help clarify each committee's responsibilities over agenda items that might be tabled to more than one standing committee, as part of reporting through the governance structure. At the time of writing, this remains a work-in-progress and is expected to be completed after a full annual cycle of business has been undertaken. The Committee has considered drafts of its annual workplan at its January and March 2022 meetings, refining this to ensure appropriate coverage of business throughout the year. As a result of discussion at the latter, meetings of the Committee have now been scheduled on a bi-monthly basis, to allow time for the adequate preparation of agenda items between meetings.

4.4 The Public Health & Wellbeing Committee's remit seeks to link explicitly to the local strategic priority proposed in the new strategy of 'improving health and wellbeing' of the population served by NHS Fife. It aims to have coverage over relevant elements of the national care and wellbeing programmes as these become established, as well as the Public Health Priorities for Scotland. It is also the intention that the Committee takes the governance lead in oversight and implementation of the new Population Health & Wellbeing Strategy and thereafter its delivery progress.

4.5 At its initial meetings, the Committee has focused on gaining assurance from the Board's ongoing work on Covid Test & Protect measures and vaccination (including the seasonal flu and Covid vaccine delivery for the 2021 Winter Period). The Committee has gained assurance that planning and workforce were in place to deal with anticipated demand over the busy Winter season, made more acute with the heightened pressures caused by the Omicron wave of Covid infection. The response of the Board continued to be agile, with local teams working closely with national colleagues both to implement the contact tracing programme and deliver new tranches of the Covid booster and seasonal flu vaccines as these came on-stream.

4.6 In January 2022, members received a detailed update on testing and tracing performance over the busy festive period, which coincided with a large number of positive Covid infections in Fife due to the spread of the Omicron variant. Resilience and response rates remained high, despite the pressures caused by the considerable increase in cases. In relation to vaccine delivery, the Committee were assured by the Board's performance in the 'Boosted by the Bells' campaign, with Fife data showing the number of booster doses delivered being above the Scottish Government target and higher than the Scottish average. Progress with the programme overall remained on track, with longer-term planning nearing completion for the stabilisation of the workforce, supported by permanent recruitment measures. Further updates on both testing and progress in the delivery of the vaccination programme were given to the Committee in March 2022. However, as Covid

updates transition into business-as-usual activities for the Board, performance tracking for these areas will move to being situated within the monthly performance reporting within the IPQR, rather than via stand-alone updates to the Committee.

4.7 At the meeting in November 2021, members took assurance from the process described for managing any vaccine incidents and how lessons learned from any local adverse events review are immediately implemented. Ongoing proactive audit undertaken locally helps to identify any incidents and feedback is provided promptly to the national team, to ensure a robust mitigation strategy is in place.

4.8 The Committee has received a series of updates on Child and Adolescent Mental Health Services (CAMHS) and Psychological Therapies (PT), the first report being considered in November 2021. Assurance was given on the Board's ongoing progress to eradicate the waiting list for CAMHS by December 2022. Support has been received from Scottish Government and a number of new posts are being recruited to. For Psychological Therapies, new roles and different roles in relation to supporting workforce pressures and challenges are being brought forward. The focus is also on access to the service and addressing the backlog of the longest waits. Recruitment challenges have a direct impact on meeting waiting list trajectories and the Committee requested further information on what is being done in the interim to support those on waiting lists in the interim, particularly those waiting the longest for treatment. A detailed update was given in January 2022 on the means by which those waiting the longest for specialist treatment were being supported. New models of care are important, particularly community mental health teams working in an outreach manner, to reach those most in need, some of whom are within Fife's most deprived communities. Changes to the recruitment of staff, and methods for upskilling the current workforce, will help address the workforce challenges that have impacted upon the timeliness of treatment for some patients. In March 2022, the Committee received a further update on the performance of both CAMHS and PT, taking assurance from the fact that both services are on track to achieve delivery targets by the stated deadlines. Challenges remain in eradicating the historic backlog of referrals for both services, but members recognised the impact of a series of improvement actions, that combined have helped address the numbers of patients waiting.

4.9 In March 2022, members considered an update on Primary Care pressures, including an outline of changes to delivery of GP services due to the pandemic and as a result of the new GP contract. Assurance was provided that a plan was in place to eliminate these pressures, assisted by the establishment of the new Primary Care Governance & Strategy Oversight Group. An early focus of the group's work will be enhancing sustainability of services, and building upon recent initiatives such as ScotGEM to support primary care resilience in the future. The Committee will receive regular reports and outputs from this group going forward.

4.10 The Committee, at its November 2021 meeting, has also received a report on progress in implementing the Mental Health Strategy. Examples of transformation, particularly around models of care, were described, in addition to details on the remobilisation of services and innovations in the recruitment and design of supporting staff roles, given ongoing workforce challenges. The Committee gained assurance that the service continues to deliver on the main strategic ambitions and that a refresh of the Mental Health Strategy for Fife will be undertaken, in line with learning post-pandemic and new national requirements.

4.11 The Committee has had input into initial discussions for the development of the Board's Population Health & Wellbeing Strategy, including review of the first stage of the survey process, to help capture public and staff feedback, and consideration of the Population Health Needs Assessment, which has also been reviewed at length by the Board. In January 2022, members discussed how participation of external stakeholders can best be enhanced, in a follow-up engagement exercise, particularly via outreach to Fife's most deprived groups and communities. Members recognise the importance of ensuring the

diversity of Fife's population is appropriately reflected and addressed in the organisational strategy.

4.12 In March 2022, members considered a detailed proposal outlining the phased approach to the Population Health & Wellbeing Strategy development. A milestone plan, outlining dedicated time for each Committee and thence the Board to consider key aspects of the strategy, was endorsed by the Committee. This work will be a significant part of the Committee's business over the remainder of this calendar year.

4.13 A Board-wide review of the Integrated Performance & Quality Report (IPQR) is expected to help define a set of performance-related metrics specific to the Committee, to allow for appropriate regular scrutiny of these at each meeting. As mentioned above, consideration of CAMHS and PT performance (specifically those metrics linked to the improvement trajectory for both services) has transitioned over to the Committee and is expected to be fully complete over the early part of the new Financial Year. Consideration is also being given to identifying a number of other metrics relevant to the Committee's remit, for inclusion in a new dedicated Public Health & Wellbeing section of the revised IPQR. It is recognised there is an opportunity to identify areas which are currently not reviewed and include them in the IPQR, such as the Covid Vaccination Programme, screening programmes, self-management of long-term conditions and the Mental Health Strategy Programme, dependent on the regularity of data reporting.

4.14 During the year, the Committee has received reports on: i) the work of the East of Scotland Regional Health Protection service; ii) the Anchor Institution Programme Board; iii) Fife Child Protection Annual Report; and iv) Adult Support and Protection Biennial Report. Members have welcomed the comprehensive detail provided in each.

5. Risk Management

5.1 A Board-wide review of risk reporting is currently underway and, when concluded, this will make recommendations for the reporting of relevant risks to the new Public Health & Wellbeing Committee. It is likely that stand-alone Board Assurance Frameworks (BAFs) in use at present will be replaced by a refreshed Corporate Risk Register, with sections pertinent to each standing committee. This will help the Committee define and monitor risks relevant to its remit as it becomes fully established.

6. Self-Assessment

6.1 Given its establishment part-way through the 2021-22 financial year and recognising the limited number of meetings thus far, the Committee has not as yet undertaken a formal self-assessment utilising the standard Board Committee format. This will be undertaken next year, as part of that regular schedule in use across all standing committees.

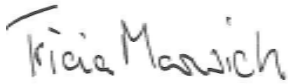
7. Conclusion

7.1 As Chair of the Public Health & Wellbeing Committee, I am satisfied that thus far, after its initial establishment, the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the meetings held through this year, I can confirm that adequate and effective governance arrangements were in place throughout NHS Fife during the year.

7.2 I can confirm that that there were no significant control weaknesses or issues at the year-end which the Committee considers should be disclosed in the Governance Statement, as they may have impacted financially or otherwise in the year or thereafter.

7.3 I would pay tribute to the dedication and commitment of fellow members of the Committee and to all attendees. I would thank all those members of staff who have prepared reports

and attended meetings of the Committee as it has become established, particularly in another most challenging year, set against the ongoing backdrop of the Coronavirus pandemic.

Signed:  Date: 16 May 2022

Tricia Marwick, Chair
On behalf of the Public Health & Wellbeing Committee

Appendix 1 – Attendance Schedule

NHS Fife Public Health & Wellbeing Committee Attendance Record
1 April 2021 to 31 March 2022

	15.10.21	15.11.21	10.01.22	08.03.22
Members				
T Marwick, Non-Executive Member **(Chair)**	P	P	P	x
M Black, Non-Executive Member	P	P	P	P
C Cooper, Non-Executive Member	P	x	x	P
R Laing, Non-Executive Member	P	P	P	P
W Brown, Employee Director	x	P	x	x
M McGurk, Director of Finance & Strategy	P	P	P	P
C McKenna, Medical Director	P	P	P	P
J Owens, Director of Nursing	x	P	P	P
C Potter, Chief Executive	P	P	P	P
J Tomlinson, Director of Public Health **(Exec.Lead)**	P	P	P	P
In Attendance				
O Adeyemi, Consultant in Public Health	P			
N Connor, Director of H&SC	x	P	P	P
L Cooper, Immunisation Programme Director		P Item 5.2		
P Donnelly, University of St Andrews		P Item 6.2		
S Fraser, Associate Director of Planning & Performance	P	P	P	x
G MacIntosh, Head of Corporate Governance & Board Secretary	P	P	P	P
J McLean, Director of Regional Planning		P Item 6.2		
F Richmond, Executive Officer to the Chief Executive & Board Chair	P	P	P	P
N Robertson, Associate Director of Nursing	P			

ANNUAL STATEMENT OF ASSURANCE FOR
NHS FIFE REMUNERATION COMMITTEE FOR 2021/22

1. Purpose

1.1 The purpose of the Remuneration Committee is to consider and agree performance objectives and performance appraisals for staff in the Executive Cohort and to oversee performance arrangements for designated senior managers.

1.2 To direct the appointment process for the Chief Executive and Executive Members of the Board.

2. Membership

2.1 During the financial year to 31 March 2022, membership of the Remuneration Committee comprised: -

Tricia Marwick	Chair / Chair of the NHS Fife Board
Carol Potter	Chief Executive
Martin Black	Non-Executive Director
Wilma Brown	Employee Director
Rona Laing	Non-Executive Director

2.2 The Committee may invite individuals to attend Committee meetings for particular agenda items. The Director of Workforce will normally be in attendance at Committee meetings. Other attendees, deputies and guests are recorded in the individual minutes of each Committee meeting. The PA to the Director of Workforce/Corporate Governance Support Officer will normally take the minute of the meeting.

3. Meetings

3.1 The Committee met on five occasions during the financial year to 31 March 2022, on the undernoted dates:

- 25 May 2021
- 27 July 2021
- 21 September 2021
- 16 November 2021
- 18 January 2022

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 The business of the Committee during the year has been impacted to some extent by the need for NHS Fife as a whole to address the ongoing challenges of the global Coronavirus pandemic, e.g. appraisal/performance management activities and the receipt of associated assurance information.

In recognition of the rapid mobilisation of services to tackle the COVID pandemic and its impact, approval to revise governance arrangements across NHS Boards was given by the

Scottish Government in a letter to Board Chairs in late March 2020. The NHS in Scotland has remained on an Emergency Footing since that date.

4.2 The Committee continued to meet throughout 2021/22 utilising videoconferencing technology. The Committee's workplan has ensured that items are covered appropriately and that the required assurances can be provided to the Board.

4.3 The Remuneration Committee's first meeting of the 2021/22 reporting year was in May 2021, where the Annual Statement of Assurance for 2020/21 and workplan for 2021/22 were considered and agreed. Also discussed in May 2021 was the Temporary Responsibility Allowance (TRA) for Nurse Directors', an update on the position relating to the development and endorsement of the Corporate Objectives for 2021/22 and an update on the position with regard to the Mid-Year Performance Management Review process for the Executive and Senior Management (ESM) cohort. The Director of Workforce also provided a brief presentation on the ESM performance management cycle and information to be provided to the Committee.

4.4 At its meeting in July 2021 the Committee considered and approved the ESM Annual Performance Appraisals outcomes for the Executive Cohort and Senior Managers for 2020/21, ensuring the submission to the NPMC (National Performance Management Committee). The Committee also noted the Corporate Objectives 2021/22 and agreed the assignment of the objectives to individual Directors at this meeting.

4.5 The Committee also considered the consequence of the review of the Chief Executive post by the National Evaluation Committee.

4.6 At the September meeting, the Committee agreed the Executive Cohort Objectives 2021/22.

4.7 In November 2021, the Committee approved the Award of Discretionary Points for Consultants (2021) and noted progress with Mid-Year Review discussions for the ESM cohort. A paper was also presented for assurance which outlined the position in respect of the salary applied to the Director of Acute Services, appointed permanently in August 2021 following a committee agreed recruitment process. An update was also provided on the South East Radiology Reporting In-Sourcing Solution (SERRIS).

4.8 Discussion took place, at the November meeting, on the Scottish Government circular DL(2021)35 – Annual Leave Buy Back and Carry Over 2021/22 whereby the Committee encouraged management to facilitate staff taking annual leave as appropriate.

4.9 As part of the November meeting, the Remuneration Committee held a training session led by David Garbutt, Chair, NHS National Education Scotland who is Chair of the National Performance Management Committee. Mr Garbutt gave a detailed presentation to support Remuneration Committees in the effective use and development of national arrangements for executive and senior manager appraisal.

4.10 In January 2022, the Committee noted an update provided by the Director of Workforce on the work undertaken by the Board Secretary & Head of Corporate Governance on a Peer Review to compare the working practices of NHS Fife with other Remuneration Committees within NHS Scotland. Feedback obtained from the Review conducted, revealed a consistency between NHS Fife's Remuneration Committee arrangements and practices and those of other Health Boards in Scotland.

4.11 A paper was also considered in respect of ESM Performance Management Outcomes 2020/21, noting that the National Performance Management Committee (NPMC) Letter of Assurance pertaining to ESM Performance Management Outcomes 2020/21 had not yet been issued.

4.12 The previously agreed job description for the Director of Pharmacy & Medicines was also discussed and the progress of the recruitment campaign in accordance with the previously endorsed values based recruitment process for the Executive cohort noted at the January 2022 meeting. The role and responsibilities of the Deputy Chief Executive post and the associated remuneration was also agreed at the January meeting.

4.13 Throughout the year the Remuneration Committee has considered and where appropriate approved the decisions relating to the Executive and Senior Management performance management arrangements.

4.14 At each meeting appropriate circulars and letters were presented and noted by the Committee.

5. Self Assessment

5.1 The Committee completed a self assessment of its own performance and effectiveness, utilising the questionnaire approved by the Committee Chair. Attendees were also invited to participate in the self assessment, which was carried out via an easily accessible online portal. A report summarising the findings of the survey was considered and approved by the Committee at its meeting in April 2022, and action points are being taken forward.

6. Conclusion

6.1 As Chair of the Remuneration Committee during financial year 2021/22, I am satisfied that, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year, I can confirm that appropriate arrangements were in place for the implementation of the circulars and the Committee fulfilled its remit and purpose.

6.2 I continue to pay tribute to the dedication and commitment of fellow members of the Committee and to all attendees. I thank all those members of staff who have prepared reports and attended meetings of the Committee, particularly during an even more challenging of years, set against the continued backdrop of the Coronavirus pandemic.

Signed: Tricia Marwick Date: 17 May 2022

Tricia Marwick, Chair

Appendix 1 – Attendance Schedule
Appendix 2 – Best Value

APPENDIX 1

NHS FIFE REMUNERATION COMMITTEE

ATTENDANCE SCHEDULE 1 APRIL 2021 – 31 MARCH 2022

	25.05.21	**27.07.21**	**21.09.21**	**16.11.21**	**18.01.22**
Tricia Marwick, Chair	ü	ü	ü	ü	ü
Carol Potter, Chief Executive	ü	ü	ü	ü	ü
Martin Black, Non-Executive	ü	ü	ü	ü	ü
Wilma Brown, Employee Director	ü	ü	X	ü	ü
Rona Laing, Non-Executive	ü	ü	ü	ü	ü
In attendance					
Linda Douglas, Director of Workforce	ü	ü	ü	ü	ü

Best Value

Vision and Leadership

A Best Value organisation will have in place a clear vision and strategic direction for what it will do to contribute to the delivery of improved outcomes for Scotland's people, making Scotland a better place to live and a more prosperous and successful country. The strategy will display a clear sense of purpose and place and be effectively communicated to all staff and stakeholders. The strategy will show a clear direction of travel and will be led by Senior Staff in an open and inclusive leadership approach, underpinned by clear plans and strategies (aligned to resources) which reflect a commitment to continuous improvement.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
There are mechanisms within the organisation to develop and monitor relevant leadership and strategic skills in Board members and senior management.	This is achieved through the development of Personal Development Plans and Annual Appraisals.	**CHAIR / CHIEF EXECUTIVE** **REMUNERATION COMMITTEE**	Annual	Annual Appraisal process for Executive and Senior Management (ESM) posts

EFFECTIVE PARTNERSHIPS

The “Effective Partnerships” theme focuses on how a Best Value organisation engages with partners in order to secure continuous improvement and improved outcomes for communities, not only through its own work but also that of its partners.

OVERVIEW
A Best Value organisation will show how it, and its partnerships, are displaying effective collaborative leadership in identifying and adapting their service delivery to the challenges that clients and communities face. The organisation will have a clear focus on the collaborative gain which can be achieved through collaborative working and community engagement in order to facilitate the achievement of its strategic objectives and outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
There is no responsibility in this area under the remit of the Remuneration Committee				

GOVERNANCE AND ACCOUNTABILITY

The "Governance and Accountability" theme focuses on how a Best Value organisation achieves effective governance arrangements, which help support Executive and Non-Executive leadership decision-making, provide suitable assurances to stakeholders on how all available resources are being used in delivering outcomes and give accessible explanation of the activities of the organisation and the outcomes delivered.

OVERVIEW
A Best Value organisation will be able to demonstrate structures, policies and leadership behaviours which support the application of good standards of governance and accountability in how the organisation is improving efficiency, focusing on priorities and achieving value for money in delivering its outcomes. These good standards will be reflected in clear roles, responsibilities and relationships within the organisation. Good governance arrangements will provide the supporting framework for the overall delivery of Best Value and will ensure open-ness and transparency. Public reporting should show the impact of the organisations activities, with clear links between the activities and what outcomes are being delivered to customers and stakeholders. Good governance provides an assurance that the organisation has a suitable focus on continuous improvement and quality. Outwith the organisation, good governance will show itself through an organisational commitment to public performance reporting about the quality of activities being delivered and commitments for future delivery.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Board and Committee decision-making processes are open and transparent.	Board meetings are held in open session and minutes are publicly available. Committee papers and minutes are publicly available.	**BOARD** **COMMITTEES**	On going	NHS Fife website
Board and Committee decision-making processes are based on evidence that can show clear links between activities and outcomes	Reports for decision to be considered by Board and Committees should clearly describe the evidence underpinning the proposed decision.	**BOARD** **COMMITTEES**	Ongoing	SBAR reports EQIA forms

USE OF RESOURCES

The "Use of Resources" theme focuses on how a Best Value organisation ensures that it makes effective, risk-aware and evidence-based decisions on the use of all of its resources.

OVERVIEW
A Best Value organisation will show that it is conscious of being publicly funded in everything it does. The organisation will be able to show how its effective management of all resources (including staff, assets, information and communications technology (ICT), procurement and knowledge) is contributing to delivery of specific outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
NHS Fife understands and exploits the value of the data and information it holds.	Annual Operational Plan /Remobilisation Plan. Integrated Performance & Quality Report.	**BOARD** **COMMITTEES**	Annual Bi-monthly	Annual Operational/ Remobilisation Plan Integrated Performance & Quality Report
NHS Fife ensures that all employees are managed effectively and efficiently, know what is expected of them, their performance is regularly assessed and they are assisted in improving.	Executive and Senior Manager (ESM) performance reporting.	**REMUNERATION COMMITTEE**	Annual and as required	Minutes of Remuneration Committee
Staff performance management recognises and monitors contribution to ensuring continuous improvement and quality.	Executive and Senior Manager Objectives Setting and Review.	**REMUNERATION COMMITTEE**	Annually	Minutes of Remuneration Committee

PERFORMANCE MANAGEMENT

The "Performance Management" theme focuses on how a Best Value organisation embeds a culture and supporting processes which ensures that it has a clear and accurate understanding of how all parts of the organisation are performing and that, based on this knowledge, it takes action that leads to demonstrable continuous improvement in performance and outcomes.

OVERVIEW

A Best Value organisation will ensure that robust arrangements are in place to monitor the achievement of outcomes (possibly delivered across multiple partnerships) as well as reporting on specific activities and projects. It will use intelligence to make open and transparent decisions within a culture which is action and improvement oriented and manages risk. The organisation will provide a clear line of sight from individual actions through to the National Outcomes and the National Performance Framework. The measures used to manage and report on performance will also enable the organisation to provide assurances on quality and link this to continuous improvement and the delivery of efficient and effective outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Reports are honest and balanced and subject to proportionate and appropriate scrutiny and challenge from the Board and its Committees.	Committee Minutes show scrutiny and challenge when performance is poor as well as good; with escalation of issues to the Board as required.	**COMMITTEES** **BOARD**	Every meeting	Minutes of Committees

APPENDIX 2

CROSS-CUTTING THEME – SUSTAINABILITY

The "Sustainability" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded a sustainable development focus in its work.

OVERVIEW
The goal of Sustainable Development is to enable all people throughout the world to satisfy their basic needs and enjoy a better quality of life without compromising the quality of life of future generations. Sustainability is integral to an overall Best Value approach and an obligation to act in a way which it considers is most sustainable is one of the three public bodies' duties set out in section 44 of the Climate Change (Scotland) Act 2009. The duty to act sustainably placed upon Public Bodies by the Climate Change Act will require Public Bodies to routinely balance their decisions and consider the wide range of impacts of their actions, beyond reduction of greenhouse gas emissions and over both the short and the long term.
The concept of sustainability is one which is still evolving. However, five broad principles of sustainability have been identified as:

- promoting good governance
- living within environmental limits
- achieving a sustainable economy
- ensuring a stronger healthier society, and
- using sound science responsibly.

Individual Public Bodies may wish to consider comparisons within the wider public sector, rather than within their usual public sector "family". This will assist them in getting an accurate gauge of their true scale and level of influence, as well as a more accurate assessment of the potential impact of any decisions they choose to make.

A Best Value organisation will demonstrate an effective use of resources in the short-term and an informed prioritisation of the use of resources in the longer-term in order to bring about sustainable development. Public bodies should also prepare for future changes as a result of emissions that have already taken place. Public Bodies will need to ensure that they are resilient enough to continue to deliver the public services on which we all rely.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
There is no responsibility in this area under the remit of the Remuneration Committee				

CROSS-CUTTING THEME – EQUALITY

The "Equality" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded an equalities focus which will secure continuous improvement in delivering equality.

OVERVIEW
Equality is integral to all our work as demonstrated by its positioning as a cross-cutting theme. Public Bodies have a range of legal duties and responsibilities with regard to equality. A Best Value organisation will demonstrate that consideration of equality issues is embedded in its vision and strategic direction and throughout all of its work.

The equality impact of policies and practices delivered through partnerships should always be considered. A focus on setting equality outcomes at the individual Public Body level will also encourage equality to be considered at the partnership level.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE:**
NHS Fife meets the requirements of equality legislation.	Equality Impact Assessments are reported to the Board and Committees as required and identify the diverse range of stakeholders.	**BOARD** **COMMITTEES**	Ongoing	EQIA form on all appropriate reports

ANNUAL STATEMENT OF ASSURANCE FOR
NHS FIFE STAFF GOVERNANCE COMMITTEE FOR 2021/22

1. Purpose

1.1 The purpose of the Staff Governance Committee is to support the development of a culture within the health system where the delivery of the highest standard possible of staff management is understood to be the responsibility of everyone working within the system, is built upon partnership and collaboration, and within the direction provided by the NHS Scotland Staff Governance Standard.

1.2 To assure the NHS Fife Board (hereafter described as "the Board") that the Staff Governance arrangements in the Integration Joint Board are working effectively.

1.3 To escalate any issues to the Board if serious concerns are identified regarding staff governance issues within all services, including those devolved to the Integration Joint Board.

2. Membership

2.1 During the financial year to 31 March 2022, membership of the Staff Governance Committee comprised: -

Margaret Wells	Chair / Non-Executive Member (to July 2021)
Sinead Braiden	Chair / Non-Executive Member (from August 2021)
Wilma Brown	Employee Director
Christina Cooper	Non-Executive Member (to September 2021)
Simon Fevre	Co-Chair, Health & Social Care Partnership Local Partnership Forum
Kirstie Macdonald	Non-Executive Member
Mansoor Mahmood	Non-Executive Member (from September 2021)
Alistair Morris	Non-Executive Member
Janette Owens	Director of Nursing
Carol Potter	Chief Executive
Andrew Verrecchia	Co-Chair, Acute Services Division Local Partnership Forum

2.2 The Committee may invite individuals to attend Committee meetings for particular agenda items, but the Director of Workforce, Director of Acute Services, Director of Health & Social Care, Deputy Director of Workforce, Heads of Service for the Workforce Directorate, and Board Secretary will normally be in attendance at Committee meetings. Other attendees, deputies and guests are recorded in the individual minutes of each Committee meeting.

3. Meetings

3.1 The Committee met on six occasions during the financial year to 31 March 2022, on the undernoted dates:

- 29 April 2021
- 1 July 2021
- 2 September 2021

- 28 October 2021
- 12 January 2022
- 3 March 2022

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 The business of the Committee during the year has been impacted greatly by the need for NHS Fife as a whole to address the ongoing challenges of the global Coronavirus pandemic. The Committee Chair has liaised closely with the Director of Workforce, as lead Executive Officer, to identify what business must be considered by the Committee and what must be prioritised in agenda planning. In the period covered by this report, some routine business has been suspended or deferred, with the occasional meeting running with a prioritised agenda. This has maximised the time available for management and operational staff to deal with the significant challenges of addressing Covid surge-related demand within clinical services, and, at the same time, allowed the Board to appropriately discharge its governance responsibilities. The Committee's workplan has been regularly reviewed to ensure that specific items related to Covid-19 have been covered appropriately and that the required assurances could be provided to the Board as part of the year-end process.

4.2 The Committee has received throughout the year reports on the mobilisation and deployment of the current workforce to address the operational pressures caused by Covid-19 activity and, as this has peaked and then reduced, the remobilisation of services thereafter. The Committee considered the updates provided, noting that protecting staff wellbeing and enhancing support has been a constant priority, and that the maintenance, as well as introduction, of a range of services, initiatives and resources, allowing staff the opportunity to rest and recharge, has been central to this work and a central part of the organisation's pandemic response.

4.3 The Staff Governance Committee's first meeting of the 2021-22 reporting year was in April 2021. Substantive agenda items included a comprehensive report on staff health and wellbeing activities, including work around promoting attendance, as services continued to operate against a general background of Covid-related pressures. Detail was given on the services available to help support staff during this time of increased activity on all services (including Mindfulness training, peer support and reflective practice to help support returning staff and their managers). The Committee received assurance that the current commitment to health and wellbeing activities, including investment in additional occupational health and psychology support services staff, was sustainable and in place for the longer term, particularly as the lasting effects of Covid become clearer. Members welcomed the information given on the support offered to staff and the positive impact this can have on overall staff absence figures. Further detailed updates on staff health and wellbeing activities were discussed at Committee meetings in September 2021 and March 2022, including the support for long Covid symptoms by occupational health services and the process of moving the staff wellbeing hubs from their temporary to permanent locations.

4.4 Regular updates on Covid-19 related topics have been given to the Committee during the year, reflecting the priorities of the Board, the ongoing Emergency Footing under which the NHS in Scotland operates, and the Board being under Scottish Government direction for the period covered by this report. In addition to detailed reports on recruitment and staff wellbeing during the pandemic, the Committee has also scrutinised the programmes for staff testing and vaccination against Covid-19, noting the rapid roll-out and success of these programmes.

4.5 At its April 2021 meeting, the Committee received an update on the Workforce Strategy and how lessons learned from the significant changes to service delivery experienced during

Covid-19 would require to be reflected within an Interim Joint Workforce Plan for 2021-22. Members reviewed NHS Fife's draft Interim Joint Workforce Plan submission to the Scottish Government, utilising the new national template and covering both the Board and the Fife Health & Social Care Partnership. Issues discussed by members included third-sector involvement, risk reporting related to the implementation of the strategy and the potential impact of failure to recruit to the supplementary staffing detailed within the Plan. In September 2021, the Committee reviewed the feedback on the Plan received from the Scottish Government and how this will influence the next three-year iteration of the Workforce Plan. The Committee noted that work had begun to redevelop the Board's overall Workforce Strategy (then in its final year), aligned to the development of the overall organisational Population Health & Wellbeing Strategy. This will involve reflection and assessment of the effectiveness and completeness of previous action plans, to ensure progress has been captured and evidenced. It will also be more effectively integrated with the annual Strategic Planning & Resource Allocation (SPRA) process, now in its second year of operation. An update on this year's SPRA process was given to members in March 2022, with the Committee being assured that the process has been considerably more embedded this year and with real ambition to integrate organisational Workforce and Financial plans going forward.

4.6 The Committee has received updates on planning in light of the Covid response, with further iterations of the Board's Remobilisation Plan prepared and submitted to members, prior to seeking Scottish Government agreement on its content. In July 2021, the Committee considered the process in place to produce the next iteration of the Joint Remobilisation Plan, incorporating information gathered from across the organisation. In October 2021, an update on the next iteration of the Remobilisation Plan (RMP4) was given, which also encompassed the annual Winter Plan detail. An action tracker, outlining key actions and progress on deliverables, has helped support the delivery of the Remobilisation Plan and scrutiny of its achievements against target dates.

4.7 At its January 2022 meeting, reflecting the extensive pressure then being experienced by staff and clinical services, the Committee's agenda was prioritised to review further updates on the workforce response and mobilisation against the Omicron wave of Covid-19 and specific governance-related items linked to Whistleblowing reporting and strategy / workforce planning activity. The Chief Executive and Director of Workforce gave a presentation on the continuing and increasing workforce challenges being experienced in Fife, particularly linked to Covid-related staff absences as the Omicron wave of infection peaked. Detail was provided on the current recruitment and deployment actions underway, in addition to the training and development structure in place to help support staffing levels. A range of support options continue to be in place to directly support staff to take time to look after their own wellbeing. The Committee welcomed the news that NHS Fife would be the first Scottish Health Board to welcome the initial cohort of internationally recruited nurses, which was testament to the strong collaborative working across Workforce, Nursing, Finance and other directorates to accomplish.

4.8 Ongoing reports have been provided on the Organisational Strategy Development work, including details on the proposed engagement approach and the development of the Population Health Needs Assessment, which will be the underpinning baseline of the eventual strategy document text. Development of the individual workstreams is being taken forward through a Portfolio approach involving all members of the Executive Directors' Group. Overall, the workstreams will be linked to the five national care programmes that have been initiated by the Scottish Government. Early engagement has taken place with staff, key stakeholders and members of the public, and updates have been given to the Committee thereon, such as the paper presented for discussion in January 2022. Members' feedback on the means of further engaging with staff and service users on the content of the new strategy have been welcomed, which will be taken forward in the next stage of more focused participation. The Public Health & Wellbeing Committee is the lead Committee for the development of the new Strategy, though the Staff Governance

Committee will continue to have a specific role in the scrutiny and assurance of developments with a defined impact upon staffing matters.

4.9 The Committee has discussed planning for the Winter Period (as part of the Board's Joint Remobilisation Plan) and reflected on Winter performance via a report on the 2020/21 period submitted to members at the March 2022 meeting. It was recognised that, particularly with Covid activity ongoing, planning for pressures and surges was, in essence, a year-round activity, which goes beyond the actual Winter season. Services have been recovering as well as remobilising, and close working relationships (particularly with colleagues in the Health & Social Care Partnership) have helped to managed delay and flow, with varying results across the year. Nevertheless, it has been important for the Board overall to address any underlying capacity issues, to ensure that pressures 365 days per year are accounted for in overall planning.

4.10 Actions that have been taken or are being considered include the potential long term Covid-19 health issues for staff, which are being addressed through local Occupational Health support and national guidance, and ongoing monitoring to ensure Workforce Hubs are robust and flexible. The Workforce Silver Command Group continues to meet to review workforce deployment. Additionally, the adapting and onboarding and development delivery approach through the use of e-enabled fast track induction and training is being focussed on by the Professional Practice Development team. Activity has at some periods been unrelenting, and the Committee were fully apprised of the impact this has upon levels of staffing and the variability of performance overall. Members were pleased to note the introduction and implementation of a new Operational Pressures Escalation Levels (OPEL) framework, which is helping manage day-to-day pressures, with clear triggers for action and escalation.

4.11 The launch of the National Whistleblowing Standards on 1 April 2021 were detailed to the Committee as outlined in last year's report, via a number of papers describing how the new Standards will be rolled out within Fife. The Board's new Whistleblowing Champion, Kirstie Macdonald, attended the April 2021 Committee meeting as an observer and designate member, prior to her appointment being formally announced on the completion of the purdah period for the 2021 Scottish Parliament elections. The Committee has since received regular reports on the roll-out of the new Standards and the first year of their operation, including an update on the Whistleblowing Champion's assurance role on the Board (given in September 2021). It is recognised that the implementation of the Standards by Boards across Scotland will vary to take account of the individual context of each organisation, but that the Whistleblowing Champion provides a dedicated means of ensuring best practice is shared and that there is a consistency of approach across Boards.

4.12 Further work is underway on the format of Whistleblowing reports, in particular to evidence an open and learning culture. Additional data on staff take-up of Whistleblowing training (which had been designated as 'core' training for all staff and managers), to gain assurance of widespread understanding and visibility of the practical process, has also been highlighted as an area to be better captured in ongoing reporting to the Staff Governance Committee and the Board. In the reporting year, it has been agreed to capture the number of 'anonymous' concerns raised within the Board, though these do not fall within the definition of Whistleblowing under the Standards. It is recognised that the formal Whistleblowing reporting process sits alongside a number of established ways for staff to raise concerns, such as the reporting of Adverse Events, employment-related routes of raising issues and direct contact with staff-side colleagues, who are often a route of escalation to senior management and the Board.

4.13 The draft Corporate Objectives 2021/22 were presented to the Committee in April (draft) and July (final) 2021. The report described what NHS Fife aims to achieve in year. For the Staff Governance Standard, relevant individual objectives were linked to broader workstreams such as: implementation of safe staffing legislation; delivery of workforce

plans that attract, recruit and retain a high-quality workforce; and improving leadership capacity and embedding the framework for talent management. Each objective had been refined, with details on what Directors are leading on or supporting more generally. The objectives are framed under the four key strategic priorities of the Board and reference the ongoing Strategy Development work being undertaken in this reporting year. The Committee were pleased to endorse the Corporative Objectives for onward submission to the Board for formal approval, noting that those for 2022/23 will come forward for review in May 2022.

4.14 Reflecting on staff experience remains an important part of the Committee's business. The Committee has considered the results of the most recent iMatter staff survey in the reporting year, with a presentation delivered to members in March 2022 detailing its findings. The Committee recognised that although response rates had dropped by 3 percentage points from 2019 to 2021 overall, the NHS Fife response rate continues to be higher than NHSScotland averages and significantly higher than the 2020 Everyone Matters Survey results, (the Everyone Matters survey was a Pulse survey, i.e. an abridged, survey undertaken in place of iMatter), with also a 10% increase in the number of actions plans completed. Members agreed that NHS Fife's 58% response rate offers robust data to inform future actions and welcomed further information on how staff feedback will influence staff-related initiatives being presented in future.

4.15 The Committee receives regular updates on recruitment, including data on consultant recruitment (including those specialities with particular challenges) and on efforts to improving nursing and midwifery recruitment, particularly in partnership with local universities and colleges. The annual report on Medical Appraisal and Revalidation for 2020/21 was considered by the Committee in October 2021, giving assurance that doctors within NHS Fife are practising to the appropriate professional standards. A complementary report on the wider NHS Fife registered workforce was reviewed by members in March 2022, with the Committee taking assurance from the revalidation and appraisal processes described therein. Further information on Personal Development plans for this group will also be captured on an ongoing basis in the Workforce Information report.

4.16 In October 2021, a detailed report on the workforce implications of the General Practice Memorandum of Understanding 2 (MoU2) was discussed, noting the requirement of an enhanced multi-disciplinary, multi-professional team built around GP practices, which will be primarily composed from the nursing, AHP and Pharmacy workforce. The risks of this, in light of the existing pressures on Nursing and Advanced Health Care Practitioners numbers, are well recognised, and are being monitored on an ongoing basis via the Workforce Sustainability BAF. A further update was considered by the Committee in March 2022, with members advised that confirmation of additional Scottish Government funding of £1.02 million has allowed further progression of MoU2 implementation across all three key workstreams. Two thirds of the Community Treatment and Care (CTAC) workforce are in place and substantive Vaccination workforce recruitment is currently underway. The Committee took assurance from the report that there has been progression in the recruitment of the workforce and noted the ongoing progress of all priority areas and the mitigating actions being taken in relation to the risks identified.

4.17 An Annual Report on Volunteering has also been reviewed by the Committee, with members welcoming the selfless commitment of over 250 individual volunteers who have offered much needed input to a number of services, including helping stock patient comfort packs for use when visiting was restricted and the ongoing help and support of volunteer staffing of the Community Listening Service. Volunteering activity has had to adapt due to Covid restrictions, but it has been heartening for members to learn of the positive input from volunteers, many of whom wish to give back to their local health services.

4.18 Progress reports on the development of a number of 'Once for Scotland' employment policies have been supplied to members, including the introduction of a new Promoting

Attendance policy, training for which has been rolled out across the organisation, supported by staff-side colleagues. In October 2021, the Committee noted the successful launch of Phase One of the nationally-authored policies, representing six individual areas including bullying & harassment, capability, conduct, grievance and a single workforce Investigation Process. The next stage in the programme will focus upon the Supporting Work / Life Balance suite of policies. Meantime, the local HR Policy Group continues to meet to update the remaining local documents, with Area Partnership Forum input prior to their endorsement.

4.19 At each meeting of the Committee, members routinely scrutinise the relevant section of the Board Assurance Framework (BAF) on Workforce Sustainability, and also receive regular updates on Absence Management performance and Well at Work activities. In October 2021 there was a detailed review of the BAF and the updated content was agreed by Committee. Within the Integrated Performance & Quality Report (IPQR), the Committee has responsibility for scrutiny of the measure on sickness absence. The Committee continued to be provided with information relating to sickness absence levels compared to the anticipated trajectory for 2021/2022. Performance has fluctuated over the course of the year, with long term sickness absence, particularly in the 'Anxiety / Stress / Depression / Other Psychiatric illnesses' category, challenging a sustainable positive improvement for this measure.

4.20 Actions continue to be undertaken to manage the challenging circumstances that lead to sickness absence, in particular that of a long-term nature, which can by its nature be extremely complicated to manage. The Committee has been supportive of additional measures relating to Staff Governance being added to the IPQR, particularly those that provide a more rounded representation of workforce performance than absence statistics alone provide. Members are in agreement of the merits of including supplementary quantitative and qualitative data, to be more reflective of the broader Staff Governance agenda and to include further metrics relevant to staff health and wellbeing.

4.21 The Committee has considered during the year a newly-formatted regular Workforce Information Overview report, containing enhanced data, which is intended to provide added context to the Committee in support of their role. The first few iterations of the report have been considered, utilising the Tableau visualisation tool, to link data from a range of workforce and financial systems to broader workforce issues. There is also opportunity to add narrative and trend-related analysis for future reports. In March 2022, it was reported that work to identify the "establishment gap" was ongoing with colleagues at regional and national level, as this continues to be an area of challenge across all Health Boards, though remains key to understanding the quantum of the workforce challenge. Members welcomed the ongoing development of this report, which will enhance the Committee's scrutiny of key issues and improve assurance reporting going forward.

4.22 Members considered the annual Staff Governance Monitoring Return draft submission for 2020/21 at the Committee's meetings in April and July 2021, the national template for which is constructed around the five Staff Governance strands and seeks to gather information on staff experience and culture. The Committee noted the helpful information contained therein on rates of appraisals delivered during the pandemic, remobilisation of staff, partnership working, equality-focused work with the introduction of a Black, Asian, Minority Ethnic (BAME) networking group and the implementation of the new national Whistleblowing Standards. Close engagement with a variety of stakeholder groups and staff-side had helped gather the information and data used to populate the return, prior to its formal submission to Scottish Government in September 2021.

4.23 Work has continued to ensure that over the year's meeting schedule full coverage of the five strands of the Staff Governance standard are reviewed. The Committee received individual papers to demonstrate that staff are well informed; appropriately trained and developed; involved in decisions; treated fairly and consistently, with dignity and respect, in

an environment where diversity is valued; and provided with a continuously improving and safe working environment, promoting the health and well-being of staff. In discussion of the Annual Internal Audit Report for 2020/21, the Committee has agreed to enhancing the sign-posting on papers and agenda items, to make clear which strand of the Standards is being addressed, to ensure full coverage across the Committee's yearly workplan.

4.24 During the year, the Committee received a number of detailed presentations, covering a variety of relevant topics including: (i) South East Payroll Services Consortia Business Case; (ii) East Region Recruitment Transformation; (iii) an outline of the Staff Governance Standards; (iv) the Redesign of Urgent Care, with a focus on collaborative working across teams; and (v) a summary of the NHS Fife Health & Safety function. The Committee were grateful to those invitees who took time to attend meetings to present, noting the usefulness of these sessions.

4.25 In October 2020, the Committee originally considered the South East Payroll Consortium Business Case, which has also had input from the Area Partnership Forum and Finance, Performance & Resources Committee. The proposal outlined the ambition to build as a single employer, with multiple bases, to ensure the resilience of payroll on a regional basis in the future, given long-standing capacity challenges across boards. Members supported the proposal in principle, noting the criticality of the service to the Health Board and the need to support the resilience and wellbeing of local payroll staff, but recommended discussions take place about a more phased approach than the draft timeline suggested. An update outlining this phasing was delivered to the Committee in July 2021.

4.26 A further update was given in January 2022, where an addendum to the original Business Case was given to address previously submitted feedback, particularly around the staff TUPE process and phasing of the implementation. Given that staffing levels in the local payroll team continue to represent a significant risk to the organisation, and recognising the criticality of the function, members welcomed the resilience the consortium approach would provide. It was also recognised that the matter needed to be concluded, to provide local payroll staff with a structured and definitive way forward, with opportunities for progression and promotion within the consortium model. The Committee have thus supported the implementation of the regional solution as soon as practically possible.

4.27 In reference to the East Region Recruitment Transformation project, which aims to implement a shared services recruitment model (a single employer, with multiple locations and Lothian as the host Board), the Committee has received detailed updates on progress in its design and eventual delivery implementation. The ambition of the programme is to enhance the recruitment service offered to existing staff and applicants, removing some of the limiting aspects of continuing with many local teams delivering the same tasks in each individual Board. Members have noted the requirement for any new service to remain responsive to the specific needs of NHS Fife, ensuring that the successful engagement that presently takes places with local schools and colleges continues and that it supports improvements in the length of time taken to hire new staff. It was noted that being part of a larger grouping will however have benefits to staff in respect of mentoring, coaching, development opportunities and promotions, not always available in a smaller team. NHS Fife recruitment staff have now transferred to NHS Lothian in line with the Transfer of Undertakings Protection of Employment legislation, (TUPE), prior to the Shared Services Agreement taking formal effect. Members welcomed the updates given and noted the staff-side assistance in helping take forward this project with the Fife staff affected.

5. Best Value

5.1 Since 2013/14 the Board has been required to provide overt assurance on Best Value. A revised Best Value Framework was considered and agreed by the NHS Board in January 2018. Appendix 3 provides evidence of where and when the Committee considered the relevant characteristics during 2021/22.

6. Risk Management

6.1 In line with the Board's agreed risk management arrangements, the Staff Governance Committee, as a governance committee of the Board, has considered risk through a range of reports and scrutiny, including oversight on the detail of the Workforce Sustainability section of the Board Assurance Framework (BAF). Progress and appropriate actions were duly noted.

6.2 During the course of the year, whilst there has been no change to rating of the workforce sustainability risks reported to the Committee within the BAF, these have been updated to include Covid-19 related workforce challenges and to reflect developments therein. Two new linked high rated workforce operational risks were added. In January 2021 the first of these, (Lack of Medical Capacity in Community Paediatrics), and updates have been provided on this throughout the year as the recruitment process for new posts in that service have progressed. the second, a risk related to nurse and midwifery recruitment has been developed, to ensure that national workforce pressures for nursing & midwifery in particular are appropriately reflected as a separate operational high-level risk. The wording for this was approved by the Committee at its October 2021 meeting, at which members held a very helpful discussion on the escalation process for reporting critical staffing levels within the Board's management structures. A presentation on nursing & midwifery staffing levels was delivered to the Committee in March 2022, with members scrutinising vacancy levels, the potential for upskilling the existing workforce, possible pension changes influencing uptake of early retirement, and options to reduce reliance on temporary 'bank' nursing staff. The Committee took assurance that this risk is being actively managed, though noting the national pressures overall on the nursing & midwifery workforce.

6.3 The Committee has supported a more fundamental review of the BAF as part of the Board-wide Risk Management Framework refresh, to enhance its focus on staff recruitment, vacancy levels and retention issues. Extant linked operational high risks are closely reviewed with the presentation of the BAF to the Committee and also used to inform the development of the Committee's workplan for the following year. The Committee has received updates on these as requested, including, in September 2021, a report on ongoing workforce pressures with Radiology Services and the actions underway to mitigate the risk the situation represents. In October 2021, the Committee took assurance from the actions underway to address workforce pressures in the Community Hospitals Medical workforce, noting the importance of transformation activities within this setting to ensure that more appropriate models of care are introduced, particularly for patients requiring rehabilitation support, best delivered in a more homely setting.

7. Self Assessment

7.1 The Committee has undertaken a self-assessment of its own effectiveness, for the year 2021/22 utilising a revised questionnaire considered and approved by the Committee Chair. Attendees were also invited to participate in this exercise, which was carried out via an easily-accessible online portal. A report summarising the findings of the survey was considered and approved by the Committee at its March 2022 meeting, and action points are being taken forward at both Committee and Board level, as appropriate.

8. Conclusion

8.1 As Chair of the Staff Governance Committee during financial year 2021/22, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year, I can confirm that adequate and effective Staff Governance planning and monitoring arrangements were in place throughout NHS Fife during the year.

8.2 I would pay tribute to the dedication and commitment of fellow members of the Committee, staff-side colleagues and to all attendees. I thank all those members of staff who have prepared reports and attended meetings of the Committee.

8.3 In particular, I acknowledge the ongoing contribution of all our staff, particularly in another most challenging year, set against the ongoing backdrop of the Coronavirus pandemic. All Committee members and I continue to be astounded and humbled by the efforts made by NHS Fife and Fife Health & Social Care staff, at what continues to be a difficult period of exceptional demand on our Acute and H&SCP services. We all remain in their debt.

Signed: Date: 12 May 2022

Sinead Braiden, Chair
On behalf of the Staff Governance Committee

Appendix 1 – Attendance Schedule
Appendix 2 – Best Value

NHS FIFE STAFF GOVERNANCE COMMITTEE
ATTENDANCE SCHEDULE 1 APRIL 2021 – 31 MARCH 2022

Present	**29/04/21**	**01/07/21**	**02/09/21**	**28/10/21**	**12/01/22**	**03/03/22**
M Wells, Non-Executive Member **(Chair)**	ü	ü				
S Braiden, Non-Executive Member **(Chair)**			ü	ü	ü	ü
W Brown, Employee Director	ü	ü	ü	ü	x	ü
C Cooper, Non-Executive Member	ü	ü	ü			
S Fevre, Co-Chair, H&SCP Local Partnership Forum	ü	ü	ü	ü	ü	ü
K Macdonald, Non-Executive Member	ü Observer	ü	ü Items 1 – 5.1	ü	ü	ü
M Mahmood, Non-Executive Member				ü	ü	ü
A Morris, Non-Executive Member	X	ü	ü	ü	ü	X
J Owens, Director of Nursing	ü	ü	ü	ü	ü	ü
C Potter, Chief Executive	x	ü	ü	ü	ü	ü
A Verrecchia, Co-Chair, Acute Services Division Local Partnership Forum	ü	ü	ü	x	x	ü
In attendance						
L Barker, Associate Director Nursing, H&SCP	ü					
K Berchtenbreiter, Head of Workforce Development	ü	ü	x	ü	ü	ü
K Booth, Head of Financial Services & Procurement					ü	
N Connor, Director of Health & Social Care	x	ü	x	ü	ü	x
B Davis, Head of Primary & Preventative Care						ü
H Denholm, Head of Payroll Services		ü Item 6.4				
C Dobson, Director of Acute Services	ü	ü	ü	ü	ü	ü
L Douglas, Director of Workforce **(Exec Lead)**	ü	ü	ü	ü	ü	ü
S Fraser, Associate Director of Planning & Performance	ü	ü	ü Item 6.2 & 6.3			
Dr H Hellewell, Associate Medical Director						ü Item 6.4
N McCormick, Director of Property & Asset Management						ü Item 5.5
M McGurk, Director of Finance & Strategy and Deputy Chief Executive	x	x	x	ü	ü	ü
F McKay, Head of Strategic Planning, Performance & Commissioning			ü			

APPENDIX 1

	29/04/21	01/07/21	02/09/21	28/10/21	12/01/22	03/03/22
Dr C McKenna, Medical Director				ü		
Dr G MacIntosh, Head of Corporate Governance & Board Secretary	ü	ü	ü	ü	ü	ü
M Michie, Deputy Director of Finance			ü			
S Raynor, Head of Workforce Resourcing and Relations	ü	ü	ü	ü	ü	ü
K Reith, Deputy Director of Workforce	ü	ü	ü	ü	ü	ü
R Waugh, Head of Workforce Planning and Staff Wellbeing	ü	ü	ü	ü	ü	ü

Best Value Framework

Vision and Leadership

A Best Value organisation will have in place a clear vision and strategic direction for what it will do to contribute to the delivery of improved outcomes for Scotland's people, making Scotland a better place to live and a more prosperous and successful country. The strategy will display a clear sense of purpose and place and be effectively communicated to all staff and stakeholders. The strategy will show a clear direction of travel and will be led by Senior Staff in an open and inclusive leadership approach, underpinned by clear plans and strategies (aligned to resources) which reflect a commitment to continuous improvement.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
NHS Fife acts in accordance with its values, positively promotes and measures a culture of ethical behaviours and encourages staff to report breaches of its values.	Whistleblowing Policy Code of Corporate Governance	**BOARD** **STAFF GOVERNANCE COMMITTEE**	Annual	Whistleblowing Champion appointed as a Board member and a member of this Committee Regular quarterly reporting on Whistleblowing activity and discussion on how this reporting can be enhanced and expanded Model Code of Conduct included in annually reviewed Code of Corporate Governance

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Resources required to achieve the strategic plan and operational plans e.g. finance, staff, asset base are identified and additional / changed resource requirements identified.	Financial Plan Workforce Plan Property & Asset Management Strategy	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **STAFF GOVERNANCE COMMITTEE** **BOARD**	Annual Annual Annual Bi-annual Bi-monthly	Annual Operational / Remobilisation Plan Financial Plan Workforce Plan Property & Asset Management Strategy Integrated Performance & Quality Report

GOVERNANCE AND ACCOUNTABILITY

The "Governance and Accountability" theme focuses on how a Best Value organisation achieves effective governance arrangements, which help support Executive and Non-Executive leadership decision-making, provide suitable assurances to stakeholders on how all available resources are being used in delivering outcomes and give accessible explanation of the activities of the organisation and the outcomes delivered.

OVERVIEW

A Best Value organisation will be able to demonstrate structures, policies and leadership behaviours which support the application of good standards of governance and accountability in how the organisation is improving efficiency, focusing on priorities and achieving value for money in delivering its outcomes. These good standards will be reflected in clear roles, responsibilities and relationships within the organisation. Good governance arrangements will provide the supporting framework for the overall delivery of Best Value and will ensure open-ness and transparency. Public reporting should show the impact of the organisation's activities, with clear links between the activities and what outcomes are being delivered to customers and stakeholders. Good governance provides an assurance that the organisation has a suitable focus on continuous improvement and quality. Outwith the organisation, good governance will show itself through an organisational commitment to public performance reporting about the quality of activities being delivered and commitments for future delivery.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Board and Committee decision-making processes are open and transparent.	Board meetings are held in open session and minutes are publically available. Committee papers and minutes are publically available.	**BOARD** **COMMITTEES**	Ongoing	Board section on NHS website, containing papers and instructions for those wishing to join meetings as public observers
Board and Committee decision-making processes are based on evidence that can show clear links between activities and outcomes	Reports for decision to be considered by Board and Committees should clearly describe the evidence underpinning the proposed decision.	**BOARD** **COMMITTEES**	Ongoing	SBAR reports EQIA forms

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife can demonstrate that it has clear mechanisms for receiving feedback from staff and responds positively to issues raised.	Annual feedback Individual feedback	**CLINICAL GOVERNANCE COMMITTEE** **STAFF GOVERNANCE COMMITTEE**	Annual Ongoing Quarterly Bi-monthly Annual Ongoing Quarterly and Annually Ongoing	Annual Review with Ministers Care Opinion Regular meetings with MPs/MSPs Integrated Performance & Quality Report iMatter survey (local and national) Reports Adverse Event reporting (Datix) and review. Whistleblowing Reporting Workforce Information Overview

APPENDIX 2

USE OF RESOURCES

The "Use of Resources" theme focuses on how a Best Value organisation ensures that it makes effective, risk-aware and evidence-based decisions on the use of all of its resources.

OVERVIEW

A Best Value organisation will show that it is conscious of being publicly funded in everything it does. The organisation will be able to show how its effective management of all resources (including staff, assets, information and communications technology (ICT), procurement and knowledge) is contributing to delivery of specific outcomes.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife ensures that all employees are managed effectively and efficiently, know what is expected of them, their performance is regularly assessed and they are assisted in improving.	AfC appraisal process and Executive and Senior Manager Performance reporting. Medical performance appraisal (also reported to Clinical Governance Committee).	**STAFF GOVERNANCE COMMITTEE** **REMUNERATION COMMITTEE**	Annual and as required Bi-monthly	Appraisal, Personal Development & iMatter reports Integrated Performance & Quality Report
NHS Fife understands and measures the learning and professional development required to support statutory and professional responsibilities and achieve organisational objectives and quality standards.	Core Training compliance reported Medical revalidation report and monitoring Nursing revalidation.	**STAFF GOVERNANCE COMMITTEE**	Ongoing	Minutes of Staff Governance Committee

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Staff performance management recognises and monitors contribution to ensuring continuous improvement and quality.	Service Improvement and Quality are core dimensions of AfC appraisal process. Executive and Senior Manager Objectives – core collective objectives include performance and leadership.	**STAFF GOVERNANCE COMMITTEE** **REMUNERATION COMMITTEE**	Ongoing	Minutes of Staff Governance Committee & Remuneration Committee

PERFORMANCE MANAGEMENT

The "Performance Management" theme focuses on how a Best Value organisation embeds a culture and supporting processes which ensures that it has a clear and accurate understanding of how all parts of the organisation are performing and that, based on this knowledge, it takes action that leads to demonstrable continuous improvement in performance and outcomes.

OVERVIEW

A Best Value organisation will ensure that robust arrangements are in place to monitor the achievement of outcomes (possibly delivered across multiple partnerships) as well as reporting on specific activities and projects. It will use intelligence to make open and transparent decisions within a culture which is action and improvement oriented and manages risk. The organisation will provide a clear line of sight from individual actions through to the National Outcomes and the National Performance Framework. The measures used to manage and report on performance will also enable the organisation to provide assurances on quality and link this to continuous improvement and the delivery of efficient and effective outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Performance is systematically measured across all key areas of activity and associated reporting provides an understanding of whether the organisation is on track to achieve its short and long-term strategic, operational and quality objectives	Integrated Performance & Quality Report encompassing all aspects of operational performance, AOP targets / measures, and financial, clinical and staff governance metrics. The Board delegates to Committees the scrutiny of performance. Board receives full Integrated Performance & Quality Report and notification of any issues for escalation from Committees.	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Code of Corporate Governance Minutes of Committees

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
The Board and its Committees approve the format and content of the performance reports they receive.	The Board / Committees review the Integrated Performance & Quality Report and agree the measures.	**COMMITTEES** **BOARD**	Annual	Integrated Performance & Quality Report
Reports are honest and balanced and subject to proportionate and appropriate scrutiny and challenge from the Board and its Committees.	Committee Minutes show scrutiny and challenge when performance is poor as well as good, with escalation of issues to the Board as required	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Minutes of Committees
The Board has received assurance on the accuracy of data used for performance monitoring.	Performance reporting information uses validated data.	**COMMITTEES** **BOARD**	Every meeting Annual	Integrated Performance & Quality Report Annual Accounts including External Audit report
NHS Fife's performance management system is effective in addressing areas of underperformance, identifying the scope for improvement, agreeing remedial action, sharing good practice and monitoring implementation.	Encompassed within the Integrated Performance & Quality Report	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Minutes of Committees

CROSS-CUTTING THEME – SUSTAINABILITY

The "Sustainability" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded a sustainable development focus in its work.

OVERVIEW

The goal of Sustainable Development is to enable all people throughout the world to satisfy their basic needs and enjoy a better quality of life without compromising the quality of life of future generations. Sustainability is integral to an overall Best Value approach and an obligation to act in a way which it considers is most sustainable is one of the three public bodies' duties set out in section 44 of the Climate Change (Scotland) Act 2009. The duty to act sustainably placed upon Public Bodies by the Climate Change Act will require Public Bodies to routinely balance their decisions and consider the wide range of impacts of their actions, beyond reduction of greenhouse gas emissions and over both the short and the long term.

The concept of sustainability is one which is still evolving. However, five broad principles of sustainability have been identified as:

- promoting good governance;
- living within environmental limits;
- achieving a sustainable economy;
- ensuring a stronger healthier society; and
- using sound science responsibly.

Individual Public Bodies may wish to consider comparisons within the wider public sector, rather than within their usual public sector "family". This will assist them in getting an accurate gauge of their true scale and level of influence, as well as a more accurate assessment of the potential impact of any decisions they choose to make.

A Best Value organisation will demonstrate an effective use of resources in the short-term and an informed prioritisation of the use of resources in the longer-term in order to bring about sustainable development. Public bodies should also prepare for future changes as a result of emissions that have already taken place. Public Bodies will need to ensure that they are resilient enough to continue to deliver the public services on which we all rely.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
NHS Fife promotes personal well-being, social cohesion and inclusion.	Healthy workforce	**STAFF GOVERNANCE COMMITTEE** **BOARD**	Ongoing	Healthy Working Lives Gold Award Equality Outcomes reporting

APPENDIX 2

CROSS-CUTTING THEME – EQUALITY

The "Equality" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded an equalities focus which will secure continuous improvement in delivering equality.

OVERVIEW

Equality is integral to all our work as demonstrated by its positioning as a cross-cutting theme. Public Bodies have a range of legal duties and responsibilities with regard to equality. A Best Value organisation will demonstrate that consideration of equality issues is embedded in its vision and strategic direction and throughout all of its work.

The equality impact of policies and practices delivered through partnerships should always be considered. A focus on setting equality outcomes at the individual Public Body level will also encourage equality to be considered at the partnership level.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE:**
NHS Fife meets the requirements of equality legislation.	Equality Reporting	**BOARD** **COMMITTEES**	Ongoing	EQIA section on all reports
The Board and senior managers understand the diversity of their customers and stakeholders.	Equality Impact Assessments are reported to the Board and Committees as required and identify the diverse range of stakeholders.	**BOARD** **COMMITTEES**	Ongoing	EQIA section on all reports
NHS Fife's Performance Management system regularly measures and reports its performance in contributing to the achievement of equality outcomes.		**CLINICAL GOVERNANCE COMMITTEE**	Ongoing	Minutes

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
NHS Fife ensures that all members of staff are aware of its equality objectives.	Induction Equality and Diversity is core dimension in KSF (Knowledge and Skills Framework) that underpins the appraisal process for AfC staff Equality and Diversity Learn Pro Module	**STAFF GOVERNANCE**	Ongoing	iMatter reports Minutes
NHS Fife's policies, functions and service planning overtly consider the different current and future needs and access requirements of groups within the community.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments consider the current and future needs and access requirements of the groups within the community.	**BOARD** **COMMITTEES**	Ongoing	Clinical Strategy (under review) EQIA section on reports
Wherever relevant, NHS Fife collects information and data on the impact of policies, services and functions on different equality groups to help inform future decisions.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments will collect this information to inform future decisions.	**BOARD** **COMMITTEES**	Ongoing	EQIA section on reports

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Date	4th April 2022
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Dear Margo

GOVERNANCE STATEMENT 2021/2022

In line with the Scottish Public Finance Manual (SPFM) guidance on the preparation of the annual Governance Statement, this letter has been prepared to give formal assurance to the Chief Executive (Accountable Officer) that adequate and effective internal controls and risk management arrangements have been in place across my directorate areas of responsibility throughout 2021/22.

Effectiveness of Risk Management Arrangements

I can confirm that risk management arrangements were in place and operating effectively. There were a number of high operational risks during the year in relation to the ongoing response to and management of the pandemic which are noted below:

There was a risk that safe staffing levels were compromised by the pandemic, impacting on care. This was managed by clear direction to service leaders on core operational priorities and by directing staff resilience to these areas. Levels were monitored on a regular basis ultimately by Pharmacy Silver Command.	There was a risk that increased demand on community pharmacies (CPs), influenced by public uncertainty, will cause disruption to usual supply and delivery service methods resulting in patients in the community not receiving their medicines on time. This was managed through close working with local CP leaders, proactive comms to the general public and mitigated by the possibility of managed service staff supporting CPs in an emergency.

The COVID vaccination programme had a fully developed risk register which was managed on a weekly basis by the programme team with appropriate escalation points to the Programme Director and SRO. The Director of Pharmacy and Medicines transferred the role of the SRO to the Director of Health of Social Care on 1st August 2022.	Pharmacy & Medicines Silver Command had oversight of the risk register which was established for COVID-19 and used to support development and management of the pandemic response. Risks relating to ongoing BAU and programmes continue to be managed either via Pharmacy SLT or an appropriate group.

Economic, Effective and Efficient use of resources

I can confirm that through engagement with the Strategic Planning and Resource Allocation Process (SPRA) and ongoing review and control of the budgets allocated to my areas of responsibility, that there was economic, effective and efficient use of resources. There were a number of important investment decisions and cost improvement activity which supported that position which are noted below:

The Board agreed funding for the Hospital Electronic Prescribing Management and Administration system which will improve quality of prescribing across settings of care.	The HSCP agreed to provide an uplift in funding for Pharmacotherapy services during the fourth year of GMS contract implementation. This will deliver additional pharmacy input into care and support sustainability of GP practices.
Investment in clinical pharmacy support for the Fife Elective Orthopaedic centre has been confirmed by Scottish Government, enhancing quality of clinical care in that setting working in partnership with the MDT.	The Scottish Government has agreed to invest in additional mental health pharmacy capacity, complementing the wider investment in this area. Recruitment is ongoing for this cohort.
Pharmacy continues to contribute strongly to cost saving activity across acute and primary care settings through proactive management of medicines and prescribing. Workplans for all settings are in place and developed in partnership with colleagues across services.	

Compliance with applicable policies, procedures, laws and regulations

I can confirm that there was full compliance with all applicable policies, procedures, laws and regulations as they related to my areas of responsibility. I can also confirm there were no known failures or weaknesses reported on the system of internal control. (*There were a number of important internal and external reviews and reports which support that position which are noted below (please ref HIS/NIS etc reviews)).*

The roles and responsibilities of Controlled Drug Accountable Officer (CDAO) are governed by Controlled Drugs (Supervision of Management and Use) Regulations 2013. There is a legal duty to share information between responsible organisations. It is a requirement for all NHS Boards to establish a Local Intelligence Network to support information sharing and to put in place processes for the disposal of unwanted CDs in NHS sites, community pharmacies and GP practices. An annual report was tabled at Clinical governance committee in August to update on ongoing work to ensure safe and effective use of CD's within Fife. Controlled Drug Local Intelligence network is established and has met twice in this reporting period.
As organisational lead for medicines, the Director of Pharmacy and Medicines is responsible for the safe supply, storage, prescribing and administration of medicines and medical gases across the organisation. Both HTM 02-01 and (s)HTM 02-01 recommend that a Medical Gas Committee be established to "oversee the general operation and management of the Medical Gas Pipeline System and all facets of the MGPS operational policy". The requirement to have a multidisciplinary group responsible for reviewing oxygen-related incidents, developing a local oxygen policy and a training programme was reinforced within the National Patient Safety Agency Rapid Response Report (NPSA/2009/RRR006). Medical gas committee in NHS Fife has met 4 times in this reporting period with 6 monthly reports to the Area Drugs and Therapeutics committee, including the annual audit of medical gas within wards/departments and medical gas stores to provide assurance. Problem assessment group was also established throughout the waves of the pandemic to ensure site resilience for oxygen demand, which has been met throughout this reporting period.
Professional guidance on the safe and secure handling of medicines by the Royal Pharmaceutical Society, covers all health care settings and all health professionals whose role involves handling of medicines and was used to develop NHS Fife Safe and Secure Use of Medicines policies and procedures, whilst ensuring compliance with relevant legislation and guidance from the Scottish Government. The Safe and Secure Use of Medicines Group (SSUOMG) have developed an audit and assurance programme consisting of rolling program of 13 audits. SSUOMG have met eight time during this reporting period with 6 monthly reports to Area Drugs and Therapeutics committee, including 4 audit reports consisting of controlled drug ward checks, medicines that require refrigeration and medical gas wards and stores audit. NHS Fife Safe and Secure Use of medicines policies and procedures was updated in July 21 and February 22 with all updates available on Blink.

Compliance with the Code of Corporate Governance

I can confirm that there were no known breaches of the Code of Corporate Governance during 2021/22. There was also compliance throughout the year with the organisational safeguards against losses, including those arising from fraud, irregularity or corruption.

Integrity and Reliability of Information and Data

I can confirm that there were adequate processes in place to ensure the integrity and reliability of information and data relevant to the operation of all directorate activities.

Internal Audit Reports and Recommendations

I can confirm that all actions arising from recommendations made by Internal Audit for my areas of responsibility have been agreed and actioned.

Yours sincerely

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Date	6 April 2022
Your Ref	
Our Ref	
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Dear Margo

GOVERNANCE STATEMENT 2021/2022

In line with the Scottish Public Finance Manual (SPFM) guidance on the preparation of the annual Governance Statement, this letter has been prepared to give formal assurance to the Chief Executive (Accountable Officer) that adequate and effective internal controls and risk management arrangements have been in place across my directorate areas of responsibility throughout 2021/22.

Effectiveness of Risk Management Arrangements

I can confirm that risk management arrangements were in place and operating effectively. A full review of the Quality and Safety Board Assurance Framework (BAF) has been completed to ensure that the risks associated with ongoing impact of the pandemic are adequately captured. This has also included identifying high risks to be linked to the Quality and Safety BAF.

Economic, Effective and Efficient use of resources

I can confirm that through engagement with the Strategic Planning and Resource Allocation Process (SPRA) and ongoing review and control of the budgets allocated to my areas of responsibility, that there was economic, effective and efficient use of resources. There were a number of important investment decisions and cost improvement activity which supported that position which are noted below.

Investment/ Cost Improvement Activity	Description

Investment of 1 WTE Band 8A Lead for Adverse Events	Investment enabled creation of separate and distinct leadership respectively for Adverse Events and Risk Management. Thereby allowing for dedicated leadership to progress the review of Adverse Events Policy and refresh of the Risk Management Framework
Agreement for investment of 1WTE Band 7 Child Death Review and 0.5 WTE Band 4 Administrator	Investment will deliver compliance with National Guidance for the Reviewing and Learning from the of Deaths of Children and Young People
Investment to establish new Simulation Suite for Medical Education at Queen Margaret Hospital	Has delivered a dedicated educational suite for the delivery of simulated teaching for medical education with access to the facility to other professional groups
Agreement for investment in 0.6 WTE Band 8a Innovation Manager	Investment will deliver support for development and implementation of Innovation Governance Framework to maintain oversight of and ensure quality and safety of innovation projects

Compliance with applicable policies, procedures, laws and regulations

I can confirm that there was full compliance with all applicable policies, procedures, laws and regulations as they related to my areas of responsibility. I can also confirm there were no known failures or weaknesses reported on the system of internal control. There were a number of important internal and external reviews and reports which support that position which are noted below.

Review	Review Summary
Network and Information Systems Audit (NIS) conducted by the Scottish Health Competent Authority – April 2021	Compliance score of 69% achieved and improvement from 53% achieved in the 2020 audit.
Network and Information Systems Audit (NIS) conducted by the Scottish Health Competent Authority – March 2022	Results of audit expected in May 2022.
Audit of Records Management Plan by National Records Scotland	Ongoing feedback being provided by NRS

Compliance with the Code of Corporate Governance

I can confirm that there were no known breaches of the Code of Corporate Governance during 2021/22. There was also compliance throughout the year with the organisational safeguards against losses, including those arising from fraud, irregularity or corruption.

Integrity and Reliability of Information and Data

I can confirm that there were adequate processes in place to ensure the integrity and reliability of information and data relevant to the operation of all directorate activities.

Internal Audit Reports and Recommendations

I can confirm that all actions arising from recommendations made by Internal Audit for my areas of responsibility have been agreed and actioned. A summary of outstanding actions is set out below.

Internal Audit Reference	Actions Status
B23-21 – ITIL Process Development	2 actions complete. 4 actions to be concluded by June 2022
B19/21 Clinical Governance Strategy and Assurance	1 action outstanding to be concluded by 31 May 2022. Clinical and Care Governance Framework has been delayed due to system p pressures. Draft Framework is currently out for feedback from key stakeholders.

Yours sincerely

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Medical Director NHS Fife

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Date	5th April 2022
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Dear Margo

GOVERNANCE STATEMENT 2021/2022

In line with the Scottish Public Finance Manual (SPFM) guidance on the preparation of the annual Governance Statement, this letter has been prepared to give formal assurance to the Chief Executive (Accountable Officer) that adequate and effective internal controls and risk management arrangements have been in place across my directorate areas of responsibility throughout 2021/22.

Effectiveness of Risk Management Arrangements

I can confirm that risk management arrangements were in place and operating effectively. There were a number of high operational risks during the year in relation to the ongoing response to and management of the pandemic which are noted below:

RISK ID: 2054	Social Distancing of waiting patients within AU1 and overcrowding risk
RISK ID: 2297	Cancer Waiting Times Access Standards
RISK ID: 2048	Women and Children reduction in workforce due to COVID

Economic, Effective and Efficient use of resources

I can confirm that through engagement with the Strategic Planning and Resource Allocation Process (SPRA) and ongoing review and control of the budgets allocated to my areas of responsibility, that there was economic, effective and efficient use of resources. There were a number of important investment decisions and cost improvement activites which supported that position which are noted below.

Directorate cost improvement plans

Directorate grip and control
Cost reduction opportunity in Community Paediatrics by recruiting two permanent posts rather than expensive locums
Repatriation of surgical activity from a territory centre
Ensuring appropriate spend was attributed to COVID-19 funding
Collaborative working with the HSCP to ensure the appropriate allocation of Scottish Government funding e.g. winter monies

Compliance with applicable policies, procedures, laws and regulations

I can confirm that there was full compliance with all applicable policies, procedures, laws and regulations as they related to my areas of responsibility. I can also confirm there were no known failures or weaknesses reported on the system of internal control. There was an important external review carried out and a report which support that position which are noted below.

Healthcare Improvement Scotland (HIS): Acute Hospital COVID-19 focused inspection - Unannounced Acute Hospital COVID-19 focused inspection to Victoria Hospital, NHS Fife (4-6 May 2021)

Compliance with the Code of Corporate Governance

I can confirm that there were no known breaches of the Code of Corporate Governance during 2021/22. There was also compliance throughout the year with the organisational safeguards against losses, including those arising from fraud, irregularity or corruption.

Integrity and Reliability of Information and Data

I can confirm that there were adequate processes in place to ensure the integrity and reliability of information and data relevant to the operation of all directorate activities.

Internal Audit Reports and Recommendations

I can confirm that all actions arising from recommendations made by Internal Audit for my areas of responsibility have been agreed and actioned.

Yours sincerely

Claire H J Dobson
Director of Acute Services
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Date: 06.04.2022
Your Ref: JO/CL
Our Ref

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Dear Margo

GOVERNANCE STATEMENT 2021/2022

In line with the Scottish Public Finance Manual (SPFM) guidance on the preparation of the annual Governance Statement, this letter has been prepared to give formal assurance to the Chief Executive (Accountable Officer) that adequate and effective internal controls and risk management arrangements have been in place across my directorate areas of responsibility throughout 2021/22.

Effectiveness of Risk Management Arrangements

I can confirm that risk management arrangements were in place and operating effectively. (*There were a number of high operational risks during the year in relation to the ongoing response to and management of the pandemic which are noted below).*

1	Risk (number 2214) 'Nursing and Midwifery Staffing levels' is a linked risk in both the Workforce Sustainability BAF and the Quality and Safety BAF. The risk is described in deta and mitigating actions are clearly articulated. Staffing levels have been impacted by covid-1 and requirement for 'new' workforce (vaccination programme); high levels of vacancies and sickness absence.
2	To support nurses, midwives and AHPs in these unprecedented times, a set of Guiding Principles was developed to support professional decision-making. The Principles were endorsed by EDG, Staff Governance Committee and Scottish Executive Nurse Directors Group

Economic, Effective and Efficient use of resources

I can confirm that through engagement with the Strategic Planning and Resource Allocation Process (SPRA) and ongoing review and control of the budgets allocated to my areas of responsibility, that there was economic, effective and efficient use of resources. (*There were a number of important investment decisions and cost improvement activity which supported that position which are noted below).*

1	Nursing Directorate: I can confirm economic, effective and efficient use of resources, demonstrating an underspend in the annual budget
2	NTC-Fife: I can confirm the efficient and effective use of resources. Additional funding achieved from Scottish Government for workforce. Project itself, in time and in budget.

Compliance with applicable policies, procedures, laws and regulations

I can confirm that there was full compliance with all applicable policies, procedures, laws and regulations as they related to my areas of responsibility. I can also confirm there were no known failures or weaknesses reported on the system of internal control. (*There were a number of important internal and external reviews and reports which support that position which are noted below (please ref HIS/NIS etc reviews)).*

1	An HIS inspection took place in VHK between the 4th and 6th of May 2021. The focus of the inspection was COVID-19. 7 areas of good practice and 2 requirements were identified. An action plan was developed to address the requirements, which related to testing patients at 5 days and the state of some equipment in ward 1o. The actions were completed and a report submitted to EDG and the CGC in October 2021.
2	A multi-agency Adult Support and Protection inspection was carried out in Fife between May a August 2021 to provide assurance to the Scottish Government about local partnership areas effective operation of adult support and protection processes and leadership for adult support and protection services. The inspectors found clear strengths in ensuring adults at risk of harm are safe, protected and supported and a small number of improvement areas identified. An improvement plan was developed to address these areas.

Compliance with the Code of Corporate Governance

I can confirm that there were no known breaches of the Code of Corporate Governance during 2021/22. There was also compliance throughout the year with the organisational safeguards against losses, including those arising from fraud, irregularity or corruption.

Integrity and Reliability of Information and Data

I can confirm that there were adequate processes in place to ensure the integrity and reliability of information and data relevant to the operation of all directorate activities.

Internal Audit Reports and Recommendations

I can confirm that all actions arising from recommendations made by Internal Audit for my areas of responsibility have been agreed and actioned.

Yours sincerely

Name: Janette Owens
Director of Nursing
NHS Fife

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Mrs Margo McGurk
Director of Finance & Strategy
NHS Fife

Hayfield House
Hayfield Road

KIRKCALDY
Fife
KY2 5AH

Date	7 April 2022
Your Ref	
Our Ref	JT/cc - Governance Statement Directors Letter 2021-22
Enquiries to	Joy Tomlinson
Extension	46459
Direct Line	01592 226459
Email	Joy.tomlinson3@nhs.scot

Dear Margo

GOVERNANCE STATEMENT 2021/2022

In line with the Scottish Public Finance Manual (SPFM) guidance on the preparation of the annual Governance Statement, this letter has been prepared to give formal assurance to the Chief Executive (Accountable Officer) that adequate and effective internal controls and risk management arrangements have been in place across my directorate areas of responsibility throughout 2021/22.

Effectiveness of Risk Management Arrangements

I can confirm that risk management arrangements were in place and operating effectively. The Public Health Department has an established Assurance Committee which provides oversight of all responsibilities and associated risks. The Public Health Assurance Committee escalates any concerns as appropriate to the Executive Director Group and Board Assurance Committees. There were a number of high operational risks during the year in relation to the ongoing response to and management of the pandemic which are noted below.

Topic area	Control
Health Protection	Team expanded in response to Pandemic and remain place.
Test and Protect	Test and Protect Oversight Group in place, risks reviewed at Public Health Assurance Committee
Strategic oversight of Immunisation programmes	Immunisation Review completed, Strategic Framework place with clear roles and responsiblities

Economic, Effective and Efficient use of resources

I can confirm that through engagement with the Strategic Planning and Resource Allocation Process (SPRA) and ongoing review and control of the budgets allocated to my areas of responsibility, that there was economic, effective and efficient use of resources. Non-recurring COVID-19 funding has been monitored carefully, supported by our Finance partners. Oversight of key areas noted below.

Areas of investment	Control mechanism
Non-recurring funding covering: • Test and Protect, contact tracing • Testing programmes for COVID19 • Enhanced Health Protection teams	Monthly reviews with Finance and Public Health service manager. Oversight through Public Health Management tea
SPRA	Dept leads complete for their area. Oversight through Public Health Management team.

Compliance with applicable policies, procedures, laws and regulations

I can confirm that there was full compliance with all applicable policies, procedures, laws and regulations as they related to my areas of responsibility. I can also confirm there were no known failures or weaknesses reported on the system of internal control.

Compliance with the Code of Corporate Governance

I can confirm that there were no known breaches of the Code of Corporate Governance during 2021/22. There was also compliance throughout the year with the organisational safeguards against losses, including those arising from fraud, irregularity or corruption.

Integrity and Reliability of Information and Data

I can confirm that there were adequate processes in place to ensure the integrity and reliability of information and data relevant to the operation of all directorate activities.

Internal Audit Reports and Recommendations

There were no Internal Audits for my areas of responsibility which required to be actioned over the last year.

Yours sincerely

Dr Joy Tomlinson
Director of Public Health
NHS Fife

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Mrs Margo McGurk
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Date	4 April 2022
Your Ref	
Our Ref	LD/KR
Enquiries to	Linda Douglas
Extension	28136
Direct Line	01592 346655 ext 28136
Email	linda.douglas@nhs.scot

Dear Margo

GOVERNANCE STATEMENT 2021/2022

In line with the Scottish Public Finance Manual (SPFM) guidance on the preparation of the annual Governance Statement, this letter has been prepared to give formal assurance to the Chief Executive (Accountable Officer) that adequate and effective internal controls and risk management arrangements have been in place across my directorate areas of responsibility throughout 2021/22.

Effectiveness of Risk Management Arrangements

I can confirm that risk management arrangements were in place and operating effectively. All Workforce Directorate and COVID Workforce risks were updated to meet reporting timetable. In addition, as part of corporate review of risks, a review of the Workforce Sustainability BAF was completed and the revised format was implemented. A comprehensive review of all workforce risks owned in service areas was also undertaken with feedback provided to risk owners. Reports on linked high operational risks were reported to SGC during the 2021/2022 meeting cycle. The present high operational risks connected to Workforce Sustainability are noted below.

There is an established and continuing risk that safe nursing and midwifery levels cannot be achieved. NHS Fife is experiencing critical nursing and midwifery shortfalls, similar to other Boards across NHS Scotland. Vacancy rates, sickness absence levels and high activity related to consequences of the pandemic are aligned to the unprecedented demand on clinical services and on nursing and midwifery. There continues to be a heavy demand on supplementary staffing. Consequently, the impact on quality of care remains.
There is a risk that we will be unable to recruit to consultant radiology posts due to a national shortage with the consequence that we will be unable to provide a full range of diagnostic services to support unscheduled and scheduled activity within NHS Fife within the required timescales.

Economic, Effective and Efficient use of resources

I can confirm that through engagement with the Strategic Planning and Resource Allocation Process (SPRA) and ongoing review and control of the budgets allocated to my areas of responsibility, that there was economic, effective and efficient use of resources. I would acknowledge the evolving arrangements through SPRA which are helping us to align our strategic, workforce and financial plans. We can build on this positive work as we address some legacy issues relating to directorate budget and move to implement our organisational programme of Financial Improvement and Sustainability.

In terms of specific Workforce Directorate activity the significant additional work which has been undertaken across our functions has been facilitated through the non-recurring COVID-19 allocations. We will be unable to sustain our current higher activity levels without consideration of the resources available to support functions, especially Occupational Health and Nurse Bank. In this past year I would also note the work undertaken to complete phase one of the implementation of the Regional Recruitment Shared Services model to deliver a more effective and efficient service to all participant Boards. As we move to complete the adoption of the full model, we will need to ensure the service develops to meet its full ambitions.

Compliance with applicable policies, procedures, laws and regulations

I can confirm that there was full compliance with all applicable policies, procedures, laws and regulations as they related to my areas of responsibility. I can also confirm there were no known failures or weaknesses reported on the system of internal control. I would note the work completed on the submission of our Staff Governance Monitoring Return and the intention communicated by Scottish Government in February 2022 to provide feedback to Boards, and their encouragement to include actions arising from our iMatter Staff Experience reports in 2020/21 and 2021/22. Although we are still to receive the formal feedback, I believe we are well placed within NHS Fife due to the work undertaken in partnership to evidence our compliance with the Staff Governance Standard.

Compliance with the Code of Corporate Governance

I can confirm that there were no known breaches of the Code of Corporate Governance during 2021/22. There was also compliance throughout the year with the organisational safeguards against losses, including those arising from fraud, irregularity or corruption.

Integrity and Reliability of Information and Data

I can confirm that there were adequate processes in place to ensure the integrity and reliability of information and data relevant to the operation of all directorate activities. This year has required us to develop additional workforce reporting, which we have developed either through our corporate systems and/or through regional Board collaboration. From feedback through Committee and Executive groups we continue to evolve the availability of workforce reporting and develop our data definitions in line with organisational level business intelligence activity. I would note that all workforce related Freedom of Information requests have been responded to in line with legislation and timescales.

Internal Audit Reports and Recommendations

I can confirm that all actions arising from recommendations made by Internal Audit for my areas of responsibility have been agreed and actioned.

Lastly some general comments, this year saw the COVID-19 pandemic have significant and sustained impact on the delivery of services provided by the Workforce Directorate (i.e. Staff Wellbeing & Workforce Planning, Workforce Resourcing & Relations and Workforce Development & Engagement), but with positive outcomes achieved. Significant change to service delivery was constructively led and managed with team members also rising to the challenge of the unprecedented increase in volume of activity and the need to be responsive to new and modified processes or requirements. We will need a period to consolidate the work undertaken to create or adapt systems of work at pace to respond to the demands presented by a global pandemic. This will ensure we are geared up to continue to meet the needs of the organisation. This includes all areas of how we deployed staff, how we recruited and onboarded new staff into the organisation, how we delivered learning and up/reskilled ourselves and our colleagues, how we communicated and engaged with our colleagues and stakeholders, how we develop and invest in human resources information systems to evidence decision making, and probably most significantly, how we enhanced and developed support to staff to sustain and enhance their wellbeing and resilience.

Yours sincerely

Linda Douglas
Director of Workforce
NHS Fife

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Mrs Carol Potter
Chief Executive
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Date	8 April 2022
Your Ref	YE Director Letter 2021/22
Our Ref	
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Dear Carol

GOVERNANCE STATEMENT 2021/2022

In line with the Scottish Public Finance Manual (SPFM) guidance on the preparation of the annual Governance Statement, this letter has been prepared to give formal assurance to the Chief Executive (Accountable Officer) that adequate and effective internal controls and risk management arrangements have been in place across my directorate areas of responsibility throughout 2021/22.

Effectiveness of Risk Management Arrangements
I can confirm that risk management arrangements were in place and operating effectively. The key directorate risk which required to be managed in-year related to the overall financial position of NHS Fife as detailed below.

Financial Position
In-year management of the financial position - the complexity of managing the core position in parallel with the additional expenditure incurred in line with the pandemic response was challenging. Additionally, whilst we successfully delivered the in-year savings target, the delivery of the legacy core overspend was not possible and non-recurring support was received from the Scottish Government to support delivery of a balanced position at the year-end.

Risk Management Improvement Programme
Significant progress was made in-year in establishing a Risk Management Improvement Programme. NHS Fife has a sound system in place to enable risk management across the organisation however as part of our approach to ensuring active governance, a review commenced to determine the effectiveness of current arrangements and any required improvements in this important area of governance. The review confirmed that NHS Fife is committed to embedding an effective risk culture and a range of improvement activities have been agreed including the development of:

- A Board Strategic Risk Profile

- A refreshed Board Risk Appetite Statement which reflects on the level of risks associated with core activities and those associated with strategic priorities and ambitions
- A Corporate Risk Register to replace the current Board Assurance Framework
- A Risk dashboard to complement the updated Integrated Performance and Quality Report (IPQR) and to support effective performance management
- An updated process to support the escalation, oversight and governance of risks
- A Risks and Opportunities Group

Work on all the above commenced during 2021/22 but will complete and be implemented by the end of Q1 2022/23.

Economic, Effective and Efficient use of resources

I can confirm that through engagement with the Strategic Planning and Resource Allocation Process (SPRA) and ongoing review and control of the budgets allocated to my areas of responsibility, that there was economical, effective and efficient use of resources. There were a number of important investment decisions and cost improvement activity which supported that position which are noted below.

- Investment in the development of a corporate PMO
- A review and redesign of our financial management team arrangements including our business partner model
- An investment in our procurement team capacity and capability

Financial Improvement & Sustainability Programme (FIS)

For a number of years NHS Fife has successfully delivered financial balance however there has been a requirement for a level of additional support from Scottish government to enable this on a nonrecurring basis. At the beginning of 2020/21 the organisation considered the development of a plan to work towards reducing and removing the underlying gap. The organisational response was understandably limited during 2020/21 and 2021/22 as a consequence of the pandemic however work progressed through the SPRA process during this time to protect time and capacity to develop the plans and infrastructure to deliver against this important organisational challenge.

As part of this work the FIS Programme was established in December 2021 to drive projects which will ensure the long-term financial improvement and sustainability of the organisation through delivering against the following key objectives:

- Develop and agree productive opportunities and savings targets for 2022/23
- Develop a clear medium-term plan
- Deliver enhanced quality of patient care with effective allocation of resources and increased capacity within the system

Through the SPRA process and FIS Programme we have identified a range of firm plans with the directorates to reduce costs during 2022/23. We have also identified a “Pipeline” of

emerging potential plans which will contribute to closing the remaining underlying gap over the medium-term.

Governance Development
To support our work on strategy development we created a Portfolio Board to deliver the development and publication of the 5-year organisational strategy and provide senior leadership to enable successful delivery across the organisation's entire range of programmes, projects and other related activities on an ongoing basis. This is an important enhancement which ensures focussed EDG time and discussion on strategic matters.

Strategy Development
In April 2021 the NHS Fife Board supported a proposal to commence the development of the new organisational strategy with the ambition to focus on delivering excellence in clinical care, reducing health inequalities and improving population health and wellbeing for the people of Fife. Work commenced on a range of activities to explore the ambition of the new strategy however in December 2021 the Omicron variant of COVID 19 emerged as a significant threat to public health and NHS Scotland retracted services, stepping back all non-essential clinical and non-clinical work. Our Strategy development work was paused with the exception of the launch of the Community and Staff conversation. In March 2022 the Board approved a refreshed approach to stage our strategy development, with stage 1 being a transitional 1-year strategic plan for 2022/23 and stage 2 the more medium to longer term strategy development.

Compliance with applicable policies, procedures, laws and regulations
I can confirm that there was full compliance with all applicable policies, procedures, laws and regulations as they related to my areas of responsibility. I can also confirm there were no known failures or weaknesses reported on the system of internal control.

Compliance with the Code of Corporate Governance
I can confirm that there were no known breaches of the Code of Corporate Governance during 2021/22. There was also compliance throughout the year with the organisational safeguards against losses, including those arising from fraud, irregularity or corruption.

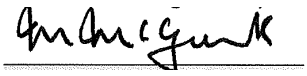
Integrity and Reliability of Information and Data
I can confirm in my role as SIRO that there were adequate processes in place to ensure the integrity and reliability of information and data relevant to the operation of all organisational activities. As Chair of the Information Governance & Security Steering Group, during financial year 2021-22, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Information Governance & Security Steering Group has allowed us to fulfil our remit. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place in the areas under our remit during the year.

I can confirm that that there were no significant control weaknesses or issues at the year-end which the Information Governance & Security Steering Group considered should be disclosed in the Governance Statement, as they may have impacted financially or otherwise in the year or thereafter.

Internal Audit Reports and Recommendations

I can confirm that all actions arising from recommendations made by Internal Audit for my areas of responsibility have been agreed and actions have either completed or are in progress.

Yours sincerely



Margo McGurk
Director of Finance & Strategy
NHS Fife

CORPORATE SERVICES
Estates, Facilities & Capital Services

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Margo McGurk
Director of Finance & Strategy
Victoria Hospital
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Date 1 April 2022
Your Ref
Our Ref NMcC/AB

Enquiries to Neil McCormick
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Email neil.mccormick@nhs.scot

Dear Margo

GOVERNANCE STATEMENT 2021/2022

In line with the Scottish Public Finance Manual (SPFM) guidance on the preparation of the annual Governance Statement, this letter has been prepared to give formal assurance to the Chief Executive (Accountable Officer) that adequate and effective internal controls and risk management arrangements have been in place across my directorate areas of responsibility throughout 2021/22.

Effectiveness of Risk Management Arrangements

I can confirm that risk management arrangements were in place and operating effectively. There were two significant operational risks during the year in relation to the ongoing response to and management of the pandemic which are noted below.

Risk of availability of Estates staff	COVID – 19 Risk Register (1750)
Risk of Suppliers being unable to deliver goods	COVID – 19 Risk Register (1753)

Economic, Effective and Efficient use of resources

I can confirm that through engagement with the Strategic Planning and Resource Allocation Process (SPRA) and ongoing review and control of the budgets allocated to my areas of responsibility, that there was economic, effective and efficient use of resources. There was an important investment decision which supports that position and is noted below.

NHS Fife – Elective Orthopaedic Centre - Full Business Case (NTC)	

Compliance with Applicable Policies, Procedures, Laws and Regulations

I can confirm that there was full compliance with all applicable policies, procedures, laws and regulations as they related to my areas of responsibility. I can also confirm there were no known failures or weaknesses reported on the system of internal control. There were a number of important internal and external reviews and reports which support that position which are noted below.

NTC Fife Orthopaedics NDAP FBC key stage review NHS Assure FBC key stage review	 20201118_FR06_Fife Elective Orthopaedic NHS Fife - Elective Care Centre Design Assurar Report V1.3
Healthcare Improvement Scotland COVID-19 focused inspection – VHK, May ‘21	
NHS Scotland National Cleaning Compliance Report - Domestic and Estates Cleaning Service Performance 2020/21	

Compliance with the Code of Corporate Governance

I can confirm that there were no known breaches of the Code of Corporate Governance during 2021/22. There was also compliance throughout the year with the organisational safeguards against losses, including those arising from fraud, irregularity or corruption.

Integrity and Reliability of Information and Data

I can confirm that there were adequate processes in place to ensure the integrity and reliability of information and data relevant to the operation of all directorate activities.

Internal Audit Reports and Recommendations

I can confirm that all actions arising from recommendations made by Internal Audit for my areas of responsibility have been agreed and actioned. The following internal audit reports have outstanding actions which have been exacerbated by the COVID-19 pandemic and the recruitment process for a new Health & Safety Manager. The actions will be completed by May 2022.

B22/21 - Manual Handling Training	
B14/21 Sharps Management	

Yours sincerely

Neil McCormick
Director of Property & Asset Management
NHS Fife

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Mrs Margo McGurk
Director of Finance & Strategy
NHS Fife
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KY2 5AH

Date	6 April 2022
Your Ref	NC/001/wja
Our Ref	
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Extension	
Direct Line	
Email	Nicky.Connor@nhs.scot

Dear Margo

GOVERNANCE STATEMENT 2021/2022

In line with the Scottish Public Finance Manual (SPFM) guidance on the preparation of the annual Governance Statement, this letter has been prepared to give formal assurance to the Chief Executive (Accountable Officer) that adequate and effective internal controls and risk management arrangements have been in place across my directorate areas of responsibility throughout 2021/22.

Effectiveness of Risk Management Arrangements

I can confirm that risk management arrangements were in place and operating effectively. (*There were a number of high operational risks during the year in relation to the ongoing response to and management of the pandemic which are noted below).*

Whole System Capacity – There is a risk that there may not be sufficient capacity in the system across a range of services to allow enough flexibility to meet the requirements of patients/service users and the organisation and support timely discharge/movement. This could lead to sub-optimum use of beds, patients remaining in hospital longer than necessary and impact on admissions.	**Nursing Resource** - There is a risk that, due to competing demands for nursing resource to support urgent programmes such as test and protect and vaccination roll-out, combined with staff absences due to illness, fatigue, childcare issues and the need to self-isolate, the HSCP may be unable to support the escalation process of capacity and flow to increase surge capacity and maintain safe staffing levels and this may impact on provision of critical services.

Adult and Child Protection - There is a risk that Adult and Child protection concerns may be increased due to the Coronavirus outbreak. This may arise from increased social isolation of families and individuals but also from new ways of working that may not fully address risks e.g PPE concerns/confusion in Care Homes etc	**NHS Fife COVID 19 Resuscitation Guidance: Community Hospitals** - As a result of amendments to the Resusitation Guidance in response to Covid 19, requiring full AGP PPE to be worn during chest compressions/airway interventions as part of a cardiac arrest call, there is a risk that we will be unable to respond to a "resus" incident in a timely fashion which could lead to a poor clinical outcome for patients and stress and anxieties for staff.
Primary Care - There is a risk we do not provide adequate support in terms of good leadership and continued dialogue, for the wider Primary Care groups, including GP's, Dentists, Optometrists and Pharmacies leading to confusion, divergence, disengagement and potential impact on service delivery. (This risk may be exacerbated by existing workforce capacity issues which were highlighted prior to Covid 19 and may potentially increase as we remobilise) This risk could also be compounded by the need to remobilise the Covid assessment centre model.	

Economic, Effective and Efficient Use of Resources

I can confirm that through engagement with the Strategic Planning and Resource Allocation Process (SPRA) and ongoing review and control of the budgets allocated to my areas of responsibility, that there was economic, effective and efficient use of resources. (*There were a number of important investment decisions and cost improvement activity which supported that position which are noted below).*

Capital Investment for Lochgelly/Kincardine Health and Wellbeing Centres
Scottish Government investment for the Vaccination Programme/Urgent Care/Mental Health
Printing and travel benefits from MORSE implementation

Compliance with Applicable Policies, Procedures, Laws and Regulations

I can confirm that there was full compliance with all applicable policies, procedures, laws and regulations as they related to my areas of responsibility. I can also confirm there were no known failures or weaknesses reported on the system of internal control. (*There were a number of important internal and external reviews and reports which support that position which are noted below (please ref HIS/NIS etc reviews)).*

Joint inspection of Adult Support and Protection in Fife led by the Care Inspectorate and supported by Health Improvement Scotland and Her Majesty's Inspectorate of Constabulary Scotland
Mental Welfare Commission Inspection of Ravenscraig Ward, Whytemans Brae, on 30 September 2021
Mental Welfare Commission Inspection of Dunino Ward, Stratheden on 2 November 202111/21

Compliance with the Code of Corporate Governance

I can confirm that there were no known breaches of the Code of Corporate Governance during 2021/22. There was also compliance throughout the year with the organisational safeguards against losses, including those arising from fraud, irregularity or corruption. *(please use the table below should any exception reporting be required).*

Integrity and Reliability of Information and Data

I can confirm that there were adequate processes in place to ensure the integrity and reliability of information and data relevant to the operation of all directorate activities. *(please use the table below should any exception reporting be required).*

Internal Audit Reports and Recommendations

I can confirm that all actions arising from recommendations made by Internal Audit for my areas of responsibility have been agreed and actioned. *(please use the table below to highlight any delays in clearing actions and plans in place to address this).*

A number of audit actions related directly to the review of the IJB Integration Scheme. This was signed off by the Scottish Government on 9 March 2022 and has since been reported through the IJB and NHS Governance structures. Any actions arising from the review are now being finalised

Yours sincerely

Nicky Connor
Director of Health and Social Care
NHS Fife

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**16 June 2022**
Title:	**Audit & Risk Committee Draft Annual Statement of Assurance 2020/21**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

- Legal requirement
- Local policy

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

- Effective

2 Report summary

2.1 Situation

All formal Committees of the NHS Board are required to provide an Annual Statement of Assurance for the NHS Board. The requirement for these statements is set out in the Code of Corporate Governance. The Audit & Risk Committee is invited to review the draft of this year's report and comment on its content, with a view to approving a final version.

2.2 Background

Each Committee must consider its proposed Annual Statement at the first Committee meeting of the new financial year. The current draft takes account of initial comments received from the Committee Chair, Director of Finance & Strategy and Head of Financial Services & Procurement.

The drafts of the Board's other committees' assurance statements have been reviewed in the production of this report and these are included on the agenda as a separate agenda item.

For Section 4.8, the IJB assurance statement is yet to be considered by their Audit & Risk Committee and will be provided to us shortly thereafter, thus content for this section remains to be written.

2.3 Assessment

In addition to recording practical details such as membership and rates of attendance, the format of the report includes a more reflective and detailed section (Section 4) on agenda business covered in the course of 2020-21, with a view to improving the level of assurance given to the NHS Board.

2.3.1 Quality/ Patient Care

Delivering robust governance across the organisation is supportive of enhanced patient care and quality standards.

2.3.2 Workforce

N/A.

2.3.3 Financial

The production and review of year-end assurance statements are a key part of the financial year-end process.

2.3.4 Risk Assessment/Management

The identification and management of risk is an important factor in providing appropriate assurance to the NHS Board.

2.3.5 Equality and Diversity, including health inequalities

This paper does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people. Consequently, an EQIA is not required.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

N/A.

2.3.8 Route to the Meeting

This paper has been considered in draft by the Committee Chair and the Director of Finance & Strategy and takes account of any initial comments thus received.

2.4 Recommendation

The paper is provided for:

- **Approval** – subject to members' comments regarding any amendments necessary

Report Contact
Dr Gillian MacIntosh
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gillian.macintosh@nhs.scot

ANNUAL STATEMENT OF ASSURANCE
FOR THE AUDIT & RISK COMMITTEE 2021/22

1. Purpose of Committee

1.1 The purpose of the Audit & Risk Committee is to provide the Board with assurance that the activities of Fife NHS Board are within the law and regulations governing the NHS in Scotland and that an effective system of internal control is maintained.

1.2 The duties of the Audit & Risk Committee are in accordance with the principles and best practice outlined in the Scottish Government Audit & Assurance Committee Handbook, dated April 2018.

2. Membership of Committee

2.1 During the financial year to 31 March 2022, membership of the Audit & Risk Committee comprised:

Martin Black	Chair / Non-Executive Member
Sinead Braiden	Non-Executive Member (to September 2021)
Cllr David Graham	Stakeholder Member, Fife Council
Alastair Grant	Non-Executive Member (from September 2021)
Aileen Lawrie	Area Clinical Forum Representative
Kirstie MacDonald	Non-Executive Member

2.2 The Committee may choose to invite individuals to attend the Committee meetings for the consideration of particular agenda items, but the Board Chief Executive, Director of Finance & Strategy (who is also the Executive lead for risk), Head of Financial Services & Procurement, Risk Manager, Board Secretary, Chief Internal Auditor and statutory External Auditor are normally in routine attendance at Committee meetings. Other attendees, deputies and guests are recorded in the individual minutes of each Committee meeting.

3. Meetings

3.1 The Committee met on six occasions during the year to 31 March 2022, on the undernoted dates:

- 13 May 2021
- 17 June 2021
- 16 September 2021
- 9 December 2021
- 18 January 2022 (Development Session)
- 17 March 2022

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 The business of the Committee during the year continues to have been impacted by the need for NHS Fife as a whole to address the ongoing challenges of the global Coronavirus pandemic. The Committee Chair has liaised closely with the Director of Finance & Strategy, as lead Executive Officer, to identify what business must be considered by the Committee and what must be prioritised in agenda planning. This has maximised the time available for management and operational staff to deal with the significant challenges of addressing Covid-surge-related demand

within clinical services, and, at the same time, allowed the Board to appropriately discharge its governance responsibilities. The impact of Covid has, once again, influenced the annual accounts audit timetable, although internally staff continue to work to established timelines to produce year-end material in a timely manner for audit review. The Committee's workplan has been regularly reviewed to ensure that any delays linked to Covid have been mitigated and that the required assurances could be provided to the Board as part of the year-end process.

4.2 The range of business covered at meetings held throughout the year, as detailed below, demonstrates that the full range of matters identified in the Audit & Risk Committee's remit is being addressed. In line with its Constitution and Terms of Reference, reviewed annually in March 2022, the Committee has considered standing agenda items concerned with the undernoted aspects:

- Internal Control frameworks and arrangements;
- Internal & External Audit planning and reporting;
- Corporate Governance, including implementation of and compliance with the NHSScotland *Blueprint for Good Governance* and updates on the adoption of Committee Assurance Principles;
- Regular updates to the NHS Fife Code of Corporate Governance;
- Scrutiny of the Board's Annual Statutory Financial Statements, including the meaningfulness of the Governance Statement;
- Risk Management arrangements and reporting, including the Board Assurance Framework and plans for revising the risk management framework; and
- other relevant matters arising during the year.

4.3 The Audit & Risk Committee's first meeting of the 2021/22 reporting year took place in May 2021, where a number of papers related to preparations for the 2020/21 annual accounts process were considered. The Committee scrutinised audit planning memoranda for both the Patients' Private Funds and the Fife Health Charity, and reviewed draft versions of the 2020/21 annual assurance statement and the internal audit plan for the year ahead. Members discussed and endorsed a set of Committee Assurance Principles, which seek to focus attention in agenda planning on key areas and gives clear guidance on how to support delivery of strong assurance and due prominence to risk awareness and management. An annual report on Payments to Primary Care Practitioners, providing assurance on the accuracy and validity of payments made, was also scrutinised by members, as part of the year-end reconciliation work.

4.4 Meetings in June and September 2021 scrutinised the governance-related year-end documentation, auditor reports and financial statements for 2020/21. This included the statutory financial statements, plus the Patients' Private Funds and Service Auditor Reports on Third Party Services provided on behalf of NHS Fife by NHS National Services Scotland and NHS Ayrshire & Arran. Regular reporting on losses and special payments has now been factored into the Committee's workplan, to help support the annual accounts process generally and, in support of Counter Fraud Standards, to increase the Committee's oversight.

4.5 In reference to External Audit, the Committee has considered in detail the annual audit plan and the annual audit report. The annual audit report includes a report to those charged with governance on matters arising for the audit of the annual financial statements, as well as comment on financial sustainability, governance and best value. The Committee has also considered national reviews undertaken by Audit Scotland, including their report 'NHS in Scotland 2021', and its implications locally. The Committee has also approved the planning memorandum for the 2021/22 accounts cycle, for the Patients' Private Funds from the respective External Auditor, and has noted the approval by the Board of Trustees of the planning memorandum for the audit of Endowment Funds held by Fife Health Charity.

4.6 For assurance purposes, the Audit & Risk Committee has considered the annual assurance statements of each of the governance committees of the Board, namely: Clinical Governance Committee; Finance, Performance & Resources Committee; Public Health & Wellbeing Committee;

Remuneration Committee; and Staff Governance Committee. These detail the activity of each committee during the year, the business they have considered in discharging their respective remits and an outline of what assurance the Board can take on key matters delegated to them. No significant issues were identified from these reports for disclosure in the financial statements, as per the related content of the Governance Statement.

4.7 Each individual assurance statement has appropriately reflected the impact of Covid-19 on the respective Committee's workplans and usual schedule of business, noting the need to prioritise key risk areas during the year and to ensure that members were apprised in particular of activity aimed at addressing the operational pressures and challenges of Covid, especially during resurgent periods of infection. Appropriate assurance has however been provided that each Committee has fulfilled their key remit areas on behalf of the Board during the reporting year. The Clinical Governance Committee report has provided due reflection on the assurance that can be taken around matters of clinical quality and safety, information security & governance, and Health & Safety. The Finance, Performance & Resources Committee has closely monitored the position in relation to the impact of additional costs associated with the pandemic, and has considered also the impact of Covid on key performance targets. The newly-established Public Health & Wellbeing Committee has taken on responsibility for oversight of the Board's seasonal flu and Covid vaccination delivery programme and delegated community-bases services, plus initial work in developing the new organisational strategy. The Staff Governance Committee has received regular updates on recruitment to support key programmes, such as Test & Protect and Covid vaccination delivery, in addition to ongoing detail on staff well-being initiatives and work underway to reduce sickness absence. The Remuneration Committee has continued its work during the pandemic period, completing its usual business of Executive cohort performance appraisal and objective setting. Further detail on all these areas can be found within the individual Committee reports mentioned above. In addition to the Committee reports, the individual Executive Directors' Assurance letters have provided helpful detail on the internal control mechanisms and mitigation of risks within individual portfolios and Directorates.

4.8 (*Text TBC*) *In reference to the assurance statement received from the Integration Joint Board, …*

4.9 In relation to internal audit, members have reviewed and discussed in detail at meetings the annual audit plans; the interim evaluation of the internal control framework; reports from the internal auditors covering a range of service areas; and management's progress in completing audit actions raised, through regular follow-up reporting. A specific progress update from the Associate Director of Digital & Information, in reference to addressing the recommendations from the Internal Audit review of the Information Technology Infrastructure Library (ITIL), was given to members in September 2021, to provide assurance that prompt action was being taken to complete the work required, given the limited assurances that could be provided. In the previous reporting year, Internal Audit flagged the need for NHS Fife to improve the governance, control framework and assurance processes in place related to Information Governance & Security, and work to address these recommendations has now been significantly advanced and embedded in practice, as highlighted in Internal Audit's mid-year evaluation.

4.10 In relation to internal audit follow-up work, whilst improvements in reducing the number of outstanding actions has been seen in this reporting year, the Committee has noted that further effort is required to enhance the effectiveness and timeliness of completing audit recommendations. The Director of Finance & Strategy continues to pursue this as a priority action, with quarterly consideration of the outstanding actions by the Executive Directors' Group to drive forward prompt resolution. Changes to the format of the report have been welcomed, with the helpful inclusion of 'Red / Amber / Green' (RAG) status. The assistance of Internal Audit in supporting strong improvements in the areas of information governance and security governance and reporting is recognised by the Committee, with helpful input from individual audit colleagues to adopting best practice reporting in these areas.

4.11 During the year, the Committee approved a revised set of Financial Operating Procedures (FOPs), following a full review of their content. The FOPs were last reviewed in detail in 2018, and a number of updating changes have been made. The review also sought to address a number of outstanding internal audit follow-up actions, all of which have now been completed. The FOPs have been published on StaffLink, to be widely accessible to staff.

4.12 On behalf of the Board, the Audit & Risk Committee receives regular updates on the workstreams being progressed within NHS Fife for compliance with the NHSScotland *Blueprint for Good Governance*, including the national work ongoing to develop a suite of standard documentation on a 'Once for Scotland' approach. Whilst many of the national workstreams have been delayed due to the impact of the pandemic on NHSScotland, the Committee has received an update on the Board's Blueprint action plan at its December 2021 meeting, noting the effective closure of the outstanding actions. With the publication of a revised Blueprint due imminently, the Committee will have a role in oversight of new compliance actions. The Board's own Code of Corporate Governance has undergone annual review and a number of clarifying changes made (including recognition of the establishment of the Board's new Public Health & Wellbeing Committee), to ensure it remains up-to-date with current practice.

4.13 The Committee has reviewed for assurance purposes the feedback received from the Sharing Intelligence for Health & Care Group's review of NHS Fife. The Group is a mechanism that enables seven national organisations, including Audit Scotland, to share, consider and respond to intelligence about care systems across Scotland, in particular NHS Boards. A further report detailing the discussions held at the follow-up meeting with the Group was tabled at the Committee in September 2021, and the key discussion points noted. Also for assurance, the Committee has received a paper outlining the Board's progress in implementing the national Whistleblowing Standards, receiving a presentation on this topic at its June 2021 meeting. Members discussed the awareness-raising work undertaken to increase visibility of the Standards, the training available to staff, and the reporting mechanism of cases within the Board. Formal review of the Board's compliance with the Standards will be undertaken by Internal Audit in this year's programme of work.

4.14 Reports have been provided to the Committee on the Organisational Strategy Development work, including details on the proposed engagement approach and the governance reporting route for each of the different aspects of the work. Development of the individual workstreams is being taken forward through a Portfolio approach involving all members of the Executive Directors' Group. Overall, the workstreams will be linked to the five national care programmes that have been initiated by the Scottish Government. Early engagement has taken place with staff, key stakeholders and members of the public, and updates have been given to the Committee thereon, such as the paper presented for discussion in March 2022. The Public Health & Wellbeing Committee is the lead Committee for the development and delivery of the new Strategy, though the Audit & Risk Committee will continue to receive general updates, to provide the appropriate assurance of progress in this area.

4.15 During the year, members of the Committee engaged in a number of training opportunities, covering best practice arrangements for Audit & Risk Committees. A training session with the Internal and External Auditors was held in June 2021, outlining the year-end processes each undertake as part of the review of the financial statements and systems of internal control, in preparation for the review and scrutiny of the annual accounts, prior to the Committee's formal consideration of the 2020/21 financial statements. The presentation slides were usefully adapted to be used as a helpful checklist by members, when the accounts were tabled for formal approval in September 2021. In December 2021, members received a briefing from the Associate Director of Digital & Information on cyber security, ongoing cyber threats and the measures by which the Board can improve its resilience to attacks of this type. The Committee noted the linkages with the NIS audit programme of work and the aspiration to raise the percentage compliance against this audit by the next iteration of this review.

4.16 In January 2022, the Committee received a briefing and awareness-raising session from the Head of the Counter Fraud Service (CFS) at NHS NSS. This was an informative presentation on the introduction of a set of Counter Fraud Standards across NHS Scotland, outlining the areas of best practice and model processes detailed within the Standards and CFS' commitment to collaborate with Boards to help embed these and work towards future compliance. Updates have also been given in the year to members on the Partnership Agreement between CFS and Health Boards, which has been recently renewed for a further three years.

4.17 Progress with fraud cases and counter fraud initiatives were discussed by the Committee in private session on a regular basis throughout the year. The Committee received quarterly fraud updates, which provided updates on NHS Fife fraud cases and investigations, counter fraud training delivered to staff, initiatives undertaken to identify and address fraud, and the work carried out by Practitioner & Counter Fraud Services in relation to detecting, deterring, disabling and dealing with fraud in the NHS. This has provided the Committee with the assurance that the risk of fraud is being proactively managed across NHS Fife. The Committee has also considered the Annual Report on Patient Exemption Checking, which detailed the work undertaken by CFS in checking the propriety of exemptions claimed by patients for ophthalmic and dental work and summarised the write offs and recoveries for NHS Fife.

4.18 Minutes of Committee meetings have been approved by the Committee and presented to Fife NHS Board. The Board also receives a verbal update at each meeting from the Chair, highlighting any key issues discussed by the Committee at its preceding meeting. The Committee maintains an action register to record and manage actions agreed from each meeting, and reviews progress against deadline dates at subsequent meetings.

5. Best Value

5.1 Since 2013/14 the Board has been required to provide overt assurance on Best Value. A revised Best Value Framework was considered and agreed by the NHS Board in January 2018. Appendix 3 provides evidence of where and when the Committee considered the relevant characteristics during 2021/22.

6. Risk Management

6.1 All NHS Boards are subject to the requirements of the Scottish Public Finance Manual (SPFM) and must operate a risk management strategy in accordance with the relevant guidance issued by Scottish Ministers. The general principles for a successful risk management strategy are set out in the SPFM.

6.2 All of the key areas within the organisation maintain a risk register. All risk registers are held on the Datix (Risk Management Information System). Training and support for all Datix modules including risk registers, are provided by the Risk Management team according to the requirements of individuals, specialities and teams etc.

6.3 In line with the Board's agreed risk management arrangements, the Audit & Risk Committee, as a governance committee of the Board, has considered risk through a range of reports and scrutiny, including oversight on the detail of the Board Assurance Framework (BAF). During 2021/22, the high-level risks identified as having the potential to impact on the delivery of NHS Fife's strategic priorities, and related operational high-level risks, were reported bi-monthly through the BAF to the governance committees, and subsequently to the Audit & Risk Committee and the Board. Due to the emerging Omicron wave of Covid-19 infection and resultant system pressures, the January 2022 governance committees took place with condensed agendas prioritised to reflect Covid-19 related business, which did not include the BAF. There was however frequent reporting to the full Board during this period on the impact of Omicron and the risks emerging from it. Regular reports recommenced as scheduled to the committees in March 2022.

6.4 The Committee have received regular updates and, in addition to their own presentation received at the Audit & Risk Committee's December 2021 meeting, noted that specific risk management development sessions took place with the Executive Directors' Group on 23 September 2021 and at the Board Development Session on 21 December 2021, to initiate the plan to refresh the NHS Fife Risk Management Framework. These sessions discussed a range of aspects of risk management and created an improvement plan to support the active governance of risk, which includes the following improvements and developments:

- a review of the Board Risk Appetite Statement;
- a review of the current Board Strategic Risk Profile;
- the establishment of a Corporate Risk Register to replace the current Board Assurance Framework;
- the creation of a risk dashboard to complement the updated Integrated Performance and Quality Report (IPQR) and to support effective performance management;
- an updated process to support the escalation, oversight and governance of risk; and
- the creation of a Risks and Opportunities Group.

6.5 The Committee is assured that good progress is being made with this improvement plan, which will support operational teams to identify and manage risks effectively and will also refocus reporting to the Board on corporate level risk. The plan will ensure alignment with the existing Strategic Planning & Resource Allocation process, to identify organisational or external risks associated with the delivery of corporate objectives. It will also support the identification and mitigation of risks identified through development and delivery of the Population Health and Wellbeing Strategy. This work is underpinned by acknowledgment of the need to promote a culture that encourages the proactive identification and mitigation of risks from ward to Board, which the Committee will continue to provide oversight on.

7. Self-Assessment

7.1 The Committee has undertaken a self-assessment of its own effectiveness, utilising a revised questionnaire considered and approved by the Committee Chair. Attendees were also invited to participate in this exercise, which was carried out via an easily-accessible online portal. A report summarising the findings of the survey was considered and approved by the Committee at its March 2022 meeting, and action points are being taken forward at both Committee and Board level. In the year ahead, the Committee will meet for a series of stand-alone Development Sessions, taking account of members' feedback on scheduled topics.

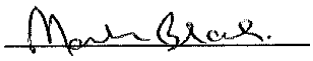
8. Conclusion

8.1 As Chair of the Audit & Risk Committee during financial year 2021/22, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place throughout NHS Fife during the year. Audit & Risk Committee members conclude that they have given due consideration to the effectiveness of the systems of internal control in NHS Fife, have carried out their role and discharged their responsibilities on behalf of the Board in respect of the Committee's remit as described in the Standing Orders.

8.2 I can confirm that that there were no significant control weaknesses or issues at the year-end which the Committee considers should be disclosed in the Governance Statement, as they may have impacted financially or otherwise in the year or thereafter.

8.3 I would pay tribute to the dedication and commitment of fellow members of the Committee and to all attendees. I would thank all those members of staff who have prepared reports and attended

meetings of the Committee, particularly in another most challenging of years, set against the backdrop of the continuing Coronavirus pandemic.

Signed:  Date: 29 July 2022

Martin Black, Chair
On behalf of the Audit & Risk Committee

Appendix 1 – Attendance Schedule
Appendix 2 – Best Value

APPENDIX 1

AUDIT & RISK COMMITTEE - ATTENDANCE RECORD
1 April 2021 – 31 March 2022

	13.05.21	17.06.21	16.09.21	09.12.21	18.01.22	17.03.22
Members						
M Black, Non-Executive Member **(Chair)**	✓	✓	✓	✓	✓	✓
S Braiden, Non-Executive Member	✓	✓	✓			
D Graham, Stakeholder Member, Fife Council	✓	x	x	✓	x	✓ Item 1 – 8.2
A Grant, Non-Executive Member				✓	✓	x
A Lawrie, Area Clinical Forum Representative	✓	✓	✓	x	x	x
K McDonald, Non-Executive Member	✓	x	✓	✓	✓	✓
In attendance						
K Booth, Head of Financial Services	✓	✓	✓	✓	✓	✓
A Brown, Principal Auditor				✓ Item 9.3		
A Clyne, Audit Scotland	✓	✓	✓	x	x	✓
G Couser, Associate Director of Quality & Clinical Governance						✓
P Cumming, Risk Manager	✓	x	✓	✓	✓	✓
L Douglas, Director of Workforce		✓				
P Fraser, Audit Scotland	✓	✓	✓	x	x	✓
T Gaskin, Chief Internal Auditor	✓	x	✓	✓	✓	✓
A Graham, Associate Director of Digital & Information			✓ Item 9	✓ Item 1		
B Howarth, Regional Audit Manager			✓			
B Hudson, Regional Audit Manager	✓	✓	✓	✓	x	✓
G MacIntosh, Head of Corporate Governance & Board Secretary	✓	✓	✓	✓	✓	✓
M McGurk, Director of Finance & Strategy **(Exec Lead)**	✓	✓	✓	✓	✓	✓ Item 1 – 8.1
M Michie, Deputy Director of Finance & Strategy						✓
A Mitchell, Independent Auditor – Thomson Cooper			✓ Item 7.1			
C Potter, Chief Executive	✓	x	✓	✓	x	x
S Raynor, Senior HR Manager		✓ Item 6.4				
S Slayford, Principal Auditor				✓ Item 9.3		

	13.05.21	17.06.21	16.09.21	09.12.21	18.01.22	17.03.22
G Young, NHS National Services Scotland, Head of Counter Fraud Standards					✓	

APPENDIX 2

BEST VALUE FRAMEWORK

Vision and Leadership

A Best Value organisation will have in place a clear vision and strategic direction for what it will do to contribute to the delivery of improved outcomes for Scotland's people, making Scotland a better place to live and a more prosperous and successful country. The strategy will display a clear sense of purpose and place and be effectively communicated to all staff and stakeholders. The strategy will show a clear direction of travel and will be led by Senior Staff in an open and inclusive leadership approach, underpinned by clear plans and strategies (aligned to resources) which reflect a commitment to continuous improvement.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
The Board has identified the risks to the achievement of its strategic and operational plans are identified together with mitigating controls.	Each strategic risk has an Assurance Framework which maps the mitigating actions/risks to help achieve the strategic and operational plans. Assurance Framework contains the overarching strategic risks related to the strategic plan.	**COMMITTEES** **AUDIT & RISK COMMITTEE** **BOARD**	Bi-monthly 5 times per year 2 times per year	Board Assurance Framework (to FP&R/CG/SG Committees) Board Assurance Framework (to A&R Committee) Board

GOVERNANCE AND ACCOUNTABILITY

The “Governance and Accountability” theme focuses on how a Best Value organisation achieves effective governance arrangements, which help support Executive and Non-Executive leadership decision-making, provide suitable assurances to stakeholders on how all available resources are being used in delivering outcomes and give accessible explanation of the activities of the organisation and the outcomes delivered.

OVERVIEW

A Best Value organisation will be able to demonstrate structures, policies and leadership behaviours which support the application of good standards of governance and accountability in how the organisation is improving efficiency, focusing on priorities and achieving value for money in delivering its outcomes. These good standards will be reflected in clear roles, responsibilities and relationships within the organisation. Good governance arrangements will provide the supporting framework for the overall delivery of Best Value and will ensure open-ness and transparency. Public reporting should show the impact of the organisation’s activities, with clear links between the activities and what outcomes are being delivered to customers and stakeholders. Good governance provides an assurance that the organisation has a suitable focus on continuous improvement and quality. Outwith the organisation, good governance will show itself through an organisational commitment to public performance reporting about the quality of activities being delivered and commitments for future delivery.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Board and Committee decision-making processes are open and transparent.	Board meetings are held in open session and minutes are publicly available. Committee papers and minutes are publicly available	**BOARD** **COMMITTEES**	On going	Meetings publicly accessible NHS website
Board and Committee decision-making processes are based on evidence that can show clear links between activities and outcomes	Reports for decision to be considered by Board and Committees should clearly describe the evidence underpinning the proposed decision.	**BOARD** **COMMITTEES**	Ongoing	SBAR reports EQIA forms

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife has a robust framework of corporate governance to provide assurance to relevant stakeholders that there are effective internal control systems in operation which comply with the SPFM and other relevant guidance.	Explicitly detailed in the Governance Statement.	**AUDIT & RISK COMMITTEE** **BOARD**	Annual Annual Ongoing	Code of Corporate Governance review Annual Assurance statements Compliance with NHS Scotland Blueprint

USE OF RESOURCES

The “Use of Resources” theme focuses on how a Best Value organisation ensures that it makes effective, risk-aware and evidence-based decisions on the use of all of its resources.

OVERVIEW
A Best Value organisation will show that it is conscious of being publicly funded in everything it does. The organisation will be able to show how its effective management of all resources (including staff, assets, information and communications technology (ICT), procurement and knowledge) is contributing to delivery of specific outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
NHS Fife maintains an effective system for financial stewardship and reporting in line with the SPFM.	Statutory Annual Accounts process	**AUDIT & RISK COMMITTEE**	Annual	Statutory Annual Accounts Assurance Statements SFIs
NHS Fife understands and exploits the value of the data and information it holds.	Annual Operational Plan Integrated Performance & Quality Report	**BOARD** **COMMITTEES**	Annual Bi-monthly	Annual Operational Plan Integrated Performance & Quality Report

PERFORMANCE MANAGEMENT

The “Performance Management” theme focuses on how a Best Value organisation embeds a culture and supporting processes which ensures that it has a clear and accurate understanding of how all parts of the organisation are performing and that, based on this knowledge, it takes action that leads to demonstrable continuous improvement in performance and outcomes.

OVERVIEW

A Best Value organisation will ensure that robust arrangements are in place to monitor the achievement of outcomes (possibly delivered across multiple partnerships) as well as reporting on specific activities and projects. It will use intelligence to make open and transparent decisions within a culture which is action and improvement oriented and manages risk. The organisation will provide a clear line of sight from individual actions through to the National Outcomes and the National Performance Framework. The measures used to manage and report on performance will also enable the organisation to provide assurances on quality and link this to continuous improvement and the delivery of efficient and effective outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Performance is systematically measured across all key areas of activity and associated reporting provides an understanding of whether the organisation is on track to achieve its short and long-term strategic, operational and quality objectives	Integrated Performance & Quality Report encompassing all aspects of operational performance, AOP targets / measures, and financial, clinical and staff governance metrics. The Board delegates to Committees the scrutiny of performance Board receives full Integrated Performance & Quality Report and notification of any issues for escalation from Committees.	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Code of Corporate Governance Minutes of Committees

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
The Board and its Committees approve the format and content of the performance reports they receive	The Board / Committees review the Integrated Performance Report and agree the measures.	**COMMITTEES** **BOARD**	Annual	Integrated Performance & Quality Report
Reports are honest and balanced and subject to proportionate and appropriate scrutiny and challenge from the Board and its Committees.	Committee Minutes show scrutiny and challenge when performance is poor as well as good; with escalation of issues to the Board as required	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Minutes of Committees
The Board has received assurance on the accuracy of data used for performance monitoring.	Performance reporting information uses validated data.	**COMMITTEES** **BOARD**	Every meeting Annual	Integrated Performance & Quality Report Annual Accounts including External Audit report
NHS Fife's performance management system is effective in addressing areas of underperformance, identifying the scope for improvement, agreeing remedial action, sharing good practice and monitoring implementation.	Encompassed within the Integrated Performance & Quality Report	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Minutes of Committees

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife overtly links Performance Management with Risk Management to support prioritisation and decision-making at Executive level, support continuous improvement and provide assurance on internal control and risk.	Board Assurance Framework	**AUDIT & RISK COMMITTEE** **BOARD**	Ongoing	Board Assurance Framework Minutes of Committees

CROSS-CUTTING THEME – SUSTAINABILITY

The "Sustainability" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded a sustainable development focus in its work.

OVERVIEW

The goal of Sustainable Development is to enable all people throughout the world to satisfy their basic needs and enjoy a better quality of life without compromising the quality of life of future generations. Sustainability is integral to an overall Best Value approach and an obligation to act in a way which it considers is most sustainable is one of the three public bodies' duties set out in section 44 of the Climate Change (Scotland) Act 2009. The duty to act sustainably placed upon Public Bodies by the Climate Change Act will require Public Bodies to routinely balance their decisions and consider the wide range of impacts of their actions, beyond reduction of greenhouse gas emissions and over both the short and the long term. The concept of sustainability is one which is still evolving. However, five broad principles of sustainability have been identified as:

- promoting good governance;
- living within environmental limits;
- achieving a sustainable economy;
- ensuring a stronger healthier society; and
- using sound science responsibly.

Individual Public Bodies may wish to consider comparisons within the wider public sector, rather than within their usual public sector "family". This will assist them in getting an accurate gauge of their true scale and level of influence, as well as a more accurate assessment of the potential impact of any decisions they choose to make. A Best Value organisation will demonstrate an effective use of resources in the short-term and an informed prioritisation of the use of resources in the longer-term in order to bring about sustainable development. Public bodies should also prepare for future changes as a result of emissions that have already taken place. Public Bodies will need to ensure that they are resilient enough to continue to deliver the public services on which we all rely.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
NHS Fife can demonstrate that it is making a contribution to sustainable development by actively considering the social, economic and environmental impacts of activities and decisions both in the shorter and longer term.	Sustainability and Environmental report incorporated in the Annual Accounts process.	**AUDIT & RISK COMMITTEE** **BOARD**	Annual	Annual Accounts Climate Change Template

CROSS-CUTTING THEME – EQUALITY

The "Equality" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded an equalities focus which will secure continuous improvement in delivering equality.

OVERVIEW
Equality is integral to all our work as demonstrated by its positioning as a cross-cutting theme. Public Bodies have a range of legal duties and responsibilities with regard to equality. A Best Value organisation will demonstrate that consideration of equality issues is embedded in its vision and strategic direction and throughout all of its work.

The equality impact of policies and practices delivered through partnerships should always be considered. A focus on setting equality outcomes at the individual Public Body level will also encourage equality to be considered at the partnership level.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE:**
NHS Fife meets the requirements of equality legislation.		**BOARD** **COMMITTEES**	Ongoing	EQIA form on all reports
The Board and senior managers understand the diversity of their customers and stakeholders.	Equality Impact Assessments are reported to the Board and Committees as required and identify the diverse range of stakeholders.	**BOARD** **COMMITTEES**	Ongoing	EQIA form on all reports
NHS Fife's policies, functions and service planning overtly consider the different current and future needs and access requirements of groups within the community.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments consider the current and future needs and access requirements of the groups within the community.	**BOARD** **COMMITTEES**	Ongoing	Clinical Strategy EQIA forms on reports

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
Wherever relevant, NHS Fife collects information and data on the impact of policies, services and functions on different equality groups to help inform future decisions.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments will collect this information to inform future decisions.	**BOARD** **COMMITTEES**	Ongoing	EQIA forms on reports

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**16 June 2022**
Title:	**Draft Letter of Significant Issues of Wider Interest**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Approval

This report relates to a:

- Government policy/directive

This aligns to the following NHS Scotland quality ambition:

- Effective

2 Report summary

2.1 Situation

The Audit & Risk Committee of NHS Fife has a responsibility to ensure any significant issues that are considered to be of wider interest are brought to the attention of the Scottish Government Portfolio Audit & Risk Committee.

2.2 Background

This is an annual return made by all NHS Board Audit & Risk Committees and follows the agreed format as detailed in the Scottish Public Finance Manual (SPFM) and the letter from the Health Finance Directorate dated 24th May 2022 (Appendix 1). The report is informed by the assurances received to support the Accountable Officer's Annual Governance Statement, note this is in draft until the Statutory Annual Accounts for 2021/22 are finalised through the external audit process. Two Guidance Notes were issued in March – April 2020 to ensure changes to internal Board governance processes, as a result of Covid-19, were appropriately reflected in the significant issues return letter.

2.3 Assessment

The draft response letter is presented in Appendix 2 with the draft Governance Statement as a supporting document.

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

The Governance Statement reflects the control environment supporting staff governance.

2.3.3 Financial

The Governance Statement reflects the control environment supporting financial governance.

2.3.4 Risk Assessment/Management

The Governance Statement reflects the effectiveness of risk management arrangements operating across the organisation.

2.3.5 Equality and Diversity, including health inequalities

No specific issue to report.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

Relevant communication and consultation within the organisation were conducted in preparation of the draft response.

2.3.8 Route to the Meeting

A draft of the response letter was approved by the Director of Finance & Strategy for discussion at the Audit & Risk Committee.

2.4 Recommendation

The paper is provided for Approval.

The Committee is invited to review the letter and the draft Governance Statement to inform approval of the response to Scottish Government.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Letter dated 24 May 2022 from Director of Health Finance Governance, Richard McCallum
- Appendix 2 – Draft Response Letter dated 30 May 2022 from Martin Black, Chair of NHS Fife Audit & Risk Committee

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Directors of Finance
NHS Scotland

cc TAG Members

via e-mail

24th May, 2022

Dear Colleagues

This letter clarifies certain aspects of the 2021-22 annual accounts process. All matters have been discussed at the latest TAG meeting.

End of Year Timetable Clarification

As you are aware, we require your draft annual accounts to be submitted by 31 May 2022. Recognising that several Health Boards plan to return by that date the annual accounts template only, we will require from those Boards to return their draft governance statements by 17 June 2022. This is to enable the timescales of the Scottish Government annual accounts process to be met.

We recognise those statements will be at the draft stage and will not have been cleared by Boards' Audit and Risk Commitees. The final Portfolio Certificate of Assurance will incorporate the content of Boards' final annual accounts.

We will also require significant issues letters to be provided as soon as they are cleared and signed off by Boards' Audit and Risk Committees.

Annual Accounting Manual Changes & Clarifications

SFR30 Threshold:
There is a change in the threshold for the agreement of SFR 30: Balances With Other NHS Scotland Bodies. The manual should read as follows:

"The total of SFR 30 balances with any one Board should be agreed to within a tolerance level of £200,000 to avoid spending significant time resolving immaterial differences."

Page 53: Transfer between reserves:
There is a change in Transfer between reserves paragraph on page 53 of the manual whereby the incomplete sentence of *"It will also contain the net total of"* has been removed. A sentence has been added: "*The reserve entries for the transfer of assets between SG consolidation entities, should be made by both the transferring and the receiving Boards, just the opposite way round"*

Page 30: Median pay disclosure table:
Although the FReM table at 6.5.24 does not clearly reflect the requirements, the split between salary and total pay and benefits (excluding pension benefits) as set out in the NHS manual on page 30 is required by FReM.

Annual Accounts Template

Note 7d Analysis of Capital Expenditure and donated assets income

You will be aware that from 2021-22 the classification of donated assets income has changed and this income is no longer included in note 7d, being shown in note 2a Summary of Revenue Outturn (SORO) instead. For the Boards that have received donated assets in 2020-21 it may result in the apparent mismatch between their 2020-21 capital outturn and Capital Resource Limit provided in that year. There is, however, no impact on prior year outturn or primary statements as the income continues to be included in the income note and asset additions in appropriate asset notes.

We are content for the Boards to include the following footnote in Note 7d: "*The discrepancy between 2020-21 net capital expenditure and Total Capital Resource Limit is due to the reclassification of accounting treatment of donated assets income received in that year. There is no impact on <Board name> performance in that year against the capital budget provided."*

Accounts Direction Letter

A revised Accounts Direction letter was issued to all boards (except Public Health Scotland - issued last year) on the 29th March 2022. The direction states the following:

"In preparing a statement of accounts in accordance with paragraph 1, <Board name> must use the <Board name> Annual Accounts template which is applicable for the financial year for which the statement of accounts is prepared."

We can confirm the above sentence refers to boards' use of the Annual Accounts Template which is issued by the Scottish Government each year. The Scottish Government understands that the submitted templates for some boards may slightly differ from the published accounts (in terms of presentation alone); this is to confirm that we require the template to be returned in the form it was issued.

Assessment of the potential implications of a recent High Court decision in respect of potential liability in connection to hospital patients discharges to care homes

We have considered the potential implications of the 27 April 2022 High Court ruling on the policy of UK Government Ministers discharging untested Covid patients into care homes. Whilst this case does not apply to Scotland there is a possibility of a similar legal action in Scotland. However, no action has been initiated so far and we consider that at this stage it is too early to determine any potential outcome of such a case or any potential liability stemming from any subsequent legal action. It is worth noting that it would also remain to be determined whether it would be more appropriate to record liabilities against individual Health Boards or centrally against the Scottish Government.

There is, therefore, no basis for any impact on the 2021-22 Health Boards accounts and we do not believe that Health Boards should be making any specific disclosures in relation to

this matter in their 2021-22 accounts. SG will be separately considering whether any disclosure in the 2021-22 SG consolidated accounts is appropriate.

If you have any concerns in relation to anything noted in this letter please notify the Scottish Government Health Finance team via nhsaccounts@gov.scot.

Yours faithfully

Richard McCallum
Director of Health Finance and Governance

Fife NHS Board

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Date	30th May 2022
Your Ref	
Our Ref	RM/Martin Black/
Enquiries to	Mrs M McGurk
Extension	Ext 28139
Direct Line	01592 648139
Email	margo.mcgurk@nhs.scot

Dear Mr McCallum

SIGNIFICANT ISSUES THAT ARE CONSIDERED TO BE OF WIDER INTEREST

I refer to your letter dated 24th May 2022, addressed to the Director of Finance of Fife NHS Board. As Chair of the Audit and Risk Committee, I have considered this letter and attach the draft Governance Statement (Annex 1) for 2021/22 to support my response. The Governance Statement details the necessary revisions to NHS Fife Board governance arrangements during the pandemic period and I can confirm the Statement was approved by the Audit and Risk Committee on 16th June 2022.

I can confirm that during the 2021/22 financial year, no other significant control weaknesses or issues arose in relation to the expected standards for good governance, risk management and control.

In relation to your letters of 25 March 2020 and 11 June 2020 requesting detail on temporary changes to governance and the rationale for these changes, I can confirm the following. Further to the information in the Governance Statement and as per the Board's responses to your correspondence, regular meetings of the Board's Governance Committees were reinstated from July 2020 and have continued thereafter. These meetings considered prioritised business relating to COVID-19 and agenda items that otherwise required approval or discussion.

Regarding Finance Guidance Note 2020/04 - COVID-19 and short-term changes to approval process for operational property transactions, the Board did not exercise any right under the COVID-19 guidance concerning property transactions and does not expect to.

In respect of Finance Guidance Note 2020/03 - COVID-19 Accountable Officer Guidance and Funding Ask Template and correspondence/returns around Mobilisation Plans; Local Mobilisation plans including cost information were submitted to Scottish Government in line with the appropriate reporting requirements and timescales.

Fraud and related matters
There have been no significant issues raised in respect of fraud, however I can confirm that updates on fraud/potential fraud cases being investigated by Counter Fraud Services were discussed with NHS Fife and reported to the Audit & Risk Committee at each meeting.

I trust that this letter will meet the reporting requirements. Please do not hesitate to contact myself or Margo McGurk, Director of Finance & Strategy if you require any further information.

Yours sincerely

MARTIN BLACK
Fife NHS Board, Audit & Risk Committee Chair

Annex 1 – Governance Statement

Governance Statement

Scope of Responsibility

As Accountable Officer, I am responsible for maintaining an adequate and effective system of internal control that supports compliance with the organisation's policies and promotes achievement of the organisation's aims and objectives, including those set by Scottish Ministers. Also, I am responsible for safeguarding the public funds and assets assigned to the organisation. These financial statements consolidate the Fife Health Board Endowment Fund, re-branded in the reporting year to the Fife Health Charity. This statement includes any relevant disclosure in respect of these Endowment funds.

Purpose of Internal Control

The system of internal control is based on an ongoing process designed to identify, prioritise, and manage the principal risks facing the organisation. The system aims to evaluate the nature and extent of risks, and manage risks efficiently, effectively, and economically.

The system of internal control is designed to manage rather than eliminate the risk of failure to achieve the organisation's aims and objectives. As such, it can only provide reasonable and not absolute assurance.

The process within the organisation accords with guidance from Scottish Ministers in the Scottish Public Finance Manual (SPFM) and supplementary NHS guidance, and has been in place for the year up to the date of approval of the annual report and accounts.

The SPFM is issued by Scottish Ministers to provide guidance to the Scottish Government and other relevant bodies on the proper handling and reporting of public funds. The SPFM sets out the relevant statutory, parliamentary, and administrative requirements, emphasises the need for efficiency, effectiveness, and economy, and promotes good practice and high standards of propriety.

Governance Framework

The Board has collective responsibility for health improvement, the promotion of integrated health and community planning through partnership working, involving the public in the design of healthcare services and staff governance.

Members of Health Boards, as detailed on page 16, are selected on the basis of their position, or the particular expertise, which enables them to contribute to the decision-making process at a strategic level.

The Board meets every two months to progress its business and holds a Development Session in intervening months to discuss topical and strategic issues for NHS Fife. The Code of Corporate Governance, which is revised on an annual basis, identifies Committees and Sub-Committees that report to the Board to help it fulfil its duties. In response to the pandemic during 2020/21, changes were made to the format and timing of governance meetings as detailed in the *Covid-19 Pandemic – Governance Arrangements* section on page 26.

These include the following governance Committees:

- Clinical Governance;
- Audit & Risk;
- Staff Governance;
- Remuneration; and
- Finance, Performance & Resources.

<u>Clinical Governance Committee</u>

Principal Function:
To provide the Board with the assurance that appropriate clinical governance mechanisms and structures are in place and effective throughout the whole of Fife Health Board's responsibilities, including health improvement activities.

Membership:
- Six Non-Executive or Stakeholder Members of the Board
- Chief Executive
- Medical Director
- Director of Nursing
- Director of Public Health
- A Staff Side Representative of NHS Fife Area Partnership Forum
- One Representative from Area Clinical Forum
- One Patient Representative

Chair:
Dr Les Bisset, Non-Executive Board Member (Until 31.03.21)

Frequency of Meetings:
As necessary to fulfil its remit and not less than six times per year.

Audit & Risk Committee

Principal Function:
To provide the Board with the assurance that the activities of Fife Health Board are within the law and regulations governing the NHS in Scotland and that an effective system of internal control is maintained. The duties of the Audit and Risk Committee are in accordance with the Scottish Government Audit and Assurance Committee Handbook, dated March 2018, and associated Treasury guidance on assurance mapping.

Membership:
- Five Non-Executive or Stakeholder Members of the Board

Chair:
Martin Black, Non-Executive Board Member

Frequency of Meetings:
As necessary to fulfil its remit and not less than four times per year.

Staff Governance Committee

Principal Function:
To support the development of a culture within the health system where the delivery of the highest standard possible of staff management is understood to be the responsibility of everyone working within the system, and is built upon partnership and collaboration, and within the direction provided by the Staff Governance Standard.

Membership:
- Four Non-Executive Members of the Board
- Employee Director (as a Stakeholder member of the Board by virtue of holding the Chair of the Area Partnership Forum)
- Chief Executive
- Director of Nursing
- Staff Side Chairpersons of the Local Partnership Forums

Chair:
Margaret Wells, Non-Executive Board Member

Frequency of Meetings:

As necessary to fulfil its remit but not less than four times a year.

Remuneration Committee

Principal Function:
To consider and agree performance objectives and performance appraisals for staff in the Executive cohort, to oversee performance arrangements for designated senior managers, and to direct the appointment process for the Chief Executive and Executive Members of the Board.

Membership:
- Fife NHS Board Chairperson
- Two Non-Executive Members of the Board
- Chief Executive
- Employee Director

Chair:
Tricia Marwick, Chairperson of Fife NHS Board

Frequency of Meetings:
As necessary to fulfil its remit but not less than three times a year.

Finance, Performance & Resources Committee

Principal Function:
To keep under review the financial position and performance against key non-financial targets of the Board and to ensure that suitable arrangements are in place to secure economy, efficiency and effectiveness in the use of all resources, and that the arrangements are working effectively.

Membership:
- Six Non-Executive or Stakeholder Members of the Board
- Chief Executive
- Director of Finance
- Medical Director
- Director of Nursing
- Director of Public Health

Chair:
Rona Laing, Non-Executive Board Member

Frequency of Meetings:
As necessary to fulfil its remit but not less than four times per year.

Other Governance Arrangements

The conduct and proceedings of the NHS Board are set out in the Standing Orders. These specify the matters which are solely reserved for the NHS Board to determine, the matters which are delegated under the scheme of delegation and the matters which are remitted to a Standing Committee of the NHS Board. In April 2020, the Board adopted the new national Model Standing Orders for NHS Boards, created to support the implementation of the NHS Blueprint for Good Governance, and to improve consistency across NHS Boards using this 'Once for Scotland' approach.

The Standing Orders also include the Code of Conduct that Board members must comply with, and, along with the Standing Financial Instructions, these documents are the focus of the NHS Board's annual review of governance arrangements. The annual review also covers the remits of the NHS Board's Standing Committees and a self-assessment of each Committee's effectiveness.

All committees of the Board are required to provide an Annual Statement of Assurance to the Audit & Risk Committee and Board, describing their membership, attendance, frequency of meetings, business addressed, outcomes and assurances provided, Best Value, risk management and to demonstrate they have fully fulfilled their roles and remit. The format and content of these reports have been further

improved in the current year, and a template for the respective sub-committees / groups that formally report into a Standing Committee has been created to ensure consistency.

All NHS Board Executive Directors undertake a review of development needs as part of the annual performance management and development process. Access to external and national programmes in line with development plans and career objectives is also available.

Ongoing work to improve Board effectiveness builds on the proposals originally approved by the Board in 2017 and 2018, in relation to the Chair's review of governance arrangements in NHS Fife. It also reflects the requirements of the NHS Scotland Blueprint for Good Governance (https://learn.nes.nhs.scot/28418/board-development/blueprint-for-good-governance), which is presently being implemented across all Boards. In mapping the Board's arrangements for governance against the standards given in the national Blueprint, detailed consideration has been given as to whether the right systems are in place to provide appropriate levels of assurance and to identify areas where improvements can be made. A recent internal audit review has been undertaken of NHS Fife's compliance with the Blueprint, with the conclusion that 'comprehensive assurance' can be taken from the implementation work progressed thus far. Whilst national work aimed at developing the individual workstreams from the Blueprint was largely paused in 2020/21, due to the pressures of the pandemic, activity is expected to increase, with the Board due to take part in the roll-out of the Active Governance component from autumn 2021.

During 2019, Board members were each invited to complete a diagnostic self-assessment questionnaire assessing the Board against the Blueprint's initial requirements, to identify common themes and areas for improved effectiveness at Board-level. The outcome of the self-assessment process was presented to Board members at the April 2019 Development Session and, following discussion, an action plan was approved at the May 2019 Board meeting. A progress update was considered by the Board in November 2019 and, following thereon, a further iteration presented in September 2020. A summary of the most recent self-assessment process, noting the largely positive evaluation of governance arrangements in place in NHS Fife, can be found at the link below: https://nhsfife.org/media/35026/blueprintupdatesept20.pdf

Each year, Board committees also undertake a detailed self-assessment exercise, via the format of an online questionnaire. Response rates frequently reach 100% of members and attendees, though participation in this reporting year was reduced due to the timing of the survey occurring within the second wave of the pandemic. The regular review of Board committee effectiveness is an important tool in identifying areas where improvements can made, such as in enhancing training opportunities, and is a central part of the internal year-end assurance process.

The Chief Executive is accountable to the NHS Board through the Chair of the Board. The Remuneration Committee agrees the Chief Executive's annual objectives in line with the Board's strategic and corporate plans.

Non-Executive Directors have a supported orientation to the organisation, as well as a series of development sessions. An enhanced induction programme has been established to support new members and a dedicated Induction Pack is update on a rolling basis. This programme, developed originally by NHS Fife, has been used to create national guidance issued to all Boards across Scotland, as an example of best practice. Opportunities for ongoing member support also exist at a national level via the NHS Scotland Board Development website (https://learn.nes.nhs.scot/17367/board-development) and related resources, and discussions around individual member development are a key part of the annual appraisal process of each member by the Chair.

To ensure that the NHS Board complies with relevant legislation, regulations, guidance and policies, a distribution process is in place to ensure that all Circulars and communications received from the Scottish Government Health and Social Care Directorate (SGHSCD), internal policies and procedures, are directed to Senior Managers who are held responsible for implementation. A dedicated Covid-19 log has operated throughout the current year to capture and track all relevant correspondence. A process to monitor compliance with regulations and procedures laid down by Scottish Ministers and the SGHSCD is in place.

In accordance with the principles of Best Value, the Board aims to foster a culture of continuous improvement. The Board Committees support the Board in delivering best value through the relevant focus within their Terms of Reference and the annual work-plans. Directors and Managers are encouraged to review, identify, and improve the efficient and effective use of resources.

During 2020/21, NHS Fife had a Whistleblowing policy in place. A dedicated Whistleblowing Champion, Katy Miller, took up position on the Board as a full Non-Executive Member in February 2020, though she resigned from that post, due to her work commitments, in November 2020. A national-led recruitment process for a successor has successfully concluded and Kirstie Macdonald has joined the Board in that role from 1 April 2021. The Board's Staff Governance Committee has undertaken review of the National Whistleblowing Standards that have been rolled out across all NHS Boards from April 2021 and is assured that adequate preparations are in place for their adoption. The Board is committed to achieving the highest possible standards of service and the highest possible ethical standards in public life in all of its practices. To achieve these ends, it encourages staff to use internal mechanisms for reporting any malpractice or illegal acts or omissions by its staff. The Board wishes to create a working environment which encourages staff to contribute their views on all aspects of patient care and patient services. All staff have a duty to protect the reputation of the service they work within. The Board does not tolerate any harassment or victimisation of staff using this policy, and treats this as a serious disciplinary offence, managed under the Board's Management of Employee Conduct policy.

There is a well-established complaints system in place whereby members of the public can make a formal complaint to the Board regarding care or treatment provided by or through the NHS, or how services in their local area are organised if this has affected care or treatment. Information on our complaints procedures is available on the NHS Fife website.

The Board is committed to working in partnership with staff, other public sector organisations and the third sector. NHS Fife strives to consult all of its key stakeholders. We do this in a variety of ways. How we inform, engage, and consult with patients and the public in transforming hospitals and services is an important part of how we plan for the future. To fulfil our responsibilities for public involvement, we routinely communicate with, and involve, the people and communities we serve, to engage with them on our plans and performance.

An Integrated Performance & Quality Report (IPQR) was presented to each Clinical Governance Committee, Finance, Performance & Resources Committee, Staff Governance Committee and Board meeting. This provides detailed monitoring information on a range of measures covering financial and clinical delivery. The impact of Covid-19 on performance against key metrics has been significant and the Board notes the challenges to be faced in recovering the position, particularly in relation to reducing waiting times and the number of referrals. The NHS Board also considers at each meeting the most up-to-date information available in relation to the financial position. In addition, an Executive Summary is prepared for the NHS Board and incorporates all matters escalated by each Committee from its own review of the IPQR.

In relation to initial challenges faced by NHS Fife around its annual programme of Seasonal Flu Immunisation, the Board had initially recognised that the 2020/21 campaign was expected to be more challenging than previous years, due to the ongoing restrictions of the pandemic, and with a different model of delivery from the previous GP-led clinics. On the programme's launch in mid-September 2020, the increased demand for flu vaccinations quickly overwhelmed the planned delivery model and communications hub, resulting in a less than satisfactory patient experience and reputational damage to the Board. An independent review into the seasonal flu programme was commissioned in October 2020 and a 'Lessons Learned' report considered in depth by Clinical Governance Committee and the Board at their meetings in November. The report made a number of important recommendations in the areas of governance, reporting routes and clarity of roles and responsibilities; dedicated planning and project management support; workforce; communications; and IT support. A related Action Plan was developed, and regular reporting on addressing these individual improvement actions has continued. In addition, an external review was commissioned to consider how the Board delivers immunisation programmes in general (noting the additional activity in this area due to Covid-19), and in particular clarifying the respective responsibilities for Public Health and colleagues in the Fife Health & Social Care Partnership. The recommendations of this review will be taken forward during 2021/22.

Robust action plans were developed following Health Improvement Scotland (HIS) external inspection visits to Glenrothes Hospital (on 7-8 July 2020) and to Adamson Hospital (28 October 2020).

The Glenrothes Hospital inspection report is available at: http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/hosp_nhs_fife/glenrothes_hospital_sep_20.aspx) resulted in the identification of four areas of good practice (particularly in the areas of hospital cleanliness and infection control support) and five requirements for improvement (one concerning the condition of equipment and the remainder to improving documentation to ensure that patient health and wellbeing were being appropriately supported and safeguarded).

The Adamson Hospital inspection report is available at: http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/hosp_nhs_fife/adamson_hospital_jan_21.aspx) highlighted three areas of good practice (including robust standards of hospital cleanliness and thorough completion of assessment such falls, oral care and pressure ulcers prevention) and eight requirements to be followed up. Six requirements related to improving documentation to ensure that patient health and wellbeing were being supported and safeguarded and two requirements were in relation to infection control practices helping support a safe environment for patients and staff. At their May 2021 meeting, the Clinical Governance Committee was pleased to note that the action plan in relation to the Glenrothes Hospital inspection had been fully completed, and that the Adamson Hospital action plan was well advanced towards full completion.

During 2020/21 the Board, as the Corporate Trustee for the Fife Health Charity, kept under review the overall governance for charitable funds, including the approach to the management and oversight of funds.

Integration Joint Board (IJB)

A number of NHS Fife Board Members also have a role on the Integration Joint Board and its Committees and maintain responsibility for their respective professional remits at all times. The Director of Health & Social Care as the Accountable Officer for the IJB is also a direct report to the NHS Fife Chief Executive. The Chief Executive maintains responsibility for all aspects of governance relating to health services across Fife.

Minutes of the IJB, and the IJB's Clinical & Care Governance Committee, are considered at the Clinical Governance Committee of the NHS Board and an annual assurance statement is also provided from the IJB's Chief Internal Auditor and the IJB's Clinical & Care Governance Committee to support the assurance process. The Integrated Performance & Quality Report encompasses all aspects of delegated services.

The approach adopted for health and social care within Fife is the 'fully delegated' model, with the IJB responsible for governance and assurance of all operational activities for its delegated functions. During 2020/21 the NHS Board and supporting governance committees maintained an overarching assurance role in relation to both clinical and financial governance, and therefore oversight of the adequacy and effectiveness of controls for delegated functions. The operational and governance framework of the IJB will continue to be developed during 2021/22 to ensure clarity and consistency of approach.

A joint review of the Fife Integration Scheme was originally scheduled to conclude by 31 March 2020 (as per the five-year review cycle required by legislation). This review was paused due to the onset of the Covid-19 pandemic. Changes to the current Scheme were agreed by the March 2020 date; however, a number of areas (including the risk share arrangement) required further consideration. A proposal to vary the risk share arrangement was discussed and the matter was then submitted to both Chief Executives of NHS Fife and Fife for consideration. Until a revised Scheme is agreed, the extant Scheme remains in force. Due to the circumstances of the pandemic, Scottish Government has indicated they are content that a local review is concluded by the statutory deadline and an indicative timescale provided on when any additional outstanding issues will be formally concluded. A letter was sent to Scottish Government which confirmed the completion of the local review and provided a timescale of 30 June 2021 for the conclusion of arrangements for the risk share within the new Scheme.

Review of Adequacy and Effectiveness

As Accountable Officer, I am responsible for reviewing the adequacy and effectiveness of the system of internal control. My review is informed by:

- Discussions with Executive Directors and senior managers who are responsible for developing, implementing and maintaining internal controls across their areas;
- Letters of Assurance from each Director;
- Reports from other inspection bodies;
- The work of the internal auditors, who submit to the Audit & Risk Committee regular reports, which include their independent and objective opinion on the effectiveness of risk management, control and governance processes, together with recommendations for improvement;
- Comments by the external auditors in their management letters and other reports;
- The completion of self-assessment questionnaires considering the Board's own performance and that of its Committees;
- The range of topics covered at Board Development Sessions, to develop the knowledge and awareness of both Executive and Non-Executive Board members;
- The Board's agreed approach to Risk Management established within the Governance Committees;
- The work of the other assurance Committees and groups supporting the Board: Staff Governance Committee, Remuneration Committee, Finance, Performance & Resources Committee, and the Clinical Governance Committee (which also embraces Information Governance & Security);

Data Quality

The Board receives a range of reports which include financial, clinical, and staffing information. In general, these reports are considered by the Executive Directors Group and at a Governance Committee prior to being discussed at the Board. This allows for detailed consideration and scrutiny of the content, completeness and clarity of the information being provided to the Board.

Assurance on the information included in reports also comes from the overall approach to the management of information (through the Information Governance & Security Steering Group) and validation processes and assurances on the quality of information provided from internal audit and other scrutiny bodies.

Risk Management

The Chief Executive of the NHS Board as Accountable Officer, whilst personally answerable to Parliament, is ultimately also accountable to the Board for the effective management of risk.

NHS Scotland bodies are subject to the requirements of the Scottish Public Finance Manual (SPFM) and must operate a risk management strategy in accordance with relevant guidance issued by Scottish Ministers. The general principles for an effective risk management strategy are set out in the SPFM.

All of the key areas within the organisation maintain a risk register. All risk registers are held on Datix, the Risk Management Information System. Training and support for all Datix modules, including risk registers, are provided by the Risk Management team according to the requirements of individuals, specialities, and teams.

During 2020/21, the high level risks identified as having the potential to impact on the delivery of NHS Fife's strategic priorities, and related operational high level risks, were reported as part of the Board Assurance Framework (BAF), to the governance committees on a bi-monthly basis, and thereafter to the Audit & Risk Committee and the Board.

Work is ongoing to review the Board's risk management arrangements, to ensure they continue to reflect good practice.

The Board agreed its risk appetite in November 2019. The risk appetite statement was due to be reviewed and updated by November 2020. This activity was delayed due to competing priorities arising from the pandemic. Further work is required to update and agree a risk appetite statement that states the type and level of risks to be eliminated, tolerated, or managed based on an assessment of the balance of risk versus reward. The review will take place in Q3 of 2020/21. This will involve consideration of the risk appetite of the Board in relation to both operational delivery and performance and strategy.

Performance against Risk Management Key Performance Indicators (KPIs) were reported to the Audit & Risk Committee during 2020/21.The adverse event components of the KPIs are reported to the NHS Fife Adverse Events & Duty of Candour Group, which reports through the Board's Clinical Governance structures. Further consideration will be given to KPI reporting to the NHS Fife Clinical Governance Committee.

The areas for development identified above will all be captured in the updated Risk Management Framework.

During 2020/21, the Director of Nursing, as Executive Lead for Risk Management, reported on all of the above to the Audit & Risk Committee.

Strategy Development and Strategic Planning and Resource Allocation

During 2020/21 the Board introduced a new Strategic Planning and Resource Allocation (SPRA) process. This is an annual process that details how each directorate/programme supports the delivery of the overall organisational strategy. The new process informed the development of the Operational Plan (RMP3) for 2021/22. Through this process, Directorate positions were consolidated, and investments and disinvestments prioritised to deliver the most effective allocation of resources. The prioritisation was influenced by the Scottish Government policy objectives and the recurring impact of Covid-19. The prioritisation process also reflected that the NHS in Scotland will operate under the direction of the Scottish Government at least until the end of June 2021.

The SPRA process creates a planning and resource allocation framework to support the development of the organisational strategy for NHS Fife. This will inform the medium-term financial plan and long-term strategic plan for NHS Fife.

Information Governance and Security

The Internal Audit Annual Report 2019/20 highlighted that assurance on the effectiveness of the Board Information Governance arrangements could be improved in some areas. During 2020/21 there was a key focus on delivering improvements to this important area of governance. As a result of the work undertaken, there has been an improvement in the effectiveness of our governance arrangements including enhancing the necessary processes and controls to provide a baseline of consistent and reliable assurance. Additionally, reporting on compliance with the control's framework has been developed and will be embedded in practice during 2021/22. There were no material deteriorations in levels of compliance against controls during 2020/21; indeed, several areas noted improved performance, including a reduction in the number of potential personal data related incidents or data protection breaches reported to the Information Commissioner (ICO), as detailed on p.17. A number of areas require further work to ensure consistent improvement and a plan has been established to target improvements in compliance where that is required, this will be continuously monitored during 2021/22.

Covid-19 Pandemic – Governance Arrangements

The business of the Board during the year has been impacted greatly by the need for NHS Fife as a whole to address the ongoing challenges of the global pandemic. In recognition of the rapid mobilisation of services to tackle rising rates of Covid-19 infection, approval to revise governance arrangements across NHS Boards was given by the Scottish Government in a letter to Board Chairs on 25 March 2020 (the NHS in Scotland has remained on an Emergency Footing continually since that date). Individual NHS Boards were invited to submit their specific proposals for governance during the pandemic period to the Office of the Chief Executive; NHS Fife returned their own submission on 30 March 2020. At their April 2020 meeting, the Board approved a 'governance-lite' approach aimed at

allowing NHS Fife to effectively respond to Covid-19 pressures, maximise the time available for management and operational staff to deal with the significant challenges of addressing demand within clinical services, and, at the same time, allow the Board to appropriately discharge its governance responsibilities.

Since the outbreak of the pandemic in mid-March 2020, the Board has continued to hold its bi-monthly meetings remotely, utilising videoconferencing via MS Teams, with a prioritised agenda in place for each Board meeting. Whilst it has not been possible to meet physically in a public setting due to the ongoing lockdown restrictions and social distancing measures, from the May 2020 Board meeting onwards, representatives from the local media were invited to listen in via Teams. Arrangements for members of the public to join virtual meetings have also been in place since shortly after that date, with NHS Fife one of the first Boards to establish a process for remote public access. Board papers continue to be published in advance on the NHS Fife website, as do the Board minutes after each meeting has taken place.

Whilst the scheduled dates in May 2020 for the Board's governance committees were stood down due to the ongoing impact of the pandemic, a series of Covid-19 related briefing sessions were held for each Board Committee in June, tailored to each Committee's specific remit. As per the letter from Richard McCallum, Director of Health Finance and Governance of 11 June 2020, prior notification of the intention to resume Committee meetings, and the rationale for that, was given by the Board to Scottish Government. Committee meetings largely resumed on their regular schedule from July 2020 onwards. Agendas for Committee meetings since that time have reflected the priorities of the Board's ongoing response to Covid-19, in addition to the consideration of business otherwise requiring formal approval or scrutiny for assurance purposes. The Chair, Vice-Chair and Committee Chairs have liaised closely with the Executive Team to identify what business must be considered by the Board and its committees and what must be prioritised in agenda planning. In the period covered by this report, some routine business has been suspended or deferred. Each Committee's workplan was however reviewed to ensure that new items related to Covid-19 were covered appropriately and that the required assurances could be provided to the Board as part of the year-end process. Each Committee also actively considered a governance checklist, prepared initially by Internal Audit and recommended by the Audit & Risk Committee for adoption by all standing committees, to help enhance agenda planning and ensure that no areas of risk were overlooked.

During the height of the pandemic, in both the first and second waves of Covid-19 related activity, weekly meetings of the Chair, Vice-Chair and members of the Executive Team were held, with a detailed note circulated to Board members for their information. The Chair and Vice-Chair additionally had regular contact with the Chief Executive and other key members of the Executive Team on priority items as and when required. Regular meetings with local elected representatives (MPs/MSPs) also continued to operate on a monthly basis.

During both the first and second waves of the pandemic, NHS Fife established an organisational command structure to provide direction, decision-making, escalation, and communication functions during the busiest times of activity. Initially, from late March 2020, meetings of Gold Command were scheduled daily. By the end of June this was reduced this to weekly as a result of the reduction in Covid-19 related activity and reporting from its supporting Silver and Bronze groups. Routine meetings such as the weekly meeting of the Executive Team, and a formal Executive Directors' Group (EDG) meeting, were resumed in June. Gold Command - and its supporting structures below - stood up once again on a weekly basis, from September 2020 to the end of March 2021, to manage the second wave of the Covid-19 pandemic. The organisational structure utilised successfully in the first two phases of the pandemic will be re-introduced, should future circumstances require.

Disclosures

During the 2020/21 financial year, no other significant control weaknesses or issues have arisen, in the expected standards for good governance, risk management and control.

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**16 June 2022**
Title:	**Service Auditor Reports on Third Party Services**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This is presented to the Audit & Committee for:

- Assurance

This report relates to a:

- Government policy/directive

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

- Effective

2 Report summary

2.1 Situation

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

2.2 Background

Service Audits are carried out to provide assurance that the services NSS and NHS Ayrshire and Arran provide on behalf of NHS Fife operate an appropriate controls environment which enables reliance to be placed on these service areas.

2.3 Assessment

NSS Service Audits – Practitioner & Counter Fraud Services (Appendix 1)

Practitioner and Counter Fraud Services is one of the strategic business units within NSS, which supports primary care across Scotland through the provision of payments to contractors across general medical practice, NHS delivered general dental practice, community pharmacy and optometry, whilst also supporting patient registration and medical

records transfer for all general practice. Counter Fraud Services (CFS) are a further component which seeks to protect the resources of the NHS from Fraud and provide a further layer of assurance to the NSS service delivery.

Following the qualified Audit opinion in 2020/21, Practitioner and Counter Fraud Services produced and completed an action plan to deliver all of the recommendations made in the 2020/21 service audit report. The Auditors noted the significant improvements implemented throughout the course of the year and confirmed that the controls in place for the year were suitably designed and were able to provide reasonable assurance that the control objectives were achieved in the year. As a result, the Auditors were able to now provide an unqualified opinion for this service for 2021/22.

Further assurance is given by way of the sub-committee of the NSS Audit and Risk Committee which was established following the qualified opinion in 2020/21, will continue to provide oversight over the service activity into 2022/23.

NSS Service Audits – IT Services (Appendix 2)

NSS provides IT services in support of a packaged Payroll Service by the NSS Payroll Department to NHS Scotland Boards. In addition, NSS provides IT services in support of the services provided by Practitioner and Counter Fraud Services which reimburse the primary care practitioners/contractors for the services that they provide.

Following on from the significant improvements noted during the 2020/21 service audit (The service Audit had been qualified in 2019/20), the Auditors have again provided an unqualified opinion on the service provided.

NHS Ayrshire and Arran - Financial Ledger Services (Appendix 3)

NHS Ayrshire and Arran hosted the National Single Instance financial ledger services on behalf of all Customer NHS Boards in Scotland. The Customer Boards including NHS Fife used the financial ledger services during 2021/22 for core financial transactions.

The Auditors have provided an unqualified opinion on the service provided and reported no critical or significant risk findings.

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

N/A

2.3.3 Financial

No direct financial impact on NHS Fife

2.3.4 Risk Assessment/Management

The Auditors confirmed that controls were consistently applied as designed across 2021/22. Engagement continued with the customer Boards throughout 2021/22 to update on performance throughout the year.

2.3.5 Equality and Diversity, including health inequalities

N/A

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The Service Audit Reports were provided to the Directors of Finance Group as per the Annual assurance process.

2.3.8 Route to the Meeting

The Service Audit reports have been provided to NHS Fife, following their consideration at the Host Boards Audit & Risk Committees.

2.4 Recommendation

The Committee is asked to take assurance from the audit opinions and the associated management responses for the services hosted by NSS and by NHS Ayrshire & Arran (NHSAA) on behalf of NHS Fife.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 - NSS Practitioner and Counter Fraud Services ISAE 3402 Report 2021/22
- Appendix 2 - NSS IT Services ISAE 3402 Report 2021/22
- Appendix 3 - NHS Ayrshire & Arran ISAE 3402 Report 2021/22

Report Contact
Kevin Booth
Head of Financial Services & Procurement
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NHS National Services Scotland

Practitioner and Counter Fraud Services – Non COVID payments

ISAE 3402 Type II Report

1 April 2021 to 31 March 2022

CONTENTS

FOREWORD

Service Audit Foreword

As with all Boards across NHS Scotland, this has been another extraordinary year that has seen all our staff maintain their efforts to deliver services throughout another period of extremely challenging circumstances.

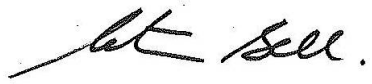
Practitioner and Counter Fraud Services (P&CFS) has continued to adapt to ensure staff maintained service excellence whilst over 80% continued to work remotely or from home. Those who have had to work within our buildings have done so with great professionalism, ensuring the environment was safe for all and therefore capacity was maintained. This capacity has allowed P&CFS to continue to deliver interim Covid-19 as well as routine payment arrangements, in line with Scottish Government direction and circulars.

A sweep up process was completed to ensure all contractors received their £500 Covid-19 bonus payments in early 2021. The team administering the Scottish Infected Blood Support Scheme (SIBSS) safely and effectively delivered an additional £10m in payments, almost double the annual budget for the Scheme, in line with the UK Four Nations Parity agreement. Scottish Government allocated all funding for this.

P&CFS produced and completed its action plan to deliver all the recommendations made in the 2020-21 Service Audit Report. Ongoing quality improvement has also continued throughout the year. This can be seen in the progress made against the two exceptions raised during testing.

I am delighted that this effort has been recognised and an unqualified position secured. I thank both my staff and our auditors for their proactive approach, ensuring improvements continue to be made.

I look forward to the opportunity to engage health board colleagues during our annual partnership agreement meetings scheduled to recommence in mid-2022. Together we can work on further progressing this situation in a collaborative and transparent way.



Martin Bell
Director of Primary Care and Counter Fraud Services

SECTION 1 - INDEPENDENT SERVICE AUDITOR'S ASSURANCE REPORT

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

20 May 2022

Dear Directors

ISAE 3402 Type II Independent Service Auditor's Assurance Report

In accordance with our Call Off Contract dated 11 April 2019 (our "Contract"), we have examined the accompanying description at pages 10 - 29 of the controls in place at the service organisation called NHS National Services Scotland ("NSS") and carried out procedures to enable us to form an independent opinion on whether NSS' management has fairly described its controls system for Practitioner and Counter Fraud Services – Non COVID ("P&CFS") payments throughout the specified period 1 April 2021 to 31 March 2022 (the "Description"), and on the design, and operation of controls related to the control objectives stated in the Description. Our opinion is set out below and should be read and considered in conjunction with this report in full.

NSS Management's Responsibilities

In this report, references to NSS' "management" means the Director of Primary Care and Counter Fraud Services and those employees to whom NSS have properly delegated day-to-day responsibility over matters for which the Chief Executive of NSS retains ultimate responsibility.

Management of NSS is responsible for (1) preparing its statement on pages 7 - 29 and describing in the Description within the statement its controls system for P&CFS payments, including the completeness, accuracy and method of presentation of the same, (2) providing the services covered by the Description, (3) selecting the criteria to be used and stating them in the statement, (4) specifying the control objectives and stating them in the Description, and (5) identifying the risks that threaten the achievement of the control objectives and designing, implementing, and documenting controls that are suitably designed and operating effectively to provide reasonable assurance that the control objectives stated in the Description will be achieved.

Service Auditor's Responsibilities

Our responsibility is to express an independent opinion to NSS based on the procedures performed and evidence obtained, as to whether (1) NSS' management Description fairly presents the controls system that was designed and implemented throughout the specified period and the aspects of the controls that may be relevant to a user organisation's internal control, as it relates to an audit of financial statements; (2) the controls included in the Description were suitably designed throughout the specified period to provide reasonable assurance that the control objectives specified would be achieved if the described controls were complied with satisfactorily, and (3) such controls were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the specified period. The criteria we used to form our judgements are the criteria used by management in making the Description, and are set out on pages 10 - 29.

Framework applied

We conducted our work in accordance with the International Standard on Assurance Engagements 3402 (ISAE 3402) "*Assurance Reports on Controls at a Service Organisation*" issued by the International Auditing and Assurance Standards Board ("IAASB"). That standard requires us to comply with ethical requirements and to plan and perform our procedures to obtain reasonable assurance about whether, in all material respects, the Description is fairly presented and the controls were suitably designed and operating effectively to achieve the related control objectives stated in the Description.

Our Independence and Quality Control

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

Scope of work

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

The Description indicates that certain control objectives specified in the Description can be achieved only if complementary user entity controls contemplated in the design of the NSS's controls are suitably designed and operating effectively, along with related controls at NSS. We have not evaluated the suitability of the design or operating effectiveness of such complementary user entity controls.

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

Limitations of Controls at a Service Organisation

NSS' management's Description is prepared to meet the common needs of a broad range of customers and their auditors and may not, therefore, include every aspect of the system that each individual customer may consider important in its own particular environment. Also, because of their nature, controls at a service organisation may not prevent or detect and correct all errors or omissions in processing or reporting transactions. Such control procedures cannot guarantee protection against (among other things) fraudulent collusion especially on the part of those holding positions of authority or trust. Also, the projection of any evaluation of effectiveness to future periods is subject to the risk that controls at a service organisation may become inadequate or fail.

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

Opinion

Our opinion has been formed on the basis of the matters outlined in this report. In our opinion, in all material respects:

(a) The Description fairly presents the Practitioner and Counter Fraud Services – Non COVID payments controls system as designed and implemented throughout the period from 1 April 2021 to 31 March 2022;

(b) The controls related to the control objectives stated in the Description were suitably designed throughout the period from 1 April 2021 to 31 March 2022; and

(c) The controls tested, which were those necessary to provide reasonable assurance that the control objectives stated in the Description were achieved, operated effectively throughout the period from 1 April 2021 to 31 March 2022.

Emphasis of Matter

We draw attention to pages 11, 17 and 19 of the Description regarding the control objective: "Controls provide reasonable assurance that verification is performed in accordance with Scottish Government Guidance" which applies in relation to each of the four payment streams: general medical services payments (control reference 1.10); general dental services payments (3.8); and general ophthalmic services payments (4.8). As explained on pages 14, 19 and 22 of the Description, post payment verification services were not performed for any of the three payment streams throughout the period 1 April 2021 to 31 March 2022 as a result of NSS suspending its post payment verification services as requested by Scottish Government circulars issued in response to the COVID pandemic. Our opinion is not modified in respect of this matter.

Other Matter

We draw attention to the fact that NSS have published a separate ISAE 3402 Type II Report in relation to IT controls ("the IT Report") and the fact that Description indicates that the control objectives specified in the Description can be achieved only if controls within the IT Report supporting the system for Practitioner and Counter Fraud Services – Non COVID payments contemplated in the design of NSS's P&CFS payments controls are suitably designed, implemented and operating effectively. This report, on the controls system for P&CFS payments, should be read in conjunction with the IT Report. Our opinion is not modified in respect of this matter.

Description of test of controls

The specific controls tested, and the nature, timing and results of those tests are listed on pages 30 - 58.

Additional Information

The information provided on page 59 of this report is presented by NSS to provide additional information and is not a part of NSS' management's Description of its controls system in operation. This information has not been subjected to the procedures applied in the examination of the Description of controls applicable to the P&CFS payments system, and accordingly, we express no opinion on it.

About this report including disclosure

This report is made to and has been prepared solely for NSS, on the terms agreed and recorded in our Contract.

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

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

auditor's assurance report has been commissioned by NSS and issued in connection with the controls of NSS.

Intended Users and Purpose

This report and description of tests of controls and results on pages 30 - 58 are only to be disclosed to User Entities who have a sufficient understanding to enable them to consider the matters stated including the basis of our consent to disclosure and their ability to rely on this report, along with other information including information about controls implemented by customers themselves, when assessing the risks of material misstatements of User Entities' financial statements. This report is not to be used by anyone other than these specified parties.

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

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

Yours faithfully

KPMG LLP

KPMG LLP

SECTION 2 - MANAGEMENT'S SYSTEM DESCRIPTION

2.1 MANAGEMENT STATEMENT LETTER

2.1.1 NSS – P&CFS

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

(a) The accompanying description at pages 10 – 29 fairly presents NSS control system for processing customers' transactions throughout the period 1 April 2021 to 31 March 2022. The criteria used in making this statement were that the accompanying description:

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

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

(ii) Includes relevant details of changes to the service organisation's system during the period 1 April 2021 to 31 March 2022.

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

(b) Subject to the information outlined in point (c) below, the controls related to the control objectives stated in the accompanying description were suitably designed and operated effectively throughout the period 1 April 2021 to 31 March 2022 to achieve those control objectives if user entities applied the complementary controls assumed in the design of NSS' controls and operated effectively throughout the period 1 April 2021 to 31 March 2022. The criteria used in making this statement were that:

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

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

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

(c) In line with KPMG's opinion outlined in Section 1 and as disclosed within our Description, we acknowledge matters surrounding the pausing of post payment verification controls during the period 1 April 2021 to 31 March 2022.

Martin Bell

Director of Primary Care and Counter Fraud Services

20 May 2022

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

2.2 NHS NATIONAL SERVICE SCOTLAND

2.2.1 NHS NATIONAL SERVICES SCOTLAND

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

NSS provides national infrastructure services and solutions to NHS Scotland.

NSS focus is on underpinning and enabling NHS Scotland and where our national solutions are appropriate, NSS also assists broader service provision across health and care. This helps to ensure the benefits and value we achieve through the national infrastructure supports many different areas of local front-line services to improve outcomes for the people of Scotland.

The national infrastructure covers clinical areas, such as the safe supply of blood, tissues and cells through to non-clinical areas, such as providing essential digital platforms and cyber security for health and care. More recently NSS has also fully supported the test and vaccination services throughout the pandemic and beyond.

2.2.2 SERVICES PROVIDED

Practitioner and Counter Fraud Services (P&CFS) is one of the strategic business units within NSS. P&CFS underpins primary care across Scotland through the provision of payments to contractors across general medical services, NHS delivered general dental practice, community pharmacy and optometry. P&CFS also supports patient registration and medical records transfer for all general practice. Throughout the Covid-19Pandemic, services also included payments of additional Covid-19 allowances across all four practitioner streams and the provision of over 2 million hybrid mailing letters in support of the Scottish Government's communications to those patients in high-risk categories, i.e. the shielding cohort.

P&CFS runs a variety of IT systems to support its activities. These systems are provided through NSS Digital and Security (DaS) and are also subject to Service Audit. The DaS Service Audit ("the IT Services Report") and this report should be read in tandem.

P&CFS also has a counter fraud section who seek to protect the precious resources of the NHS across Scotland from fraud or theft. This adds a further layer of assurance to our service delivery.

2.2.3 PRACTITIONER & COUNTER FRAUD SERVICES

P&CFS Strategic Business Unit supports payments and patient registration processes for NHS Services to Scotland's GPs, dentists, community pharmacists, and optometrists, processing and checking millions of claims every month. Each year, practitioner payments totalling approximately £2.8 billion are made by P&CFS and recorded in the NHS Boards' financial statements. The Scottish Government Health and Social Care Directorates (SGHSCD) allocate resources for monthly payments, which are processed by P&CFS. P&CFS notifies both SGHSCD and the NHS Boards of the payments made, and the NHS Boards are then treated as having received and spent the appropriate amount by SGHSCD.

As the organisation that calculates and makes the practitioner payments, P&CFS must provide probity assurance evidence to each NHS Board and their external auditors. NSS Finance is responsible for helping ensure the interface with the banking service through which practitioners are reimbursed. In addition to the above, P&CFS is also responsible for undertaking payment verification procedures (probity assurance checks) on behalf of NHS Boards for all four practitioner payment streams.

P&CFS supports four practitioner payment streams:

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

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

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

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

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

P&CFS is responsible for collating financial reports for four practitioner payment streams and providing summarised data to NHS Boards and the SGHSCD to support budget allocation and financial reporting within NHS Scotland. P&CFS Senior Management meets with each NHS Board to:

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

In 2021-22, the above meetings have not been held as priority has been given to the continued response to the Covid-19 pandemic, but specific engagement with NHS Boards continued during the year. P&CFS also works with the SGHSCD in the implementation of legislative and regulatory changes, as well as monitoring clinical standards within dentistry.

POLICIES, PROCEDURES AND MONITORING ACTIVITIES

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

The four payment streams are also ISO 9001:2015 accredited (not in scope for this report). ISO 9001:2015 is an internationally recognised quality standard, relevant to organisations which provides some external assurance that its products and services satisfy its customers' quality requirements and comply with any regulatory requirements in respect of the products and services provided.

In order to achieve and maintain this accreditation, the key P&CFS processes for each payment stream need to be documented, described and supported by detailed manuals and procedures. Built into the quality procedures are quality checks and internal audit checks which are undertaken by dedicated P&CFS staff to confirm the key controls continue to be in place and operating as intended. The ISO accreditation is subject to six-monthly external review, with action plans developed for any issues raised.

GMS

Payments are made to General Practitioner (GP) Practices on a monthly basis in accordance with the GMS or 17C Contract Regulations, Statement of Financial Entitlements, SGHSCD circulars and Scottish Public Pensions Agency (SPPA) directives.

Payment values are based on factors including the location of the GP Practice, the number and type of patients registered at the GP Practice and the different services provided. Key elements that contribute to a GP Practice's monthly payment are:

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

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

Control Objective

Controls provide reasonable assurance that:

- GMS payments are made completely and accurately based on authorised claims to the valid contractors;
- GMS payments are made only once; and

- Verification is performed in accordance with Scottish Government Guidance.

Record of Authorised Individuals

1.1 NHS Board Authorised Individuals

Each financial year, NHS Board and Special Health Board Directors of Finance email P&CFS, a matrix of their personnel who can authorise payments to contractors and amendments to their contractor lists.

On receipt, the matrices are uploaded to Compass and are accessible for regional office staff to authenticate documents generated from NHS Board and Special Health Board staff.

1.2 GP Practice Authorised Individuals

When GP Practice staff change, a revised mandate is sent by a member of the GP Practice staff to P&CFS. The mandate contains the names and signatures where available of GPs in the GP Partnership and those Practice staff authorised by the GP Partnership to submit claims and patient registration data on behalf of the GP Partnership to P&CFS. Claims are accepted from GPs or staff who have submitted a signature and are uploaded to Compass and are accessible for regional office staff to authenticate documents generated from GP Practices.

Payment rate/formula/pricing updates

1.3 GMS Contract Payment Rates

The Scottish Government (SG) controls the updates to existing payment rates and creation of new payments through the publication of the annual Statement of Financial Entitlements (SFE) and individual Primary Care Admin Medical (PCA(M)) circulars by publishing these on the SG web site: https://www.publications.scot.nhs.uk/

On publication of the SFE or PCA(M) circulars, that results in a change to an existing payment or creation of a new payment, the Primary Medical Services Payment System (PMSPS) is updated either by the National Finance Manager (NFM), Finance Services Manager (FSM), Payment Verification Lead, or nominated Contractor Finance staff with a document produced detailing the change created. This document notes who it was independently authorised and input by and then checked by.

Payment Processing

1.4 GMS Payments Authorisation and Input to PMSPS

[Excludes: Global Sum Monthly Allocation (SWF); Temporary Patient Adjustment (TPA); Opted-out Services; Income and Expenses Guarantee (I&EG) which are included in GMS Contract Payment Rates].

There are five instances where payments are generated for input to PMSPS:

1.4a Contractor Finance staff validate payment instructions from NHS Boards by:

- verifying the signatory against the NHS Board's authorisation matrix; and
- verifying that the payment is not duplicate before inputting the verified data into PMSPS.

The completion of the verification and validation is evidenced by annotations in the payment spreadsheet against 'Verified & Input by'.

An independent team member reviews that the verification and validation is correct and the input is accurate and annotates the payment spreadsheet with 'Checked by' as evidence of the review.

1.4b Contractor Finance staff validate payment instructions from GP Practices by:

- verifying the signatory against the GP Practice mandate; and
- validating that the payments are not duplicate before inputting the verified data into PMSPS.

The completion of the verification and validation is evidenced by annotations in the payment spreadsheet against 'Verified & Input by'.

An independent team member reviews that the verification and validation of the payment instruction is correct and the input is accurate and annotates the payment spreadsheet with 'Checked by' as evidence of the review.

*1.4c (i) Glasgow Regional Office (*GRO) - Rates / Water & Waste Invoices

On receipt of the invoices relating to rates & reimbursements the Glasgow regional payment team check and mark the invoice with 'examined and found to be correct in all respects', this is then authorised by an independent team member signing. On completion the invoice is then signed independently as 'verified & checked'.

A batch summary is created for all the invoices, and this is annotated 'compiled by' and 'checked by' by independent team members. The invoices are then paid by sending on the details to Finance. The monthly

invoice totals are recorded on a separate premises spreadsheet for the team's reference, and this is used as the basis for the upload into PMSPS as a payment on account, with the totals being independently marked as compiled by, verified by, input by and audit checked by.

The Payment on account will then be subsequently balanced with the charge being assigned to the appropriate account element.

The frequency of these payments for rates are generally annually in May whereas the water & waste payments are more ad hoc.

*1.4c (ii) Edinburgh Regional Office (*ERO) – Rates / Water & Waste Invoices

Supplier invoices for rates / water & waste received by the Edinburgh payment team are validated for duplicate payments by a team member before creating a Bankers Automated Clearing Service (BACS) request. Completion of the validation is evidenced by the stamp, 'Examined and found to be correct in all respects' on the invoice. BACS requests are authorised by an independent team member.

Reviewed payment requests are added to a Reimbursement & Payment on Account spreadsheet and are reviewed for accuracy by an independent team member and authorised by the Health Board. Health Board Validation and authorisations are evidenced by signatures against 'prepared by' and 'reviewed by' annotations on the spreadsheet.

Authorised payment requests are added to PMSPS as Payments on Account and are reviewed for accuracy by an independent team member and are evidenced by signatures against 'verified by' and 'checked by' annotations. on the spreadsheet.

1.4c (iii) ERO – Water/Waste Practice Reimbursements

On receipt of invoices from the practice which they have paid, the Edinburgh payment team check against previous invoices and then add to the board spreadsheet. The spreadsheet is sent to the health board and notes 'prepared by', the board then respond authorising and this is then added to the sheet. (FV have the independent 'prepared by and then reviewed by' before it is sent to the board).

The payment is then added to PMSPS with the independent 'verified by' and 'checked by' notation on the spreadsheet.

These payments are ad hoc.

1.4d) For payments made as a result of internal calculations, the summary totals from the calculation are added to a bulk upload template by a Contractor Finance team member. The calculations and subsequent totals to be paid are reviewed for completeness and accuracy by the National Finance Manager, Finance Services Manager or nominated Contractor Finance staff independent of the preparer. Completion of the review is evidenced by the annotations 'Calculated & Input by' and then 'Checked by' on the spreadsheet.

1.4e) For new/estimated general practitioner payments where practice claims are received for Enhanced Services that are less than the historic monthly totals, a monthly reconciliation is performed by the Financial Services Manager between historic figures and the claim totals to derive a top up amount for the Practices. The reconciliation is reviewed by another member of the medical payment team or the National Finance Manager and evidenced through the 'calculated and input by' and 'checked by' annotations on the payment calculation spreadsheet.

Reconciliation & Checking

1.5 Month-end PMSPS Payment Reconciliation

At the end of each month and before payments are approved in PMSPS, a Contractor Finance payment approver performs a reconciliation between the source documentation and the PMSPS Organisational Summary Statement and the Creditors Payment Report to verify the accuracy of the amounts and to confirm that no duplicate payments have been made and checks and balances have been completed prior to finally approving the payment in PMSPS.

Evidence of this reconciliation is documented by the payment approver completing, signing and dating the template 'End of Payment Control Checklist' which is filed by payment month in the digital payment folder for each NHS Board.

1.6 Global Sum Calculation & Variance Checks

On a quarterly basis, the Finance Services Manager (FSM) or National Finance Manager performs a quarterly

comparison of the current Global Sum payment amounts with the previous quarter by reviewing the comparison template created based on the SWF quarterly shares.

Where a +/- 5% difference is identified, the variances are investigated by the Regional Registration Manager, the National Finance Manager or Financial Analyst Specialist. The email correspondence and supporting evidence of the investigation and findings is retained with the weighted movements captured in the SWF quarterly comparison template.

Contractor Standing Data Updates

1.7 PMSPS Standing Data - GP Practices & GP Contractors

Amendments to PMSPS GP Practice & GP Contractor Standing Data are advised by email to P&CFS regional offices from authorised NHS Board staff in respect of: new GP Practice/contractors; amendments to existing GP Practice/contractors; and cessation of GP Practices/contractors. It is first checked the amendment comes from an authorised signatory. The input is then checked independently of the inputter and evidenced on each document with 'Verified & Input By' and 'Checked By' signatures of the staff involved. The inputter signature is the confirmation that the advisor is valid and the amendments have been input to the payment system.

1.8 PMSPS Standing Data - GP Practice Bank Account

Amendments to PMSPS Contractor Bank Account Standing Data are advised by completion of a GP Practice Bank Mandate from GP Practices or system generated report from the BACS in respect of bank account changes.

The input is checked independently of the inputter and evidenced on each document with 'Input By' and 'Checked By' signatures of the staff involved. The inputter signature is the confirmation that the advisor is valid and the amendments have been input to the payment system and checked against the mandate.

1.9 PMSPS and CHI Contractor Detail Reconciliation

When the quarterly CHI file fails to load, the Finance Services Manager (FSM) reviews the discrepancies identified by AOA as a result of the automated reconciliation of contractors' data from the PMSPS system against the CHI system. The resolution process is an exchange of emails that are saved within the Global Sum digital directory.

Scottish Government Guidance verification

1.10 GMS Payment Verification (PV)

The National Finance Manager and PV Lead produce a schedule of PV work to be undertaken by the PV team in accordance with the Payment Verification Protocol guidance published by the Scottish Government

Findings from the PV work undertaken on contractor payments are reported to the respective NHS Boards and where appropriate to the relevant contractor by Contractor Finance.

In line with Scottish Government circulars, post payment verification across medical service areas remained paused throughout the audit period. This was due to the ongoing nature of interim payment structures across dentistry, alongside a low level of items of service claimed. It has not therefore, been necessary to carry out post payment verification work on items of service claims as the level of these claims has little, if any, financial impact on payments made. Across medical services, Minimal overall payments are determined by individual patient claims, and therefore post payment verification checking and analysis of levels of claims has not been considered an integral part of some of the payment calculations.

GPS

Payments are made on a monthly basis for pharmaceutical services (Community Pharmacists and Dispensing doctors) and for the supply of prescribed appliances. Key elements that contribute to a pharmacist's payment are:

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

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

Control Objective

Controls provide reasonable assurance that:

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

Payment rate/formula/pricing updates

2.1 GPS Contract Payment Rates, Fees & Allowances

The Scottish Government (SG) controls the updates to existing payment rates and creation of new payments through the publication of individual Primary Care Admin Pharmacy (PCA(P)) circulars by publishing these on the SG web site: https://www.publications.scot.nhs.uk/

On publication of the PCA(P) circulars P&CFS staff advise the Data Driven and Innovation (DDI) Prescribing team in Public Health Scotland (PHS) of the details. A member of the DDI Prescribing team then updates the eVadis system and the input is checked independently of the person updating eVadis.

Review for payments validity

2.2 Prescription and stock order claims

Scanned by the Document Handling team based at Bain Square, the DCVP system is populated monthly with prescription and stock order claim forms, each supported by a GP34 batch declaration from a registered pharmacy, dispensing doctor or appliance supplier.

The paper prescription and stock order claims are scanned and retained for three months. The evidence is held in the Bain Square Document Handling department and Stockroom.

Payment Processing

2.3 GPS Payments Authorisation and Input to eFinancials

2.3a Payment instructions from an NHS Board including local NHS Board claims submitted monthly to the Pharmacy Payments team are:

- verified as authorised by verifying the signatory against the NHS Board's authorisation matrix;
- validated that they are not duplicate payments;
- input the verified data into the overall Kaizen Pharmacy Payment spreadsheet; and
- input into eFinancials for payment.

The validation and input into eFinancials are reviewed for accuracy by a team member independent of the preparer. The completion of the review is evidenced through the annotation 'Certified correct for payment' on the Kaizen spreadsheet.

2.3b For special payments initiated at the request of an NHS Board, the validation of authorisation and input into eFinancials are reviewed for accuracy by a team member independent of the preparer. The completion of the review is evidenced through the annotation 'Certified correct for payment' on the Special Payments documentation.

For special payments initiated as a result of an internal check, the calculation performed by the National Finance Manager, Payment Lead or nominated Contractor Finance staff are reviewed by a team member independent of the preparer before processing payments in eFinancials. The completion of the review is evidenced by the annotation 'Checked By' on the Special Payments documentation.

2.3c For ad hoc payments based on internal calculation by the National Finance Manager, Payment Lead or nominated Contractor Finance staff, the calculations are reviewed for accuracy by a team member independent of the preparer before processing the payments in eFinancials. The review is evidenced by the 'Checked By' annotation on the internally generated document.

Review for payment completeness, accuracy and duplicates

2.4 Variance analysis

Payment Variance analysis compares the DCVP net amount to be paid in the month against the same amount from the previous month. The Pharmacy Payment team review these figures and differences that exceed 50% are further investigated to verify their accuracy.

The monthly reports are annotated.

2.5 Pharmacy First Payments (Procedure DW024)

On a monthly basis, and before Pharmacy First payments are made, the Patient Registration team checks that the payment schedule has been updated for new and closed contractors. The check is annotated on the file copy. Two *.csv files, PFirstBase and PFirstAct, are then emailed by the Patient Registration team to nss.psdspsaa@nhs.scot for them to be uploaded to DCVP.

2.6 Prescriptions Reconciliation

On a monthly basis, the Document Handling team:

- reviews the contractors for whom prescription forms were received for each NHS Board in the batch headers (GP 34 batch declarations) and the number of forms that have been scanned onto the DCVP system to confirm the completeness of the number of prescription forms processed on the system and
- generates the End of Month report to evidence the review and the corrections made and store it in the Scanning Department folder.

2.7 High Value Payments Review

On a monthly basis, post payment, the Adjustment team produce a report detailing individual item payments in excess of £500. To verify the accuracy of manually keyed items reported against the individual script from contractors, the Adjustment team confirm correct item and quantity have been processed. This is checked and verified by a second adjustment team member and the report is annotated by both.

Errors identified as a result of the review are corrected by way of an adjustment by the Adjustment team.

Contractor Standing Data Updates

2.8 eFinancials Standing Data - Pharmacy Practices & Pharmacy Contractors

Amendments to Pharmacy Practices & Pharmacy Contractor Standing Data are advised to Contractor Finance by authorised NHS Board staff in respect of: new practice/ contractors; amendments to existing Practice/Contractors; and cessation of practices/ contractors. Input is checked independently of the inputter and evidenced on each document with 'Verified & Input By' and 'Checked By' signatures of the staff involved. The annotation 'Verified & Input By' is performed by one person whose role is to verify the NHS Board signatory validity and then input the verified data into eFinancials. The annotation 'Checked By' is the independent member of staff who has checked the input is accurate.

2.9 eFinancials Standing Data - Pharmacy Contractor Bank Account

Amendments to Pharmacy Contractor Bank Account Data are advised to Contractor Finance on receipt of a Pharmacy Contractor Bank Mandate or system generated report from the Bankers Automated Clearing Service (BACS) in respect of changes to existing Contractor bank account details. BACS reports are actioned as notified by the Bank. On receipt of a Bank Mandate from an existing contractor, the stated current bank details are checked against the data currently held in eFinancials and if these agree, the new bank details are updated in eFinancials. For new contractors, the details on the Pharmacy Contractor Bank Mandate are actioned following formal NHS Board notification of the new practice/ contractor details. Input is checked independently of the inputter and evidenced on each document with 'Verified & Input By' and 'Checked By' signatures of the staff involved. The annotation 'Verified & Input By' is performed by one person whose role is to verify the Bank Mandate validity and then input the data into eFinancials. The annotation 'Checked By' is the independent member of staff who has checked the input is accurate.

Scottish Government Guidance verification

2.10GPS Payment Verification (PV)

The National Finance Manager and PV Lead produce a schedule of PV reviews in accordance with the Payment Verification Protocol published by the Scottish Government.

Findings from the PV work undertaken on contractor payments are reported to the respective NHS Health Boards and where appropriate to the relevant contractor by Contractor Finance.

GDS

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

to dental payments are set out below:

- Emergency support payments to dentists who are affected by Covid-19 which top up other payments to the level set out in circulars;
- Continuing adult dental care payments;
- Specific dental treatment for eligible payments, e.g. orthodontic treatment, fillings etc.;
- Treatment of children calculated based on the number of children registered with the practice;
- Other payments as set out in the Statement of Dental Remuneration, for example out-of-hours treatment and remote access payments; and
- P&CFS administer pension deductions from dental payments and remit these to SPPA.

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

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

Control Objective

Controls provide reasonable assurance that:

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

Payment rate/formula/pricing updates

3.1 GDS Contract Payment Rates

The Scottish Government (SG) controls the updates to existing payment rates and creation of new payments through the publication of individual Primary Care Admin Dental (PCA(D)) circulars by publishing these on the SG web site: https://www.publications.scot.nhs.uk/

On publication of the PCA(D) circulars, the updates are logged by the Operations Manager or Operational Team leaders in an excel spreadsheet and checked for completion and accuracy by an independent member of P&CFS staff.

An extract from the excel spreadsheet is sent to Business Test and Support who load the data into the live MIDAS system, and the successful upload to live is checked for completion and accuracy by an independent member of P&CFS staff. This is documented in the Statement of Dental Remuneration (SDR) sign off sheet.

Review for payments validity

3.2 Verification, Calculation & Authorisation of Patient Refunds

Patient refund applications are received by the GDS Payment team from NHS Business Services Authority (BSA) who confirms the exemption status. Patient refunds are calculated weekly by a member of the GDS CF Payment team and these are checked for accuracy independently by another member of the GDS CF Payment team.

Patient refunds are authorised by the National Finance Manager, Senior Financial Analyst, Payment Lead or nominated Contractor Finance staff prior to being sent to NSS treasury for payment through the NSS Service Now portal.

Return of invalid claims

3.3 Payment Adjustment, non-payment and patient detail amendment claims

Adjustment/non-payment/patient detail amendment claims are logged on the adjustment spreadsheet / non-payment spreadsheet /patient detail amendment spreadsheet by a Customer Admin team member. Once completed, the claim forms are returned to the contractor with a comment of the outcome to explain the reason for the payment adjustment / non-payment / Patient detail amendment within 20 working days of receipt.

Claims that have not been completed and returned to the contractor within 20 days are highlighted in the KPI spreadsheet for follow up in the weekly monitoring of volumes and turnaround carried out by the Operational Team Leader.

Payment Processing

3.4 GDS Payments Authorisation and Input to MIDAS

3.4a Contractor Finance staff validate payment instructions from NHS Boards by:

- verifying the signatory against the NHS Board authorisation matrix;
- verifying that the payment is not duplicate payments before processing GDS payments.

Completion of the validation and verification is evidenced by annotations in the payment spreadsheet against 'Verified & Input By'. An independent team member reviews the verification and validation is correct and the input into MIDAS is accurate and annotates the payment spreadsheet with 'Checked By' as evidence of the review.

3.4b Payment instructions from a Dental Contractor are validated by Contractor Finance staff by:

- checking that the payment is not duplicate before calculating the payment due and inputting the payment into MIDAS; and

A team member independent from the preparer, reviews the calculation and input into MIDAS for accuracy and evidences the review by annotating the payment spreadsheet with 'Checked By'.

3.4c For payments made as a result of internal calculations by the National Finance Manager or nominated Contractor Finance staff:

- the preparer checks that the payment is not duplicate;
- a Contractor Finance team member different from the preparer reviews the payment calculations for accuracy;
- an authoriser different from the reviewer signs off the calculations.

The completion of the validation, review of accuracy of the calculation and the authorisation are evidenced through the annotations 'Prepared By', 'Checked By' and 'Authorised By' in the payment spreadsheet.

Contractor Standing Data Updates

3.5 MIDAS Standing Data - Dental Practices & Dental Contractors

Amendments to MIDAS Standing Data are advised to the Customer Admin team by authorised NHS Board staff in respect of: new practice / contractors; amendments to existing practice/ contractors; and resignation of practices / contractors by submission of a GP21A form. The annotation 'Verified & Input By' is performed by one person whose role is to verify that the NHS Board signatory is on the NHS Board authorisation matrix (this is logged on the GP21a spreadsheet by the verified by person), if not on the NHS Board authorisation matrix, the GP21A is returned to the Health Board with no action taken, and valid GP21A requests are then input into MIDAS (this is logged on the GP21a spreadsheet by the 'input by' person).

On the GP21A form at part 2 the verifier / inputter signs and dates that part to show the request has been completed.

A sample of each day's cases are checked during the month, using the Dental & Ophthalmic (D&O) sampling plan table. The annotation 'Checked By' is the independent member of staff who has checked the input is accurate (this is logged on the GP21a spreadsheet by the 'checked by' person).

3.6 eFinancials Standing Data - Dental Contractor Bank Account

Amendments to eFinancials Standing Data are advised to Contractor Finance on receipt of a Dental Contractor Bank Mandate or system generated report from the Bankers Automated Clearing Service (BACS) in respect of bank account changes. On receipt of a Bank Mandate, the contractor is contacted and asked to confirm the change is valid. This is logged on a control spreadsheet. Input is independently checked and evidenced on the spreadsheet with 'Input By' and 'Checked By'. The annotation 'Input By' is performed by one person whose role is to input the data into eFinancials. The annotation 'Checked By' is the independent member of staff who has checked for accuracy. The authorisations are approved and recorded within eFinancials (FPM system).

Patient list updates

3.7 Patient removal and review

The Customer Admin team checks that the request for patient removal is supported by a signed GP200 form before the removal is processed. The Customer Admin team check that the patient is registered with the dentist on the GP200 against MIDAS records before removal, if not registered with the dentist but registered with another dentist in the same practice the GP200 is returned to the Health Board, if not registered with the dentist but registered with another dentist in another practice, no action is taken.

a) Customer Admin team process completion of the removal requests to remove patients accordingly: current / future month requests are completed within the month the patient is to be withdrawn.
b) Retrospective requests are completed within the schedule month they are batched in view of receipt.

Scottish Government Guidance verification

3.8 GDS Payment Verification (PV)

The National Finance Manager and PV Lead produce a schedule of PV reviews in accordance with the Payment Verification Protocol published by the Scottish Government.

Findings from the PV work undertaken on contractor payments are discussed with the NHS Board in quarterly PV meetings and the outcome communicated to contractor in question, where appropriate.

In line with Scottish Government circulars, post payment verification across dental and ophthalmic service areas remained paused throughout the audit period. This was due to the ongoing nature of interim payment structures across dentistry, alongside a low level of items of service claimed. It has not therefore, been necessary to carry out post payment verification work on items of service claims as the level of these claims has little, if any, financial impact on payments made. Across ophthalmic services, Minimal overall payments are determined by individual patient claims, and therefore post payment verification checking and analysis of levels of claims has not been considered an integral part of some of the payment calculations.

3.9 Monthly Payment Samples

Before each monthly payment is made, the amounts to be paid in MIDAS for a sample of three contractors are checked against the SDR by a D&O member of staff. Any issues noted to Test and Support team including any duplicate payment errors, are followed up and resolved prior to payment.

3.10Emergency Financial Support Payments

New emergency support payments and the associated top up payments are logged on a recalculation spreadsheet which is updated each month by a Contractor Finance team member. A reviewer independent of the preparer reviews the calculations for accuracy. Completion of the calculation and the review are evidenced by the 'Prepared by' and 'Checked By' annotations on the recalculation spreadsheet.

Journals for entering the emergency support or top up payments are approved for input into MIDAS by a Contractor Finance team member independent from the preparer. Preparation of the journal and approval for input into MIDAS are evidenced through 'Prepared By' and 'Checked By' annotations on the monthly Journals file.

GOS

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

- Emergency support payments though these were revised and phased out during the year;
- Ophthalmic treatments received are priced based on agreed fee rates;
- Fee paid for eye tests undertaken; and
- Relevant spectacles and repairs payments.

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

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

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

Control Objective

Controls provide reasonable assurance that:

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

Payment rate/formula/pricing updates

4.1 GOS Contract Payment Rates

The Scottish Government (SG) controls the updates to existing payment rates and creation of new payments through the publication of individual Primary Care Admin Ophthalmic (PCA(O)) circulars by publishing these on the SG web site: https://www.publications.scot.nhs.uk/.

On publication of the PCA(O) circulars, the updates are input by Operations Manager or Operational Team Leaders, in the live OPTIX system, and the updates inputted are checked for completion and accuracy by an independent member of P&CFS staff. This is documented in SOR sign off sheet.

Review for payments validity

4.2 Review of paper HES claims validity

Customer Admin team checks that claim for payments relating to Hospital Eye Services (HES), the sole remaining category of paper claims, is supported with a valid claim form which is signed by an optician and includes the payment location code and / or list number of a registered contractor, as listed on the Ophthalmic List. The claim form information is input into OPTIX, the OPTIX system will not allow claims to be processed if mandatory information is missing / invalid on the HES claim and the invalid claim will be returned to the practitioner.

4.3 Verification, Calculation & Authorisation of Patient Refunds

Patient refund applications are received by the GOS Payment team from NHS BSA who confirms the exemption status.

Patient refunds are calculated weekly by a member of the GOS CF Payment team and these are checked for accuracy independently by another member of the GOS CF Payment team.

Patient refunds are authorised by the National Finance Manager, Senior Finance Analyst, Payment Lead or nominated Contractor Finance staff prior to being sent to NSS Treasury for payment through the NSS Service Now portal.

Return of invalid claims

4.4 Payment Adjustment, non-payment and patient detail amendment claims

Adjustment/non-payment/patient detail amendment claims are logged on the adjustment spreadsheet /non-payment spreadsheet /patient detail amendment spreadsheet by a Customer Admin team member. Once completed, the claim forms are returned to the contractor with a comment of the outcome to explain the reason for the adjustment/non-payment/patient detail amendment within 20 working days of receipt.

Claims that have not been completed and returned to the contractor within 20 days are highlighted in the KPI spreadsheet for follow up in the weekly monitoring of volumes / turnaround carried out by the Operational Team Leader.

Payment Processing

4.5 GOS Payments Authorisation and Input to OPTIX

4.5a Contractor Finance staff validate payment instructions from NHS Boards by:

- verifying the signatory against the NHS Board Authorisation Matrix; and
- verifying that the payment is not duplicate before processing GOS payments.

Completion of the validation and verification is evidenced by annotations in the payment spreadsheet against 'Verified & Input By'. An independent team member reviews that the verification and validation is correct and the input into OPTIX is accurate and annotates the payment spreadsheet with 'Checked By' as evidence of the review.

4.5b Payment instructions from Ophthalmic Practices are validated by Contractor Finance staff by:

- validating the Ophthalmic Practice's eligibility by verifying the signatory against the Practitioner Services Delegated Authority Matrix; and
- verifying that the payment is not duplicate before calculating the payment due and inputting the payment into OPTIX.

A team member independent from the preparer reviews the calculation and input into MIDAS for accuracy and evidences the review by annotating the payment spreadsheet with 'Checked By'

4.5c For payments made as a result of internal calculations by the National Finance Manager or nominated Contractor Finance staff:

- the preparer checks that the payment is not duplicate;
- a Contractor Finance team member different from the preparer reviews the payment calculations for accuracy by; and
- an authoriser different from the reviewer signs off the calculations.

The completion of the validation, review of accuracy of the calculations and input into OPTIX, and the authorisation are evidenced through the annotations 'Prepared by', 'Checked by' and 'Authorised By'.

Practitioners/contractors list updates

4.6 OPTIX Standing Data - Ophthalmic Practices & Ophthalmic Contractors

Amendments to OPTIX Standing Data are advised to Customer Admin by authorised NHS Board staff in respect of new practice/ contractors; amendments to existing practice/ contractors; and resignation of practice/ contractors by submission of a GOS6a form. The NHS Board signatory is on the NHS Board authorisation matrix, (this is logged on the GOS6a spreadsheet by the verified by person), if not on the NHS Board authorisation matrix, the GOS6a is returned to the Health Board with no action taken and valid GOS6a requests are then input into OPTIX (this is logged on the GOS6a spreadsheet by the input by person).

On the GOS6a form at part 2 the verifier / inputter signs and dates that part to show the request has been completed.

A sample of each day's cases are checked during the month, using the D&O sampling plan table. The annotation 'Checked By' is the independent member of staff who has checked the input is accurate (this is logged on the GOS6a spreadsheet by the checked by person).

4.7 eFinancials Standing Data - Ophthalmic Contractor Bank Account

Amendments to eFinancials Standing Data are advised to Contractor Finance on receipt of an Ophthalmic Contractor Bank Mandate or system generated report from the Bankers Automated Clearing Service (BACS) in respect of bank account changes. On receipt of a Bank Mandate, the contractor is contacted and asked to confirm the change is valid. This is logged on a control spreadsheet. The input is evidenced on each document with 'Input By' and 'Checked By'. The annotation 'Input By' is performed by one person whose role is to input the data into eFinancials. The annotation 'Checked By' is the independent member of staff who has checked for accuracy. The authorisations are approved and recorded within eFinancials

Scottish Government Guidance verification

4.8 GOS Payment Verification (PV)

The National Finance Manager and PV Lead produce a schedule of PV work in accordance with the Payment Verification Protocol published by the Scottish Government.

Findings from the PV work undertaken on practice payments are discussed with the NHS Board in quarterly PV meetings and the outcome communicated to the practice in question where appropriate.

In line with Scottish Government circulars, post payment verification across dental and ophthalmic service areas remained paused throughout the audit period. This was due to the ongoing nature of interim payment structures across dentistry, alongside a low level of items of service claimed. It has not therefore, been necessary to carry out post payment verification work on items of service claims as the level of these claims has little, if any, financial impact on payments made. Across ophthalmic services, Minimal overall payments are determined by individual patient claims, and therefore post payment verification checking and analysis of levels of claims has not been considered an integral part of some of the payment calculations.

4.9 Monthly Payment Samples

Before each monthly payment is made, the amounts to be paid in OPTIX for a sample of three contractors are

checked by a D&O member of staff. Any issues noted to Test and Support team, including duplicate payment errors, are followed up and resolved prior to payment.

4.10Emergency Financial Support Payments

New emergency support payments and the associated top up payments are logged on a recalculation spreadsheet which is updated each month. A reviewer independent of the preparer reviews the monthly

calculations for accuracy. Completion of the calculation and the review are evidenced by the 'Prepared by' and 'Checked By' annotations on the recalculation spreadsheet.

Journals for entering the emergency support or top up payments are approved for input into OPTIX by a team member independent from the preparer.

REPORTS TO NHS BOARDS AND SCOTTISH GOVERNMENT FOR ALL PAYMENT STREAMS

Control Objective

Controls provide reasonable assurance that reports to NHS Boards and Scottish Government outlining all Family Health Services (FHS) Payment streams are complete and accurate.

5.1 Monthly NHS Board reports (the appendices)

The monthly NHS board report (the appendices) covering the four payment streams is reviewed for completeness and accuracy by a member of the Contractor Finance team, independent from the preparer of the report, by comparing it against the source documentation compiled by the preparer from the Contractor Finance team. This review is performed before the report is submitted to the NHS Board.

Completion of this review is documented as a sign off on the report. The annotation: 'Prepared By' is performed by one person whose role is to confirm the accuracy of the input of the data; 'Reviewed By' is performed by an independent person whose role is to check the information is accurate.

5.2 Reconciliation against eFinancials

The Contractor Finance team performs a reconciliation of the total amount from each monthly NHS Board report against the total amount recorded in eFinancials before the report is submitted.

Non-reconciling items are annotated, investigated and resolved through to completion and reported to the NHS Boards

Completion of this reconciliation is documented as a sign off on the report. The annotation: 'Prepared & Input By' is performed by one person whose role is to confirm the accuracy of the input of the data; 'Checked By' is performed by an independent person whose role is to check the information is accurate.

5.3 Form 12 report

On a monthly basis, a member of the Contractor Finance team, other than the inputter, reviews the completeness and accuracy of the Form 12 report summarising the financial information across all four payment streams by comparing it against four streams spreadsheets before the report is submitted to each NHS Board and SG. The annotation: 'Prepared By' is performed by one person whose role is to confirm the accuracy of the input of the data; 'Reviewed By' is performed by an independent person whose role is to check the information is accurate.

5.4 Reconciliation of Form 12 report and the appendices

A member of the Contractor Finance team performs a reconciliation between the information on the monthly board reports (the appendices) and the Form 12 report to verify their completeness and accuracy before the reports are submitted with reasons and any actions highlighted to boards. Non-reconciling items are investigated and resolved through to completion.

Completion of this reconciliation is documented as a sign off on the report. The annotation: 'Prepared By' is performed by one person whose role is to confirm the accuracy of the input of the data; 'Reviewed By' is performed by an independent person whose role is to check the information is accurate.

2.3 CONTROL ENVIRONMENT

2.3.1 NSS BOARD

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

1) Audit and Risk;
2) Clinical Governance;
3) Finance, Procurement and Performance;
4) Staff Governance; and
5) Remuneration and Succession Planning.

Throughout the period of this Service Audit, the NSS Audit and Risk Committee established a sub-group, the Service Audit Steering Group, to oversee monthly, the progress being made to deliver an action plan of recommendations delivered in the 2020-21 Service Audit Report as well as wider quality improvements as recommended by Deloitte following a review of wider systems and processes conducted in May-June 2021.

2.4.2 RISK MANAGEMENT IN NSS

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

NSS operates an integrated risk management process and P&CFS fully comply with this. Governance is maintained through routine Operational Risk Champion meetings and internally, P&CFS review risks monthly to assure they are updated, scored and reviewed to reflect the ever-changing environment we work within.

2.4.3 NSS INFORMATION GOVERNANCE

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

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

Information governance covers the following:

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

2.4.4 INFORMATION AND COMMUNICATION

Communication within NSS is maintained through regular meetings, daily interactions, email, and regular electronic bulletins. NSS staff have access to an intranet and MS Teams which is leveraged currently in a distributed working pattern given the pandemic.

In respect of the services provided by P&CFS to our service users and their supporting professional bodies, direct communication is utilised routinely. Formal meetings (using MS Teams throughout this period due to the pandemic) are augmented with newsletters and wider publications on our internet site. P&CFS also undertakes monthly operational meetings with Scottish Government Primary Care Division and director level engagement every 8-12 weeks. Again, these meetings are supplemented by formal reporting and sharing of minutes and actions arising.

Internally, communications between DaS and P&CFS include the various governance groups already referenced with channels including face to face meetings, the inputs and outputs to those meetings, e.g. minutes, action trackers, performance and other reports.

2.5 IT SYSTEMS

The following IT systems fall within the scope of this service audit report and so the IT Services Report should be read in tandem with this document to such that a full picture is achieved:

System	Entities Responsible	Services Supported	Operating System	Database
General Medical Services (Primary Medical Services Payment System) PMSPS	Sopra Steria (application layer and database) Atos (operating system)	This calculates the monthly payments to GP Practices.	Solaris 11	Oracle 12c
General Pharmaceutical Services (DCVP)	Sopra Steria (application layer and database) Atos (operating system)	This system validates and values scripts submitted by dispensing contractors once or twice per month.	Solaris 8/10	Oracle 8/9
General Dental Services (MIDAS)	Sopra Steria (application layer and database) Atos (operating system)	Primary system for dental payments.	Solaris 11	Oracle 12c
General Ophthalmic Services (OPTIX)	Sopra Steria (application layer and database) Atos (operating system)	The main system used by GOS to calculate payments to contractors.	Solaris 11	Oracle 12c
eVadis	NSS (application, operating system and database)	eVadis is a pharmacy drug dictionary and contractors' database. Pricing information from eVadis is uplifted into DCVP monthly.	Solaris 10	Oracle 10.2.0.4

2.6 SUB-SERVICE ORGANISATIONS

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

System	Services Supported	Approach	Justification
NSS DaS	Atos provides managed technical services (including hardware and associated software), storage, application support and development. The control objectives applicable are: 1. Logical Access Management; 2. Physical Access Management; 3. Change Management; 4. Interface and Job Scheduling; 5. Third Party Risk Management; and 6. Incident and Problem Management. Atos provides managed Technical Services (including hardware and associated software); storage; application support and development. The control objectives applicable are: 1. Verification on completeness, validity and accuracy of General Medical Services	Carved-out Please refer to the IT Services Report for the testing performed on the Atos controls.	A material component of the service is outsourced to Atos as an IT infrastructure and service provider. Furthermore, the provisioning of the service from Atos is managed by NSS.

	payments; 2. Verification on completeness, validity and accuracy of General Pharmaceutical Services payments; 3. Verification on completeness, validity and accuracy of General Dental Services payments; 4. Verification on completeness, validity and accuracy of General Ophthalmic Services payments; and 5. Reports to NHS Boards and Scottish Government for all payment streams.		
NHS Ayrshire and Arran	The provision of the National Single instance eFinancials product utilised by P&CFS and NSS Payroll Team. The control objectives applicable are: 1. Verification on completeness, validity and accuracy of General Medical Services payments; 2. Verification on completeness, validity and accuracy of General Pharmaceutical Services payments; 3. Verification on completeness, validity and accuracy of General Dental Services payments; 4. Verification on completeness, validity and accuracy of General Ophthalmic Services payments; and 5. Reports to NHS Boards and Scottish Government for all payment streams.	Carved-out	NSS rely on the ISAE 3402 Independent Assurance report from NHS Ayrshire and Arran to provide assurance over the control objectives mentioned. The report covers the period between 1 April 2021 and 31 March 2022 which is the same period as this report.

2.7 COMPLEMENTARY USER ENTITY CONSIDERATIONS

The effectiveness of the controls relating to the services provided by P&CFS are enabled by our systems, provided by DaS. The control environment for DaS is also subject to Service Audit and the report on that area should be read in conjunction with this report.

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

Specific NHS Board responsibilities and controls include:

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

contractors are routed through Practitioner Services. This will help the expenditure analysis by Practitioner Services to reflect the actual net expenditure incurred and will help drive consistency with recovery of overpayments where Practitioner Services is the recovering body where it has made the payment under specific Regulations.

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

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

2.8 MANUALLY MAINTAINED POPULATIONS USED IN OPERATION OF CONTROLS

Certain control activities set out on Section 3 operate on an ad hoc basis, and system generated lists of populations could not be provided. The table below outlines each of the controls where completeness and accuracy of the populations could not be tested and alongside the reasons for these given the nature of transactions and how they are initiated.

Control Ref.	Control Description	Reason
1.2	**GP Practice Authorised Individuals** When GP Practice staff change, a revised mandate is sent by a member of the GP Practice staff to P&CFS. The mandate contains the names and signatures where available of GPs in the GP Partnership and those Practice staff authorised by the GP Partnership to submit claims and patient registration data on behalf of the GP Partnership to P&CFS. On receipt, the mandates are uploaded to Compass and are accessible for regional office staff to authenticate documents generated from GP Practices.	Changes are a result of a contractor altering or changes to contractor configurations which are by their nature ad hoc, external to P&CFS and do not lend themselves to being listed as a full population. However we do maintain mandates for every practice so all payments are verified against the latest mandate held and a payment would not be actioned unless it is from a signatory on the mandate, so any out of date mandates would be identified if claims were made by new staff members.
2.3	**GPS Payments Authorisation and Input to eFinancials** ***2.3a*** Payment instructions from an NHS Board including local NHS Board claims submitted monthly to the Pharmacy Payments team are: verified as authorised by verifying the signatory against the NHS Board's authorisation matrix; validated that they are not duplicate payments; input the verified data into the overall Kaizen Pharmacy	By their very nature, other claims are a result of contractor activity for the services provided or reimbursement for expenditure which are specific to individual contractors, external to P&CFS and do not lend themselves to being listed as a full population. However, we monitor NHS Board and

Control Ref.	Control Description	Reason
	Payment spreadsheet; and input into eFinancials for payment. The validation and input into eFinancials are reviewed for accuracy by a team member independent of the preparer. The completion of the review is evidenced through the annotation 'Certified correct for payment' on the Kaizen spreadsheet. ***2.3b*** For special payments initiated at the request of an NHS Board, the validation of authorisation and input into eFinancials are reviewed for accuracy by a team member independent of the preparer. The completion of the review is evidenced through the annotation 'Certified correct for payment' on the Special Payments documentation. For special payments initiated as a result of an internal check, the calculation performed by the National Finance Manager, Payment Lead or nominated Contractor Finance staff are reviewed by a team member independent of the preparer before processing payments in eFinancials. The completion of the review is evidenced by the annotation 'Checked By' on the Special Payments documentation. ***2.3c*** For ad hoc payments based on internal calculation by the National Finance Manager, Payment Lead or nominated Contractor Finance staff, the calculations are reviewed for accuracy by a team member independent of the preparer before processing the payments in eFinancials. The review is evidenced by the 'Checked By' annotation on the internally generated document.	contractor communications regarding errors and/or missing payments to verify the completeness of the claims.
2.8	**eFinancials Standing Data - Pharmacy Practices & Pharmacy Contractors** Amendments to Pharmacy Practices & Pharmacy Contractor Standing Data are advised to Contractor Finance by authorised NHS Board staff in respect of: new practice/ contractors; amendments to existing practice/ contractors; and cessation of practice/ contractors, input is checked independently of the inputter and evidenced on each document with 'Verified & Input By' and 'Checked By' signatures of the staff involved. The annotation 'Verified & Input By' is performed by one person whose role is to verify the NHS Board signatory validity and then input the verified data into eFinancials. The annotation 'Checked By' is the independent member of staff who has checked the input is accurate.	Changes are a result of a contractor altering or changes to contractor configurations which are by their nature ad hoc, external to P&CFS and do not lend themselves to being listed as a full population. If an error were to be made, the NHS Board or the practice would contact P&CFS querying the error.
2.9	**eFinancials Standing Data - Pharmacy Contractor Bank Account** Amendments to Pharmacy Contractor Bank Account Data are advised to Contractor Finance on receipt of a Pharmacy Contractor Bank Mandate or system generated report from the Bankers Automated Clearing Service (BACS) in respect of changes to existing contractor bank account details. BACS reports are actioned as notified by the Bank. On receipt of a Bank Mandate from an existing contractor, the stated current bank details are checked against the data currently held in eFinancials and if these agree, the new bank details are updated in eFinancials. For new contractors, the details on	Changes are a result of a contractor altering or changes to contractor configurations which are by their nature ad hoc, external to P&CFS and do not lend themselves to being listed as a full population. If an error were to be made, the NHS Board or the practice would contact P&CFS querying the error.

Control Ref.	Control Description	Reason
	the Pharmacy Contractor Bank Mandate are actioned following formal NHS Board notification of the new practice/ contractor details. Input is checked independently of the inputter and evidenced on each document with 'Verified & Input By' and 'Checked By' signatures of the staff involved. The annotation 'Verified & Input By' is performed by one person whose role is to verify the Bank Mandate validity and then input the data into eFinancials. The annotation 'Checked By' is the independent member of staff who has checked the input is accurate.	
3.2	**Verification, Calculation & Authorisation of Patient Refunds** Patient refund applications are received by the GDS Payment team from NHS BSA who confirms the exemption status. Patient refunds are calculated weekly by a member of the GDS CF Payment team and these are checked for accuracy independently by another member of the GDS CF Payment team. Patient refunds are authorised by the National Finance Manager, Senior Financial Analyst, Payment Lead or nominated Contractor Finance staff prior to being sent to NSS treasury for payment through the NSS Service Now portal.	By their very nature, patient refund claims are a result of patients seeking refunds for the payments they made for the services provided which are specific to individual patients, external to P&CFS and do not lend themselves to being listed as a full population. If P&CFS did not fulfil their duty of processing refunds, they would be made aware by an NHS Board, practice or patient through the complaints process, which is monitored.
3.3	**Payment Adjustment, non-payment and patient detail amendment claims** Adjustment/non-payment/patient detail amendment claims are logged on the adjustment spreadsheet / non-payment spreadsheet /patient detail amendment spreadsheet by a Customer Admin team member. Once completed, the claim forms are returned to the contractor with a comment of the outcome to explain the reason for the payment adjustment / non-payment / Patient detail amendment within 20 working days of receipt. Claims that have not been completed and returned to the contractor within 20 days are highlighted in the KPI spreadsheet for follow up in the weekly monitoring of volumes and turnaround carried out by the Operational Team Leader.	By their very nature, other claims are a result of practice activity for the services provided or reimbursement for expenditure which are specific to individual practices, external to P&CFS and do not lend themselves to being listed as a full population. However, we monitor NHS Board and Practice communications regarding errors and/or missing payments to verify the completeness of the claims.
4.3	**Verification, Calculation & Authorisation of Patient Refunds** Patient refund applications are received by the GOS Payment team from NHS BSA who confirms the exemption status. Patient refunds are calculated weekly by a member of the GOS CF Payment team and these are checked for accuracy independently by another member of the GOS CF Payment team. Patient refunds are authorised by the National Finance Manager, Senior Finance Analyst, Payment Lead or nominated Contractor Finance staff prior to being sent to NSS Treasury for payment through the NSS Service Now portal.	By their very nature, patient refund claims are a result of patients seeking refunds for the payments they made for the services provided which are specific to individual patients, external to P&CFS and do not lend themselves to being listed as a full population. If P&CFS did not fulfil their duty of processing refunds, they would be made aware by an NHS Board , practice or patient through the complaints process, which is monitored.

Control Ref.	Control Description	Reason
4.4	**Payment Adjustment, non-payment and patient detail amendment claims** Adjustment/non-payment/patient detail amendment claims are logged on the adjustment spreadsheet /non-payment spreadsheet /patient detail amendment spreadsheet by a Customer Admin team member. Once completed, the claim forms are returned to the contractor with a comment of the outcome to explain the reason for the adjustment/non-payment/patient detail amendment within 20 working days of receipt. Claims that have not been completed and returned to the contractor within 20 days are highlighted in the KPI spreadsheet for follow up in the weekly monitoring of volumes / turnaround carried out by the Operational Team Leader (TL).	By their very nature, other claims are a result of practice activity for the services provided or reimbursement for expenditure which are specific to individual practices, external to P&CFS and do not lend themselves to being listed as a full population. However, we monitor NHS Board and Practice communications regarding errors and/or missing payments to verify the completeness of the claims.

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

TESTS OF THE CONTROL ENVIRONMENT

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

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

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

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

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

DESCRIPTION OF TESTS PERFORMED

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

TEST PROCEDURE	DESCRIPTION
Enquiry	Enquired of appropriate NSS personnel who operate the control. Enquiries were used to obtain, among other things, knowledge and additional information about the control.
Inspection	Read documents, reports and electronic files that contain an indication of performance of the control. This includes, among other things, examining management reports, operational logs and other relevant documentation.
Observation	Observed the application of a specific control by NSS personnel. Observations are primarily performed where there is no documentary evidence of the operating effectiveness of the controls.

TESTS OF THE CONTROL ENVIRONMENT

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

3.1 GENERAL MEDICAL SERVICES PAYMENTS

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

Controls provide reasonable assurance that:

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

Control Ref.	Control Activity specified by NSS	Tests Performed by KPMG LLP	Results of Testing
Record of authorised individuals			
1.1	**NHS Board Authorised Individuals** Each financial year, NHS Board and Special Health Board Directors of Finance email P&CFS, a matrix of their personnel who can authorise: payments to contractors; and amendments to their contractor lists. On receipt, the matrices are uploaded to Compass and are accessible for regional office staff to authenticate documents generated from NHS Board and Special Health Board staff.	For a selection of NHS Boards, inspected the email correspondence with the P&CFS team and the Compass system and noted that: - the NHS Board had emailed P&CFS a matrix of their personnel who can authorise payments to contractors and make amendments to their contractor lists; and - the matrix had been uploaded to Compass. On a selection of dates, inspected the access configurations on the Compass system and noted that it had been accessible for regional office staff to authenticate documents generated from NHS Board and Special Health Board staff.	No exceptions noted.
1.2	**GP Practice Authorised Individuals** When GP Practice staff change, a revised mandate is sent by a member of the GP Practice staff to P&CFS. The mandate contains the names and signatures where available of GPs in the GP Partnership and those Practice staff authorised by the GP Partnership to submit claims and patient registration data on behalf of the GP Partnership to P&CFS. On receipt, the mandates are uploaded to Compass and are accessible for regional office staff to authenticate documents generated from GP Practices.	For a selection of revised mandates sent by members of the GP Practice staff to P&CFS, inspected the completed mandate and the Compass system noted that: - it contained the names and signatures where available of all GPs in the GP Partnership and those Practice staff authorised by the GP Partnership to submit claims and patient registration data on behalf of the GP Partnership to P&CFS such that claims could be accepted from GPs or staff who have submitted a signature; and - the mandates had been uploaded to Compass and had been accessible for regional office staff to authenticate documents generated from GP Practices. On a selection of dates, inspected the access configurations on the Compass system and noted that it had been accessible for regional office staff to authenticate documents generated from GP Practices.	No exceptions noted.

Payment rate/ formula/ pricing updates			
1.3	**GMS Contract Payment Rates** The Scottish Government (SG) controls the updates to existing payment rates and creation of new payments through the publication of the annual Statement of Financial Entitlements (SFE) and individual Primary Care Admin Medical (PCA(M)) circulars by publishing these on the SG web site: https://www.publications.scot.nhs.uk/ On publication of the SFE or PCA(M) circulars, that results in a change to an existing payment or creation of a new payment, the Primary Medical Services Payment System (PMSPS) is updated either by the National Finance Manager (NFM), Finance Services Manager (FSM), Payment Verification Lead, or nominated Contractor Finance staff with a document produced detailing the change created. This document notes who it was independently authorised and input by and then checked by.	For a selection of SFE or PCA(M) circulars published by the SG in the period, that resulted in changes to existing payments or creation of a new payment, inspected the document produced detailing the change created and the record on PMSPS system and noted that: - PMSPS had been updated either by the NFM, FSM, Payment Verification Lead, or nominated Contractor Finance staff; and - the document had noted who it had been independently authorised and input by and then checked by.	No exceptions noted.
Payment processing **GMS Payments Authorisation and Input to PMSPS** [Excludes: Global Sum Monthly Allocation (SWF); Temporary Patient Adjustment (TPA); Opted-out Services; Income and Expenses Guarantee (I&EG) which are included in GMS Contract Payment Rates]. There are five instances where payments are generated for input to PMSPS:			
1.4	***1.4a*** Contractor Finance staff validate payment instructions from NHS Boards by: - verifying the signatory against the NHS Board's Authorisation Matrix; and - verifying that the payment is not duplicate before inputting the verified data into PMSPS. The completion of the verification and validation is evidenced by annotations in the payment spreadsheet against 'Verified & Input by'. An independent team member reviews that the verification and validation is correct and the input is accurate and annotates the payment spreadsheet with 'Checked by' as evidence of the review.	For a selection of payments made as a result of payment instructions from an NHS Board, inspected the payment instruction, the source emails, the Board Authorisation Matrices and the payment spreadsheets and noted that Contractor Finance staff validated the payment instruction by: - verifying the signatory against the NHS Board's Authorisation Matrix; and - verifying that the payment is not duplicate before inputting the verified data into PMSPS. For the same selection of payments, inspected the payment spreadsheets and noted that they had been: - annotated with 'Verified & Input By' by one person who verified the NHS Board signatory and input the verified data into PMSPS; - reviewed by an independent member of staff that the verification and validation is correct and the input is accurate; and - annotated with 'Checked by' as evidence of the review.	No exceptions noted.

	1.4b Contractor Finance staff validate payment instructions from GP Practices by: - verifying the signatory against the GP Practice mandate; and - validating that the payments are not duplicate before inputting the verified data into PMSPS. The completion of the verification and validation is evidenced by annotations in the payment spreadsheet against 'Verified & Input by'. An independent team member reviews that the verification and validation of the payment instruction is correct and the input is accurate and annotates the payment spreadsheet with 'Checked by' as evidence of the review.	For a selection of payments made as a result of a payment instruction from GP Practices, inspected the payment instructions, the source emails, the Practice's authorisation matrices and the payment spreadsheets and noted that Contractor Finance staff validated the payment instructions by: - verifying the signatory against the GP Practice's authorisation matrix; - verifying that the payment is not duplicate before inputting the verified data into PMSPS; For the same selection of payments, inspected the payment spreadsheet and noted that they had been: - annotated with 'Verified & Input By' by one person who verified the GP Practice signatory and input the verified data into PMSPS; - reviewed by an independent member of staff that the verification and validation is correct and the input is accurate; and - annotated with 'Checked by' as evidence of the review.	No exceptions noted.
	1.4c (i) GRO - Rates / Water & Waste Invoices On receipt of the invoices relating to rates & reimbursements the Glasgow Regional Payment team check and mark the invoice with 'examined and found to be correct in all respects', this is then authorised by an independent team member signing. On completion the invoice is then signed independently as 'verified & checked' A batch summary is created for all the invoices, and this is annotated 'compiled by' and 'checked by' by independent team members. The invoices are then paid by sending on the details to Finance. The monthly invoice totals are recorded on a separate premises spreadsheet for the team's reference, and this is used as the basis for the upload into PMSPS as a payment on account, with the totals being independently marked as compiled by, verified by, input by and audit checked by.	For a selection of payments for an invoice relating to rates & reimbursements for the Glasgow region, inspected the processed invoice and noted that it had been: - checked and marked with 'examined and found to be correct in all respects' by the Glasgow Regional Payment team; - authorised and signed by an independent team member; and - signed independently as 'verified & checked' on completion. For the same selection of payments, inspected the batch summary records and noted that it had been: - created for the invoice; - annotated 'compiled by' and 'checked by' by independent team members.	No exceptions noted.

	The Payment on account is then subsequently balanced with the charge being assigned to the appropriate account element. The frequency of these payments for rates are generally annually in May whereas the water & waste payments are more ad hoc.	For the same selection of payments, inspected email records and the premises spreadsheet and the payment system noted that: - the invoice details had been sent to Finance; - the monthly invoice totals had been recorded on a separate premises spreadsheet for the team's reference, and had been used as the basis for the upload into PMSPS as a payment on account; - the totals had been independently marked as compiled by, verified by, input by and audit checked by; and - the payment on account had been balanced with the charge assigned to the account element.	
	1.4c (ii) ERO – Rates / Water & Waste Invoices Supplier invoices for rates / water & waste received by the Edinburgh Payment team are validated for duplicate payments by a team member before creating a BACS request. Completion of the validation is evidenced by the stamp 'Examined and found to be correct in all respects' on the invoice. BACS requests are authorised by an independent team member. Reviewed payment requests are added to a Reimbursement & Payment on Account spreadsheet, and are reviewed for accuracy by an independent team member and authorised by the Health Board. Health Board Validation and authorisations are evidenced by signatures against 'prepared by' and 'reviewed by' annotations on the spreadsheet. Authorised payment requests are added to PMSPS as Payments on Account and are reviewed for accuracy by an independent team member and are evidenced by signatures against 'verified by' and 'checked by' annotations on the spreadsheet.	For a selection of payments for invoices relating to rates / water & waste for the Edinburgh region, inspected the processed invoices and the BACS requests and noted that: - the Edinburgh Payment team had validated the invoice for duplicate payments; - the invoice had been stamped with 'examined and found to be correct in all respects' on the invoice; and - a BACS request had been created and it had been signed independently as payment authorised. For the same selection of payments, inspected the Reimbursement & Payment on Account spreadsheets and noted that: - the reviewed payment request had been added to the spreadsheet; - it had been reviewed for accuracy by an independent team member; - it had been authorised by Health Board; and - the spreadsheet had been annotated with 'prepared by' and 'reviewed by' to evidence the validation and authorisations.	No exceptions noted.

		For a selection of payments for invoices relating to rates / water & waste for the Edinburgh region, inspected the Reimbursement & Payment on Account spreadsheets and noted that: - the authorised payment request had been added to PMSPS as Payment on Account; - it had been reviewed for accuracy by an independent team member; and - the spreadsheet had been annotated with 'verified by' and 'checked by' to evidence the review.	
	1.4c (iii) ERO – Water/Waste Practice Reimbursements On receipt of invoices from the practice which they have paid, the Edinburgh Payment team check against previous invoices and then add to the board spreadsheet. The spreadsheet is sent to the health board and notes 'prepared by', the board then respond authorising and this is then added to the sheet. (FV have the independent 'prepared by' and then 'reviewed by' before it is sent to the board). The payment is then added to PMSPS with the independent 'verified by' and 'checked by' notation on the spreadsheet. These payments are ad hoc.	For a selection of payments for invoices relating to water / waste practice reimbursements for the Edinburgh region, inspected the Board spreadsheet and noted that: - the Edinburgh Payment team had checked the invoice against prior invoices and added them to the Board spreadsheet; - the spreadsheet had been annotated with 'prepared by'; the spreadsheet had been authorised by Health Board; and - the spreadsheet had been annotated with the independent 'verified by' and 'checked by' once the payment had been added to the PMSPS system.	No exceptions noted.
	1.4d For payments made as a result of internal calculations, the summary totals from the calculation are added to a bulk upload template by a Contractor Finance team member. The calculations and subsequent totals to be paid are reviewed for completeness and accuracy by the National Finance Manager, Finance Services Manager or nominated Contractor Finance staff independent of the preparer. Completion of the review is evidenced by the annotations 'Calculated & Input by' and then 'Checked by' on the spreadsheet.	For a selection of payments that resulted from internal calculations, inspected the bulk upload templates to determine whether: - the summary totals from the calculation had been added to it by a Contractor Finance team member; - the calculations and subsequent totals to be paid had been reviewed for completeness and accuracy by the National Finance Manager independent of the preparer; and - they had been annotated with 'Calculated & Input by' and with 'Checked by' to evidence the completion of the review.	**Exceptions noted:** For two out of five payments that resulted from internal calculations it could not be evidenced that the calculations selected and subsequent totals to be paid had been reviewed by a team member independent of the preparer.
Management response: A review was carried out as soon as the auditors highlighted this exception to us. On review, it was clear that the checks had been carried out correctly but that in these two instances, the team member used their post title / role rather than actual name. This meant it was not possible for the auditors to verify that the check was completed by a team member independent of the preparer. The risk associated with this exception is low. However, the team were briefed immediately and guidance tightened to ensure individuals use their names and not post titles on all subsequent preparation and checks.			

	1.4e For new / estimated general practitioner payments where practice claims are received for Enhanced Services that are less than the historic monthly totals, a monthly reconciliation is performed by the Financial Services Manager between historic figures and the claim totals to derive a top up amount for the Practices. The reconciliation is reviewed by another member of the medical payment team or the National Finance Manager and evidenced through the 'calculated and input by' and 'checked by' annotations on the payment calculation spreadsheet.	For a selection of new / estimated general practitioner payments, inspected the monthly payment calculation spreadsheets and noted that: - the Financial Services Manager had carried out the reconciliation between historic figures and the claim totals to derive a top up amount for the Practices; - the reconciliations had been reviewed by another member of the medical payment team or the National Finance Manager; and - the spreadsheets had been annotated with 'calculated and input by' and 'checked by' to evidence the reconciliation and review.	No exceptions noted.
Reconciliation & Checking			
1.5	**Month-end PMSPS Payment Reconciliation** At the end of each month and before payments are approved in PMSPS, a Contractor Finance payment approver performs a reconciliation between the source documentation and the PMSPS Organisational Summary Statement and the Creditors Payment Report to verify the accuracy of the amounts and to confirm that no duplicate payments have been made and checks and balances have been completed prior to finally approving the payment in PMSPS. Evidence of this reconciliation is documented by the payment approver completing, signing and dating the template 'End of Payment Control Checklist' which is filed by payment month in the digital payment folder for each NHS Board.	For a selection of months and Boards, inspected the End of Payment Control Checklist and noted that: - at the end of the month and before payments had been approved in PMSPS, a Contractor Finance payment approver had performed a reconciliation between the source documentation and the PMSPS Organisational Summary Statement and the Creditors Payment Report to verify the accuracy of the amounts and to confirm that no duplicate payments had been made and checks and balances had been completed prior to finally approving the payment in PMSPS; - the approver had completed, signed and dated the 'End of Payment Control Checklist'; and - the checklist has been filed by payment month in the digital payment folder for the NHS Board.	No exceptions noted.

1.6	**Global Sum Calculation & Variance Checks** On a quarterly basis, the Finance Services Manager (FSM) or National Finance Manager performs a quarterly comparison of the current Global Sum payment amounts with the previous quarter by reviewing the comparison template created based on the SWF quarterly shares. Where a +/- 5% difference is identified, the variances are investigated by the Regional Registration Manager, the National Finance Manager or Financial Analyst Specialist. The email correspondence and supporting evidence of the investigation and findings is retained with the weighted movements captured in the SWF quarterly comparison template.	For a selection of quarters, inspected the documentation of the quarterly comparison of the current Global Sum payment and noted that: - a comparison of the current Global Sum payment amounts with the previous quarter had been performed by the Finance Services Manager (FSM) by reviewing the comparison template created based on the SWF quarterly shares; - where a +/- 5% variance identified, it was investigated by the Regional Registration Manager, the National Finance Manager or Financial Analyst Specialist; and - the email correspondence and supporting evidence of the investigation and findings had been retained with the weighted movements captured in the SWF quarterly comparison template.	No exceptions noted.
Contractor Standing Data Updates			
1.7	**PMSPS Standing Data - GP Practices & GP Contractors** Amendments to PMSPS GP Practice & GP Contractor Standing Data are advised by email to P&CFS regional offices from authorised NHS Board staff in respect of: new GP practice/ contractors; amendments to existing GP practice/ contractors; and cessation of GP practice/ contractors. It is first checked that the amendment comes from an authorised signatory. The input is then checked independently of the inputter and evidenced on each document with 'Verified & Input By' and 'Checked By' signatures of the staff involved. The inputter signature is the confirmation that the advisor is valid and the amendments have been input to the payment system.	For a selection of amendments to PMSPS GP Practice & GP Contractor standing data, inspected the email correspondence from the Boards, the amendment instruction and the PSMPS and noted that: - the amendment to standing data had been emailed to P&CFS regional offices from authorised NHS Board staff; - staff had checked for authorised signatory, input the amendment into the payment system and had signed off the instruction with 'Verified & Input By' to evidence the validation and input; and - the input had been checked independently of the inputter and evidenced on the document with and 'Checked By'.	No exceptions noted.

1.8	**PMSPS Standing Data - GP Practice Bank Account** Amendments to PMSPS Contractor Bank Account Standing Data are advised by completion of a GP Practice Bank Mandate from GP Practices or system generated report from the Bankers Automated Clearing Service (BACS) in respect of bank account changes. The input is checked independently of the inputter and evidenced on each document with 'Input By' and 'Checked By' signatures of the staff involved. The inputter signature is the confirmation that the advisor is valid and the amendments have been input to the payment system and checked against the mandate.	For a selection of amendments to PMSPS Contractor Bank Account standing data, inspected the GP Practice Bank Mandates or BACS system generated report and the PSMPS and noted that: - a completed GP Practice Bank Mandate from GP Practices or a BACS system generated report had been provided for the amendment; - staff had verified that the adviser is valid and input the amendment into the system and annotated the instruction to evidence the input; and - the input had been independently checked by another member of staff who had signed off the instruction with 'Checked By' to evidence the check.	No exceptions noted.
1.9	**PMSPS and CHI Contractor Detail Reconciliation** When the quarterly CHI file fails to load, the Finance Services Manager (FSM) reviews the discrepancies identified by AOA as a result of the automated reconciliation of contractors' data from the PMSPS system against the CHI system. The resolution process is an exchange of emails that are saved within the Global Sum digital directory.	For a selection of quarters, inspected the fail notification, email communications and the Global Sum digital directory and noted that: - when the CHI file failed to load, the FSM had reviewed the discrepancies identified by the AOA as a result of the automated reconciliation of contractors' data from the PMSPS system against the CHI system; and - the discrepancies had been resolved and the email exchanges had been saved within the Global Sum digital directory.	No exceptions noted.
Scottish Government Guidance verification			
1.10	**GMS Payment Verification (PV)** The National Finance Manager and PV Lead produce a schedule of PV work to be undertaken by the PV team in accordance with the Payment Verification Protocol guidance published by the Scottish Government Findings from the PV work undertaken on contractor payments are reported to the respective NHS Boards and where appropriate to the relevant contractor by Contractor Finance.	Enquired of management to determine whether PV work had been undertaken within the period.	Payment verification work had been suspended for the period 1 April 2021 - 31 March 2022 as explained in section 2.2.3 of Management's Description. Consequently, we were unable to test the design, implementation and operating effectiveness could not be performed for this control.

3.2 GENERAL PHARMACEUTICAL SERVICES PAYMENTS

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

Controls provide reasonable assurance that:

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

Control Ref.	Control Descriptions specified by NSS	Tests Performed by KPMG LLP	Results of Testing
Payment rate/formula/pricing updates			
2.1	**GPS Contract Payment Rates, Fees & Allowances** The Scottish Government (SG) controls the updates to existing payment rates and creation of new payments through the publication of individual Primary Care Admin Pharmacy (PCA(P)) circulars by publishing these on the SG web site: https://www.publications.scot.nhs.uk/ On publication of the PCA(P) circulars P&CFS staff advise the Data Driven and Innovation (DDI) Prescribing team in Public Health Scotland (PHS) of the details. A member of the DDI Prescribing team then updates the eVadis system and the input is checked independently of the person updating eVadis.	Inspected the list of PCA(P) circulars to determine whether there had been any updates to existing payment rates or creation of new payments within the period.	No exceptions noted. There had been no Scottish Government (SG) circulars providing updates to existing payment rates and creation of new payments. Consequently, we could not test the design, implementation and operating effectiveness of this control.
Review for payments validity			
2.2	**Prescription and stock order claims** Scanned by the Document Handling Team based at Bain Square, the DCVP system is populated monthly with prescription and stock order claim forms, each supported by a GP34 batch declaration from a registered pharmacy, dispensing doctor or appliance supplier. The paper prescription and stock order claims are scanned and retained for three months. The evidence is held in the Bain Square Document Handling department and Stock Room.	For a selection of months, inspected the DCVP system and noted that it had been populated with prescription and stock order claims. For a selection of claim order forms, inspected the GP34 batch declaration and noted that the claim forms had been supported by a batch declaration from a registered pharmacy, dispensing doctor or appliance supplier.	No exceptions noted.

Payment Processing			
2.3	**GPS Payments Authorisation and Input to eFinancials** ***2.3a*** Payment instructions from an NHS Board including local NHS Board claims submitted monthly to the Pharmacy Payments team are: - verified as authorised by verifying the signatory against the NHS Board's Authorisation Matrix; - validated that they are not duplicate payments; - input the verified data into the overall Kaizen Pharmacy Payment spreadsheet; and - input into eFinancials for payment. The validation and input into eFinancials are reviewed for accuracy by a team member independent of the preparer. The completion of the review is evidenced through the annotation 'Certified correct for payment' on the Kaizen spreadsheet.	For a selection of months and NHS Boards, inspected the Kaizen Pharmacy Payment spreadsheets related to payment instructions and claims submitted to the Pharmacy Payments team by NHS Boards including local NHS Boards, and noted that the team had: - verified the payment instructions / claims as authorised by verifying the signatory against the NHS Board's Authorisation Matrix; - validated that they are not duplicate payments; - input the verified data into the overall Kaizen Pharmacy Payment spreadsheet; - input into eFinancials for payment; - the validation and input into eFinancials had been reviewed for accuracy by a team member independent of the preparer; and - it had been annotated with 'Certified correct for payment' to evidence the completion of the review.	No exceptions noted.
	2.3b For special payments initiated at the request of an NHS Board, the validation of authorisation and input into eFinancials are reviewed for accuracy by a team member independent of the preparer. The completion of the review is evidenced through the annotation 'Certified correct for payment' on the Special Payments documentation. For special payments initiated as a result of an internal check, the calculation performed by the National Finance Manager, Payment Lead or nominated Contractor Finance staff are reviewed by a team member independent of the preparer before processing payments in eFinancials. The completion of the review is evidenced by the annotation 'Checked By' on the Special Payments documentation.	For a selection of special payments initiated at the request of NHS Boards, inspected the Special Payments documentation and noted that: - the validation of authorisation and input into eFinancials had been reviewed for accuracy by a team member independent of the preparer; - the documentation had been annotated 'Certified correct for payment' to evidence the completion of the review. For a selection of special payments resulting from internal checks, inspected the Special Payments documentation and noted that: - the calculation performed by the National Finance Manager, Payment Lead or nominated Contractor Finance staff had been reviewed by a team member independent of the preparer before processing payments in eFinancials; and - the documentation had been annotated with 'Checked By' to evidence the completion of the review.	No exceptions noted.

	2.3c For ad hoc payments based on internal calculation by the National Finance Manager, Payment Lead or nominated Contractor Finance staff, the calculations are reviewed for accuracy by a team member independent of the preparer before processing the payments in eFinancials. The review is evidenced by the 'Checked By' annotation on the internally generated document.	For a selection of ad hoc payments based on internal calculations, inspected the internally generated document and noted that: - the calculation performed by the National Finance Manager, Payment Lead or nominated Contractor Finance staff had been reviewed by a team member independent of the preparer before processing payments in eFinancials; and - the document had been annotated with 'Checked By' to evidence the completion of the review.	No exceptions noted.
Review for payment completeness, accuracy and duplicates			
2.4	**Variance analysis** Payment Variance analysis compares the DCVP net amount to be paid in the month against the same amount from the previous month. The Pharmacy Payment team review these figures and differences that exceed 50% are further investigated to verify their accuracy. The monthly reports are annotated.	For a selection of months, inspected the monthly reports and noted that the Pharmacy Payment team had: - performed a Payment Variance analysis to compare the DCVP net amount to be paid in the month against the same amount from the previous month; - reviewed and investigated the figures and differences that exceed 50% to verify their accuracy; and - annotated the reports.	No exceptions noted.
2.5	**Pharmacy First Payments** On a monthly basis, and before Pharmacy First payments are made, the Patient Registration team checks that the payment schedule has been updated for new and closed contractors. The check is annotated on the file copy. Two *.csv files, PFirstBase and PFirstAct, are then emailed by the Patient Registration team to nss.psdspsaa@nhs.scot for them to be uploaded to DCVP.	1 April 2021 to 31 July 2021 For a selection of months, inspected the records of checks made by the Patient Registration team to determine whether the team had checked that the payment schedule had been updated for new and closed contractors. 1 August 2021 to 31 March 2022 For a selection of months, inspected records of checks made by the Patient Registration team and email correspondence with the psdspsaa mailbox and noted that the Patient Registration team had: - checked that the payment schedule had been updated for new and closed contractors before Pharmacy First payments had been made; - annotated the check on the file copy; and - emailed the two *.csv files PFirstBase and PFirstAct to nss.psdspsaa@nhs.scot for them to be uploaded to DCVP.	**Exception noted:** 1 April 2021 to 31 July 2021 For four out of four months selected, it could not be evidenced that the Patient Registration team checked that the payment schedule had been updated for new and closed contractors. 1 August 2021 to 31 March 2022 No exceptions noted.

Management response: A review was carried out as soon as the auditors highlighted this exception to us. On review, it was found that this had been a new control for 2021-22 following the introduction of a new Pharmacy First Scheme and that the control had been carried out but not evidenced. The risk is assessed as low. We used this as a quality improvement intervention, ensuring all team members were immediately briefed to ensure full understanding of the new control measure and the importance of it being evidenced. This improvement process was successful with no further exceptions being found during subsequent audit testing.			
2.6	**Prescriptions Reconciliation** On a monthly basis, the Document Handling team: - reviews the contractors for whom prescription forms were received for each NHS Board in the batch headers (GP 34 batch declarations) and the number of forms that have been scanned onto the DCVP system to confirm the completeness of the number of prescription forms processed on the system; and - generates the End of Month report to evidence the review and the corrections made and store it in the Scanning Department folder.	For a selection of months and NHS Boards, inspected the records of the review by the Document Handling team and the Scanning Department folders and noted that the Document Handling team: - had reviewed the contractors for whom prescription forms were received for the NHS Board in the batch headers and the number of forms that had been scanned onto the DCVP system to confirm the completeness of the number of prescription forms processed on the system; - generated the End of Month report to evidence the review and the corrections made; and - stored the report in the Scanning Department folder.	No exceptions noted.
2.7	**High Value Payments Review** On a monthly basis, post payment, the Adjustment team produce a report detailing individual item payments in excess of £500. To verify the accuracy of manually keyed items reported against the individual script from contractors, the adjustment team confirm correct item and quantity have been processed. This is checked and verified by a second adjustment team member and the report is annotated by both. Errors identified as a result of the review are corrected by way of an adjustment by the Adjustment team.	For a selection of months, inspected the report produced by the Adjustments team and noted that: - the report detailed individual item payments in excess of £500; - the Adjustment team had confirmed that the correct item and quantity had been processed to verify the accuracy of manually keyed items reported against the individual script from contractors; - the review had been checked and verified by a second Adjustment team member; and - the report is annotated by both. For a selection of errors identified as a result of the review, inspected the payment system and noted that they had been corrected by way of an adjustment by the Adjustment team.	No exceptions noted.

Contractor Standing Data Updates			
2.8	**eFinancials Standing Data - Pharmacy Practices & Pharmacy Contractors** Amendments to Pharmacy Practices & Pharmacy Contractor Standing Data are advised to Contractor Finance by authorised NHS Board staff in respect of: new practice/ contractors; amendments to existing practice/ contractors; and cessation of practice/ contractors, input is checked independently of the inputter and evidenced on each document with 'Verified & Input By' and 'Checked By' signatures of the staff involved. The annotation 'Verified & Input By' is performed by one person whose role is to verify the NHS Board signatory validity and then input the verified data into eFinancials. The annotation 'Checked By' is the independent member of staff who has checked the input is accurate.	For a selection of amendments to Pharmacy Practices & Pharmacy Contractor Standing Data on the eFinancials system, inspected the amendment instruction document and noted that: - a Contractor Finance staff had verified the validity of the NHS Board signatory and input the amendment into eFinancials; - an independent member of staff had checked that the input had been accurate; and - the document had been annotated with 'Verified & Input By' and 'Checked By' signatures of the staff involved.	No exceptions noted.
2.9	**eFinancials Standing Data - Pharmacy Contractor Bank Account** Amendments to Pharmacy Contractor Bank Account Data are advised to Contractor Finance on receipt of a Pharmacy Contractor Bank Mandate or system generated report from the Bankers Automated Clearing Service (BACS) in respect of changes to existing contractor bank account details. BACS reports are actioned as notified by the Bank. On receipt of a Bank Mandate from an existing contractor, the stated current bank details are checked against the data currently held in eFinancials and if these agree, the new bank details are updated in eFinancials. For new contractors, the details on the Pharmacy Contractor Bank Mandate are actioned following formal NHS Board notification of the new practice/ contractor details. Input is checked independently of the inputter and evidenced on each document with 'Verified & Input By' and 'Checked By' signatures of the staff involved. The annotation 'Verified & Input By' is performed by one person whose role is to verify the Bank Mandate validity and then input the data into eFinancials. The annotation 'Checked By' is the independent member of staff who has checked the input is accurate.	For a selection of amendments to Pharmacy Contractor Bank Account Data on the eFinancials system advised via BACS, inspected the system and noted that these had been actioned. For a selection of amendments Pharmacy Contractor Bank Account Data on the eFinancials system for existing contractors, inspected the Pharmacy Contractor Bank Mandate and noted that: - the amendment was advised to Contractor Finance via a Pharmacy Contractor Bank Mandate; - staff had checked that the data held in eFinancials agreed with the stated data and updated the new bank details; - an independent member of staff had checked that the input had been accurate; and - the document had been annotated with 'Verified & Input By' and 'Checked By' signatures of the staff involved. For a selection of amendments to Pharmacy Contractor Bank Account Data on the eFinancials system for new contractors, inspected the Board notification and the Pharmacy Contractor Bank Mandate and noted that: - the amendment had been advised to Contractor Finance via a NHS Board notification of the new practice/ contractor details;	No exceptions noted.

		- staff had checked that the data held in eFinancials agreed with the stated data and updated the new bank details; - an independent member of staff had checked that the input had been accurate; and - the document had been annotated with 'Verified & Input By' and 'Checked By' signatures of the staff involved.	No exceptions noted.
Scottish Government Guidance verification			
2.10	**GPS Payment Verification (PV)** The National Finance Manager and PV Lead produce a schedule of PV reviews in accordance with the Payment Verification Protocol published by the Scottish Government. Findings from the PV work undertaken on contractor payments are reported to the respective NHS Health Boards and where appropriate to the relevant contractor by Contractor Finance.	For a selection of quarters, inspected the schedule of PV reviews and the email correspondence with the NHS Health Board and noted that the National Finance Manager and PV Lead had produced a schedule of PV reviews in accordance with the Payment Verification Protocol published by the Scottish Government and the findings from the PV work undertaken on contractor payments had been reported to the Board.	No exceptions noted.

3.3 GENERAL DENTAL SERVICES PAYMENTS

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

Controls provide reasonable assurance that:

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

Control Ref.	Control Descriptions specified by NSS	Tests Performed by KPMG LLP	Results of Testing
Payment rate/formula/pricing updates			
3.1	**GDS Contract Payment Rates** The Scottish Government (SG) controls the updates to existing payment rates and creation of new payments through the publication of individual Primary Care Admin Dental (PCA(D)) circulars by publishing these on the SG web site: https://www.publications.scot.nhs.uk/ On publication of the PCA(D) circulars, the updates are logged by the Operations Manager or Operational Team Leaders in an excel spreadsheet and checked for completion and accuracy by an independent member of P&CFS staff. An extract from the excel spreadsheet is sent to Business Test and Support who load the data into the live MIDAS system, and the successful upload to live is checked for completion and accuracy by an independent member of P&CFS staff. This is documented in the SDR sign off sheet.	For a selection of PCA(D) circulars, inspected the SOR sign off sheet and noted that: - the update had been logged by the Operations Manager or Operational Team leaders in an excel spreadsheet and checked for completion and accuracy by an independent member of P&CFS staff; and - the successful upload to live had been checked for completion and accuracy by an independent member of P&CFS staff and had been documented in the SDR sign off sheet.	No exceptions noted.

Review for payments validity			
3.2	**Verification, Calculation & Authorisation of Patient Refunds** Patient refund applications are received by the GDS CF Payment team from NHS BSA who confirms the exemption status. Patient refunds are calculated weekly by a member of the GDS CF Payment team and these are checked for accuracy independently by another member of the GDS CF Payment team. Patient refunds are authorised by the National Finance Manager, Senior Financial Analyst, Payment Lead or nominated Contractor Finance staff prior to being sent to NSS treasury for payment through the NSS Service Now portal.	For a selection of patient refund applications received by the GDS Payment team, inspected the application form, weekly calculations, refund authorisations and the payment system and noted that: - the exemption status of the refund had been confirmed by NHS BSA; - the patient refund had been calculated within the weekly calculations by a member of the GDS CF Payment team; - the calculations had been checked for accuracy by another member of the GDS CF Payment team; and - the refunds had been authorised by the National Finance Manager, Senior Financial Analyst, Payment Lead or nominated Contractor Finance staff prior to being sent to NSS treasury for payment through the NSS Service Now portal.	No exceptions noted.
Return of invalid claims			
3.3	**Payment Adjustment, non-payment and patient detail amendment claims** Adjustment/non-payment/patient detail amendment claims are logged on the adjustment spreadsheet / non-payment spreadsheet /patient detail amendment spreadsheet by a Customer Admin team member. Once completed, the claim forms are returned to the contractor with a comment of the outcome to explain the reason for the payment adjustment / non-payment / Patient detail amendment within 20 working days of receipt. Claims that have not been completed and returned to the contractor within 20 days are highlighted in the KPI spreadsheet for follow up in the weekly monitoring of volumes and turnaround carried out by the Operational Team Leader.	For a selection of adjustment / non-payment /patient detail amendment claims, inspected the completed claim form, the adjustment / non-payment /patient detail amendment spreadsheet and the email correspondence and noted that: - the claim had been logged on the spreadsheet by a Customer Admin team member; and - the completed claim form had been returned to the contractor with a comment of the outcome to explain the reason for the payment adjustment within 20 working days of receipt. For a selection of weeks, inspected the KPI spreadsheet and noted that claims that had not been completed and returned to the contractor within 20 days had been highlighted in the KPI spreadsheet for follow up in the weekly monitoring of volumes and turnaround carried out by the Operational Team Leader.	No exceptions noted.

Payment Processing			
3.4	**GDS Payments Authorisation and Input to MIDAS** ***3.4a*** Contractor Finance staff validate payment instructions from NHS Boards by: - verifying the signatory against the NHS Board Authorisation Matrix; - verifying that the payment is not duplicate payments before processing GDS payments. Completion of the validation and verification is evidenced by annotations in the payment spreadsheet against 'Verified & Input By'. An independent team member reviews the verification and validation is correct and the input into MIDAS is accurate and annotates the payment spreadsheet with 'Checked By' as evidence of the review.	For a selection of payments made as a result of payment instructions from an NHS Board, inspected the payment instruction, the source emails, the Board authorisation matrices and the payment spreadsheets and noted that Contractor Finance staff validated the payment instruction by: - verifying the signatory against the NHS Board's Authorisation Matrix; and - verifying that the payment is not duplicate before processing GDS payments. For a selection of payments made as a result of a payment instructions from an NHS Board, inspected the payment spreadsheets and noted that they had been: - annotated with 'Verified & Input By' by one person who verified the NHS Board signatory and input the verified data into MIDAS; - reviewed by an independent member of staff that the verification and validation is correct and the input is accurate; and - annotated with 'Checked by' as evidence of the review.	No exceptions noted.
	3.4b Payment instructions from a Dental Contractor are validated by Contractor Finance staff by: - validating the Dental Contractor's eligibility by verifying the signatory against the Practitioner Services Delegated Authority Matrix; and - checking that the payment is not duplicate before calculating the payment due and inputting the payment into MIDAS. A team member independent from the preparer, reviews the calculation and input into MIDAS for accuracy and evidences the review by annotating the payment spreadsheet with 'Checked By'.	For a selection of payments made as a result of a payment instruction from Dental Contractors, inspected the payment instructions and the payment spreadsheets and noted that Contractor Finance staff validated the payment instructions by: - verifying the signatory against the Practitioner Services Delegated Authority Matrix; and - verifying that the payment is not duplicate before inputting the verified data into MIDAS. For a selection of payments made as a result of a payment instructions from Dental Contractors, inspected the payment spreadsheet and noted that they had been: - reviewed by an independent member of staff that the verification and validation is correct and the input is accurate; and - annotated with 'Checked by' as evidence of the review.	No exceptions noted.

	3.4c For payments made as a result of internal calculations by the National Finance Manager or nominated Contractor Finance staff: - the preparer checks that the payment is not duplicate; - a Contractor Finance team member different from the preparer reviews the payment calculations for accuracy; - an authoriser different from the reviewer signs off the calculations. The completion of the validation, review of accuracy of the calculation and the authorisation are evidenced through the annotations 'Prepared By', 'Checked By' and 'Authorised By' in the payment spreadsheet.	For a selection of payments that resulted from internal calculations, inspected the payment spreadsheet and noted that: - the preparer had checked that the payment was not duplicate; - a Contractor Finance team member the different from the preparer had reviewed the calculations for accuracy; - an authoriser different from the reviewer had signed off the calculations; and - they had been annotated with 'Prepared By', 'Checked by' and with 'Authorised By' to evidence the completion of the review and sign off.	No exceptions noted.
Contractor Standing Data Updates			
3.5	**MIDAS Standing Data - Dental Practices & Dental Contractors** Amendments to MIDAS Standing Data are advised to the Customer Admin team by authorised NHS Board staff in respect of: new practice/ contractors; amendments to existing practice/ contractors and resignation of practice/ contractors by submission of a GP21A form. The annotation 'Verified & Input By' is performed by one person whose role is to verify that the NHS Board signatory is on the NHS Board authorisation matrix (this is logged on the GP21a spreadsheet by the verified by person), if not on the NHS Board authorisation matrix, the GP21A is returned to the Health Board with no action taken, and valid GP21A requests are then input into MIDAS (this is logged on the GP21a spreadsheet by the 'input by' person). On the GP21A form at part 2 the verifier /inputter signs and dates that part to show the request has been completed. A sample of each day's cases are checked during the month, using the D&O sampling plan table. The annotation 'Checked By' is the independent member of staff who has checked the input is accurate (this is logged on the GP21a spreadsheet by the checked by person).	For a selection of amendments to MIDAS Standing Data, inspected the GP21A form and noted that a GP21A form had been submitted by authorised NHS Board staff in respect of new practice/ contractors; amendments to existing practice/ contractors; and resignation of practice/ contractors. For the same selection of amendments, inspected the GP21 spreadsheets and the completed GP21A forms and noted that: - staff had verified that the NHS Board signatory is on the NHS Board authorisation matrix; - where the request had not passed the validation, no action had been taken; - input valid requests into MIDAS; - signed and dated the GP21A form at part 2 the to show the request has been completed; and - an independent member of staff who has checked the input is accurate. For a selection of dates, inspected the GP21 spreadsheets and noted that a sample of each day's cases had been checked during the month using the D&O sampling plan table.	No exceptions noted.

3.6	**eFinancials Standing Data - Dental Contractor Bank Account** Amendments to eFinancials Standing Data are advised to Contractor Finance on receipt of a Dental Contractor Bank Mandate or system generated report from the Bankers Automated Clearing Service (BACS) in respect of bank account changes. On receipt of a Bank Mandate, the contractor is contacted and asked to confirm the change is valid. This is logged on a control spreadsheet. Input is independently checked and evidenced on the spreadsheet with 'Input By' and 'Checked By'. The annotation 'Input By' is performed by one person whose role is to input the data into eFinancials. The annotation 'Checked By' is the independent member of staff who has checked for accuracy. The authorisations are approved and recorded within eFinancials.	For a selection of amendments to eFinancials, inspected the system and the Dental Contractor Bank Mandate or system generated report from BACS and the control spreadsheet and noted that: - the amendment had been advised to Contractor Finance via a Dental Contractor Bank Mandate or system generated BACS report; - staff had contacted the contractor to confirm the change was valid; - an independent member of staff had checked that the input had been accurate; - the control spreadsheet had been annotated with document had been annotated with 'Input By' and 'Checked By' signatures of the staff involved; and - the authorisations had been approved and recorded within eFinancials.	No exceptions noted.
Patient list updates			
3.7	**Patient removal and review** Customer Admin team checks that the request for patient removal is supported by a signed GP200 form before the removal is processed. The Customer Admin team check that the patient is registered with the dentist on the GP200 against MIDAS records before removal, if not registered with the dentist but registered with another dentist in the same practice the GP200 is returned to the Health Board, if not registered with the dentist but registered with another dentist in another practice, no action is taken. a) The Customer Admin team process completion of the removal requests to remove patients accordingly: current / future month requests are completed within the month the patient is to be withdrawn. b) Retrospective requests are completed within the schedule month they are batched in view of receipt.	For a selection of patient removals, inspected the signed GP200 form, the batch headers and noted that the Customer Admin team: - had checked that the request for patient removal was supported by a signed GP200 form before the removal had been processed. - had check that the patient was registered with the dentist on the GP200 against MIDAS records before removal; and - had completed the removal requests to remove patients within the month the patient was to be withdrawn where the requests were for the same or future months and within the scheduled month for retrospective requests.	No exceptions noted.

Scottish Government Guidance verification			
3.8	**GDS Payment Verification (PV)** The National Finance Manager and PV Lead produce a schedule of PV reviews in accordance with the Payment Verification Protocol published by the Scottish Government. Findings from the PV work undertaken on contractor payments are discussed with the NHS Board in quarterly PV meetings and the outcome communicated to contractor in question, where appropriate.	Enquired of management to determine whether PV work had been undertaken within the period.	Payment verification work had been suspended for the period 1 April 2021 - 31 March 2022 as explained in section 2.2.3 of Management's Description. Consequently, we were unable to test the design, implementation and operating effectiveness could not be performed for this control.
3.9	**Monthly Payment Samples** Before each monthly payment is made, the amounts to be paid in MIDAS for a sample of three contractors are checked against the SDR by a D&O member of staff. Any issues noted to Test and Support team including any duplicate payment errors, are followed up and resolved prior to payment.	For a selection of months, inspected the records of sample checking and the payment schedule for the month and noted that the amounts to be paid in MIDAS for a sample of three contractors had been checked against the SDR by a D&O member of staff before the monthly payment had been made. Inspected the results of the monthly sample checks to determine whether there had been any issues noted to Test and Support team including any duplicate payment errors, to follow up and resolve prior to payment.	No exceptions noted. There had been no issues noted to the Test and Support team including any duplicate payment errors, to follow up and resolve prior to payment. Consequently we were unable to test the design, implementation and effectiveness of this element of the control.
3.10	**Emergency Financial Support Payments** New emergency support payments and the associated top up payments are logged on a recalculation spreadsheet which is updated each month by a Contractor Finance team member. A reviewer independent of the preparer reviews the calculations for accuracy. Completion of the calculation and the review are evidenced by the 'Prepared by' and 'Checked By' annotations on the recalculation spreadsheet. Journals for entering the emergency support or top up payments are approved for input into MIDAS by a Contractor Finance team member independent from the preparer. Preparation of the journal and approval for input into MIDAS are evidenced through 'Prepared By' and 'Checked By' annotations on the monthly Journals file.	For a selection of months, inspected the recalculation spreadsheet and noted that: - new emergency support payments and the associated top up payments logged on the recalculation spreadsheet had been updated for the month by a Contractor Finance team member; - a reviewer independent of the preparer had reviewed the calculations for accuracy; and - the recalculation spreadsheet had been annotated with 'Prepared by' and 'Checked By' to evidence the update and review. For a selection of months, inspected the monthly Journals file and noted that: - journals for entering the emergency support or top up payments for the month had been approved for input into MIDAS by a Contractor Finance team member independent from the preparer; and - the file had been annotated with 'Prepared by' and 'Checked By' to evidence the update and review.	No exceptions noted.

3.4 GENERAL OPHTHALMIC SERVICES PAYMENTS

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

Controls provide reasonable assurance that:

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

Control Ref.	Control Descriptions specified by NSS	Tests Performed by KPMG LLP	Results of Testing
Payment rate/ formula/ pricing updates			
4.1	**GOS Contract Payment Rates** The Scottish Government (SG) controls the updates to existing payment rates and creation of new payments through the publication of individual Primary Care Admin Ophthalmic (PCA(O)) circulars by publishing these on the SG web site: https://www.publications.scot.nhs.uk/ On publication of the PCA(O) circulars, the updates are input by Operations Manager or Operational Team Leaders, in the live OPTIX system, and the updates inputted are checked for completion and accuracy by an independent member of P&CFS staff. This is documented in the SOR sign off sheet.	For a selection of PCA(O) circulars, inspected the SOR sign off sheet and noted that: - the update had been input by an Operations Manager or Operational Team Leader in the live OPTIX system, - the inputted update had been checked for completion and accuracy by an independent member of P&CFS staff; and - the actions had been documented in SOR sign off sheet.	No exceptions noted.
Review for payments validity			
4.2	**Review of paper HES claims validity** Customer Admin team checks that claim for payments relating to hospital eye services (HES), the sole remaining category of paper claims, is supported with a valid claim form which is signed by an optician and includes the payment location code and / or list number of a registered contractor, as listed on the Ophthalmic List. The claim form information is input into OPTIX , the OPTIX system will not allow claims to be processed if mandatory information is missing / invalid on the hospital eye services (HES) claim and the invalid claim will be returned to the practitioner.	For a selection of payments related to HES, inspected the claim form, batch header and OPTIX system and noted that Customer Admin team had: - checked that claim for payments HES had been supported with a valid claim form signed by an optician and included the payment location code and / or list number of a registered contractor, as listed on the Ophthalmic List; and - input the claim form information into OPTIX. On a selection of dates, inspected the OPTIX payment screen settings and noted that the system does not allow claims to be processed if mandatory information is missing / invalid on the hospital eye services HES claim.	No exceptions noted.

4.3	**Verification, Calculation & Authorisation of Patient Refunds** Patient refund applications are received by the GOS CF Payment team from NHS BSA who confirms the exemption status. Patient refunds are calculated weekly by a member of the GOS CF Payment team and these are checked for accuracy independently by another member of the GOS CF Payment team. Patient refunds are authorised by the National Finance Manager, Senior Finance Analyst, Payment Lead or nominated Contractor Finance staff prior to being sent to NSS Treasury for payment through the NSS Service Now portal.	For a selection of patient refund applications received by the GOS Payment team, inspected the application form, weekly calculations, refund authorisations and the payment system and noted that: - the exemption status of the refund had been confirmed by NHS BSA; - the patient refund had been calculated within the weekly calculations by a member of the GOS CF Payment team; - the calculations had been checked for accuracy by another member of the GOS CF Payment team; and - the refunds had been authorised by the National Finance Manager, Senior Financial Analyst, Payment Lead or nominated Contractor Finance staff prior to being sent to NSS treasury for payment through the NSS Service Now portal.	No exceptions noted.
Return of invalid claims			
4.4	**Payment Adjustment, non-payment and patient detail amendment claims** Adjustment / non-payment / patient detail amendment claims are logged on the adjustment spreadsheet / non-payment spreadsheet / patient detail amendment spreadsheet by a Customer Admin team member. Once completed, the claim forms are returned to the contractor with a comment of the outcome to explain the reason for the adjustment / non-payment / patient detail amendment within 20 working days of receipt. Claims that have not been completed and returned to the contractor within 20 days are highlighted in the KPI spreadsheet for follow up in the weekly monitoring of volumes / turnaround carried out by the Operational Team Leader.	For a selection of adjustment / non-payment / patient detail amendment claims, inspected the completed claim form, the adjustment / non-payment /patient detail amendment spreadsheet and the email correspondence and noted that: - the claim had been logged on the spreadsheet by a Customer Admin team member; and - the completed claim form had been returned to the contractor with a comment of the outcome to explain the reason for the payment adjustment within 20 working days of receipt. For a selection of weeks, inspected the KPI spreadsheet and noted that claims that had not been completed and returned to the contractor within 20 days had been highlighted in the KPI spreadsheet for follow up in the weekly monitoring of volumes and turnaround carried out by the Operational Team Leader.	No exceptions noted.

Payment Processing			
4.5	**GOS Payments Authorisation and Input to OPTIX** ***4.5a*** Contractor Finance staff validate payment instructions from NHS Boards by: - verifying the signatory against the NHS Board Authorisation Matrix; and - verifying that the payment is not duplicate before processing GOS payments. Completion of the validation and verification is evidenced by annotations in the payment spreadsheet against 'Verified & Input By'. An independent team member reviews that the verification and validation is correct and the input into OPTIX is accurate and annotates the payment spreadsheet with 'Checked By' as evidence of the review.	For a selection of payments made as a result of payment instructions from an NHS Board, inspected the payment instruction, the source emails, the NHS Board Authorisation Matrices and the payment spreadsheets and noted that Contractor Finance staff validated the payment instruction by: - verifying the signatory against the NHS Board's Authorisation Matrix; and - verifying that the payment had not been duplicate before processing GOS payments. For the same selection of payment instructions, inspected the payment spreadsheets and noted that they had been: - annotated with 'Verified & Input By' by one person who verified the NHS Board signatory and input the verified data into OPTIX; - reviewed by an independent member of staff that the verification and validation had been correct and the input had been accurate; and - annotated with 'Checked by' as evidence of the review.	No exceptions noted.
	4.5b Payment instructions from Ophthalmic Practices are validated by Contractor Finance staff by: - validating the Ophthalmic Practice's eligibility by verifying the signatory against the Practitioner Services Delegated Authority Matrix; and - verifying that the payment is not duplicate before calculating the payment due and inputting the payment into OPTIX. A team member independent from the preparer reviews the calculation and input into MIDAS for accuracy and evidences the review by annotating the payment spreadsheet with 'Checked By'.	For a selection of payments made as a result of a payment instruction from Ophthalmic Contractors, inspected the payment instructions and the payment spreadsheets and noted that Contractor Finance staff validated the payment instructions by: - validating the Ophthalmic Practice's eligibility by verifying the signatory against the Practitioner Services Delegated Authority Matrix; and - verifying that the payment is not duplicate before inputting the verified data into OPTIX; For a selection of payments made as a result of a payment instructions from Ophthalmic Contractors, inspected the payment spreadsheet and noted that they had been: - reviewed by an independent member of staff that the verification and validation is correct and the input is accurate; and - annotated with 'Checked by' as evidence of the review.	No exceptions noted.

	4.5c For payments made as a result of internal calculations by the National Finance Manager or nominated Contractor Finance staff: - the preparer checks that the payment is not duplicate; - a Contractor Finance team member different from the preparer reviews the payment calculations for accuracy by; and - an authoriser different from the reviewer signs off the calculations. The completion of the validation, review of accuracy of the calculations and input into OPTIX, and the authorisation are evidenced through the annotations 'Prepared by', 'Checked by' and 'Authorised By'.	For a selection of payments that resulted from internal calculations, inspected the bulk upload templates and noted that: - the preparer had checked that the payment was not duplicate; - a Contractor Finance team member the different from the preparer had reviewed the calculations for accuracy; - an authoriser different from the reviewer had signed off the calculations; and - they had been annotated with 'Prepared By', 'Checked by' and with 'Authorised By' to evidence the completion of the review of accuracy of the calculations and input into OPTIX, and the authorisation.	No exceptions noted.
Practitioners/contractors list updates			
4.6	**OPTIX Standing Data - Ophthalmic Practices & Ophthalmic Contractors** Amendments to OPTIX Standing Data are advised to Customer Admin by authorised NHS Board staff in respect of new practice/ contractors; amendments to existing practice/ contractors; and resignation of practice/ contractors by submission of a GOS6a form. The NHS Board signatory is on the NHS Board authorisation matrix, (this is logged on the GOS6a spreadsheet by the verified by person), if not on the NHS Board authorisation matrix, the GOS6a is returned to the Health Board with no action taken and valid GOS6a requests are then input into OPTIX (this is logged on the GOS6a spreadsheet by the input by person). On the GOS6a form at part 2 the verifier / inputter signs and dates that part to show the request has been completed. A sample of each day's cases are checked during the month, using the D&O sampling plan table. The annotation 'Checked By' is the independent member of staff who has checked the input is accurate (this is logged on the GOS6a spreadsheet by the checked by person).	For a selection of amendments to OPTIX Standing Data, inspected the GOS6a form and noted that a GOS6a form had been submitted by authorised NHS Board staff in respect of new practice/ contractors; amendments to existing practice/ contractors; and resignation of practice/ contractors. For a selection of amendments to OPTIX Standing Data, inspected the GOS6a spreadsheets and the completed GOS6a forms and noted that: - staff had verified that the NHS Board signatory is on the NHS Board authorisation matrix; - where the request had not passed the validation, no action had been taken; - staff had input valid requests into OPTIX; - signed and dated the GOS6a form at part 2 the to show the request has been completed; and - an independent member of staff had checked the input is accurate. For a selection of dates, inspected the GOS6a spreadsheets and noted that a sample of each day's cases had been checked during the month using the D&O sampling plan table.	No exceptions noted.

4.7	**eFinancials Standing Data - Ophthalmic Contractor Bank Account** Amendments to eFinancials Standing Data are advised to Contractor Finance on receipt of an Ophthalmic Contractor Bank Mandate or system generated report from the Bankers Automated Clearing Service (BACS) in respect of bank account changes. On receipt of a Bank Mandate, the contractor is contacted and asked to confirm the change is valid. This is logged on a control spreadsheet. The input is evidenced on each document with 'Input By' and 'Checked By'. The annotation 'Input By' is performed by one person whose role is to input the data into eFinancials. The annotation 'Checked By' is the independent member of staff who has checked for accuracy. The authorisations are approved and recorded within eFinancials.	For a selection of amendments to eFinancials, standing data inspected the system and the Ophthalmic Contractor Bank Mandate or system generated report from BACS and the control spreadsheet and noted that: - the amendment was advised to Contractor Finance via an Ophthalmic Contractor Bank Mandate or system generated BACS report; - staff had contacted the contractor to confirm the change was valid - an independent member of staff had checked that the input had been accurate; - the control spreadsheet had been annotated with document had been annotated with 'Input By' and 'Checked By' signatures of the staff involved; and - the authorisations had been approved and recorded within eFinancials.	No exceptions noted.
Scottish Government Guidance verification			
4.8	**GOS Payment Verification (PV)** The National Finance Manager and PV Lead produce a schedule of PV work in accordance with the Payment Verification Protocol published by the Scottish Government. Findings from the PV work undertaken on practice payments are discussed with the NHS Board in quarterly PV meetings and the outcome communicated to the practice in question where appropriate.	Enquired of management to determine whether PV work had been undertaken within the period.	Payment verification work had been suspended for the period 1 April 2021 - 31 March 2022 as explained in section 2.2.3 of Management's Description. Consequently, we were unable to test the design, implementation and operating effectiveness could not be performed for this control.
4.9	**Monthly Payment Samples** Before each monthly payment is made, the amounts to be paid in OPTIX for a sample of three contractors are checked by a D&O member of staff. Any issues noted to Test and Support team, including duplicate payment errors, are followed up and resolved prior to payment.	For a selection of months, inspected the records of sample checking and noted that the amounts to be paid in OPTIX for a sample of three contractors had been checked by a D&O member of staff before the monthly payment had been made. Inspected the results of the monthly sample checks to determine whether there had been any issues noted to Test and Support team including any duplicate payment errors, to follow up and resolve prior to payment.	No exceptions noted. There had been no issues noted to the Test and Support team including any duplicate payment errors, to follow up and resolve prior to payment. Consequently we were unable to test the design, implementation and effectiveness of this element of the control.

4.10	**Emergency Financial Support Payments** New emergency support payments and the associated top up payments are logged on a recalculation spreadsheet which is updated each month. A reviewer independent of the preparer reviews the monthly calculations for accuracy. Completion of the calculation and the review are evidenced by the 'Prepared by' and 'Checked By' annotations on the recalculation spreadsheet. Journals for entering the emergency support or top up payments are approved for input into OPTIX by a team member independent from the preparer. Preparation of the journal and approval for input into MIDAS are evidenced through 'Prepared By' and 'Checked By' annotations on the monthly Journals file.	For a selection of months, inspected the recalculation spreadsheet and noted that: - new emergency support payments and the associated top up payments logged on the recalculation spreadsheet had been updated for the month by a Contractor Finance team member. - a reviewer independent of the preparer had reviewed the calculations for accuracy; and - the recalculation spreadsheet had been annotated with 'Prepared by' and 'Checked By' to evidence the update and review. For a selection of months, inspected the monthly Journals file and noted that: - journals for entering the emergency support or top up payments for the month had been approved for input into OPTIX by a Contractor Finance team member independent from the preparer; and - the file had been annotated with 'Prepared by' and 'Checked By' to evidence the update and review.	No exceptions noted.

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

REPORTS TO NHS BOARDS AND SCOTTISH GOVERNMENT FOR ALL PAYMENT STREAMS

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

Control Ref.	Control Descriptions specified by NSS	Tests Performed by KPMG LLP	Results of Testing
5.1	**Monthly NHS Board reports (the appendices)** The monthly NHS board report (the appendices) covering the four payment streams is reviewed for completeness and accuracy by a member of the Contractor Finance team, independent from the preparer of the report, by comparing it against the source documentation compiled by the preparer from the Contractor Finance team. This review is performed before the report is submitted to the NHS Board. Completion of this review is documented as a sign off on the report. The annotation: 'Prepared By' is performed by one person whose role is to confirm the accuracy of the input of the data; 'Reviewed By' is performed by an independent person whose role is to check the information is accurate.	For a selection of months, inspected the completed board report (appendices) for the month covering the four payment streams, and noted that: - it had been reviewed for completeness and accuracy by a member of the Contractor Finance team, independent from the preparer of the report, by comparing it against the source documentation compiled by the preparer from the Contractor Finance team; - the review had been performed before the report was submitted to the NHS Board; and - the report document had been annotated with 'Prepared By' and 'Reviewed By' to evidence the sign off of the report.	No exceptions noted.
5.2	**Reconciliation against eFinancials** The Contractor Finance team performs a reconciliation of the total amount from each monthly NHS Board report against the total amount recorded in eFinancials before the report is submitted. Non-reconciling items are annotated, investigated and resolved through to completion and reported to the NHS Boards. Completion of this reconciliation is documented as a sign off on the report. The annotation: 'Prepared & Input By' is performed by one person whose role is to confirm the accuracy of the input of the data; 'Checked By' is performed by an independent person whose role is to check the information is accurate.	For a selection of months, inspected the monthly reconciliation documents and noted that: - the Contractor Finance team had performed a reconciliation of the total amount from each monthly NHS Board report against the total amount recorded in eFinancials before the report was submitted. - non-reconciling items had been annotated, investigated and resolved through to completion and reported to the NHS Boards; - the reconciliation had been reviewed for accuracy by a team member independent of the preparer; and - the report document had been annotated with 'Prepared By' and 'Reviewed By' to evidence the sign off of the report.	No exceptions noted.

5.4	**Form 12 report** On a monthly basis, a member of the Contractor Finance team, other than the inputter, reviews the completeness and accuracy of the Form 12 report summarising the financial information across all four payment streams by comparing it against four streams spreadsheets before the report is submitted to each NHS Board and SG. The annotation: 'Prepared By' is performed by one person whose role is to confirm the accuracy of the input of the data; 'Reviewed By' is performed by an independent person whose role is to check the information is accurate.	For a selection of months, inspected the Form 12 completed for the month and noted that: - the Form 12 report contained a summary of the financial information across all four payment streams; - a member of the Contractor Finance team, other than the inputter had reviewed the completeness and accuracy of the Form 12 report by comparing it against four streams spreadsheets; - the review had been performed before the report was submitted to the NHS Board and SG; and - the report document had been annotated with 'Prepared By' and 'Reviewed By' to evidence the sign off of the report.	No exceptions noted.
5.5	**Reconciliation of Form 12 report and the appendices** A member of the Contractor Finance team performs a reconciliation between the information on the monthly board reports (the appendices) and the Form 12 report to verify their completeness and accuracy before the reports are submitted with reasons and any actions highlighted to boards. Non-reconciling items are investigated and resolved through to completion. Completion of this reconciliation is documented as a sign off on the report. The annotation: 'Prepared By' is performed by one person whose role is to confirm the accuracy of the input of the data; 'Reviewed By' is performed by an independent person whose role is to check the information is accurate.	For a selection of months, inspected the completed reconciliations, and noted that: - a member of the Contractor Finance team had performed a reconciliation between the information on the monthly board reports (the appendices) and the Form 12 report to verify their completeness and accuracy before the reports were submitted with reasons and any actions highlighted to boards; - non-reconciling items had been investigated and resolved through to completion; and - the report document had been annotated with 'Prepared By' and 'Reviewed By' to evidence the sign off of the report.	No exceptions noted.

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

4.1 OUR VALUES

The NSS values are a collection of guiding principles around what the organisation considers to be professional, ethical and effective personal conduct within a working environment.

In 2009, staff from across the organisation, were involved in creating and defining our values and translating them into behaviours to bring them to life.

This common set of values, endorsed by Staff Governance, helps us all create a better NSS community, whilst honouring the traditions and good work of our Strategic Business Units (SBUs) and Directorates.

Our values outlined below are communicated through the organisation's intranet:

- Committed to each other;
- Customer focus;
- Integrity;
- Openness;
- Respect and care; and
- Excel and improve.

4.2 COVID-19

As a result of Covid-19 response, recovery and renew activity, P&CFS has complied with government guidance and the distributed workforce are in the most part working remotely with no impact to services and support provision. NSS has continued to work in partnership to plan and adjust working practices for Covid-19 recovery plans in line with government guidance and has been instrumental in the provision of systems and services to manage through the pandemic for Scotland.

All NSS teams have seen a sustained rise in demand for existing services and the creation of new solutions and services resulting in the need to balance capacity across teams. These new services, including provision of PPE and delivery of 2 million shielding letters through our hybrid mail service for example have been deployed whilst continuing to maintain and deliver existing services within SLA and manage the increasing demand associated with enabling the NSS workforce to work from home. A particular pressure for P&CFS has been the need to calculate and pay the Emergency Support Payments to GDS and GOS contractor whilst their core business was disrupted by the pandemic.

The use of key technologies has been deployed and increased connectivity and access enabled across the networks to ensure all users can effectively conduct their work in this distributed model. Equipment has been provided and despatched where necessary to support NSS and extended teams and across the Health Boards where necessary to fully respond to the Covid-19 and general Business needs.

In some cases, the need to pause or revise processes have been taken by NSS to manage the volume of work across the teams and ensure our teams are able to work in a safe and secure manner.

NHS National Services Scotland

IT Services

ISAE 3402
Type II Report

1 April 2021 to 31 March 2022

Contents

FOREWORD

I present the ISAE 3402 Type II 21/22 Report for NSS which outlines the state of our control environment for the period 21/22.

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

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

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

NSS Digital and Security provides a range of services and remains committed to further addressing the improvement opportunities highlighted in this report; We already made significant improvements in partnership with KPMG, specifically around ability to better evidence controls across the framework and will continue to improve our processes, documentation and practices where possible.

The governance surrounding our control framework continues to get significant focus from NSS senior management and the entire NSS team, ensuring that we continue to evolve the framework and ensure greater compliance as we move to our improved transformed solutions.

Steven Flockhart

Director Digital and Security

20 May 2022

KPMG LLP
1 Sovereign Square
Sovereign Street
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United Kingdom

SECTION 1 – INDEPENDENT SERVICE AUDITOR'S ASSURANCE REPORT

Private & confidential
Mary Morgan
Chief Executive
NHS National Services Scotland
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

20 May 2022

Dear Mrs Morgan

ISAE 3402 Type II Independent Service Auditor's Assurance Report

In accordance with our Call Off Contract dated 11 April 2019 (our "Contract"), we have examined the accompanying description on pages 10 – 38 of the controls in place at the service organisation called NHS National Services Scotland ("NSS") and Atos IT Services UK Ltd ("Atos" or the "the Included Subservice Organisation") carried out procedures to enable us to form an independent opinion on whether NSS's management has fairly described its controls system for processing IT services for Payroll and Practitioner and Counter Fraud Services ("P&CFS") activities throughout the specified period 1 April 2021 to 31 March 2022 (the "Description") and on the design and operation of controls related to the control objectives stated in the Description. Our opinion is set out below and should be read and considered in conjunction with this report in full.

NSS and Atos Managements' Responsibilities

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

Management of NSS is responsible for (1) preparing its statement on pages 6 – 7 and describing in the Description within the statement its controls system for processing customers' transactions, including the completeness, accuracy and method of presentation of the same, (2) providing the services covered by the Description, (3) selecting the criteria to be used and stating them in the statement, (4) specifying the control objectives and stating them in the Description, and (5) identifying the risks that threaten the achievement of the control objectives and designing, implementing, and documenting controls that are suitably designed, implemented and operating effectively to provide reasonable assurance that the control objectives stated in the Description will be achieved.

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

Service Auditor's Responsibilities

Our responsibility is to express an independent opinion to NSS based on the procedures performed and evidence obtained, as to whether (1) NSS's and Atos's management Description fairly presents the controls system that was designed and implemented throughout the specified period and the aspects of the controls that may be relevant to a user organisation's internal control, as it relates to an audit of financial statements; (2) the controls included in the Description were suitably designed throughout the specified period to provide reasonable assurance that the control objectives specified would be achieved if the described controls were complied with satisfactorily, and (3) such controls were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the specified period. The criteria we used to form our judgements are the criteria used by management in making the Description, and are set out on pages 6 – 9.

Framework applied

We conducted our engagement in accordance with) International Standard on Assurance Engagements 3402 ("ISAE 3402") *Assurance Reports on Controls at a Service Organization* issued by the International Auditing and Assurance Standards Board ("IAASB"). That standard requires us to comply with ethical requirements and to plan and perform our procedures to obtain reasonable assurance about whether, in all material respects, the Description is fairly presented and the controls were suitably designed and operating effectively to achieve the related control objectives stated in the Description.

Our Independence and Quality Control

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

Scope of work

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

Atos is an independent service organisation that provides IT services to support infrastructure and applications for NSS. NSS's Description includes a description of the Atos' IT system used by NSS to provide IT services for Payroll and P&CFS services to its customers, as well as relevant control objectives and controls of the included Subservice Organisation.

The Description indicates that certain control objectives specified in the Description can be achieved only if complementary user entity controls contemplated in the design of the NSS's controls are suitably designed and operating effectively, along with related controls at NSS. We have not evaluated the suitability of the design or operating effectiveness of such complementary user entity controls

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

Limitations of Controls at a Service Organisation

NSS's and Atos' managements' Description is prepared to meet the common needs of a broad range of customers and their auditors and may not, therefore, include every aspect of the controls system that each individual customer may consider important in its own particular environment. Also, because of their nature, controls at a service organisation may not prevent or detect and correct all errors or omissions in processing or reporting transactions. Such control procedures cannot guarantee protection against (among other things) fraudulent collusion especially

on the part of those holding positions of authority or trust. Also, the projection of any evaluation of effectiveness to future periods is subject to the risk that controls at a service organisation may become inadequate or fail.

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

Opinion

Our opinion has been formed on the basis of the matters outlined in this report. In our opinion, in all material respects:

1) The Description fairly presents the controls system for processing IT services for Payroll and P&CFS activities as designed and implemented throughout the period from 1 April 2021 to 31 March 2022;

2) The controls related to the control objectives stated in the Description were suitably designed throughout the period from 1 April 2021 to 31 March 2022; and

3) The controls tested, which were those necessary to provide reasonable assurance that the control objectives stated in the Description were achieved, operated effectively throughout the period from 1 April 2021 to 31 March 2022.

Emphasis of Matter

We draw attention to pages 18 and 21 of the Description regarding control objective 1, 'Controls provide reasonable assurance that logical access to applications, operating systems and databases is restricted to authorised individuals'. As explained on page 14 of the Description throughout the period 1 April 2021 to 31 March 2022, the master user listing was manually maintained as the system was unable to generate a list of all users. Page 14 of the Description also explains that the master list is reconciled against the Active Directory on a quarterly basis.

We draw attention to pages 18 and 29 of the Description regarding control objective 3, 'Controls provide reasonable assurance that changes to the infrastructure, data, software, and procedures managed by Atos for NSS are evaluated to understand their impact to NSS' processing environment and its security, and tested and approved prior to their implementation to the live environment'. As explained on page 17 of the Description throughout the period 1 April 2021 to 31 March 2022, the list of changes was manually maintained as the system was unable to generate a list of all changes. Page 17 of the Description also explains that the NSS's Portfolio change listing was reviewed together with the independent list of changes in Service Now in the governance meeting.

Our opinion is not modified in respect of these matters.

Description of test of controls

The specific controls tested and the nature, timing and results of those tests are listed on pages 20 – 38.

Additional Information

The information provided on page 39 of this report is presented by NSS to provide additional information and is not a part of NSS and Atos management's Description of its controls system. This information has not been subjected to the same procedures applied in the examination of the Description of controls applicable to the processing of transactions for users, and accordingly, we express no opinion on it.

About this report including disclosure

This report is made to and has been prepared solely for NSS, on the terms agreed and recorded in our Contract.

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

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

Intended Users and Purpose

This report and Description of tests of controls and results on pages 20 – 38 are only to be disclosed to User Entities who have a sufficient understanding to enable them to consider the matters stated including the basis of our consent to disclosure and their ability to rely on this report, along with other information including information about controls implemented by customers themselves, when assessing the risks of material misstatements of User Entities' financial statements. This report is not to be used by anyone other than these specified parties.

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

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

Yours faithfully

KPMG LLP

KPMG LLP

SECTION 2 – MANAGEMENT'S SYSTEM DESCRIPTION

2.1 MANAGEMENT STATEMENT LETTERS

2.1.1 NSS

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

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

(a) The accompanying description at pages 10 – 19 fairly presents NSS's control system for processing customers' transactions throughout the period 1 April 2021 to 31 March 2022. The criteria used in making this statement were that the accompanying description:

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

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

(i) Includes relevant details of changes to the service organisation's system during the period 1 April 2021 to 31 March 2022.

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

(b) The controls related to the control objectives stated in the accompanying description were suitably designed and operated effectively throughout the period 1 April 2021 to 31 March 2022 to achieve those control objectives if subservice organisations and user entities applied the complementary controls assumed in the design of NSS's controls and operated effectively throughout the period 1 April 2021 to 31 March 2022. The criteria used in making this statement were that:

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

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

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

Steven Flockhart
Director Digital and Security
20 May 2022
Signed on behalf of the Board of Directors / Senior Management
National Services Scotland

2.1.2 ATOS

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

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

(a) The accompanying description at pages 13 – 15 fairly presents Atos' control system applicable to service provided by NSS for processing customers' transactions throughout the period 1 April 2021 to 31 March 2022. The criteria used in making this statement were that the accompanying description:

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

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

(ii) Includes relevant details of changes to the service organisation's system during the period 1 April 2021 to 31 March 2022.

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

(b) The controls related to the control objectives stated in the accompanying description were suitably designed and operated effectively throughout the period 1 April 2021 to 31 March 2022 to achieve those control objectives if subservice organisations and user entities applied the complementary controls assumed in the design of Atos' controls system applicable to service provided by NSS and operated effectively throughout the period 1 April 2021 to 31 March 2022. The criteria used in making this statement were that:

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

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

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

Kirsty Craig
Client Executive
20 May 2022
Signed on behalf of the Senior Management of Atos

2.2 NHS NATIONAL SERVICES SCOTLAND

2.2.1 NHS NATIONAL SERVICES SCOTLAND

NHS National Services Scotland (NSS) provides national infrastructure services and solutions to NHS Scotland. NSS also plays a role in the delivery of healthcare to patients and the public. NSS' support role to NHS Scotland means that it works with partner organisations, especially NHS boards, in the delivery of its services. Made up of Strategic Business Units and Corporate Support services, it employs around 3,900 staff.

NSS' main focus is on supporting NHS Scotland, but are now working more across health and care. This helps to ensure that the benefits and value we achieve through the national infrastructure can help many different areas of local front-line services to improve outcomes for the people of Scotland.

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

2.2.2 Services Provided

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

NSS DaS also provide IT services in support of the delivery of a 'packaged' Payroll Service by the NSS Payroll Department to NHS Scotland Boards in accordance with the Service Level Agreement in place between the NSS Payroll Department and those Boards.

This report covers the IT services underpinning the P&CFS and Payroll services provided by NSS.

In providing these services, NSS DaS utilises a combination of its own resources and a number of third party service providers including its principal IT delivery partner, Atos. On a day-to-day basis, the contract is managed by the NSS Contract, Vendor and Service Management Team (CVSMT) who are responsible for liaising between the NHS Boards and Atos.

2.2.3 NSS Digital and Security (DaS)

DaS aims to work collaboratively with the public sector partners to identify and deliver trusted and secure digital solutions to help achieve the ambitions for health and social care in Scotland. DaS was formerly the NSS Information Technology Strategic Business Unit. Services provided by DaS are the following:

- Cyber Security and Compliance – Helping secure Scotland's health and care information.
- Innovation Enablement – Helps with accelerating ideas from concept to solutions.
- Professional Digital Services – A partner, supporting the delivery journey by providing architecture, governance and delivery activities to help reduce risk and effort.
- Enterprise Digital Solutions – Providing tailored technology and advice to automate services, to help increase productivity and save time.
- Digital Infrastructure – Cloud services and network solutions to deliver Scotland's health and care.
- Business Insight and Intelligence – Delivering intelligent data which help organisations to make business decisions.
- Clinical Informatics – A clinical advisory service, aiming to enhance individual, population and health outcomes by analysing, designing, implementing, reviewing and evaluating clinical systems.

DaS is organised into service delivery pillars represented in the following table:

DaS					
Clinical Informatics	**Cyber Security & information Governance**	**Cloud Engineering & Operations**	**Portfolio Services**	**Innovation & Transformation**	**Office of the Chief Digital Officer**
Help ensure clinical outcomes for IT delivered services from DaS are assured and improved through subject matter consideration at the outset of new capabilities and throughout the lifecycle and delivery of IT services.	Help ensure the integrity of the IT estate and that the quality and security of service across critical business systems remain without breach and that processes advance to stay ahead of external and internal threats. Information governance processes and repositories are managed and maintained by this tower.	Aim to maintain and improve the DaS suite of scalable production services, infrastructure and telecoms across the entire customer and user based focusing on quality of service and asset management. Support NHS Scotland in its transition from data centre to Cloud.	Portfolio Services help deliver scaled National programmes across NHS Scotland in a consistent approach. Relationship management of our customer pipeline opportunities supported by contract and vendor management services and support.	Digital Innovation and Transformation are driving a roadmap of technology solutions to replace legacy and provision national digital capabilities across channels, integration and data, and platforms. Through solution design, DevOps and Agile methods, efficiencies of scale and rapid delivery of value is aimed to achieve.	Connect strategy to delivery through portfolio and workforce planning, intake governance and alignment to enterprise objectives, operational controls, reporting, talent development and communications and engagement.

Teams within the pillars contribute to the delivery of the services provided to P&CFS and NSS Payroll as described in the following sections.

Cloud Engineering and Operations – Business IT Department (P&CFS)

The Business IT department support P&CFS through specific IT services. These services are not an operational overhead but are viewed as a business partner in the delivery of P&CFS objectives. The focus is meeting the changing needs of the business and its IT estate.

The magnitude of the business services encompass approximately 10 major technical service system groupings below which process and validate the £2bn worth of Primary Care payments in Scotland across 5.5million GP registrations, 5.1million Dental registrations; carrying out 50,000 clinical assessment per annum.

- Portfolio Services – IT change and programme management of the yearly P&CFS development portfolio. Helps ensure that the activity surrounding P&CFS system changes is managed and reported on regarding progress.
- Service Management – Management of supplier group to help ensure services delivered provide business benefit to the customer group.
- Business Application Development Lifecycle Services – Business Systems Analysis (BSA) of emerging business changes with provision of requirements. The BSA service primarily focuses on the mechanisation and automation of business processes. The BSA works with business processes, tools, people, and culture, and focus on the business's strategy. Also encompassed under this service is acceptance testing of software or hardware components aiming to achieve stability, quality, compliance with requirements whilst assessing whether they are acceptable for delivery to production environments.
- Operational Services – This includes service operation, information requests and provision, business as usual (BAU) / service testing including accreditation, primary care payment schedule activities, service review meetings, major incident reports review, service audit, statistics relating to service and management reporting, system training, system administration, downtime and release to production as well as early life support and post development implementations.
- Technical Services – Technical guidance, provision and foundation support of department specialisms. This covers various areas such as tooling, strategic direction and developing solutions and etc.

Cloud Engineering and Operations – Local Infrastructure

This team is responsible for a range of core IT services to parts of NSS as follows:

- Administration of user accounts including setting up, termination, changes to privileges and rights;
- Provision of local IT facilities including telephone and IT workstation facilities, local and network file storage and associated networking and associated back-up and restoration facilities, virus and malware facilities;
- Provision of service desk for local telephone and IT related issues;
- First and second line support for local telephone and IT related issues; and
- Specifically in relation to the P&CFS Pharmacy payment stream, the management of the eVadis drug pricing database including the monthly updates that are part of the processing schedule (noting this service is provided to P&CFS Pharmacy only).

Portfolio Services – Contract, Vendor and Service Management Team

This team is responsible for:

- Establishing and supporting the contract governance structures and associated processes in accordance with the provisions of the contract;
- Management of contract payments in accordance with the provisions of the contract and in accordance with NSS Standing Financial Instructions;
- In association with NSS Finance, to determine the apportionment of contract charges from customer organisations in accordance with the mechanisms agreed with Scottish Government Health and Social Care Directorate and recovery of those amounts from the customer organisations;
- Managing the contract change procedure in accordance with the provisions of the contract;
- Managing the review of service delivery by the contractor in accordance with the provisions of the contract including those which relate to managing instances where performance falls below expected standards;
- Supporting the Contract Management Board in undertaking strategic reviews of the contract including those activities associated with the decision making process in respect of contract extension options and the associated cost vs. benefits analysis; and
- Managing the benchmarking process in accordance with the provisions of the contract to help ensure ongoing value for money can be evidenced throughout the term of the agreement.

2.3 NHS SCOTLAND NATIONAL IT SERVICES CONTRACT

2.3.1 BACKGROUND

Within the range of services provided by DaS to P&CFS and NSS Payroll, a part of those services is delivered through the strategic National IT Services Contract (NITC) with Atos.

The contract operates as an 'outsourced services' model with NSS acting in an intelligent customer and supervisory role on behalf of and in consort with the other NHS Scotland Health Boards to which the services are provided – including those services provided to other parts of NSS, namely P&CFS and NSS Payroll.

Included within the systems, applications and services provided under the NITC within the scope of this audit are:

- Provision of the systems which support ePharmacy Programme throughout Scotland;
- Provision of the systems which are used to calculate payments for the four payment stream to primary care practitioners (General Practitioners, Pharmacists, Dentists and Opticians) under the management of NSS Practitioner and Counter Fraud Services Strategic Business Unit (SBU); and
- Provision of the NHS Payroll System utilised by in-scope Health Boards in Scotland to make salary and associated payments to their staff.

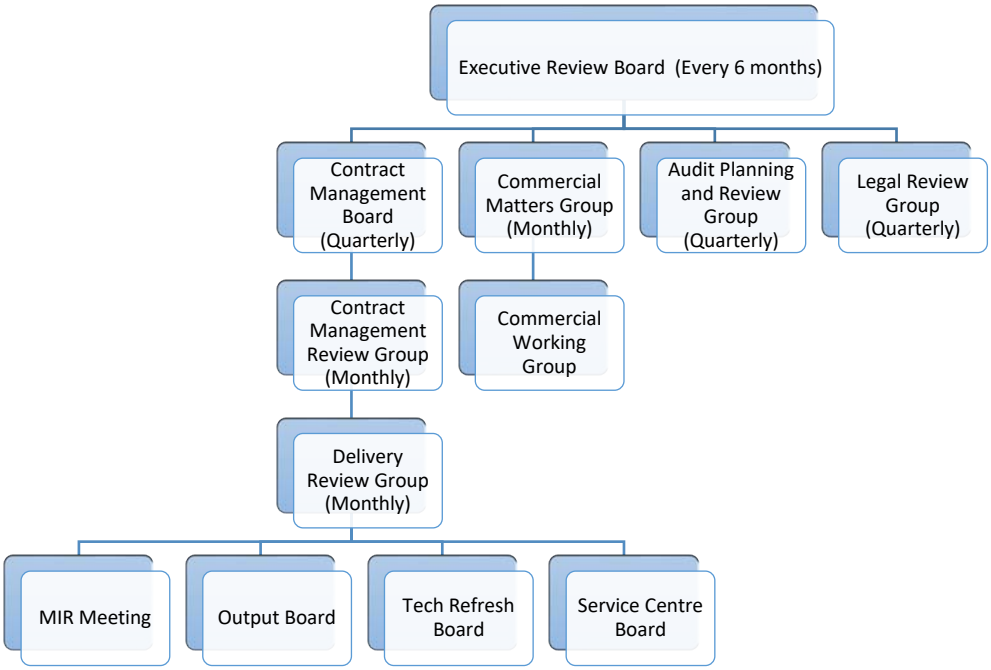
Key features of the contract include:

- A range of Key Performance Indicators and Performance Indicators across the range of services provided under the contract which are specified in the NITC and which Atos are required to deliver their services to;
- The facility to terminate individual services with six months' notice and with any associated termination costs capped; and
- Charges rebates (Service Credits) linked to failure to meet Key Performance Indicators.

2.3.2 Contract Governance

Service delivery and performance under the NITC contract is managed via a range of Contract Governance structures which are formally defined within the contract and take representation from across the NHS Scotland Health Boards. This Contract Governance interfaces with and dovetails into further governance arrangements established for specific systems and Health Board purposes for systems and services delivered by the NITC.

The Contract Governance is represented in the following diagram.



Contract Risk Management is considered a part of the remit of the Contract Management Review Group (CMRG) with escalation to the wider Atos and NSS Risk Management processes as needed.

The NITC incorporates a defined Contract Change Procedure. This includes a specific approval process compliant with NSS's Standing Financial Instructions. This procedure is utilised both for making changes which are of a non-commercial nature (e.g. those which vary the terms and conditions of the contract without any commercial impact), as well as for commissioning additional services which may involve variation to terms and conditions as well as commercial considerations. DaS CVSMT administer the Contract Change Procedure for services delivered under the NITC.

The principal operational service delivery assurance mechanism within the NITC Contract Governance is the Delivery Review Group (DRG) which meets monthly to review performance to the contract Key Performance Indicators and Performance Indicators. The group membership is from senior operational staff within the Health Boards who receive the services. The group operates to defined terms of reference and defined inputs (including performance and project and application delivery reports) and outputs. Where necessary, matters arising from the DRG are escalated to other groups within the overall NITC Contract Governance.

In parallel with the DRG, a Major Incident Review process operates which focuses on learning lessons and helping to ensure continuous improvement from any major service affecting incidents that arise. This operates to a process managed by CVSMT with an associated monthly meeting and records.

2.4 ATOS

2.4.1 INTRODUCTION

Atos provides IT services to support key infrastructure and applications for NHS Scotland.

Atos' aim is to use its capability, capacity and experience to support NHS Scotland organisations in helping improve patient care for the people of Scotland. Atos works with providers/partners to present NHS Scotland with services – these range from SMEs with niche products through to global players within the industry.

By utilising its own capability and those of partners and suppliers, Atos aims to fulfil the spectrum of requirements to meet NHS Scotland's Digital Health and Care Strategy needs for technology enabled health care. The scope of Atos' contract with NHS Scotland spans both health and care. This includes managed services, systems integration, application development and business consulting.

The contract took effect on 1 April 2007 and is in place until 31 March 2026.

Not all controls within the scope of this report are managed by Atos. For those controls that do fall to Atos to manage, Atos is responsible for the design, implementation and maintenance of controls to help ensure with reasonable assurance and on an ongoing basis that the control objectives are achieved. Atos utilises the COBIT 5.0 ICT Governance framework to identify those control measures most critical to the efficient and effective delivery of information technology services, particularly those provided by Atos to the NHS in Scotland, under the contract.

Atos complies with the NHS Scotland standards as detailed in the contract schedule part 10 (Agency Policies and Standards) including certification to ISO/IEC9001 (Quality Management Standard), ISO/IEC27001 (Information Security Standard), ISO/IEC20000 (IT Service Management Standard) and follow ISO/IEC27002 (Information Security Standard – Code of Practice) and ITIL (IT Infrastructure) guidelines. Atos has an annual programme of internal and external audit reviews which seeks to confirm conformance with the above standards.

2.4.2 CONTROLS FOR THE AREAS COVERED BY ATOS

A summary of the controls for each of these areas is provided below:

(a) Logical Access Management

Logical Access management helps to ensure the confidentiality, integrity and availability of information technology services.

With the increased reliance on technology for areas of service delivery throughout NHS Scotland, it is essential that access to technology is subject to logical security measures that are clearly understood and applied consistently across hardware, operating systems and applications.

The Master List used for the user access review of database and operating system users is not a system generated list. The original record was created from a manual reconciliation of system accounts extant at that time and personnel records identifying staff associated with the NHS Scotland account at that time. The Master List spreadsheet is checked on a quarterly basis against the HR DASid system, the Active Directory to provide comfort over its completeness and accuracy and also with team leads to attest to the appropriateness of access granted.

(b) Physical Access Management

Physical Access management helps to ensure the confidentiality, integrity and availability of information technology services.

With the increased reliance on technology for areas of service delivery throughout NHS Scotland it is essential that access to technology is subject to physical security measures that are clearly understood and applied consistently across hardware, operating systems and applications.

Atos complies and is certified to ISO/IEC27001 (Information Security Standard), ISO/IEC20000 (IT Service Management Standard) and follow ISO/IEC27002 (Information Security Standard – Code of Practice) and ITIL (IT Infrastructure) guidelines.

(c) Change Management

The IT System Development Life Cycle is a process which involves many stages, from establishing the feasibility of the system to live operation and ongoing maintenance of the system. Essentially, it is used to convert a management requirement into an application which is custom developed, purchased or a combination of both.

As technology evolves and business processes change, there is a need for applications to similarly evolve to meet the requirements of management and users. Applications can often be in a continual development cycle. It is essential for the operation of systems that developments to IT systems follow a System Development Life Cycle which helps ensure there is detailed analysis and understanding of requirements, development controls, system and user testing, followed by controlled release and maintenance of the systems.

A master record of configuration items against which changes are implemented is maintained. It provides reference baselines for the change management service and an information point for the ITIL functions for the current states of the server and desktop estate.

The spreadsheet used for change migration access control is manually compiled but reviewed by management as marked with version control. The document captures names of individuals and their team, not which systems that they have access to and which specific access.

(d) Interface and Job Scheduling

Atos have an automated system for job-scheduling implemented. Operations Control personnel monitor job execution and follow defined job handling directives in case of events (errors), according to the Error Management procedures described in the Production Plan Management Operational Blueprint or equivalent local procedure.

(e) Third Party Risk Management

Atos uses a number of third party organisations for the provision of NHS Scotland services, within the scope of this service report. These third party organisations provide application development and support services primarily for NSS Practitioner and Counter Fraud Services, controls operated by there third party organisations are not in scope of this report. The Atos Programme Management Office maintains a Register of Sub-Contractors that are used on the NSS account which specifies the contractual arrangement in place with each supplier, the services provided by them, the risks that relate to them/the services that they provide and the Technical Service Line Towers that are assigned as owners of the relationship with the third parties. The register is updated and reviewed on a yearly basis as a minimum, or when there are changes to any contractual arrangement/services from the third-party.

(f) Incident and Problem Management

A 24/7 national Service Desk operated by Atos is the first point of contact for NHS Scotland users for the reporting of faults, issues or any other request for services. The operation of a Service Desk requires that user issues are logged and managed to a resolution within specified timeframes, according to the relative priority of the issue being experienced. These timeframes will typically be identified in a service level agreement.

In addition, it is essential that the Service Desk works towards building a knowledge base in order that they can quickly diagnose and resolve issues effectively and efficiently. The Service Desk also works closely with the ITIL team, known as Service Management Centre within Atos, who provide incident management and problem management systems in order that issues are resolved to prevent their recurrence rather than provide temporary resolutions.

2.5 CONTROL ENVIRONMENT

2.5.1 NSS Board

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

1) Audit and Risk;
2) Clinical Governance;
3) Finance, Procurement and Performance;
4) Staff Governance; and
5) Remuneration and Succession Planning.

2.5.2 RISK MANAGEMENT IN NSS

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

2.5.3 NSS INFORMATION GOVERNANCE

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

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

Information governance covers the following:

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

2.5.4 NSS INFORMATION AND COMMUNICATION

Communication within NSS is maintained through regular meetings, daily interactions, email, and communication bulletins. NSS staff have access to an intranet and Microsoft Teams which is leveraged currently in a distributed working pattern given the pandemic.

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

Please refer to section 2.7 below for further description of the IT systems that are used by NSS in performing its service and the extent of responsibilities and controls over the systems listed.

2.6 CONTROLS FOR THE AREAS COVERED BY NSS

A summary of the controls for each of the NSS areas is provided below:

(a) Logical Access Management

Identity and Access Management (IAM)

There are multiple sources (authorities) when considering IAM within the NSS application estate e.g. Active Directory, LDAP and bespoke. Apart from the General Pharmaceutical Services (DCVP) keying front-end, which currently depends upon Active Directory, the majority of prime P&CFS business applications being audited (e.g. General Dental Services (MIDAS), General Ophthalmic Services (OPTIX), General Medical Services (PMSPS) and eVadis) rely upon bespoke per-application IAM mechanisms. The per-application approach was a tactical cost-efficiency approach adopted during the Application Compliance Programme.

Note the NSS Joiner/ Mover/Leaver processes as outlined provide a higher-level network access control providing a prerequisite access following which, specific system user access can be applied.

Passwords

The implementation of the password policy is an intrinsic part of the application build which cannot be viewed or managed from the Applications' user interface. Therefore, the underlying application code is the sole visible implementation of the password policy within the system.

User Lists

The systems, with bespoke IAM mechanisms, under audit scrutiny are built to allow the management of individual user accounts. To generate a complete list of users known to a system requires data to be manually extracted from system tables using techniques and tools. For completeness of information, both NSS users and supplier (support) users are visible in any lists provided. The appropriate management of supplier accounts, however, is wholly the supplier's responsibility.

(b) Change Management

P&CFS Systems

Change request follows the standard NSS change management procedure. The following processes are specific for P&CFS systems in-scope for audit:

The IT Change Governance process covers the management of any installation or alteration to hardware, network, system or application software, procedure or environmental facilities which adds to deletes from or modifies the service delivery environment. The process is split into three primary stages:

- Pipeline & Evaluation – Commissioning;
- Planning & Control – Governance forums & portfolio / Committed Development Pool (CDP); and
- Delivery – Analysis, Development, Testing and Implementation.

There are various forums instigated to control aspects of funding, resourcing and approval of changes which include:

- Internal Governance Board (IGB) – provides the strategic direction for developments, assesses & prioritises change items, recommends the adoption or rejection of P&CFS Changes and identifies funding sources;
- Digital Strategy & IT Demand Group (DSID) – Reviews overall status of P&CFS deliverables, provides resource availability assessment, review of development plans and escalation for Delivery Unit;
- P&CFS Delivery Unit (DU) – Operational delivery, provides detailed plans for activities, monitors progress and assesses & escalates individual development risks.

The P&CFS Portfolio document is reviewed at the various governance meetings and is communicated on a monthly cycle to stakeholders.

Currently the P&CFS Portfolio document is an excel spreadsheet (for ease of sharing with the stakeholder community) supplemented with elements such as “Commissioning new developments” implemented in a ServiceNow Visual Task Board (VTB). Report outputs from the VTB have been incorporated into the portfolio for additional progress information.

The P&CFS portfolio document is manually maintained by the P&CFS Change Management team as part of the Change Review meeting.

2.7 IT SYSTEMS

The following IT systems are in-scope of this service audit report:

System	Entities Responsible	Services Supported	Operating System	Database
ePayroll	Atos (application and database) Fujitsu (operating system)	Primary system for the payroll process.	Fujitsu VME	IDMS
General Medical Services (Primary Medical Services Payment System) PMSPS	Sopra Steria (application layer and database) Atos (operating system)	This calculates the monthly payments to GP Practices.	Solaris 11	Oracle 12c
General Pharmaceutical Services (DCVP)	Sopra Steria (application layer and database) Atos (operating system)	This system validates and values scripts submitted by dispensing contractors once or twice per month.	Solaris 8/10	Oracle 8/9
General Dental Services (MIDAS)	Sopra Steria (application layer and database) Atos (operating system)	Primary system for dental payments.	Solaris 11	Oracle 12c
General Ophthalmic Services (OPTIX)	Sopra Steria (application layer and database) Atos (operating system)	The main system used by GOS to calculate payments to contractors.	Solaris 11	Oracle 12c

System	Entities Responsible	Services Supported	Operating System	Database
eVadis	NSS (application, operating system and database)	eVadis is a pharmacy drug dictionary and contractors database. Pricing information from eVadis is uplifted into DCVP monthly.	Solaris 10	Oracle 10.2.0.4

2.8 SUB-SERVICE ORGANISATIONS

System	Services Supported	Approach	Justification
Atos	Atos provides managed technical services (including hardware and associated software), storage, application support and development. The control objectives applicable are: 1. Logical Access Management; 2. Physical Access Management; 3. Change Management; 4. Interface and Job Scheduling; 5. Third Party Risk Management; and 6. Incident and Problem Management.	Inclusive	A material component of the service is outsourced to Atos as an IT infrastructure and service provider. Furthermore, the provisioning of the service from Atos is managed by NSS. Therefore, to help ensure that this report provides sufficient coverage for user auditors, we have adopted an inclusive approach.

2.9 CONTROL OBJECTIVES

- **Logical access management** – Controls provide reasonable assurance that logical access to applications, operating systems and databases is restricted to authorised individuals.
- **Physical access management** – Controls provide reasonable assurance that physical access to the data centres for NSS services are restricted to authorised personnel.
- **Change management** – Controls provide reasonable assurance that changes to the infrastructure, data, software, and procedures managed by Atos for NSS are evaluated to understand their impact to the NSS' processing environment and its security; and tested and approved prior to their implementation to the live environment.
- **Interface and job scheduling management** – Controls provide reasonable assurance that automated interfacing and job processing are performed completely as per the defined schedules, and that failures are identified and remediated.
- **Third party risk management** – Controls provide reasonable assurance that risks associated with vendors and business partners that contribute to the delivery of services are assessed, monitored and managed.
- **Incident and problem management** – Controls provide reasonable assurance that incidents and problems are responded to, investigated, tracked and resolved through to completion following a defined incident and problem management policy.

2.10 COMPLEMENTARY USER ENTITY CONTROLS

The effectiveness of the controls relating to the services provided by NSS DaS to NSS P&CFS and NSS Payroll team in contributing to the services that they in turn provide to their customer organisations within the NHS Scotland Health Boards rely upon NSS P&CFS, NSS Payroll team and NHS Health Boards implementing their own complementary controls. The complementary controls are included in the respective P&CFS and Payroll reports. They describe other internal controls that are expected be in operation within user organisations to complement the controls operated by NSS.

The independent service auditor's opinion presented in this ISAE 3402 report does not include a review over the design, implementation and operating effectiveness of the user entity controls. The independent auditors of the user organisations should consider whether these user entity controls are present and operating effectively.

SECTION 3 – NSS CONTROL OBJECTIVES AND RELATED CONTROLS, AND KPMG LLP'S TESTS OF CONTROLS AND RESULTS OF TESTS

TESTS OF THE CONTROL ENVIRONMENT

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

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

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

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

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

DESCRIPTION OF TESTS PERFORMED

Tests performed to determine the design, implementation and operating effectiveness of the controls detailed in this section are described below:

TEST PROCEDURE	DESCRIPTION
Enquiry	Enquired of appropriate NSS and Atos personnel. Enquiries were used to obtain, among other things, knowledge and additional information about the control.
Inspection	Read documents, reports and electronic files that contain an indication of performance of the control. This includes, among other things, examining management reports, operational logs and other relevant documentation.
Observation	Observed the application of a specific control by NSS and Atos personnel. Observations are primarily performed where there is no documentary evidence of the operating effectiveness of the controls.

TESTS OF THE CONTROL ENVIRONMENT

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

3.1 LOGICAL ACCESS

Controls provide reasonable assurance that logical access to applications, operating systems and databases is restricted to authorised individuals.

Control Ref.	Control Activities Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
1.1	Logical access controls are defined in the following documents: • UK and Ireland Information Security Policy; • Password Standard; • Emergency Access to Production System Procedure; and • Access Management Policy. These policies and procedures documents are reviewed by a Senior Manager on an annual basis as a minimum or when there are major changes to the in-scope systems.	Inspected the UK and Ireland Information Security Policy, Password Standard, Emergency Access to Production System Procedure, and the Access Management Policy and noted that: • logical access controls had been defined within these documents; and • these documents had been reviewed within the last 12 months or when there had been major changes to the in-scope systems reviewed by a Senior Manager.	No exceptions noted.
1.2	Each user ID in the NSS network is unique except for generic/service accounts that are hard coded into the systems. These accounts are reviewed annually by the Service Delivery Director and restricted to the authorised support staff.	Inspected user list and noted that each user ID in the NSS network had been unique except for generic/service accounts that had been hard coded into the systems. Inspected the user access review document and noted that the generic/service accounts had been reviewed and restricted to the authorised support staff.	No exceptions noted.
1.3	The NHS Scotland Security Policy and Standards document defines the minimum password requirements to be implemented within the in-scope system. The requirements are as below: • Minimum length of six characters; • Alphanumeric character;	Inspected NHS Scotland Security Policy and Standards document and noted that the minimum password requirements to be implemented within the in-scope system had been defined in the NHS Scotland Security Policy and Standards document with the following requirements: • Minimum length of six characters; • Alphanumeric character; • Password is valid for a maximum of 30 days; and	No exceptions noted.

Control Ref.	Control Activities Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
	• Password is valid for a maximum of 30 days; and • Password cannot be the same as the previous passwords for 12 months. These requirements are enforced through the system settings across the in-scope systems.	• Password cannot be the same as the previous passwords for 12 months. For a selection of dates, inspected system settings and noted that the password requirements had been enforced through the system settings across the in-scope systems.	
1.4	*DCVP, MIDAS, Optix, PMSPS (application) and eVadis (application, operating system and database)* On a quarterly basis, a review is performed over account creation and amendment activities and confirmation is obtained over the appropriateness of active accounts with the respective Line Managers. Issues identified are investigated, tracked and resolved to completion using the Service Now ticketing system by the Line Managers. *DCVP, MIDAS, Optix, PMSPS and ePayroll (operating system and database)* On a quarterly basis, a review is performed to check that the current user list only contains users who are still Atos employees and are authorised by their manager to be working on the NHS account. The review is performed by the Line Manager by crosschecking the tracker against the AD and DASid system. Issues identified are investigated, tracked and resolved to completion using the Service Now ticketing	*DCVP, MIDAS, Optix, PMSPS (application) and eVadis (application, operating system and database)* For a selection of quarters, inspected the quarterly review document and noted that a review had been performed over account creation and amendment activities and confirmation had been obtained over the appropriateness of active accounts with the respective Line Managers. For a selection of quarters, inspected the quarterly review document and noted that issues identified from the review had been investigated, tracked and resolved to completion using the Service Now ticketing system by the Line Managers. Enquired with management to determine whether the completeness and accuracy of the user list generated for the quarterly review had been documented. *DCVP, MIDAS, Optix, PMSPS and ePayroll (operating system and database)* For a selection of quarters, inspected the quarterly review document and noted that the review had been performed by the Line Manager: • To check that the current user list only contains users who were still Atos employees and had been authorised by their manager to be working on the NHS account; • By crosschecking the tracker against the AD and DASid system; and • Issues identified had been investigated, tracked and resolved to completion using the Service	*DCVP, MIDAS, Optix, PMSPS (application) and eVadis (application, operating system and database)* *1 April 2021 – 30 June 2021* **Exception noted:** For the selected quarter, we were informed that the completeness and accuracy of the user list generated for the quarterly review was not formally documented. **Management response:** The issue was noted in Quarter One and subsequently from Quarter Two onwards, the process was revised whereby the Business Owner now raises a Service Now ticket to document the completeness and accuracy of the user list extracted. *1 July 2021 – 31 March 2022* No exceptions noted. *DCVP, MIDAS, Optix, PMSPS and ePayroll (operating system and database)* No exceptions noted. *ePayroll (application)* No exceptions noted. As there had been no issues noted from the user access review, we were unable to

Control Ref.	Control Activities Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
	system by the Line Managers. *ePayroll (application level)* On an annual basis, a review is performed over account creation and amendment activities and confirmation is obtained over the appropriateness of active accounts with the respective Line Managers. Issues identified are investigated, tracked and resolved to completion using the Service Now ticketing system by the Line Manager.	Now ticketing system by the Line Managers. *ePayroll (application level)* Inspected email correspondence and noted that the review had been performed over account creation and amendment activities and confirmation had been obtained over the appropriateness of active accounts with the respective Line Managers. Inspected the annual review document to determine whether the issues identified from the review had been investigated, tracked and resolved to completion using the Service Now ticketing system by the Line Manager.	test the implementation and operating effectiveness of this element of the control.
1.5	*DCVP, eVadis, MIDAS, Optix and PMSPS (application, operating system and database)* *ePayroll (operating system and database)* The Atos Service Desk team (for operating system and database users) and Business IT team (application users) verifies that approval from the individual's Team Leader is in place before access to operating systems and databases is provided. The level of access requested, approved and assigned is outlined and documented by Atos or the Business IT team. *ePayroll (application level)* The Payroll team verifies that approval from the Team Leader is in place before access to ePayroll is provided. The level of access requested and approval are outlined and documented by the Payroll team.	*DCVP, MIDAS and Optix (operating system and database)* *PMSPS (application, operating system and database)* *ePayroll (operating system and database)* For a selection of new user access requests, inspected the ticket raised and noted that: • The approval from the Team Leader had been verified by the Atos Service Desk team (for operating system and database users) and Business IT team (application users) before access to the NSS' operating systems and databases had been provided; and • The approval and the level of access requested, approved and assigned had been outlined and documented by Atos or the Business IT team. *DVCP, OPTIX and MIDAS (application)* For a selection of new user access requests, inspected the ticket raised to determine whether: • The approval from the Team Leader had been verified by the Atos Service Desk team (for operating system and database users) and Business IT team (application users)	*DCVP, MIDAS and Optix (operating system and database)* *PMSPS (application, operating system and database)* *ePayroll (operating system and database)* No exceptions noted. *OPTIX (application)* **Exception noted:** *For one out of three selected new OPTIX user requests, it was noted that the detail of the access approval was not documented in the request ticket.* *MIDAS (application)* **Exception noted:** For one out of three selected new MIDAS user requests, it was noted that the detail of the access approval was not documented in the request ticket. **Management response:** The new user requests for MIDAS and OPTIX account were fulfilled without further

Control Ref.	Control Activities Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
		before access to the NSS' operating systems and databases had been provided and; • The approval and the level of access requested, approved and assigned had been outlined and documented by Atos or the Business IT team. *ePayroll (application level)* For a selection of new user access requests, inspected the email and noted that the approval from the Team Leader had been in place and had been verified by the Payroll team before access to NSS' applications had been provided. Further noted that the level of access requested and approval had been outlined and documented by the Payroll team.	recourse to Line Management for confirmation. It was however confirmed by P&CFS Management as part of the Quarterly Review so the accounts themselves and the requests, therefore, were valid. The parties involved in the process had been formally reminded to follow the new user request process. *DVCP (application)* **Limitation of scope:** As there had been no new users noted for the audit period, we were unable to test the implementation and operating effectiveness of this element of the control. *ePayroll (application level)* No exceptions noted.
1.6	*DCVP, eVadis, MIDAS, Optix, and PMSPS (application, operating system and database), and ePayroll (operating system and database)* The Atos Service Desk team (for operating system and database users) and Business IT team (application users) remove leaver's access to the applications, operating systems and databases within five days of their leaving date. This is documented by Atos Service Desk team and Business IT team.	*DCVP, ePayroll, MIDAS, Optix and PMSPS (operating system and database)* *eVadis (application, operating system and database)* For a selection of leavers, inspected the Service Now ticket to determine whether leaver's access to the applications, operating systems and databases had been removed by the Atos Service Desk team within five days of their leaving date and had been documented. *DCVP and MIDAS (application)* Inspected a leaver's list and user's list to determine whether the leaver's access to the applications, operating systems and databases had been removed by Atos or Business IT Team within five days of their leaving date and had been documented by Atos or Business IT team.	*DCVP, eVadis, ePayroll, MIDAS, Optix and PMSPS (operating system and database)* **Exception noted:** For 19 out of 25 users removed, confirmation of the removal request within five days of their leaving date had not been recorded in the Service Now ticket. **Management response:** The users identified were removed by an automatic weekly scripted removal process therefore the Service Now ticket is not required. The removal of these accounts was recorded in the Active Directory log. *PMSPS and Optix (application)* *ePayroll (application)*

Control Ref.	Control Activities Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
	ePayroll (application level) The Payroll team remove leaver's access to the application within 5 days of their leaving date. This is documented by Payroll Team.	*ePayroll (application level)* For a selection of leavers, inspected the notification email and user's list and noted that the Payroll team had removed the leaver's access to the application within 5 days of their leaving date.	No exceptions noted. *eVadis (application, operating system and database)* **Limitation of scope:** As there had been no leavers noted for the audit period, we were unable to test the implementation and operating effectiveness of this element of the control. *DCVP (application)* **Exception noted:** For six out of 14 selected DCVP leavers, it was noted that the leavers' account was not removed. *MIDAS (application)* **Exception noted:** For three out of three selected MIDAS leavers, it was noted that the leavers' account was not removed. **Management response:** The accounts identified in DCVP and MIDAS were disabled at the Active Directory and access to the building was removed. The process relies upon Operational Business Managers to inform DaS to remove the application access. The parties involved in the process had been formally reminded to follow the user deletion process.
1.7	*DCVP, eVadis, MIDAS, Optix, and PMSPS (application, operating system and database level), and ePayroll (operating system and database level)* Privileged accounts within the applications,	*DCVP, MIDAS, Optix, and PMSPS (application, operating system and database level), and ePayroll (operating system and database level)* For a selection of quarters, inspected the user access review document and noted that the privileged accounts within the applications, operating systems and databases had been	*DCVP, MIDAS, Optix, PMSPS and ePayroll (operating system and database)* No exceptions noted.

Control Ref.	Control Activities Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
	operating systems and databases are restricted to designated individuals within the relevant support teams. Active privileged accounts are reviewed quarterly by the Line Managers for application accounts and monthly for operating systems and databases accounts. Privileged access that is no longer required / applicable are revoked. This is tracked and monitored using the Service Now ticketing system by the Line Managers. *ePayroll (application level)* Privileged accounts within the application are restricted to designated individuals within the relevant support teams. Active privileged accounts are reviewed annually. Privileged access that is no longer required / applicable are revoked. This is tracked and monitored using the Service Now ticketing system by the Line Managers.	restricted to designated individuals within the relevant support teams. For a selection of quarters, inspected the user access review document and noted that the active privileged accounts had been reviewed quarterly, the privileged access that is no longer required / applicable had been revoked, tracked and monitored using the Service Now ticketing system by the Line Managers. Enquired with management to determine whether the completeness and accuracy of the user list generated for the quarterly review had been documented. *eVadis (application, operating system and database level)* For a selection of quarters, inspected the user access review document to determine whether the privileged accounts within the applications, operating systems and databases had been restricted to designated individuals within the relevant support teams. For a selection of quarters, inspected the user access review document to determine whether the active privileged accounts had been reviewed quarterly, the privileged access that is no longer required / applicable had been revoked, tracked and monitored using the Service Now ticketing system by the Line Managers. Enquired with management to determine whether the completeness and accuracy of the user list generated for the quarterly review had been documented.	*DCVP, MIDAS, Optix, PMSPS (application) and eVadis (application, operating system and database)* *1 April 2021 – 30 September 2021* **Exception noted:** We were informed that the completeness and accuracy of the user list generated for the quarterly review was not formally documented. **Management response:** Subsequent to the issues noted in Quarter One and Two, the process was improved for Quarter 3 to include the raising of a Ticket in ServiceNow by the DaS Administrative Owner of the System to document the extraction of the user list generated. *1 Oct 2021-31 March 2022* No exceptions noted. *eVadis (application, operating system and database level)* *1 April 2021-30 Sept 2021* **Exception noted:** For two selected quarters, reviews of active privileged accounts were not performed. **Management response:** Subsequent to the issues noted in Quarter One and Two, the process was improved for Quarter 3 to include the raising of a Ticket in ServiceNow by the DaS Administrative Owner of the System to document the review of the active privileged accounts. *1 October 2021-31 March 2022* No exceptions noted.

Control Ref.	Control Activities Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
		ePayroll (application level) Inspected the user list and noted that the privileged accounts within the applications, operating systems and databases had been restricted to designated individuals within the relevant support teams. Inspected the privileged access review document and noted that active privileged accounts had been reviewed within the last 12 months. Inspected the privileged access review document to determine whether the privileged access that was no longer required / applicable had been revoked. Further noted that the action had been tracked and had been monitored using the Service Now ticketing system by the Line Managers.	*ePayroll (application level)* No exceptions noted. There had been no issues noted from the user access review. Consequently, we are unable to conclude on the implementation and operating effectiveness of this element of the control.

3.2 PHYSICAL ACCESS MANAGEMENT

Controls provide reasonable assurance that physical access to the data centres for NSS services are restricted to authorised personnel.

Control Ref.	Control Activities Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
2.1	Atos performs annual assessment of the physical security of the third-party data centres through a review of the ISO 27001 report. The assessment results are approved by NHS NSS management.	Inspected meeting minutes and noted Atos performed an assessment of the physical security of the third-party data centres through a review of the ISO 27001 report. Further noted that the assessment results had been approved by NHS NSS management.	No exceptions noted.

3.3 CHANGE MANAGEMENT

Controls provide reasonable assurance that changes to the infrastructure, data, software, and procedures managed by Atos for NSS are:

- evaluated to understand their impact to NSS' processing environment and its security;
- tested and approved prior to their implementation to the live environment.

Control Ref.	Control Activities Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
3.1	The processes for managing change and configuration are formally documented in the Change Management Policy and controlled. These cover changes to NSS' applications and the underlying operating systems, databases, servers and infrastructures that are managed by Atos. The document is reviewed and approved on an annual basis by a Senior Manager.	Inspected the Change Management Policy and noted that the process for managing change and configuration had been documented and the changes to NSS' applications and the underlying operating systems, databases, servers and infrastructures that were managed by Atos had been covered. Further noted that these documents had been reviewed and had been approved within the last 12 months by a Senior Manager.	No exceptions noted.
3.2	Non-emergency changes to NSS' applications and the supporting operating systems, databases, servers and infrastructures are developed and tested in separate environments and recorded in Service Now Configuration Management Database (CMDB).	Inspected the list of environments recorded in Service Now CMDB and noted non-emergency changes to NSS' applications and the supporting operating systems, databases, servers and infrastructures had been developed and tested in separate environments and recorded in CMDB.	No exceptions noted.

Control Ref.	Control Activities Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
3.3	Non-emergency changes to NHS NSS' applications and the supporting operating systems, databases, servers and infrastructures are approved by management (Atos and NSS) and/or the CAB and are implemented to the production environment after the testing is completed and approval is provided in accordance with the Change Management Process document. For standard changes, they are pre-approved changes, hence no additional approved by management (Atos and NSS) and/or the CAB is required. The dates and track record of the testing, approval and implementation are recorded in the Service Management Change Tool or change document.	For a selection of non-emergency changes, inspected the change ticket raised and supporting documentation from the Service Management Change Tool and noted that: • The change had been approved by management (Atos and NSS) and/or the CAB and had been implemented to the production environment after the testing had been completed and approval had been provided in accordance with the Change Management Process document; • For standard changes, no additional approval had been required; and • The dates and track record of the testing, approval and implementation had been recorded in the Service Management Change Tool or change document.	No exceptions noted.
3.4	Privileged access to make changes to the production applications is restricted to a job role independent of developers, in accordance with the Change Management Process document. *Note: The provisioning, amendments and removal of privileged access follows the user access management process described in control 1.5 and control 1.6.*	For a selection of dates, inspected the list of users with access to make changes to production applications and noted that privileged access to make changes to the production applications had been restricted to a job role independent of developers, in accordance with the Change Management Process document.	No exceptions noted.
3.5	Emergency changes are subject to retrospective CAB review and approval within five working days after its implementation. This is documented in the Service Management Change Tool.	*DCVP, ePayroll, MIDAS, Optix and PMSPS* For a selection of emergency changes, inspected change tickets and noted that emergency changes had been subjected to retrospective CAB review had been approved within five working days after its implementation and had been documented in the Service Management Change Tool. *eVadis* Inspected the change management document and system to determine whether there had been any	*DCVP, ePayroll, MIDAS, Optix and PMSPS* No exceptions noted. *eVadis* We noted that there had been no emergency changes in eVadis. Consequently, we were unable to test the implementation and operating effectiveness of this element of the control.

Control Ref.	Control Activities Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
		emergency changes to eVadis during the reporting period.	
3.6	*DCVP, ePayroll, eVadis, MIDAS, Optix and PMSPS* On a weekly basis, ongoing non-standard changes in the applications and the supporting operating systems, databases, servers and infrastructures are reviewed by CAB to verify that the change process has been followed. System generated lists of changes from Service Management Change Tool are used by the CAB to perform the weekly review. If the Change Manager identifies changes that do not follow the change management process, queries are raised with the staff that makes the change to verify the appropriateness of the change and confirm whether any further actions are needed on those changes. This is tracked through to completion using the Service Management Change Tool.	*DCVP, ePayroll, eVadis, MIDAS, Optix and PMSPS* For a selection of weeks, inspected the meeting minutes from the CAB meetings and noted that ongoing non-standard changes in the applications and the supporting operating systems, databases, servers and infrastructures had been reviewed by CAB to verify that the change process had been followed. Further noted that system generated lists of changes from Service Now had been used by the CAB to perform the weekly review. Inspected meeting minutes from the CAB meetings to determine whether there had been any changes that did not follow the change management process.	*DCVP, ePayroll, eVadis, MIDAS, Optix and PMSPS* No exceptions noted. We were informed by management that there had been no changes which required tracking, therefore we were unable to test the implementation and operating effectiveness of this element of the control.

Control Ref.	Control Activities Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
	For NSS P&CFS only: *1 April 2021 – 31 Dec 2021* On a weekly basis, ongoing non-standard changes in the applications and the supporting operating systems, databases, servers and infrastructures are reviewed by the Change Manager, representatives from Business IT (DaS)and the suppliers to verify that the change process has been followed. If the Change Manager identifies changes that do not follow the change management process, queries are raised with the staff that makes the change to verify the appropriateness of the change and confirm whether any further actions are needed on those changes. This is tracked through to completion within the weekly status update tracker. *1 January 2022 – 31 March 2022* On a monthly basis, ongoing non-standard changes in the applications and the supporting operating systems, databases, servers and infrastructures are reviewed by the Change Manager, representatives from Business IT (DaS) and the suppliers to verify that the change process has been followed. If the Change Manager identifies changes that do not follow the change management process, queries are raised with the staff that makes the change to verify the appropriateness of the change and confirm whether any further actions are needed on those changes. This is tracked through to completion within the monthly status update tracker.	*For NSS P&CFS only:* *1 April 2021 – 31 Dec 2021* For a selection of weeks, inspected the weekly status update tracker to determine whether ongoing non-standard changes in the applications and the supporting operating systems, databases, servers and infrastructures had been reviewed by the Change Manager, representatives from Business IT (DaS) and the suppliers to verify that the change process has been followed. Further noted that for changes that did not follow the change management process, queries had been raised with the staff that made the change to verify the appropriateness of the change and confirm whether any further actions were needed on those changes. *1 January 2022 – 31 March 2022* For a selection of months, inspected the monthly status update tracker and noted that ongoing non-standard changes in the applications and the supporting operating systems, databases, servers and infrastructures had been reviewed by the Change Manager, representatives from Business IT (DaS) and the suppliers to verify that the change process has been followed. Further noted that for changes that did not follow the change management process, queries had been raised with the staff that made the change to verify the appropriateness of the change and confirm whether any further actions were needed on those changes.	*For NSS P&CFS only:* *1 April 2021 – 31 Dec 2021* **Exception noted:** For three out of six weeks selected, it was noted that the weekly meeting minutes had not been documented. **Management response:** For the meeting weeks identified, one of the parties was not present and the rescheduled meetings were not formally documented. Contingency measures had been introduced through identification of delegates for each of the two principal representatives from each of Atos and DaS. *1 Jan 2022 – 31 March 2022* No exceptions noted.
3.7	Configuration baseline for the hardware infrastructure used for the NSS service is maintained in the CMDB. The database is updated by IT Support teams when there is a	Inspected the configuration baseline for the hardware infrastructure used for the NSS service and noted that it had been maintained in the CMDB. For a selection of updates to the database, inspected the ticket raised	No exceptions noted.

Control Ref.	Control Activities Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
	change to the infrastructure or the configuration. The previous version of the configuration is kept to enable rollback of the change. *Note: Changes to the configuration baseline follows the change management process in control 3.4.*	and noted that the database had been updated by the IT Support teams following a change to the infrastructure or the configuration. Further noted that the previous version of the configuration had been kept to enable rollback of the change.	

3.4 INTERFACE AND JOB SCHEDULING MANAGEMENT

Controls provide reasonable assurance that automated interfacing and job processing are performed completely as per the defined schedules, and that failures are identified and remediated.

Control Ref.	Control Activities Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
4.1	Business and service requirements and the procedures to monitor completion of interface and job scheduling are documented. This is reviewed and approved by a Senior Manager on an annual basis as a minimum, or when there is a change in the interface and job scheduling tools.	Inspected the policies and procedures and noted that business and service requirements and the procedures to monitor completion of interface and job scheduling had been documented. Further noted that these documents had been reviewed and approved by a Senior Manager within the last 12 months or following a major change to the interface and job scheduling tools.	No exceptions noted.
4.2	The completion of data interface is monitored for NSS' applications managed by Atos. A Service Now ticket is raised when an interface does not finish completely. The cause of the error is investigated and is resolved by the Atos Support team. This is tracked through to completion using the service management toolset.	For a selection of data interface tickets, inspected the ticket and noted that completion of data interface had been monitored for NSS' applications managed by Atos and Service Now ticket had been raised when an interface did not finish completely. Further noted that the cause of the error has been investigated and had been resolved by the Atos Support team. This had been tracked through to completion using the service management toolset.	No exceptions noted.
4.3	Automated jobs are scheduled in the specified tool with a pre-determined frequency as defined within the ServiceNow change request raised by NSS. New scheduled job request for new customer are verified as part of the change implementation and any issues noted are logged in the ServiceNow request ticket. If no issue ticket will be marked as complete without comment.	Enquired of management to determine whether there had been any new scheduled job requests for new customers during the reporting period which required verification.	We were informed by the management that there had been no new scheduled job requests for new customers during the audit period. Consequently, we were unable to test the implementation and operating effectiveness of this element of the control.
4.4	Amendments to job scheduling are received from NHS via a ServiceNow change request and updates are made by Atos Support team within the applicable tool (Control M or Helmsman). Request, approval and amendments are tracked in the ServiceNow change request.	For a selection of amendment requests, inspected the request and noted that the amendments to job scheduling had been received from NHS via ServiceNow change request and updates had been made by the Atos Support team within the applicable tool (Control M or Helmsman). Further noted that the request, approval and amendments had been tracked in the ServiceNow change request.	No exceptions noted.

3.5 THIRD PARTY RISK MANAGEMENT

Controls provide reasonable assurance that risks associated with vendors and business partners that contribute to the delivery of services are assessed, monitored and managed.

Control Ref.	Control Activities Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
5.1	On a monthly basis, the NSS' Account Service Manager from Atos chairs a review meeting, focusing on service, with Atos suppliers who are providing BAU services. Issues are discussed and tracked in the review meeting and are documented in meeting minutes.	For a selection of months, inspected the meeting minutes and noted the NSS' Account Service Manager from Atos had chaired the review meeting, focused on service, with Atos suppliers who had been providing BAU services. Further noted that the issues had been discussed, had been tracked in the review meeting and had been documented.	No exceptions noted.
5.2	The strategy and processes to manage Atos third parties are outlined in the Supplier Management document. The document is updated and reviewed by a Manager every two years as a minimum.	Inspected the Supplier Management document and noted that the strategy and processes to manage third parties had been outlined in the document. Further noted that the document had been updated and reviewed by a Manager within the last two years as a minimum.	No exceptions noted.
5.3	The Atos Programme Management Office maintains a Register of Sub-Contractors that are used on the NHS NSS' account. This register specifies the contractual arrangement in place with each supplier. The register is updated and reviewed on a yearly basis as a minimum, or when there are changes to any contractual arrangement/services from the third-party.	Inspected the Register of Sub-Contractors used on the NSS account and noted that the list had been maintained by the Atos Programme Management Office and the contractual arrangement in place with each supplier had been specified in the register. Inspected the register's audit log and noted that the register had been updated and had been reviewed within the last 12 months, or when there were changes to any contractual arrangement/services from the third-party.	No exceptions noted.

3.6 INCIDENT AND PROBLEM MANAGEMENT

Controls provide reasonable assurance that incidents and problems are responded to, investigated, tracked and resolved through to completion following a defined incident and problem management policy.

Control Ref.	Control Activities Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
6.1	Incident response policies and procedures are in place and documented. The policies define: • The classification and prioritisation definition of each incident; • The SLA for each type of classification and priority; and • The stakeholders of each system to whom updates on incident should be sent. These policies are reviewed by a Senior Manager on an annual basis, as a minimum, and are communicated to the Service Desk team through advisory communications and made available via the service management toolset.	Inspected the Incident Management policies and procedures and noted that the Incident response policies and procedures had been in place and had been documented. Further noted that the following had been defined: • The classification and prioritisation definition of each incident; • The SLA for each type of classification and priority; and • The stakeholders of each system to whom updates on incident should be sent. Inspected the Incident Management policies and procedures and noted that these policies had been reviewed by a Senior Manager within the last 12 months, and had been communicated to the Service Desk team through advisory communications and had been made available via the service management toolset.	No exceptions noted.
6.2	*Policy documentation and review* Problem Management Process is in place and documented. It defines the mechanism to identify problems from incidents and root cause assessment procedure. The document is reviewed by a Senior Manager and approved an annual basis, and the review recorded. *Policy changes* Any changes that arise are communicated to the Service Desk team through advisory communications and made available via the service management toolset.	*Policy documentation and review* Inspected the Problem Management Process document and noted that the mechanism to identify problems from incidents and root cause assessment procedure had been defined. Further noted that the document had been reviewed by a Senior Manager and had been approved within the last 12 months, and the review had been recorded. *Policy changes* Enquired of management to determine whether there had been any changes to the policy.	*Policy documentation and review* No exceptions noted. *Policy changes* We were informed by management that there had been no changes in the Problem Management Process document that required communication to the Service Desk team. Consequently, we were unable to test the implementation and operating effectiveness of this element of the control.

Control Ref.	Control Activities Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
6.3	Problems are reviewed by NSS and Atos and stakeholders through a monthly review meeting which is combined with the Monthly Incident Review (MIR). This meeting operates to a formal agenda, documentation set and is formally minuted. This meeting approves the closure of problems by the customer.	For a selection of months, inspected the minutes from the review meetings and noted that the problems had been reviewed by NSS and Atos and stakeholders through a monthly review meeting which had been combined with the MIR review. Further noted that the meeting had been operated to a formal agenda, documentation set and had been formally minuted and the closure of problems by the customer had been approved in the meeting.	No exceptions noted.
6.4	The Service Desk team assigns a classification, priority and engages team(s) for the incident ticket logged in the service management tool. In respect of end user / customer raised P1 and P2 incidents, the Incident Manager reviews the ticket and assesses the appropriateness of the priority based on the circumstances of the incident, which may result in the priority being either increased or decreased. The Incident Manager engages the Technical Resolver team(s), and the Service Desk team assigns the ticket to the engaged team(s). *Note: Alerts / events related incidents are not required to be reviewed by the Incident Manager unless the applicable resolver team in receipt of the alert determines it to have or potentially have end user impact.*	For a selection of incidents, inspected the incident ticket and noted that classification, priority and engaged team(s) had been assigned by the Service Desk team for the incident ticket logged in the service management tool. For a selection of end user / customer raised P1 and P2 incidents, inspected the incident ticket and noted that the ticket had been reviewed by the Incident Manager and the appropriateness of the priority based on the circumstances of the incident had been assessed, which may result in the priority being either increased or decreased. Further noted that the Technical Resolver team(s) had been engaged by the Incident Manager, and the ticket had been assigned by the Service Desk team to the engaged team(s).	No exceptions noted.

Control Ref.	Control Activities Specified by NSS	Tests Performed by KPMG LLP	Results of Testing
6.5	On a monthly basis, the Service Desk Management Team Leaders reviews SLA report and the KPI performance report to assess trends on incidents, repeat incidents that requires to be escalated as a problem, and identify incidents that are not resolved or likely not to be resolved within the agreed SLA timeline The review is documented, including actions taken to expedite the incidents resolution or recurring incidents that need to be escalated as a problem. Actions and changes determined as a result of the MIR is assigned and tracked using the service management toolset.	For a selection of months, inspected the MIR reports and noted that the SLA report and the KPI performance report had been reviewed by the Service Desk Management Team Leaders to assess trends on incidents, repeat incidents that required to be escalated as a problem, and identify incidents that were not resolved or likely not to be resolved within the agreed SLA timeline. For a selection of months, inspected the MIR reports and noted that actions taken to expedite the incidents resolution or recurring incidents that needed to be escalated as a problem had been documented. Further noted that actions and changes determined as a result of the MIR had been assigned and had been tracked using the service management toolset.	No exceptions noted.

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

4.1 OUR VALUES

The NSS values are a collection of guiding principles around what the organisation considers to be professional, ethical and effective personal conduct within a working environment.

In 2009, staff from across the organisation, were involved in creating and defining our values and translating them into behaviours to bring them to life.

This common set of values, endorsed by Staff Governance, helps us all create a better NSS community, whilst honouring the traditions and good work of our SBUs and Directorates.

Our values outlined below are communicated through the organisation's intranet:

- Committed to each other;
- Customer focus;
- Integrity;
- Openness;
- Respect and care;
- Excel and improve.

4.2 COVID-19

As a result of COVID-19 response, recover and renew activity, the teams have complied with government guidance and the distributed workforce are in the most part working remotely with no impact to services and support provision. NSS has continued to work in partnership to plan and adjust working practices for COVID-19 recovery plans in line with government guidance and has been instrumental in the provision of systems and services to manage through the pandemic for Scotland

All NSS teams have seen a dramatic and sustained rise in demand for existing services and the creation of new solutions and services resulting in the need to increase capacity across the teams to manage and support. These new services, including dashboards and data services to manage oxygen flow and PPE for example, test & protect case management solutions, vaccination scheduling capabilities, hospitality apps, care home portals, haulier testing portals and hospitality check in/out application and all associated support models and ability to on-board resources to manage the services in the community have been deployed whilst continuing to maintain and deliver existing services within SLA and manage the increasing demand associated with enabling the NSS workforce to work from home.

The use of key technologies has been deployed and increased connectivity and access enabled across the networks to ensure all users can effectively conduct their work in this distributed model. Equipment has been provided and despatched where necessary to support NSSs and extended teams and also across the Health Boards where necessary to fully respond to the COVID-19 and general Business needs.

In some cases, the need to pause or revise processes have been taken by NSS to manage the volume of work across the teams and ensure our teams are able to work in a safe and secure manner.

NHS Ayrshire & Arran

National Single Instance Financial Ledger Services for the year ended 31 March 2022

Our purpose

Working together to achieve the healthiest life possible for everyone in Ayrshire and Arran

Contents

Introduction

NHS Ayrshire & Arran ("NHS A&A") operated the National Single Instance ("NSI") financial ledger services on behalf of all Customer NHS Boards for the financial year ended 31 March 2022. This report sets out the overarching control objectives in place for the service, as set out in the Service Level Agreement, along with the individual controls we have designed and operated for the year 1 April 2021 to 31 March 2022 to achieve the stated control objectives.

NHS A&A management detail in this report:

- The relevant control objectives, as agreed with the Customer NHS Boards;
- The specific controls which were operating as described during the year 1 April 2021 to 31 March 2022 to meet each of these agreed objectives; and
- The results of testing by the appointed Independent Service Auditor, BDO LLP.

Section 1: Management's Statement

Description

NHS Ayrshire & Arran ("NHS A&A") management is responsible for the design, implementation and maintenance of controls to ensure, with reasonable assurance, and on an ongoing basis, that the control objectives as set out are achieved. NHS A&A's management has reviewed the relevant National Single Instance ("NSI") financial ledger services control objectives and the relevant controls in operation for the year under review (1 April 2021 to 31 March 2022). These controls are reviewed and assessed with the agreement of the Customer NHS Boards concerned.

In carrying out those responsibilities we have regard not only to the interests of Customer NHS Boards but also to those of NHS A&A and the general effectiveness and efficiency of the relevant operations.

The accompanying description of the service has been prepared for Customer NHS Boards who have used the NSI financial ledger services and their auditors who have sufficient understanding to consider the description, along with other information including information about controls operated by Customer NHS Boards themselves, when assessing the risks of material misstatements within the Customer NHS Boards' financial statements.

We have evaluated the fairness of the description and the suitability and effectiveness of NHS A&A's controls having regard to the International Standard on Assurance Engagements 3402 ("ISAE 3402"), issued by the International Auditing and Assurance Standards Board.

We confirm that:

a) The accompanying description at Sections 3-5 fairly presents the NSI financial ledger services throughout the period 1 April 2021 to 31 March 2022. The criteria used in making this assertion were that the accompanying description:

   i) Presents how the services were designed and implemented, including: the types of services provided, and as appropriate, the nature of transactions processed; the procedures, both automated and manual, by which Customer NHS Board transactions were initiated, recorded and processed; the accounting records and related data, that was maintained and corrected as necessary; the system which captured and addressed significant events and conditions, other than Customer NHS Board transactions; the components of the information systems supporting the relevant transactions that protected the confidentiality and integrity of data; relevant control objectives and controls designed to achieve those objectives; controls that we assumed, in the design of the system, would be implemented by user entities, and which, if necessary to achieve control objectives stated in the accompanying description, are identified in the description along with the specific control objectives that cannot be achieved by ourselves alone; and other aspects of our control environment, risk assessment process, monitoring and information and communication systems that were relevant to our control activities;

   ii) Includes relevant details of changes (if any) to NHS A&A's systems during the period; and

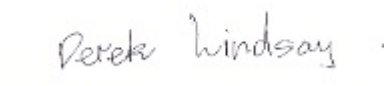
   iii) Does not omit or distort information relevant to the scope of the services being described, while acknowledging that the description is prepared to meet the common needs of the Customer NHS Boards and their auditors and may not, therefore, include every aspect of the services that the Customer NHS Boards may consider important in its own particular environment.

b) The controls related to the control objectives stated in the accompanying description were suitably designed and operated effectively throughout the period 1 April 2021 to 31 March 2022. The criteria used in making this assertion were that:

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

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

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



Derek Lindsay
Director of Finance
Signed on behalf of NHS Ayrshire & Arran

20 April 2022

Section 2: Independent Service Auditor's Assurance Report

Independent service auditor's assurance report on National Single Instance Financial Ledger Services controls at NHS Ayrshire & Arran (the "Service Organisation")

To the Directors of NHS Ayrshire & Arran

Scope

We have been engaged to report on NHS Ayrshire & Arran's description of its National Single Instance ("NSI") Financial Ledger Service controls throughout the period 1 April 2021 to 31 March 2022 (the "description"), and on the suitability of the design and operating effectiveness of controls to achieve the related control objectives.

The Service Organisation uses a variety of sub-service organisations as described in Section 3. The description includes only the controls and related control objectives of the Service Organisation and excludes the control objectives and related controls of the sub-service organisations. Our examination did not extend to controls of the sub-service organisations.

The description indicates that certain control objectives specified in the description can be achieved only if complementary user entity controls contemplated in the design of the Service Organisation's controls are suitably designed and operating effectively, along with related controls at the Service Organisation. We have not evaluated the suitability of the design or operating effectiveness of such complementary user entity controls.

While the controls and related control objectives may be informed by the Service Organisation's need to satisfy legal or regulatory requirements, our scope of work and our conclusions do not constitute assurance over compliance with those laws and regulations.

Service Organisation's Responsibilities

The Service Organisation is responsible for: preparing the description in sections 3 to 5 and the accompanying management statement set out in section 1, including the completeness, accuracy and method of presentation of the description and the management statement; providing the NSI financial ledger services covered by the description; specifying the criteria and stating them in the description; identifying the risks that threaten the achievement of the control objectives; and designing, implementing and effectively operating controls to achieve the stated control objectives.

The control objectives stated in the description in section 4 are those specified by the Service Organisation.

Service Auditor's Responsibilities

Our responsibility is to express an opinion on the fairness of the presentation of the description and on the suitability of the design and operating effectiveness of the controls to achieve the related control objectives stated in that description based on our procedures. We conducted our engagement in accordance with International Standard on Assurance Engagements 3402. That standard requires that we comply with ethical requirements and plan and perform our procedures to obtain reasonable assurance about whether, in all material respects, the description is fairly presented and the controls were suitably designed and operating effectively to achieve the related control objectives stated in the description.

An assurance engagement to report on the description, design and operating effectiveness of controls at a service organisation involves performing procedures to obtain evidence about the presentation of the description and the suitability of design and operating effectiveness of the controls. Our procedures included assessing the risks that the description is not fairly presented and that the controls were not suitably designed or operating effectively to achieve

the related control objectives stated in the description. Our procedures also included testing the operating effectiveness of those controls that we consider necessary to provide reasonable assurance that the related control objectives stated in the description were achieved. An assurance engagement of this type also includes evaluating the overall presentation of the description, the suitability of the control objectives stated therein, and the suitability of the criteria specified by the Service Organisation and described in section 1.

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

Limitations of Controls at a Service Organisation

The Service Organisation's description is prepared to meet the common needs of a broad range of Customer NHS Boards and their auditors and may not, therefore, include every aspect of the Service Organisation's activities that each individual Customer NHS Board may consider important in its own particular environment. In addition, because of their nature, controls at a service organisation may not prevent or detect all errors or omissions in processing or reporting transactions. Also, the projection of any evaluation of effectiveness to future periods is subject to the risk that controls at a service organisation may become inadequate or fail.

Opinion

Our opinion has been formed on the basis of the matters outlined in this report. The criteria we used in forming our opinion are those described in the management assertion in Section 1.

In our opinion, in all material respects:

a) The description in sections 3 to 5 fairly presents the Service Organisation's financial ledger services as designed and implemented throughout the period from 1 April 2021 to 31 March 2022;

b) The controls related to the control objectives stated in the description were suitably designed to provide reasonable assurance that the specified control objectives would be achieved if the described controls operated effectively throughout the period from 1 April 2021 to 31 March 2022 and customers applied the complementary user entity controls referred to in the scope paragraph of this assurance report; and

c) The controls tested which, together with the complementary user entity controls referred to in the scope paragraph of this assurance report, if operating effectively, were those necessary to provide reasonable assurance that the control objectives stated in the description were achieved, operated effectively throughout the period from 1 April 2021 to 31 March 2022.

Description of Test of Controls

The specific controls tested and the nature, timing and results of those tests are detailed in Section 5.

Other information

The information included in Section 7 describing the Service Organisation's responses to exceptions noted is presented by the Service Organisation to provide additional information and is not part of the Service Organisation's description of controls that may be relevant to customers' internal control as it relates to an audit of financial statements. Such information has not been subjected to the procedures applied in the examination of the description of the Service Organisation, related to the NSI financial ledger services, and accordingly, we express no opinion on it.

Intended Users and Purpose

This report and the description of tests of controls and results thereof in section 5 are intended solely for the use of the Service Organisation and solely for the purpose of reporting on the controls of the Service Organisation, in accordance with the terms of our engagement letter dated 25 January 2022 (the "agreement").

Our report must not be recited or referred to in whole or in part in any other document nor made available, copied or recited to any other party, in any circumstances, without our express prior written permission. We permit the disclosure of this report, in full only, including the description of tests of controls and results thereof by the Service Organisation at its discretion to Customer NHS Boards using its NSI financial ledger services and to the auditors of such Customer NHS Boards, to enable Customer NHS Boards and their auditors to verify that a service auditor's report has been commissioned by the Service Organisation and issued in connection with the controls of the Service Organisation, and without assuming or accepting any responsibility or liability to Customer NHS Boards or their auditors on our part.

We are prepared to extend our assumption of responsibility to those Customer NHS Boards of the Service Organisation who first accept in writing the relevant terms of the agreement entered previously with the Service Organisation as if the Customer NHS Board had signed the agreement when originally issued, and including the provisions limiting liability contained in the agreement ("Contracted Customers"). This extension will not apply to a Customer NHS Board where we inform that Customer NHS Board, whether before or after the Customer NHS Board accepts the relevant terms of the agreement, that they do not meet our acceptance criteria.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Service Organisation and Contracted Customers for our work, for this report or for the opinions we have formed.

Signature: 

BDO LLP

Date of Assurance Report: 29th April 2022

Section 3: Management's description of system

Introduction

NHS Ayrshire & Arran ("NHS A&A") hosted the National Single Instance ("NSI") financial ledger services on behalf of all Customer NHS Boards in Scotland for the financial year ended 31 March 2022. These 22 Customer NHS Boards all used the NSI financial ledger services during 2021/22 for core financial transactions. The Finance System used is Advanced (formally Advanced Business Solutions- ABS) Ltd.'s eFinancials 5.0.2 Business Suite (system upgrade from 4.0.4 Business Suite was completed on the 19th February 2018). The business suite also includes the third party product, RAM's Asset 4000/Forecast4000/Asset Modifier, for Fixed Asset Accounting. Use is also made of Business Objects Xi (BI v4) for reporting against the eFinancials database and a mirror copy of the Live database which is held on a Netezza server/database. These services are provided through a national contract managed on behalf of NHS Scotland by NHS Ayrshire & Arran.

Overview of Third Party Service Providers

NHS Ayrshire & Arran uses various outsourced third-party service providers to perform certain aspects of its operations. This is primarily to improve efficiency where the specialist nature of the tasks requires specific expertise. Relevant to this are the following third-party service providers:

- Atos provides national IT services to the NHS in Scotland and hosts the servers upon which the NSI financial ledger sits.
- ABS maintains the eFinancials application therefore is responsible for the provision of software upgrades, control improvements and eFinancials system developments and changes.
- NSS Business Intelligence Team maintains the Business Intelligence environment and processes any user/universe changes as instructed by the NSI Team.

Main Finance Systems accessed at Boards

- eFinancials - Financial Ledgers;
- Asset 4000 Real Asset Management (RAM) - Fixed Assets;
- Finance Process Manager (FPM) – Customer/Supplier Standing;
- Business Intelligence 4 (BI4) – Reporting and Analysis;
- DbCapture (V1 Product Suite) – OCR Document Management; and
- DbBACS (V1 Product Suite) – BACS File Transmissions.

Summary of Services Offered

The following 22 Customer NHS Boards utilise the NHS Ayrshire & Arran hosted NSI financial ledger services:

- NHS 24;
- NHS Ayrshire & Arran;
- NHS Borders;
- NHS Dumfries & Galloway;
- NHS Education for Scotland;
- NHS Fife;
- NHS Forth Valley;
- NHS Grampian;

- NHS Greater Glasgow & Clyde;
- NHS Public Health Scotland;
- NHS Healthcare Improvement Scotland;
- NHS Highland;
- NHS Lanarkshire;
- NHS Lothian;
- NHS National Services Scotland;
- NHS National Waiting Times;
- NHS Orkney;
- NHS Scottish Ambulance Service;
- NHS Shetland;
- NHS State Hospital For Scotland;
- NHS Tayside; and
- NHS Western Isles.

The National Finance Systems Team (the "NSI Team") provides a helpdesk service (Zendesk) where standing data and support tickets are raised via a web portal or through an email. The range of services provided by the NSI Team is listed below:

- Agreeing system modifications and developments with the relevant NHS Scotland Finance/Procurement governance arrangements and the software owners;
- Ensures that software developments are consistent and functionality is maintained/enhanced;
- Liaising with ATOS to ensure timeous resolution of all logged faults in line with SLAs;
- Liaising with the Advanced Help Desk to ensure timeous resolution of all logged faults in line with SLAs;
- Liaising with the NSS BI team to ensure timeous resolution of all logged faults in line with SLAs;
- Login and password administration for eFinancials and RAM;
- First line and second line application support;
- Control of secure access to eFinancials and RAM via allocation of roles;
- Administration of User Accounts for eFinancials and RAM;
- User Support/Training/Advice;
- Standing Data maintenance;
- Netezza/Change Data Capture (CDC) Maintenance in conjunction with Advanced; and
- BOXi Universe Maintenance.

Responsibilities of NHS Ayrshire & Arran and Individual Customer NHS Boards

NHS A&A has established a Service Level Agreement ("SLA") with each of the Customer NHS Boards which is reviewed on an annual basis by NHS A&A and the governance group National Finance Systems Management Group (on behalf of the Customer NHS Boards). The SLA sets out the responsibilities of NHS A&A to provide the NSI financial ledger services and the responsibilities of the individual Customer NHS Boards. NHS A&A has defined the control objectives and key controls in place for the financial ledger arrangements operated by the NSI financial ledger services and these have been agreed with each NHS Board and are re-confirmed annually by the National Finance Systems Management Group.

Financial Ledger Arrangements – Processes

NSI financial ledger services provides certain financial ledger services for the Customer NHS Boards that receive this service. This service is provided through a geographically dispersed and remotely managed delivery model managed by the National Finance Systems Manager, who is responsible for the National Finance System Support Team ("NSI Team"). The NSI Team has team members based in NHS A&A, NHS Greater Glasgow & Clyde, NHS Lanarkshire, NHS Lothian, NHS National Services Scotland and NHS Tayside Health Boards. A number of these staff were previously employed by the Health Boards where they are currently based. These staff became NHS A&A employees through a TUPE process which came into effect on the 1 April 2014. As part of the TUPE process, agreements are in place with local Boards to continue to host these remotely located members of the NSI Team.

Authorised users

When a new or a change of user access request, for any of the Finance Systems managed under the SLA, is received from a Customer Health Board, the NSI Team will check that the request is authorised by an appropriate named individual within that Customer Health Board before the request is processed by an appropriate member of the NSI Team.

Access to any of the Finance Systems managed under the SLA agreement is restricted to authorised personnel as approved by the Customer Health Boards.

Business Objects

Access to Business Objects is managed by the NSI Team to ensure that only individuals authorised by the Customer Health Boards have access to their own Health Board data. Note that some Boards receiving services from other Boards allow access to their Board's data to staff from other Boards on a user by user basis.

Note that a third party, National Services Scotland Business Intelligence Team, processes requests logged with them by the NSI Team on behalf of the Boards.

Changes to eFinancials and RAM standing data

eFinancials standing data is maintained on behalf of the Customer Health Boards by the NSI Team. Boards maintain their own RAM standing data with the NSI Team maintaining system-wide settings and user access levels.

Customer and supplier standing data (as well as other standing data elements) is created or amended by the NSI Team on receipt of a request form from an authorised approver from a Customer Health Board. The set-up of the data is performed by restricted personnel within the NSI Team.

System upgrades and developments

The NSI Team agrees system modifications and developments with the relevant Scottish NHS Boards and the software owners.

The NSI Team ensures software developments are consistent and functionality is maintained / enhanced.

The NSI Team liaises with support teams from ATOS, Advanced (ABS) and the NSS BI team to ensure timeous resolution of all logged faults in line with the SLA.

System queries

The NSI Team provides/arranges system support, training and advice for each of the Finance Systems managed under the SLA.

The NSI Team assists with login and password administration queries for each of the Finance Systems managed under the SLA.

Period-end general ledger close

The NSI Team performs the month-end financial ledger close processes for the General Ledger and each of the Boards sub-ledgers. Where exceptions are identified by the NSI Team these are reported to the relevant Customer NHS Boards.

The NSI Team performs the year-end financial ledger close process for the General Ledger and each of the Boards sub-ledgers. Where exceptions are identified by the NSI Team these are reported to the relevant Customer NHS Boards.

Monitoring and governance

Service delivery is governed by an extensive SLA with all the Customer NHS Boards. The National Finance Systems Management Group (includes customer representation) provides the direct monitoring and governance for the service. Monthly KPIs are produced on performance against the SLA targets and issued quarterly.

Financial Ledger Arrangements (In Scope)

The aspects of the NSI Financial Ledger Services which are within the scope of this report are:

- Managing user access to each of the Finance Systems managed under the SLA, processing documentation for standing data requests including the creation of new supplier/customer accounts and Chart of Accounts requests as well as standing data amendments and the deletion/marking codes inactive of standing data elements;
- Managing software upgrades on behalf of the Customer NHS Boards and liaising with the third party supplier over any necessary changes to the core software; and
- Logging system queries from the Customer NHS Boards which relate to the service provision and taking these forward internally or with third parties as required.

Financial ledger Arrangements (Excluded from Scope)

Excluded from the scope of this report are the following services and related controls:

- Any transactional processing services provided by any Board to another Board, for example accounts payable services, on behalf of Customer NHS Boards;
- Atos provides national IT services to the NHS in Scotland and hosts the servers upon which the financial ledger sits. Therefore, IT general controls, controls over the server, backup of financial ledger data and disaster recovery arrangements are outside the scope of this report;
- The National Services Scotland Business Intelligence Team provides Business Intelligence services to the NHS in Scotland and hosts the servers that the Business Intelligence reporting tools sit on. Therefore, IT general controls, controls over the server, backup of Business Intelligence reporting solutions are outside the scope of this report; and
- Advanced Business Solutions (“ABS”) maintains eFinancials and therefore is responsible for the provision of software upgrades, control improvements and eFinancials system developments and changes. These activities are outside the scope of this report.

Complementary Controls

The following controls are expected to be in operation at the Customer NHS Boards to complement the NSI service:

- Reviewing and approving the authorisation matrices used to approve requests in eFinancials/FPM (for standing data and user access requests) and RAM/DbCapture (for user access requests);
- Communicating changes to the local authorisation matrices to NSI on a timely basis;

- Individual Customer NHS Boards perform user access reviews twice per calendar year and as a result of this review Boards will inform the NSI Team of any required changes to user access levels that should be undertaken;
- Any changes/updates to standing data records (including requests for new records) have been reviewed/validated by appropriate authorised individuals in the Customer NHS Boards before the request is submitted for input by the NSI Team; and
- Individual Customer NHS Boards undertake housekeeping and ensure that they process transactions in-line with agreed timetables as well as reviewing and resolving any issues with their ledgers that are identified and notified to them by the NSI Team.

Section 4: Summary of agreed control objectives

Set out below are the control objectives over the financial ledger services provided by the NSI Team to the Customer NHS Boards, as set out in the Service Agreement between NHS A&A and each individual Customer NHS Board, as relevant to this report.

Ref	Financial Systems Services Control Objective	Consideration of key risks
1	Only authorised users (as determined by Customer NHS Boards) can access the Finance Systems used under this SLA.	o Access to the Finance Systems is granted to an individual without the necessary approval of the Customer NHS Board; o Amendment to access rights requests is not appropriately authorised by the Customer NHS Board but still processed by NSI Team; and o Access to each of the Finance Systems is not adequately restricted.
2	Business Objects reporting data is restricted to authorised users.	o Data for a specific Board(s) is visible to any other NHS Boards Business Objects users; o Changes to the eFinancials and RAM universes are made by unauthorised users.
3	Changes to eFinancials and RAM standing data will only be undertaken when appropriately authorised by the Customer NHS Board.	o Changes to standing data are made by the NSI Team without appropriate authorisation from the individual Customer NHS Board, resulting in risk of supplier payment and customer invoice submission errors.
4	Ensure that Third Party Performance is managed and monitored in line with contractual service level agreements.	o Third Party service provider's performance does not meet the contractual standards that are required to allow the NSI Team to provide a professional and resilient service to the Boards using the National Finance Systems Team's services.
5	Ensure that system bugs and/or any required system enhancements are logged on the third party helpdesk or development forum and these are managed/ coordinated and monitored by the NSI Team and any fixes/developments received are only applied to the LIVE system after successful User Acceptance Testing.	o Logging of incidents/changes are not adequate, resulting in a fix/enhancement not being delivered for a system deficiency; and o User acceptance testing is not completed by the NSI Team before a system change is made to the live environment by the supplier.

Ref	Financial Systems Services Control Objective	Consideration of key risks
6	Finance System queries received by the NSI Team are accurately recorded and managed through to closure using the helpdesk system.	o Not all queries are logged resulting in action not being taken by the NSI Team or the supplier to address the issues reported; o Queries are resolved in an "ad hoc" manner not following procedures; o A full record of all queries is not available for analysis; and o Incidents, standing data requests and queries are not formally logged and monitored in line with the agreed SLA resulting in poor and untimely support provision and a loss of control of the issues that are arising with the system.
7	eFinancials and RAM monthly ledger closedowns are closed accurately and on a timely basis as set out in the timetable agreed with the Customer NHS Boards.	o Common period closedowns are not coordinated and agreed with Customer NHS Boards resulting in closedown failures. Outstanding transactions may not be processed in advance of the scheduled closedown routines and therefore delay the rollover to the next accounting period.
8	Responsibilities set out in the Customer NHS Board Service Level Agreement are completed and reported as agreed.	o Performance reporting may not identify areas for improvement internally and may not provide necessary assurances to Customer NHS Boards.

Section 5: Testing of Controls

CONTROL OBJECTIVE 1: Only authorised users (as determined by Customer NHS Boards) can access the Finance Systems used under this SLA.			
Ref	**NSI Team description of controls**	**Service Auditor's testing**	**Exceptions Noted**
1.1	User access rights to each of the Finance Systems managed under the SLA (eFinancials/RAM/FPM/BOXi/DbCapture/BACS & GoAnywhere) are granted/amended on receipt of an authorised request from individual Customer Boards (BACS and GoAnywhere reviews implemented from second half of 2018/19). o An up-to-date list of individuals allowed to authorise changes is maintained by Boards and shared with the NSI Team. The list is formally reviewed on a six monthly basis to ensure it remains accurate.	**Inspection** For a sample of user access right requests relating to systems eFinancials, RAM, FPM, BOXi, BACS, GoAnywhere and DbCapture, we inspected 40 service desk tickets against Board authoriser listings to confirm that requests were appropriately authorised prior to implementation.	No exceptions noted.
1.2	A review of user access is carried out on a six monthly basis by requesting information from Health Boards that user access remains appropriate.	**Inspection** For a bi-annual sample, and for a sample of five NHS Boards, we inspected evidence to confirm that the NSI team circulated user access listings to NHS Boards to allow them to review and confirm the validity of system access. Also, we inspected evidence to confirm that the feedback (i.e. user access changes) received from the NHS Boards was suitably actioned by the NSI service desk, and that the required service tickets were in place and completed for all reviews.	No exceptions noted.

Ref	NSI Team description of controls	Service Auditor's testing	Exceptions Noted
1.3	Logical access to eFinancials is controlled through an appropriate authentication method as defined in 'NHS Scotland eFinancials Business Suite National Single Instance Finance System - System Operating Procedures' (v4.): o Authentication by unique user ID and complex password. o Minimum password length is 8 characters. o System enforced user password changes at regular intervals (90 days). o Automatic lockout of the user ID after a predetermined number of incorrect log-in attempts (3 failures). o Access to data/sub-ledgers is managed through the assignment of roles to users. o The number of users with full administrator access is restricted to members of the NSI Team.	**Inspection** We inspected the eFinancials system security settings to confirm that: o Board user authentication is by unique user ID and complex password; o Minimum password length is set to be 8 characters; o System enforced user password change is set to occur every 90 days; o Automatic lockout of user accounts will occur after 3 incorrect log-in attempts; o Access to data/sub-ledgers is managed through the assignment of roles to users; and o The number of users with full administrator access is restricted to members of the NSI Team.	No exceptions noted.

CONTROL OBJECTIVE 2: Business Objects reporting data is restricted to authorised users.			
Ref	**NSI Team description of controls**	**Service Auditor's testing**	**Exceptions Noted**
2.1	User access rights to Business Objects are granted/amended on receipt of an authorised request from individual Customer Boards.	**Inspection** For a sample of 30 user access right requests relating to the BOXi system, we inspected service desk tickets against Board authoriser listings to confirm that the requests were appropriately authorised prior to implementation.	No exceptions noted.
2.2	Users can only access specific Board data through the use of security views.	**Inspection** We inspected system settings to confirm that security views have been implemented, through SQL based queries against BOXi universe tables/objects, in order to prevent Boards from viewing data other than their own.	No exceptions noted.
2.3	Only the NSI Team can perform Business Objects Universe Maintenance. Requests for changes to the Universe are made through the helpdesk by users.	**Inspection** We inspected the LDAP security group membership setup to allow administration and maintenance level access to BOXi to confirm that access is restricted to members of the NSI team. **Enquiry** Confirmed through enquiry that the standard service desk change management process (see control objective 3) is followed to control any changes or amendments to the BOXi universe required by the Boards.	No exceptions noted.

CONTROL OBJECTIVE 3: Changes to eFinancials and RAM standing data will only be undertaken when appropriately authorised by the Customer NHS Board.			
Ref	**NSI Team description of controls**	**Service Auditor's testing**	**Exceptions Noted**
3.1	Customer standing data within eFinancials is amended on receipt of an authorised request from the relevant Customer Board.	**Inspection** For a sample of 30 changes to customer standing data within eFinancials, we inspected evidence to confirm that these were amended following receipt of an authorised request from the relevant NHS Board.	No exceptions noted.
3.2	Supplier standing data within eFinancials is amended on receipt of an authorised request from the relevant Customer Board.	**Inspection** For a sample of 30 supplier standing data changes within eFinancials, we inspected evidence to confirm that these were amended following receipt of an authorised request from the relevant NHS Board.	No exceptions noted.
3.3	Amendments to the Chart of Accounts, Cost Centres, Job Codes, Activity Codes, Alternative Deliver Addresses, Site Addresses and Internal Delivery Addresses ("IDAs") within eFinancials are only made on receipt of an authorised request from Customer NHS Board.	**Inspection** For a sample of 30 amendments to the Chart of Accounts, Cost Centres, Job Codes, Activity Codes, Alternative Deliver Addresses, Site Addresses and Internal Delivery Addresses ("IDAs") within eFinancials, we inspected evidence to confirm that these were implemented following receipt of an authorised request from the relevant NHS Board.	No exceptions noted.
3.4	Ad-hoc Board specific standing data requests are created/amended within eFinancials on receipt of an authorised request from the relevant Customer Board.	**Inspection** For a sample of 30 ad-hoc Board specific standing data requests within eFinancials, we inspected evidence to confirm that these were created/amended following receipt of an authorised request from the relevant NHS Board.	No exceptions noted.
3.5	Ad-hoc shared standing data areas are only created/amended within eFinancials on receipt of an authorised request through the appropriate governance channels.	**Inspection** For a sample of 30 ad-hoc shared standing data area requests within eFinancials, we inspected evidence to confirm that these were only created/amended following receipt of an authorised request through an appropriate NHS governance channel.	No exceptions noted.

CONTROL OBJECTIVE 4: Ensure that Third Party Performance is managed and monitored in line with contractual service level agreements.			
Ref	**NSI Team description of controls**	**Service Auditor's testing**	**Exceptions Noted**
4.1	Appropriate and current support contracts with third-party suppliers (Atos, Advanced and the NSS BI Team) are in place and performance is monitored through agreed KPIs which are reviewed by the NSI Team Manager on a monthly (Atos and Advanced) and quarterly (NSS BI Team) basis with follow-up actions taken to address any exceptions.	**Inspection** Inspected evidence to confirm that support contracts with defined KPIs are in place for all three third parties currently supporting NSI service provision. **Inspection** For a sample of four months and two quarters, we inspected evidence to confirm that NSI Management reviewed monthly (for Atos and Advanced) and quarterly (for NSS BI Team) KPIs and followed-up on actions to address any exceptions.	No exceptions noted.
4.2	Atos and Advanced provide monthly service performance reports to NSI Management.	**Inspection** For a sample of four months, we inspected evidence to confirm that service performance reports were produced by Atos, and Advanced and that these were reviewed by NSI Management.	No exceptions noted.
4.3	Monthly service review meetings are held with Atos, attended by NSI Management and Atos Service Management.	**Inspection** For a sample of four months, we inspected evidence to confirm that monthly service review meetings were held between NSI Team and Atos and that these meetings were attended by relevant individuals from both parties.	No exceptions noted.
4.4	4-monthly service review meetings are held with Advanced to review performance attended by an Advanced Support Manager and NSI Management.	**Inspection** For a sample of 4-monthly service review meetings, we inspected evidence to confirm that service review meetings were held between NSI Team and Advanced to review service performance and that these meetings were attended by relevant individuals from both parties.	No exceptions noted.

Ref	NSI Team description of controls	Service Auditor's testing	Exceptions Noted
4.5	Fortnightly service calls are held with Advanced to discuss and review current performance issues with participation by an Advanced Support Manager and NSI Service Management.	**Inspection** For a sample of eight fortnightly calls, we inspected evidence to confirm that calls were held between the NSI Team and Advanced to discuss service performance issues and that there was participation on calls by relevant individuals from both parties.	No exceptions noted.

CONTROL OBJECTIVE 5: Ensure that system bugs and/or any required system enhancements are logged on the third party helpdesk or development forum and these are managed/ coordinated and monitored by the NSI Team and any fixes/developments received are only applied to the LIVE system after successful User Acceptance Testing.			
Ref	**NSI Team description of controls**	**Service Auditor's testing**	**Exceptions Noted**
5.1	All system functionality issues are logged on the third party helpdesk/support desk.	**Enquiry & Observation** Confirmed through enquiry and observation the process for logging system functionality issues on the third party (Advanced) helpdesk and (NSI) support desk. Note: As part of our testing for controls 5.2 and 5.3, we confirmed through inspection that these processes are being followed by the NSI Team.	No exceptions noted.
5.2	All application fixes/changes received are logged on the NSI Fix Log to monitor progress throughout the change lifecycle. This includes the relevant NSI Helpdesk (Zendesk) ticket reference and third party helpdesk reference.	**Inspection** For a sample of three implemented fixes/changes logged on the NSI Fix Log and Zendesk, we inspected evidence to confirm that the Zendesk ticket was used to record progress throughout the lifecycle of the change. Also, confirmed that the ticket included details of the relevant NSI and third party (Advanced) service desk reference.	No exceptions noted.
5.3	All changes/developments are subject to User Acceptance Testing ("UAT") and NSI Management approval prior to being deployed to the live environment.	**Inspection** For a sample of three fixes/changes, we inspected evidence to confirm that these were subject to NSI user acceptance testing and management approval prior to being deployed in the live environment.	No exceptions noted.

Ref	NSI Team description of controls	Service Auditor's testing	Exceptions Noted
5.4	A service desk ticket must be raised with Atos in order to apply a fix/change to any system environment (development, test and live).	**Enquiry** Confirmed through enquiry that only Atos has system access rights that would allow the application of changes to the various environments supporting the eFinancials and RAM systems. **Inspection** For a sample of three fixes/changes, we inspected evidence to confirm that these were applied to the live environment by third party Atos through a request logged within the Zendesk ticket.	No exceptions noted.
5.5	Third Party application developers do not have direct access to the live environment and can only gain access in a controlled manner.	**Enquiry** Confirmed through enquiry that third party application developers (i.e. Advanced) have not been setup with direct access to the live environment. By default, their system access is locked down and can only be enabled through the NSI Team raising a call with the Atos service desk. Also, confirmed that Atos provides metrics on the number of instances of third party access in its monthly service performance report. Data for these reports is collated from the Atos service desk.	No exceptions noted.

CONTROL OBJECTIVE 6: Finance System queries received by the NSI Team are accurately recorded and managed through to closure using the helpdesk system.			
Ref	**NSI Team description of controls**	**Service Auditor's testing**	**Exceptions Noted**
6.1	All queries, standing data requests and issues are logged and recorded as tickets on the NSI Helpdesk and, where appropriate, with the Advanced (ABS-eFinancials and Atos) Helpdesks. o A minimum dataset is defined for all tickets; severity levels are agreed and actioned accordingly. o All requests are assigned a severity level by the NSI Team based on the policy defined in the relevant Board Service Level Agreement in order to prioritise the requests and manage the timely resolution of queries. o All tickets have a current status and target resolution date logged on the system.	**Enquiry & Observation** Confirmed through enquiry and observation that a minimum dataset is enforced for all tickets raised on the NSI service desk (Zendesk). **Inspection** We inspected a sample of 220 service desk tickets to confirm that a minimum dataset, including severity levels, incident status and target resolution date, was recorded for each ticket logged on Zendesk. We also conducted data analytics on the populations provided with ticket extracts from Zendesk and verified that minimum datasets were met.	No exceptions noted.

CONTROL OBJECTIVE 7: eFinancials and RAM monthly ledger closedowns are closed accurately and on a timely basis as set out in the timetable agreed with the Customer NHS Boards.			
Ref	**NSI Team description of controls**	**Service Auditor's testing**	**Exceptions Noted**
7.1	Month-end financial ledger close procedures are undertaken in accordance with the agreed timetable with the individual Customer NHS Boards. The process to close the General Ledger and each of the Boards sub-ledgers is run as per the agreed timetable and any issues identified on the exception reports will be taken forward by the NSI Team to ensure each of the Ledgers are successfully closed.	**Inspection** For a sample of four months, and for a sample of five Boards, we inspected evidence to confirm that the process to close the General, Purchase and Sales ledgers for each Board was run as per the agreed timetable. Also, confirmed that where necessary, issues identified during the close process were investigated and escalated by the NSI team to ensure close timelines were met.	No exceptions noted.

CONTROL OBJECTIVE 8: Responsibilities set out in the Customer NHS Board Service Level Agreement are completed and reported as agreed.			
Ref	**NSI Team description of controls**	**Service Auditor's testing**	**Exceptions Noted**
8.1	Quarterly performance reports against agreed KPIs (as defined in the Service Level Agreement) are produced and provided to the Customer NHS Board in line with the Service Level Agreement.	**Inspection** For a sample of two quarters, we inspected evidence to confirm that performance reports with agreed KPI metrics were produced and submitted to NHS Boards, and we verified that our sample of five NHS Boards all had signed SLAs in place with NHS A&A.	No exceptions noted.
8.2	The National Financial Systems Management Group ("NFSMG") meets on a quarterly basis in order to monitor the NSI service provision. The members of the group receive performance reports on a quarterly basis in advance of the NFSMG meetings. This includes a performance summary overview from the monthly NSI KPI reports, monthly Atos service reports and Advanced incident reports to identify those areas which require follow-up and action.	**Inspection** For a sample of two quarters, we inspected evidence to confirm that the NFSMG met formally to monitor and review NSI service provision. Also, we inspected evidence to confirm that NFSMG received third party service performance information in advance of meetings and that this highlighted areas where service improvement was required.	No exceptions noted.
8.3	The 'NHS Scotland eFinancials Business Suite National Single Instance Finance System - System Operating Procedures' document is reviewed by an appropriate individual in the NSI Team. These are reviewed for completeness on an annual basis and updates are subject to authorisation by the NFSMG.	**Inspection** We inspected evidence to confirm that the SOP 'eFinancials Business Suite National Single Instance Finance System - System Operating Procedures' was subject to annual review by NSI Management and that any updates made were formally authorised by NFSMG.	No exceptions noted.

Ref	NSI Team description of controls	Service Auditor's testing	Exceptions Noted
8.4	System Disaster Recovery (DR) arrangements for the eFinancials system are tested annually by Atos to ensure systems can be run from the secondary hosting site in an emergency.	**Inspection** We inspected the Atos 'NHSS eFinancials DR' report to confirm that a disaster recovery test was performed for the eFinancials system and that the result of the test was documented. Also, we confirmed that the report details lessons learned and post-test improvement actions/requirements.	No exceptions noted.

Section 6: Other information provided by the Independent Service Auditor

Introduction

This report is intended to provide interested parties with information sufficient to understand the processes and controls operated by NHS A&A in respect of the Financial Ledger Services provided to Customer NHS Boards.

It is each individual Customer NHS Board's responsibility to evaluate this information in relation to the internal controls in place at their organisation. If effective internal controls are not in place at the individual Customer Board, the controls applied by the NHS A&A Financial Ledger services may not compensate for such weaknesses.

The objective of a coordinated system of controls is to provide reasonable, but not absolute, assurance regarding the level of control over Customer NHS Boards' financial ledger, as operated by NHS A&A's NSI Team. The concept of reasonable assurance recognises that the cost of a system of internal control should not exceed the benefits derived and also recognises that the evaluation of these factors necessarily requires estimates and judgements by management.

Tests of Controls

Testing of control procedures by BDO was restricted to the control objectives and related control procedures outlined by management of NHS A&A as set out in Section 5 of this report, which management believes are the relevant control procedures for the stated objectives. Testing was not extended to control procedures in place at Customer NHS Boards.

The tests, which are described in Section 5 included such tests as were considered necessary in the circumstances to evaluate whether those control procedures, and the extent of compliance with them, were sufficient to provide reasonable, but not absolute, assurance that the specified control objectives were achieved during the period from 1 April 2021 to 31 March 2022. Our tests were designed to cover a representative number of transactions and procedures throughout the period.

In selecting particular tests of the operating effectiveness of the controls, we considered:

- The nature of the controls being tested;
- The types and competence of available evidential matter;
- The nature of the control objectives to be achieved;
- The assessed level of control risk;
- The expected efficiency and effectiveness of the test; and
- The testing of controls relevant to the stated control objective.

The types of testing performed are described briefly below.

Enquiry

Enquiries seeking relevant information or representation from NHS A&A personnel were performed to obtain, among other things:

- Knowledge and additional information regarding the controls; and
- Corroborating evidence of the control.

Observation

Observed the application or existence of the specific controls, as represented.

Inspection

Inspected documents and records indicating performance of the controls. This included, amongst other things:

- Inspection of applicable management reports;
- Examination of source documentation and authorisations; and
- Examination of documents or records for evidence of performance such as the existence of initials or signatures.

The sample sizes that have been applied in testing controls, depending on the frequency the control is applied and the assessed level of control risk, are set out in the table below:

Frequency of control	**Number of items tested**
Annual	1
Biannual	1
Quarterly	2
Monthly	4
Weekly	8
Daily	30
Multiple Times per Day	30

Section 7: Other information provided by management

Further information on reported exceptions

In relation to the exceptions noted within the Service Auditors procedures, set out in section 5, we provide the following explanations/disclosures.

Ref	NSI Team description of controls	Exception	Response
NA	NA	No exceptions noted.	NA

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**16 June 2022**
Title:	**Final Risk Management Annual Report 2021/22**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

- Local framework and policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This report provides an overview of the risk management activity undertaken during the period 2021 - 2022, further to the version considered by the Committee on 18 May 2022. It has taken on board, comments from members to enhance the specificity of some content. Additionally, following EDG feedback, it reflects further iterations of the draft strategic risks in relation to:

Strategic Priority 1: To improve the Quality of Health and Care Services 3. and

Strategic Priority 3: To Improve Staff Experience and Wellbeing 1.

2.2 Background

The report forms a component of the governance reporting arrangements for risk management in accordance with the risk management component of the NHS Fife Code of Corporate Governance.

2.3 Assessment

NHS Fife is committed to embedding an effective risk culture. During 2021.2022, it was recognised that the profile of risk management in NHS Fife required to be elevated to support delivery of the strategic priorities, and specifically two key strategic work streams:

1. The further development of the Strategic Planning and Resource Allocation (SPRA) process.
2. Transformation of the NHS Fife Clinical Strategy into a Population Health and Wellbeing Strategy for NHS Fife, with the Board aspiring to become an Anchor Institution.

Delivery of both work streams requires close alignment of strategic planning and risk management. Effective risk management arrangements will contribute to delivery through:

- Enabling operational teams to identify and manage operational risks effectively;
- Alignment with the SPRA process to identify organisational risks to assist in informing organisational objectives;
- Identifying risks which may compromise delivery of the objectives;
- Foreseeing and managing risks generated through delivery of the Population Health and Wellbeing Strategy and;
- Supporting the organisation to identify possible opportunities for innovation

To achieve the above and following engagement with EDG and the Board, it was agreed that the Risk Management Framework should be refreshed to implement:

I. A Board Strategic Risk Profile
II. A Corporate Risk Register to replace the current Board Assurance Framework
III. A Risk Dashboard to complement the updated Integrated Performance and Quality Report (IPQR) and to support effective performance management
IV. An updated process to support the escalation, oversight and governance of risks
V. A Risks and Opportunities Group

This report summarises progress in relation to the above and the focus for 2022/2023.

2.3.1 Quality/ Patient Care

Elevating the risk management framework in NHS Fife will further support achievement of the quality ambitions of safe, effective, person - centred care through improved operational governance and better alignment with strategic planning.

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2.3.2 Workforce

All staff in the organisation have a responsibility for identifying risk. Staff must be enabled to do this by being appropriately informed and involved in operational risk management.

Education will be provided to support the development of necessary capability and capacity.

2.3.3 Financial

There are no direct financial implications linked to this paper. Those associated with the upgrade to the Board's risk management system referenced in the report, will be considered in the related business case which is currently being prepared.

2.3.4 Risk Assessment / Management

The report summarises activities to develop the Board's risk management arrangements in order to identify risks to, and support delivery of the strategic priorities.

2.3.5 Equality and Diversity, including health inequalities

An Equality and Diversity (E&D) assessment has not been conducted but there are not considered to be direct E&D implications associated with this report.

2.3.6 Other impact

None identified.

2.3.7 Communication, involvement, engagement and consultation

The content of the report reflects the results of engagement with the following:

- Director of Finance and Strategy
- Executive Directors' Group
- Associate Director of Quality and Clinical Governance
- Senior Leadership Teams
- Risk Management Coordinators

2.3.8 Route to the Meeting Margo McGurk**,** Director of Finance and Strategy on 07/06/22

2.4 Recommendation

The Audit and Risk Committee is asked to:

- **take assurance** from the report

3 List of appendices

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Risk Management Annual Report

2021-2022

1. RECOMMENDATION

The Board is asked to note and take assurance from the risk management activities carried out during the period April 2021- March 2022.

2. INTRODUCTION

NHS Fife is committed to embedding a culture in which effective risk management is central to our strategic planning, decision making, and delivery on our corporate objectives and strategic priorities.

This report confirms that adequate and effective risk management arrangements were in place throughout the year. The report also reflects progress against key activities within the risk management improvement programme, approved in 2021/22, which will further enhance the effectiveness of our risk management framework arrangements going forward.

3. RISK MANAGEMENT GOVERNANCE

The Director of Finance and Strategy provides strategic leadership and direction for risk management in NHS Fife.

The Audit & Risk Committee has responsibility for evaluating the overall effectiveness of the risk management arrangements and reviews and challenges how these are operating across the organisation.

Throughout 2021/22, Internal Audit have supported the development of the risk management improvement programme through supportive challenge and advice on specific elements of this work. The Internal Control Evaluation 2021/22 includes positive comment in relation to progress being made in relation to this work.

The Board Assurance Framework (BAF), brings together information on key risks including controls, mitigating actions, assurances, gaps, linked operational risks and an assessment of current performance. Table 1 sets out the BAF components and the assigned committees.

Table 1	
Board Assurance Component	**Governance Committee**
Quality & Safety	Clinical Governance Committee
Digital & Information	Clinical Governance Committee
Strategic Planning	Clinical Governance Committee Finance, Performance & Resources Committee
Financial Sustainability	Finance, Performance & Resources Committee
Environmental Sustainability	Finance, Performance & Resources Committee
Workforce Sustainability	Staff Governance Committee
Integration Joint Board (IJB	IJB and the Board

Executive Directors responsible for each component of the BAF are required to provide an assurance report, bi-monthly to the aligned governance committee.

During 2021/22, the high-level risks under the above categories identified as having the potential to impact on the delivery of NHS Fife's strategic priorities, and related operational high level risks, were reported through the BAF to the governance committees, and subsequently to the Audit & Risk Committee and Fife NHS Board. The exceptions were reports on the BAF to the governance committees scheduled for January 2022. Due to the emerging Omicron wave of COVID-19 infection and resultant system pressures, the governance committees took place with prioritised agendas to reflect COVID-related business. Regular assurance reports recommenced as scheduled to the committees in March 2022. Table 2 summarises the reporting schedule.

Table 2		**Board Assurance (BAF) Committee Reporting Schedule**							
Committee		Apr 2021	May 2021	Jul 2021	Sep 2021	Oct 2021	Nov 2021	Jan 2022	Mar 2022
Finance, Performance & Resources (FPRC)									
BAF	Financial Sustainability	N/A	✓	✓	✓	N/ A	✓	×	✓
	Environmental Sustainability	N/A	✓	✓	✓	N/ A	✓	×	✓
	Strategic Planning	N/A	✓	✓	✓	N/ A	✓	×	✓
Clinical Governance (CGC)									
BAF	Quality & Safety	✓	N/A	✓	✓	N/ A	✓	×	✓
	Digital & information	✓	N/A	✓	✓	N/ A	✓	×	✓
	Strategic Planning	✓	N/A	✓	✓	N/ A	✓	×	✓
Staff Governance (SGC)									
BAF	Workforce Sustainability	✓	N/A	✓	✓	✓	N/A	×	✓

During 2021- 2022, and in response to Internal Audit recommendations, each component of the BAF was updated to reflect the impacts of the COVID-19 pandemic.

4. RISK MANAGEMENT IN 2021-2022

During 2021/22, there was a reset across NHS Fife, with two key strategic work streams being progressed:

1. Consolidation and further development of the Strategic Planning and Resource Allocation (SPRA) process; and
2. Evaluation of delivery against the objectives within the NHS Fife Clinical Strategy and the development the new Fife Population Health & Wellbeing Strategy.

It was recognised that effective organisational risk management arrangements are crucial to the successful delivery of these work streams and there was an opportunity to elevate the profile of risk management by fully integrating it within the strategic planning process. To support this work, it was agreed that the Risk Management Framework should be refreshed.

In May 2021, the need for dedicated resource and leadership for risk management was recognised and funding was secured to support a secondment to allow the Risk Manager to

be released from adverse events and other portfolios of work, in order to focus on the refresh of the Risk Management Framework. In February 2022, the need to sustain this position was acknowledged and funding was secured on a substantive basis.

Effective risk management requires senior leadership to ensure it contributes to creating a culture that encourages the proactive identification and mitigation of risks from ward to Board. This means promoting risk management as part of business as usual, enabling it to be embedded into daily work, and making it integral to planning, performance and transformational change. In the past year, the Executive Directors and the Board have demonstrated their commitment to this goal by engaging in focused discussions about the refresh of the Framework, and through their endorsement of improvement priorities.

Risk Maturity

In September 2021, as part of the review of organisational risk management processes and to support their further development, the Executive Directors' Group took the opportunity to assess the organisation's risk maturity against 6 key elements:

1. Leadership
2. Risk Strategy & Policy
3. People
4. Processes
5. Risk Handling
6. Outcomes

The findings enabled EDG to:

- identify the actions required to further develop our risk management arrangements
- highlight areas of good practice on which to build

The review informed the development of a risk management improvement programme designed to strengthen our processes by supporting a structured and consistent approach to identifying and analysing risks and opportunities. It particularly drew attention to the need to review and update the Board's risk appetite. This is fundamental to the development of an effective and efficient framework and will allow Executive Directors and the Board to have greater visibility of the organisation's risk profile, to know that risks are being managed well, that the risk appetite is being implemented, and that we are in a position to seize opportunities where appropriate.

Risk Appetite

The update of the Board's risk appetite will be taken forward in collaboration with EDG and the Board in June 2022. This will be considered through the types of risk - clinical quality and safety, workforce, property & infrastructure including digital and information, and finance, in relation to our strategic priorities. Key reflections will include:

- What have we learned from our experience during the last 26 months?
- What have been the key risks and opportunities over this period?
- Will these continue to present in the future?
- Are there new risks we will be willing to take as we develop the new strategy?

Risk Assurance

During 2021/22, an Assurance Mapping Group made up of members of Boards covered by the FTF Internal Audit Service and facilitated by the Chief Internal Auditor, continued to meet. NHS Fife is represented by the Head of Corporate Governance & Board Secretary, and the Risk Manager. The group has developed a set of assurance principles. A plan to embed their use to support delivery of the refreshed Framework will be developed in Q2 2022/23.

Risk Leadership and Focus: Risks and Opportunities Group

Based on the model used in NHS 24, a Risks and Opportunities Group will be established. The group will be chaired by the Associate Director of Quality and Clinical Governance, with membership likely to include the Risk Manager and Associate and Deputy Directors. Governance lines are to be confirmed but the group is likely to report into EDG. Draft Terms of Reference are being developed and it is anticipated that the group will meet initially in August 2022. The Group's broad remit will be to:

- Promote effective risk management and seek opportunity for the organisation
- Consider risks and opportunities to the strategic priorities of the organisation
- Review aggregation of risk across the organisation to determine the most appropriate response on behalf of the whole organisation
- Based on changing risk levels, provide direction and focus to the assurance functions
- Horizon scan for future opportunities, threats and risks aligned to the strategic priorities
- Ensure continuous improvement of the internal control environment

Engagement with Senior Leadership Teams

It is recognised that to achieve consistent and effective application of risk management, it must be part of Business as Usual (BAU). Risk Management when deployed effectively, should add value by being integral to daily work and support activities as opposed to being seen as a separate, self-contained process. To ensure that the refreshed framework achieves this goal, it was agreed there should be engagement with Senior Leadership Teams (SLT) to:

- set the Framework refresh in context
- provide an opportunity to discuss plans to improve our risk management arrangements
- encourage teams to reflect on their risks and consider if these reflect their risk landscape

Two methods of engagement have been used during April and May 2022:

1. meetings with SLTs via MS TEAMs
2. a FORMS Survey

Feedback and themes from the sessions and the survey will be analysed, and used to further inform the improvement programme.

5. STRATEGIC RISK

In December 2021, later than planned but unavoidable as a consequence of the ongoing pandemic, the Board approved proposals to replace the Board Assurance Framework process with a new Corporate Risk Register and to develop complementary dashboard reporting.

It was felt these developments would re-focus our reporting, fulfil the Board's requirements in terms of active governance of risk and provide enhanced assurance.

The status of these developments is summarised below:

Strategic Risk Profile

A draft Board Strategic Risk Profile which aligns to the Population Health and Wellbeing Strategy has been drafted. See Appendix 1. Following a presentation to the Board in March 2022, it was agreed that additional risks should be developed in relation to environmental sustainability, specifically climate change, and health inequalities. The Directors of Property & Asset Management and Public Health are working to develop the respective risks.

The risk profile is being reviewed to ensure it reflects the current risk landscape. When this process is complete, a revised profile will be submitted for Board approval.

Timescale: 30/06/22

6. CORPORATE RISK

Corporate Risk Register

A Corporate Risk Register (CRR) will be established to replace the BAF. This will contain the highest scoring risks from across the organisation that have the potential to affect the whole organisation, or operational risks which have been escalated i.e. can no longer be managed by a service or require senior ownership and support to mitigate. It has been agreed that the register will comprise risks under the following categories:

1. Clinical Quality and Safety
2. Property and Infrastructure (including Digital and Information)
3. Workforce
4. Finance

The corporate risk profile is being developed through discussions with the governance committees, EDG and the Senior Leadership Teams (SLTs) and has involved consideration of existing risks, and potential new risks. Importantly, this approach has allowed staff side colleagues to engage in the process through their membership of EDG and SLTs. Indicative areas of risk for inclusion are: workforce capacity and capability,, unscheduled and urgent care, whole system capacity, waiting times; COVID - 19; prescribing and medicines management; infrastructure; cyber resilience, financial planning, public protection and Child and Adult Mental Health Services (CAMHS).

The process to support the escalation, oversight and governance of risks is under development; this will include the requirement to have Director sign- off for any risks escalating to or de-escalating from the CRR. In addition, when risks are escalated to CRR, the Directors will recommend the committee to which the risk should be aligned. Going forward, risk appetite will be a key consideration underpinning escalation decisions.

Timescale: 30/06/22

RISK DASHBOARD

A dashboard will be introduced which aligns to the refreshed Integrated Performance & Quality Report (IPQR) and will include metrics related to corporate risks. The dashboard will provide a simple, visual, high-level overview for assurance, weave risk management into business as usual (BAU), and allow for regular scrutiny of corporate risks. It will align to improvement actions within the IPQR and integrate with Key Performance Indicators (KPIs) and Quality Performance Indicators (QPIs).

Each risk category will be aligned to a governance committee; this will be noted on the risk register and referenced in the risk narrative of the IPQR. Some risks may need to be assigned to more than one committee. Following agreement on the corporate risks, the dashboard will be compiled and included in the IPQR.

Timescale: 31/07/22

7. OPERATIONAL RISK

A key area for improvement in 2022/23 will be to strengthen the approach to operational risk management.

Risk registers are currently held in Datix, and risks are reported and monitored through the governance structures including at service, directorate, management team and SLT level across the organisation. Feedback from SLTs indicates that approaches to managing operational risk vary in terms of prioritisation, consistency, and reliability. It is expected that the revised arrangements will strengthen existing processes.

Education and support will be provided to enable staff to develop their capability to effectively participate in risk management. Emphasis will be placed on the importance of connecting risk to objectives and ensuring that risks are appropriately assessed, articulated and managed in accordance with the Board's risk appetite.

8. COVID- 19

During 2021- 22, COVID -19 risks continued to be identified and managed across the system. These reflected the volatile and multi-faceted COVID -19 risk landscape across the Acute Services Division (ASD) and the Fife Health and Social Care Partnership (HSCP); this included risks associated with planning, service delivery, workforce, pharmacy, estates and facilities, medical physics, procurement, personal protective equipment (PPE), infection control, vaccination programmes, and public health considerations.

During 2021/22, monthly high level risk reports were prepared for EDG. Over time, the overall number of risks has reduced from 94 to 40. There are currently no procurement or pharmacy COVID risks. There are currently10 high level risks.

At EDG on 5 May 2022, it was agreed that while some elements of the risks may remain, such as workforce pressures, these are no longer primarily linked to the pandemic. Risks will now be managed as business as usual, included in the operational risk registers or escalated to the corporate risk register as required.

9. DATIX RISK MANAGEMENT SYSTEM

Datix is the repository for risks, incidents (adverse events), safety alerts, complaints and claims within the ASD and Fife HSCP. The system has more than 1400 registered users.

As previously reported, RL Datix does not intend to further develop the web versions, and will offer only problem fixes. Datix Cloud IQ is the upgrade path from DatixWeb. At time of writing, a business case is being developed for NHS Fife.

Datix Module Development

During 2021/2022, in response to user feedback and organisational requirements, a range of system developments were carried out on Datix with user engagement as appropriate. These included:

Risk Register Module

Pending a system upgrade, work is underway to redesign the module to support key developments in the Risk Management Framework.

Learning from Excellence (Greatix)

Greatix functionality has been expanded allowing staff to record examples of good practice in relation to their colleagues. The reporting form is available to all NHS Fife staff to complete; no login is required; feedback can be given locally to staff who have had their excellence recorded. 86 Greatix reports were submitted in 2021-22.This enhancement demonstrates the value that the organisation places on the contribution of all staff to service delivery in Fife, and to recognising excellence. In this way it reinforces our commitment to allow all staff to feel they are part of a culture of safety and improvement that they can affect positively.

Restructure of Community Services

During 2021-22, risk management staff supported a major restructure of HSCP services which involved making changes within Datix, including amending hundreds of user permissions to maintain seamless access to data.

User Permissions

During 2021-2022, in response to changes in staff roles due to the pandemic and through engagement with users, action was taken to identify and remove leavers more timeously in order to maintain system efficiency and effectiveness in relation to system access, and to notifications of significant adverse events and safety alerts/hazard notices.

Communications
The DatixWeb Feedback Newsletter, which reports on system changes and improvements was paused due to COVID-19 with information issued on Staff Link; it has now been reinstated. The format is being evaluated and may change to SWAY; hardcopies will be available for staff without easy access to email or Staff Link. Issue 300 was recently published.

10. RISK MANAGEMENT TRAINING

During 2021/22, training was delivered on topics including risk management principles and the Datix modules. Risk management Learnpro modules and user guides are available on Blink. The latter are now available on TURAS with risk register and actions modules in development. The team has continued to deliver training via MS Teams during 2021-22.Uptake has continued to be very good with 57 sessions delivered to over 370 staff.

11. ORGANISATIONAL LEARNING

In August 2021, the NHS Fife Organisational Learning Group was set up. The Group is co - chaired by the Associate Director of Quality and Clinical Governance, and the Associate Nurse Director, Corporate Nursing Directorate. The group has a multidisciplinary membership and a remit which includes promoting effective risk management as a means of supporting organisational learning, quality improvement and decision making. This facet of the group's remit will be developed during 2022/23.

12. RISK MANAGEMENT INPUT TO GROUPS AND COMMITTEES in 2021/22

Input to NHS Fife Groups and Committees in reports and / or representation	
• COVID - 19 Vaccination Programme • Safe & Secure Use of Medicines, Policy and Procedures Group • Medical Gas Committee • Point of Care Testing Committee • Adverse Events & Duty of Candour Group • Audit & Risk Committee • Clinical Governance Committee • Clinical Governance Oversight Group • Decontamination Group	• HSCP Health & Safety Forum • Hospital Transfusion Committee • Infection Control Committee • Information Governance Operational Group • IPQR Review Group • Local Partnership Forum • Organisational Learning Group • Tissue Viability Working Group • Violence & Aggression Management Forum

Input to National Groups	
• Datix Scottish User Group - Chair, NHS Fife Risk Management Coordinator* • Healthcare Improvement Scotland (HIS) Adverse Events Network • HIS Expert Reference Group • Scottish Government Digital Strategy Group - *as above	• MHRA and IRIC national working group led by MHRA: Standardisation of medical device coding in line with international standards. To report through NHS National Services Scotland and HIS once completed. • Healthcare IT Incidents SLWG

13. RISK MANAGEMENT OBJECTIVES 2022/23

In 2022/23, the focus will be to roll out the refreshed Risk Management Framework, specifically:

- promote a culture that encourages the proactive identification and mitigation of risk from ward to Board
- agree the Board risk appetite and embed and reflect in risk management practice
- align the organisational risk profile to the strategic planning agenda
- implement a structured approach to the review and management of risks through organisational governance structures
- review the format and content of the reports presented to governance committees
- apply assurance principles into 'business as usual' based on active governance
- update risk key performance indicators and promote their use as a management tool
- develop the policy and guidance components of the Framework
- provide staff with access to training and resources commensurate with their role.

Appendix 1

DRAFT RISKS TO NHS FIFE'S STRATEGIC PRIORITIES

STRATEGIC PRIORITY: To Improve Health and Wellbeing
1. There is a risk that after more than 2 years of reduced levels of healthcare service as a consequence of the COVID -19 pandemic, and foreseeable continuation into the future compounded by the challenges of emerging variants and other respiratory pathogens, population health and wellbeing will be adversely affected which could result in: • increased population morbidity and mortality • increased pressure on healthcare and support services affecting service delivery • reduced capacity for non urgent services • high levels of employee absence due to personal illness and caring responsibilities • limited capacity to develop, transform and sustain services • non delivery on key quality performance measures
2.There is a risk that the development and the delivery of the NHS Fife Population Health and Wellbeing Strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements, resulting in delays to progression and implementation of this critical component of Fife's strategic approach to delivering the 4 national Care Programmes: Integrated Unscheduled Care; Integrated Planned Care; Place and Wellbeing; and Preventative and Proactive Care.
3. There is a risk that if the Population Health and Wellbeing Strategy does not incorporate learning from the COVID-19 pandemic and align with the motivations, aspirations and expectations of the people of Fife, the Board's vision, corporate objectives and key priorities will not be achieved, resulting in services that are neither transformational nor sustainable in the long term.
STRATEGIC PRIORITY:To Improve the Quality of Health and Care Services
1.There is a risk that due to failure of clinical governance, performance and management systems (including information governance & information security), NHS Fife may be unable to provide safe, effective, person centred care. Additionally, there is a risk that the effects of the COVID - 19 pandemic, including restricted capacity, reduced elective & non urgent services, and workforce pressures, will impact on the quality & safety of patient care and service delivery.
2. There is a risk that sustained whole system pressures due to factors including COVID -19, and demand outstripping capacity within acute, primary and social care services will result in: • inability to timeously discharge medically fit patients, thus increasing their length of stay resulting in: • increased clinical risk including healthcare associated infection and deconditioning • reduced number of downstream beds • delayed patient pathways and negative impacts on safe capacity and patient flow • financial and workforce impacts due to the need to open and staff additional beds • increased Emergency Department (ED) attendances • unmet performance targets including 4 hour ED access, patients in delay, waiting times, treatment times, Remobilisation Plan • sub optimal patient experience and outcomes • reputational harm
3.There is a risk that if effective strategic workforce planning (including aligning funding requirements), is not adequately supported by the necessary planning and analytical capacity, capability and integrated business systems, we will not have the right size of workforce, with the right skills and competencies, organised appropriately within an affordable budget, to deliver services, respond to the impacts of COVID-19, and implement transformational change, which will result in sub optimal service delivery, reduced staff confidence and wellbeing, reputational harm, and reduced rates of recruitment and retention.
4.There is a risk that failure to invest appropriately in D&I resilience including the D&I Strategy and current operational lifecycle commitment, may result in an inablity to make essential transformation across Health and Social care to deliver sustainable and integrated services that are safe, secure and compliant with governance

frameworks and associated legislation including Cyber Essentials and Network & Informations Systems Regulations, and future proofed as far as reasonable and practicable.

STRATEGIC PRIORITY:To Improve Staff Experience and Wellbeing

1. There is a risk that because of a limited workforce supply (local and national), if we cannot retain our existing staff, support their recovery and resilience post pandemic, maintain their health and wellbeing and offer good work experiences which allow them to thrive, the situation will further deteriorate, resulting in:

- depleted staff resilience / 'burn out'
- diminished job satisfaction
- adverse impacts on service quality
- reduced capacity to meaningfully engage with and influence key organisational developments such as the Population Health & Wellbeing Strategy and beconing an Anchor Institution
- inability to recruit

2. There is a risk that operating under restrictions including social distancing and working from home through subsequent waves of the pandemic whilst trying to recover / maintain services and manage increased public need, expectations and tensions, may result in

- sub optimal working relationships
- staff feeling isolated
- reduced staff resilience
- increased staff absence
- impact on safety and quality of patient care and services

3. There is a risk that at a time of significant pace and scale of change, we are unable to meet our obligations in relation to required staff training and development, resulting in:

- staff feeling unsupported and vulnerable due to not having the correct competencies
- reduced staff resilience
- reduced job satisfaction
- negative impacts on role performance and the safety and quality of patient care and services
- reputational damage
- impacts on retention and recruitment rates

STRATEGIC PRIORITY:To Deliver Value and Sustainability

1.There is a risk that the funding required to deliver the current and anticipated future service models, particularly in the context of the EU exit and the COVID - 19 pandemic, and associated supply chain issues and increased prices, will not match costs incurred, which may result in an inability to maintain and develop services and meet legislative requirements.

2.There is a risk that failure to implement, monitor and review an effective financial planning, management and performance framework, including fully identifying the level of savings required to achieve recurring financial balance, may result in the Board being unable to deliver on its required financial targets.

3.There is a risk that failure to assess our property and assets, and secure resources to support improvements to the condition, capacity and resilience of the estate and infrastructure may:

- affect compliance with statutory obligations in relation to environmental & sustainability legislation
- limit our ability to redesign and accommodate reconfigured services and different models of care to meet clinical demand
- impede delivery of the Population Health and Wellbeing Strategy

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**16 June 2022**
Title:	**Internal Audit Annual Report 2021/22**
Responsible Executive/Non-Executive:	**M McGurk, Director of Finance**
Report Author:	**T Gaskin, Chief Internal Auditor**

1 Purpose

This is presented to the Audit and Risk Committee for:

- Assurance

This report relates to a:

- Government policy/directive
- Legal requirement

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

- Effective

2 Report summary

2.1 Situation

The purpose of this report is to present the **FINAL** 2021/22 Annual Internal Audit Report to the NHS Fife Audit and Risk Committee. This report is for the Committee to consider as part of the wider portfolio of year end governance assurances.

2.2 Background

The Audit & Risk Committee is asked to approve this report with completed action plan as part of the portfolio of evidence provided in support of its evaluation of the internal control environment and the Governance Statement.

This annual report provides details on the outcomes of the 2021/22 internal audit and the Chief Internal Auditor's opinion on the Board's internal control framework for the financial year 2021/22.

2.3 Assessment

Based on work undertaken throughout the year we have concluded that:

- The Board has adequate and effective internal controls in place;
- The 2021/22 internal audit plan has been delivered in line with Public Sector Internal Audit Standards.

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

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

Therefore, **it is my opinion** that:

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

We noted the following key themes:

- The Board continues to respond positively to the governance challenges posed by Covid19. During 2021/22, NHS Fife has adapted its approach to governance when needed to ensure the organisation could effectively respond to Covid19 and discharge its governance responsibilities, maximising time available for staff to deal with Covid19.
- Operational performance in the face of the challenges posed by Covid has been difficult during the year and it is likely that the challenge will continue in the medium term until strategic solutions can be found, working in partnership with the IJB.
- As previously reported in the 2021/22 ICE report, during 2021/22 the necessary focus has been on the immediate priority of the response to Covid19 and on government mandated actions and performance. The challenge now is balancing short term risks against longer term risks which can only be mitigated through strategic change. The shape of future strategy will be dependent on a number of complex factors, not all of which are known yet, but the Board has instigated the necessary preparatory work and a risk assessment to ensure the most urgent work is prioritised.
- Whilst the Board planned to update all strategies during 2021/22, this work was necessarily delayed due to Covid19. Updated timetables, detailing the roles and responsibilities of Standing Committees and the Board with key stages and targets documented will aid the progress needed to achieve the March 2023 completion date. Whilst the SGHSCD has set a number of very challenging national objectives, NHS Fife will need to be mindful that its own strategic objectives must be deliverable within acceptable risk tolerances.
- NHS Fife continues to progress its overhaul of its Risk Management Framework. Covid 19 risks will be considered as linked operational risks, corporate risks in their own right, or will be treated as business as usual as part of the Risk Management Framework development.
- This report contains a number of recommendations that reflect the changes to the risk environment in which the Board operates. There are opportunities now further to

enhance governance through the further application of assurance mapping principles. Our recommendations are aimed at ensuring coherence between Governance Structures, Performance Management, Risk Management and Assurance.

2.3.1 Quality/ Patient Care

The Triple Aim is a core consideration in planning all internal audit reviews.

2.3.2 Workforce

Management responsibilities, skill sets and structures are a core consideration in planning all internal audit reviews.

2.3.3 Financial

Financial Governance is a key pillar of the Annual Internal Audit Plan and value for money is a core consideration in planning all internal audit reviews.

2.3.4 Risk Assessment/Management

The internal audit planning process which produces the Annual Internal Audit Plan takes into account inherent and control risk for all aspects of the Audit Universe. Individual internal audit assignments identify the key risks at the planning stage and our work is designed to evaluate whether appropriate systems are in place and operating effectively to mitigate the risks identified. Legal requirements are a core consideration in planning all internal audit reviews.

2.3.5 Equality and Diversity, including health inequalities

All internal audit reviews which involve review of policies and procedures examine the way in which equality and diversity is incorporated in Board documentation.

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

All papers have been produced by Internal Audit and shared with the Director of Finance and Strategy.

2.3.8 Route to the Meeting

This paper has been produced by the Regional Audit Manager, reviewed by the Chief Internal Auditor and agreed by the Director of Finance and Strategy.

2.4 Recommendation

The Audit and Risk Committee is asked to:

- **Approve** this report as part of the portfolio of evidence provided in support of its evaluation of the internal control environment and the Governance Statement.

3 List of appendices

The following appendices are included with this report:

- Annual Internal Audit Report 2021/22

FTF Internal Audit Service

Annual Internal Audit Report 2021/22

Report No. B06/23

Issued To: Carol Potter, Chief Executive
Margo McGurk, Director of Finance and Strategy
NHS Fife Executive Directors Group

Gillian MacIntosh, Head of Corporate Governance and Board Secretary

Audit & Risk Committee
External Audit

Contents

Draft Report Issued	2 June 2022
Management Responses Received	6 June 2022
Target Audit & Risk Committee Date	16 June 2022
Final Report Issued	**13 June 2022**

INTRODUCTION AND CONCLUSION

1. This annual report to the Audit & Risk Committee provides details on the outcomes of the 2021/22 internal audit and my opinion on the Board's internal control framework for the financial year 2021/22.

2. Based on work undertaken throughout the year we have concluded that:

- The Board has adequate and effective internal controls in place;
- The 2021/22 internal audit plan has been delivered in line with Public Sector Internal Audit Standards.

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

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

ACTION

4. The Audit & Risk Committee is asked to **take assurance from** this report in evaluating the internal control environment and **report** accordingly to the Board.

AUDIT SCOPE & OBJECTIVES

5. The Strategic and Annual Internal Audit Plans for 2021/22 incorporated the requirements of the NHSScotland Governance Statement and were based on a joint risk assessment by Internal Audit and the Director of Finance & Strategy and were approved by both the Executive Directors Group (EDG) and the Audit & Risk Committee. The resultant audits range from risk based reviews of individual systems and controls through to the strategic governance and control environment.

6. The authority, role and objectives for Internal Audit are set out in Appendix 3 of the Board's Standing Financial Instructions and are consistent with Public Sector Internal Audit Standards.

7. Internal Audit is also required to provide the Audit & Risk Committee with an annual assurance statement on the adequacy and effectiveness of internal controls. The Audit & Assurance Committee Handbook states:

The Audit & Risk Committee should support the Accountable Officer and the Board by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of the financial statements and the annual report. The scope of the Committee's work should encompass all the assurance needs of the Accountable Officer and the Board. Within this the Committee should have particular engagement with the work of Internal Audit, risk management, the External Auditor, and financial management and reporting issues.

INTERNAL CONTROL

8. The Internal Control Evaluation (ICE), issued December 2021, was informed by detailed review of formal evidence sources including Board, Standing Committee, EDG and other papers. The ICE noted actions to enhance governance and achieve transformation and concluded that NHS Fife's assurance structures were adequate and effective. 12 recommendations were agreed for implementation by management.

9. The status of previous recommendations is summarised in the table on page 11. In addition, 3 recommendations from previous Internal Control Evaluations and Annual Reports remain in progress due to the ongoing impact of Covid:

   - Development of Population Health and Wellbeing Strategy.
   - Refinement of the Property Asset Management Strategy to support the Population Health and Wellbeing Strategy.
   - Development of Clinical and Care Governance Strategic Framework.

10. Throughout the year, our audits have provided assurance and made recommendations for improvements. Of these, the ICE was the most significant. We have undertaken detailed follow up of the agreed actions arising from that report as well as testing to identify any material changes to the control environment in the period from the issue of the ICE to the year-end. We have reflected on the ongoing impact of Covid19 on the governance arrangements in place during the year. Some areas for further development were identified and will be followed up in the 2022/23 ICE. Where applicable, our detailed findings have been included in the NHS Fife 2021/22 Governance Statement.

11. Our assessment of the progress to address ICE recommendations is detailed in the table on page 11. NHS Fife has demonstrated good progress with only minor slippage on the majority of actions, although clearly, the revision of the overall and supporting strategies will be a significant task and much work remains to be done. The 2022/23 ICE will provide an update on the remaining actions as well as providing an opinion on the efficacy of implementation of all agreed actions.

12. For 2021/22, the Governance Statement format and guidance were included within the NHSScotland Annual Accounts Manual. Whilst Health and Social Care Integration is not specifically referenced, the guidance does make clear that the Governance Statement applies to the consolidated financial statements as a whole, which would therefore include activities under the direction of IJBs.

13. The Board has produced a Governance Statement which states that:

    '*During the 2021/22 financial year, no other significant control weaknesses or issues have arisen, in the expected standards for good governance, risk management and control*'.

14. Our audit work has provided evidence of compliance with the requirements of the Accountable Officer Memorandum, and this combined with a sound corporate governance framework in place within the Board throughout 2021/22, provides assurance for the Chief Executive as Accountable Officer.

15. Therefore, **it is my opinion** that:

    - The Board has adequate and effective internal controls in place;

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

16. All Executive Directors and Senior Managers were required to provide a statement confirming that adequate and effective internal controls and risk management arrangements were in place throughout the year across all areas of responsibility and, this process has been further enhanced by guidance written by the Director of Finance and Strategy. These assurances have been reviewed and no breaches of Standing Orders / Standing Financial Instructions were identified.

17. The Governance Statement reflects the necessary changes to Board governance and operating arrangements due to Covid19. The Governance Statement includes details of the Board performance profile and risk management arrangements, and the future intention to revise organisational and supporting strategies. All elements of the Governance Statement have been considered by Internal Audit in previous internal audit annual reports and the ICE and have been followed up in detail in this report.

Key Themes

18. Detailed findings are shown later in the report. Key themes emerging from this review and other audit work during the year, as well as consideration of the overall impact of Covid19 and the need to ensure sustainable services, are detailed in the following paragraphs.

19. The Board continues to respond positively to the governance challenges posed by Covid19. During 2021/22, NHS Fife has adapted its approach to governance when needed to ensure the organisation could effectively respond to Covid19 and discharge its governance responsibilities, maximising time available for staff to deal with Covid19.

20. Operational performance in the face of the challenges posed by Covid has been difficult during the year and it is likely that the challenge will continue in the medium term until strategic solutions can be found, working in partnership with the IJB.

21. As previously reported in the 2021/22 ICE report, during 2021/22 the necessary focus has been on the immediate priority of the response to Covid19 and on government mandated actions and performance. The challenge now is balancing short term risks against longer term risks which can only be mitigated through strategic change. The shape of future strategy will be dependent on a number of complex factors, not all of which are known yet, but the Board has instigated the necessary preparatory work and a risk assessment to ensure the most urgent work is prioritised.

22. Whilst the Board planned to update all strategies during 2021/22, this work was necessarily paused due to Covid19. Updated timetables, detailing the roles and responsibilities of Standing Committees and the Board with key stages and targets documented will aid the progress needed to achieve the March 2023 completion date. Whilst the SGHSCD has set a number of very challenging national objectives, NHS Fife will need to be mindful that its own strategic objectives must be deliverable within acceptable risk tolerances.

23. NHS Fife continues to progress its Risk Management Framework Improvement Programme. Covid 19 risks will be considered as linked operational risks, corporate risks in their own right, or will be treated as business as usual as part of the Risk Management Framework development.

24. This report contains a number of recommendations that reflect the changes to the risk environment in which the Board operates. There are opportunities now to further enhance governance through the application of assurance mapping principles. Our recommendations are aimed at ensuring coherence between Governance Structures, Performance Management, Risk Management and Assurance.

Key developments since the issue of the ICE included:

- The April 2022 NHS Fife Board Development session on Culture, Values and the Role of the Board and Developing our Population Health and Wellbeing Strategy.
- A Risk Management Framework Improvement Programme was approved by the NHS Fife Board in March 2022.
- The updated Fife IJB Integration Scheme was formally signed off by the Scottish Government on 8 March 2022.
- Progress against the 4th iteration of the Remobilisation Plan was reported to the May 2022 meeting of the Finance, Performance & Resources Committee (FPRC), with all incomplete action to be included in the 2022/23 Annual Delivery Plan.
- The development of the Operational Pressures Escalation Levels (OPEL) process to manage day-to-day pressures, with clear triggers for action and escalation.
- A review of the Integrated Performance and Quality Report (IPQR) content and format to address actions from the Board's Active Governance session and to ensure it remains relevant and clear to Board members.
- As of April 2022, NHS Scotland is no longer on emergency footing.

25. During 2021/22 we delivered 25 audit products (May 2021 to June 2022) with a further two products issued in draft. These audits reviewed the systems of financial and management control operating within the Board.

26. Our 2021/22 audits of the various financial and business systems provided opinions on the adequacy of controls in these areas. Summarised findings or the full report for each review were presented to the Audit & Risk Committee throughout the year.

27. A number of our reports, including the ICE and Strategy development, have been wide ranging and complex audits and have relevance to a wide range of areas within NHS Fife. These reports continue to assist NHS Fife to build on the very good work already being done to improve and sustain service provision.

28. Board management continue to respond positively to our findings and action plans have been agreed to improve the systems of control. Internal audit have maintained a system for the follow-up of audit recommendations and reporting of results to the Audit & Risk Committee. As reported to the March 2022 Audit & Risk Committee, 37 audit actions were remaining, with 11 risk assessed as Amber – action required, 23 risk assessed as Green – good progress and 3 not yet due.

ADDED VALUE

29. The Internal Audit Service has been responsive to the needs of the Board and has assisted the Board and added value by:

- Examining a wide range of controls in place across the organisation.
- Undertaking Fife IJB internal audits and providing a Chief Internal Auditor Service.
- For the Fife Integrated Joint Board (IJB), updating and enhancing the IJB Governance Statement self assessment checklist.
- Providing initial comment on a draft version of the now approved Integration Scheme.

- CIA liaison with the Director of Finance & Strategy, on issues of governance, risk, control and assurance.
- Assurance mapping and risk management advice, in particular on Digital and Information risk reports.
- Advice on the revised Terms of Reference for the Digital Information Board, Information Governance and Security Steering and Operational Groups and attendance at their meetings.
- Assurance reporting regarding Whistle blowing (quarterly and annual).
- Commenting on Terms of Reference for the Quality Management Assurance Group.
- Facilitating the work of the Assurance Mapping group and liaising with the Board Secretary to consider how the agreed principles can be adapted to the specific needs of NHS Fife.
- Highlighting national governance developments with relevance to NHS Fife.
- Continued development and use of the principles for Health & Social Care Integration (HSCI) governance and sustainability within the Board and its IJB partner.
- Detailed review of the process for revising NHS Fife's overall Strategy.
- Providing opinion on and evidence in support of the Governance Statement at year-end and conducting an extensive Internal Control Evaluation which permitted remedial action to be taken in-year. This review made recommendations focused on enhancements to ensure NHS Fife has in place appropriate and proportionate governance, which supports and monitors the delivery of objectives and is commensurate with the challenging environment within which it is operating.
- Contribution to the development of the NHS Fife Risk Management Strategy and Fife IJB Risk Management Framework.
- Advice provided to the Fraud Liaison Officer in response to an ongoing incident and attendance at meeting.

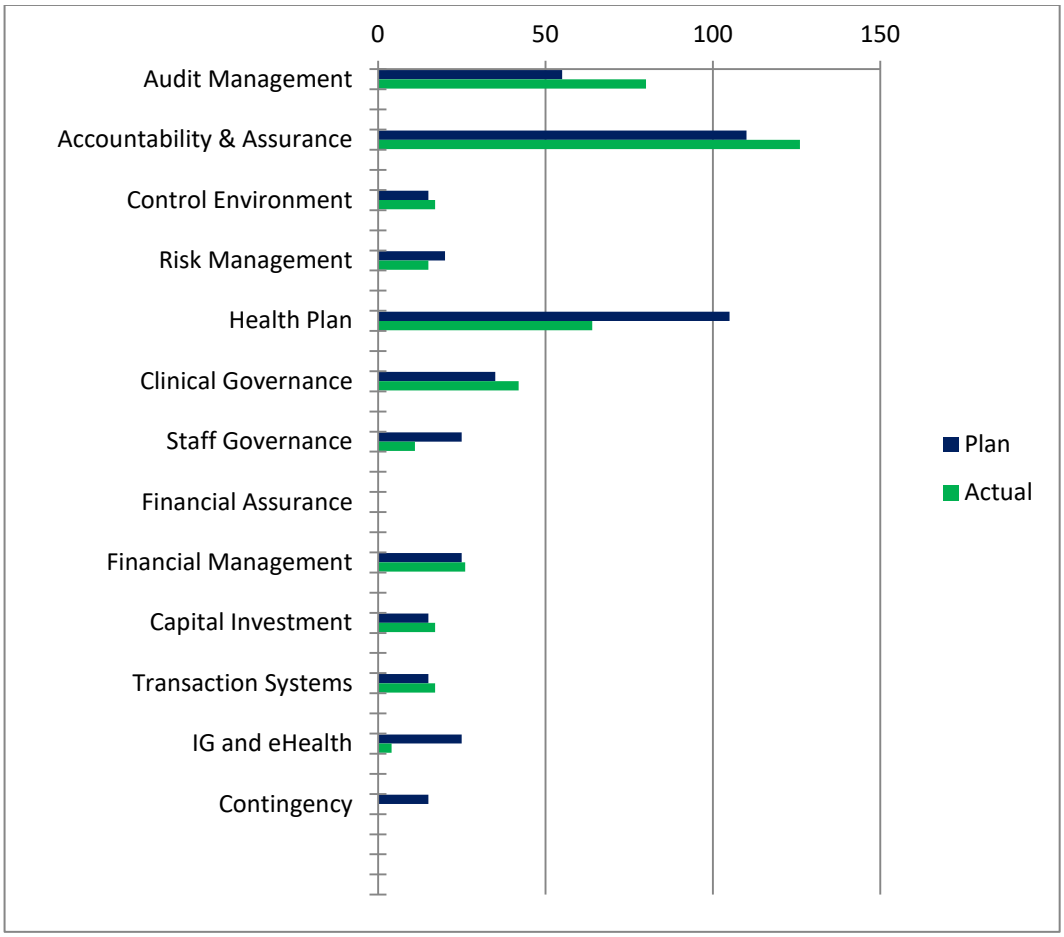
30. Internal Audit have also used time made available by necessary senior management prioritisation of Covid19 duties to reflect on our working practices, both to build on action taken in response to previous External Quality Reviews and to adapt to a post Covid19 environment. This has included:

    - Update of the Committee Assurance Principles.
    - Development of a good practice template for the process of developing new Strategic Plans in IJBs and Health Boards.
    - Development of the FTF website.
    - Review and update of the FTF self assessment against the Public Sector Internal Audit Standards.
    - Reviewed our recommendation priorities to include an additional category 'Moderate' and updated the assurance definitions.
    - Updated the Property Transaction Monitoring Checklist for FTF clients.

31. The 2021/22 Annual Internal Audit Plan included provision for delivering audit services, together with council colleagues, and providing the Chief Internal Auditor function to Fife Integrated Joint Board as well as progressing the audit plan of Fife IJB agreed with the IJB. Internal Audit has continued to highlight governance and assurance aspects of integration and the need for clear lines of accountability and ownership of risk as well as the requirement for a revised Strategic Plan and working with partners to clear intractable and long-standing issues.

INTERNAL AUDIT COVERAGE

32. Figure 1: Internal Audit Cover 2021/22



33. Figure 1 summarises the 2021/22 outturn position against the planned internal audit cover. The initial Annual Internal Audit Plan was approved by the Audit & Risk Committee at its meeting on 13 May 2021. It was agreed at that time that the plan would be revised as changes to the risk profile and other factors became better known, and the Audit & Risk Committee approved amendments in March 2022. We have delivered 412 days against the 455 planned days.

34. Following a recommendation from the External Quality Assessment (EQA) carried out on Internal Audit in 2018/19, we continue with the agreed process of risk assessing outstanding 2021/22 audits for inclusion in the 2022/23 plan.

35. A summary of 2021/22 performance is shown in Section 3.

PERFORMANCE AGAINST THE SERVICE SPECIFICATION AND PUBLIC SECTOR INTERNAL AUDIT STANDARDS (PSIAS)

36. Due to prioritisation of Covid19 duties, the FTF Partnership Board met only once in 2021/22. The Partnership Board is chaired by the NHS Tayside Director of Finance and the FTF client Directors of Finance are members. The FTF Management Team attends all meetings. During the year the Partnership Board reviewed the Internal Audit Shared Service Agreement 2018-2023 and the Internal Audit Service Specification, as well as approving the 2021/22 budget. The Partnership Board also approved revised risk assessment definitions for internal audit reporting.

37. We have designed protocols for the proper conduct of the audit work at the Board to ensure compliance with the specification and the Public Sector Internal Audit Standards (PSIAS).

38. Internal Audit is compliant with PSIAS, and has organisational independence as defined by PSIAS, except that, in common with many NHSScotland bodies, the Chief Internal Auditor reports through the Director of Finance and Strategy rather than the Accountable Officer. There are no impairments to independence or objectivity.

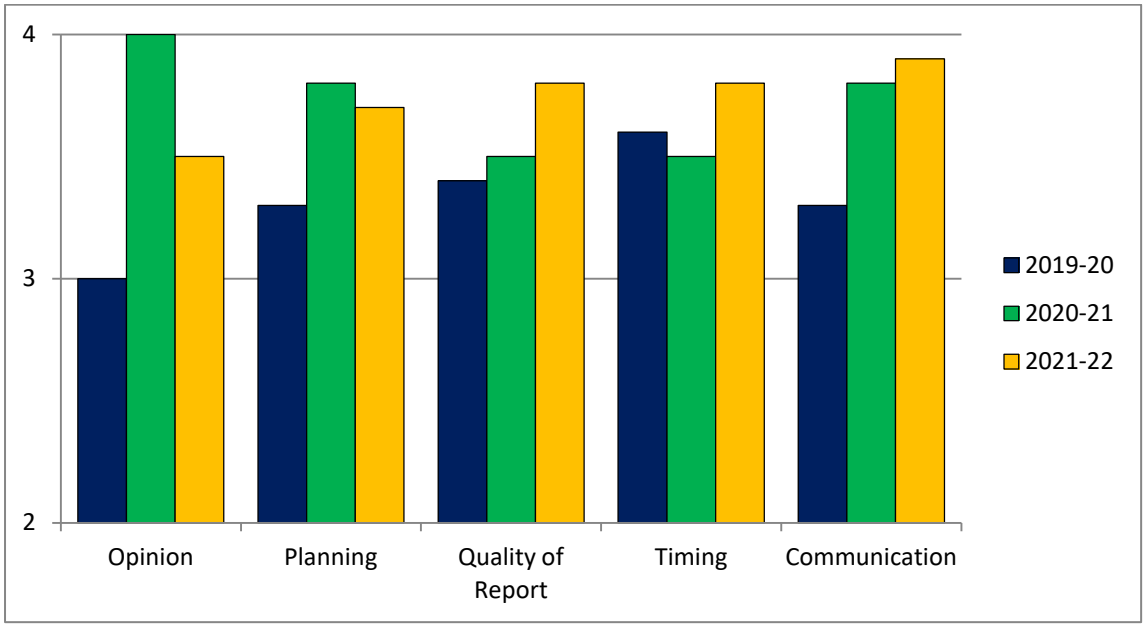
39. Internal and External Audit liaise closely to ensure that the audit work undertaken in the Board fulfils both regulatory and legislative requirements. Both sets of auditors are committed to avoiding duplication and securing the maximum value from the Board's investment in audit.

40. Public Sector Internal Audit Standards (PSIAS) require an independent external assessment of internal audit functions once every five years. The most recent External Quality Assessment (EQA) of the NHS Fife Internal Audit Service in 2018/19 concluded that, *'it is my opinion that the FTF Internal Audit service for Fife and Forth Valley generally conforms with the PSIAS.'* FTF has updated its self assessment which is due to presented to the June 2022 Audit & Risk Committee.

41. A key measure of the quality and effectiveness of the audits is the Board responses to our client satisfaction surveys, which are sent to line managers following the issue of each audit report. Figure 2 shows that, overall, our audits have been perceived as good or very good by the report recipients.

42. Figure 2: Summary of Client Satisfaction Surveys

Scoring: 1 = poor, 2 = fair, 3= good, 4 = very good.



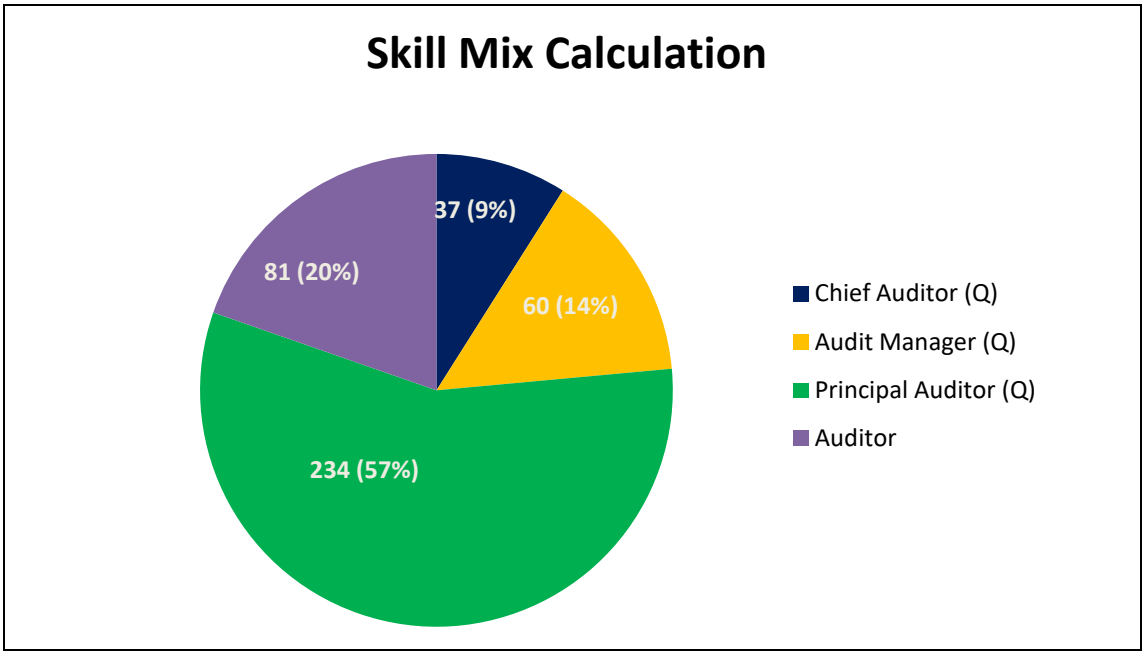
43. Other detailed performance statistics are shown in Section 3.

STAFFING AND SKILL MIX

44. Figure 3 below provides an analysis, by staff grade and qualification, of our time. In 2021/22 the audit was delivered with a skill mix of 81%, which substantially exceeds the minimum service specification requirement of 50% and reflects the complexities of the work undertaken during the year.

45. **Figure 3: Audit Staff Skill Mix 2021/22**

Audit Staff Inputs in 2021/22[days] Q= qualified input.



ACKNOWLEDGEMENT

46. On behalf of the Internal Audit Service I would like to take this opportunity to thank all members of staff within the Board for the help and co-operation extended to Internal Audit.

47. My team and I have greatly appreciated the positive support of the Chief Executive, Director of Finance & Strategy, the Board Secretary, EDG and the Audit & Risk Committee.

A Gaskin, BSc. ACA
Chief Internal Auditor

ICE 2021/22(B08/22) - Update of Progress Against Actions		
Agreed Management Actions with Dates	**Progress with agreed Management Actions**	**Assurance Against Progress**
1. Board Assurance Framework • The inclusion of appropriate analysis in each SBAR supporting the BAFs regarding the adequacy and effectiveness of key controls and actions would promote/aid further scrutiny by committee members. • The Board Assurance Framework should encompass and link Covid19 risks, to ensure the NHS Board has appropriate oversight and transparency over these risks. • Once the revised Integration Scheme has been approved by the Scottish Government, the IJB BAF should be revised to ensure that it adequately describes the risk the mitigating controls and appropriately scored. ***Action Owner: Chief Executive & Director of Finance*** ***Original date of expected completion for all of the above is the 31 March 2022.***	A detailed Risk Management Improvement Plan has been developed. It was agreed with the EDG in February 2022 and presented for assurance to each Standing Committee in May 2022. This sets out the further work required to complete and embed the changes required. ***Date Expected Completed – 31 July 2022***	 **Minor slippage on agreed timelines**
2. Performance Reporting • As part of this Active Governance action plan, consideration should be given to how Performance Reports can provide overt assurance on the accuracy of the narrative and scores for related strategic (BAF) risks as well as the adequacy and effectiveness of key controls. • The risk section of Board and Committee papers should be given higher priority than at present and should contain basic information to facilitate a focused discussion on the risk implications, be overtly linked to any operational or BAF risks and contain enough information for members to be able to form a conclusion on whether the score narrative and other elements of the related risk are adequately described. ***Action Owner:*** **Director of Finance and Strategy** ***Original date of expected completion for all of the above is the 31 March 2022.***	A detailed Improvement Plan has been developed and was agreed with EDG in February 2022 and the FPRC in March 2022. This sets out the further work required to complete and embed the changes required. Aspects of the plan have been completed. ***Date Expected Completed – 30 June 2022***	 **Minor slippage on agreed timelines**

3.Organisational Duty of Candour • An update on the number of instances Organisational Duty of Candour has been applied in NHS Fife in 2021/22 should be scheduled for presentation to Clinical Governance Committee (CGC) prior to it concluding on its Annual Assurance Report and Statement, which should highlight any issues experienced and be sufficient allow it to conclude whether there were adequate and effective Duty of Candour arrangements throughout 2021/22. • The Committee should be informed when it can expect the final report on the year's activity and how arrangements will be developed in future to allow more timely reporting. ***Action Owner: Medical Director*** ***Original date of expected completion for all of the above is the 31 March 2022.***	The CGC considered the Interim 2020/21 NHS Fife Duty of Candour report at its 13 January 2022 meeting, and it was noted by Fife NHS Board at their meeting on 29 March 2022, although this related exclusively to Duty of Candour Activity that occurred in the financial year 2020/21. The CGC has not received any update on Duty of Candour Activity occurring in financial year 2021/22. The Medical Director advised that delays to the adverse event process in its entirety are a known consequence of the impact of the Covid-19 pandemic on service pressures. Recovery to a state where more timely reporting is heavily dependent on the recovery of the backlog of closure of adverse event reviews.	 **Significant Slippage**
4. Adverse Events KPIs • The revised approach for Adverse Events should include regular reporting of KPIs to CGC on the completion of adverse events within agreed timescales. ***Action Owner: Medical Director*** ***Original date of expected completion for all of the above is the 30 April 2022.***	The Clinical Governance Oversight Group (CGOG) merged with the Adverse Events and Duty of Candour Group and its revised Terms of reference were presented to the CGOG meeting on 19 April 2022. These include the responsibility '*To oversee the development and implementation of local guidance relating to Adverse Events and Duty of Candour including monitoring of performance against agreed measures*'. For this action to be considered complete we need evidence of the new reporting arrangements to CGOG operating in practice and will report on this in the 2022/23 ICE report. The Medical Director advised that there is currently no plan, unless by escalation, to routinely report these KPI's with the CGC.	 **Minor slippage on agreed timelines**
5. Succession Planning • The Staff Governance Committee (SGC) and Remuneration Committee should be assured	Within the draft Workforce Plan 2022-25 there is a medium term action for	 On track

on succession planning arrangements within NHS Fife and of the potential risks associated with this area. ***Action Owner: Director of Workforce*** ***Original date of expected completion for all of the above is the 31 October 2022.***	Directorate level Workforce Plans, to consider succession planning implications for a range of critical roles, including advanced practitioners grades and above. This will give assurance to the SGC that succession planning is being considered, but the SGC and Remuneration Committee still require a full update on the implementation of these arrangements and the potential risks associated with this area.	
6. Staff Governance Standards • To enable the SGC to fully ascertain the SGS initiatives introduced during 2021/22 and provide a measure of their success in meeting the requirements of the SGS, the assurances given at those meetings should give an equivalent level of assurance to that of previous years (per the previously maintained SGAP), setting out actions and assurances still to be provided and the reasons for any delays. ***Action Owner: Director of workforce.*** ***Original date of expected completion for all of the above is the 31 March 2022.***	This recommendation has not been implemented as agreed. For 2021/22 only verbal updates on the action taken to meet the SGS has been provided at the September 2021 and March 2022 SGC meetings. No documented record has been provided of the initiatives introduced and the actions and assurances still to be provided and the reason for any delays. As part of its 2021/22 Annual Assurance Statement the Committee has agreed to "enhancing the signposting on papers and agenda items, to make it clear which strand of the Standards is being addressed, to ensure full coverage across the Committee's yearly workplan".	 **Significant Slippage**

7.IPQR and Financial Sustainability BAF • Links between the Financial Sustainability BAF and IPQR should be clear and overtly linked so the controls/mitigations of the BAF provide assurance that challenges within the IPQR is being managed. • The financial sustainability BAF should be updated to include links to Strategy, PMO Savings Programme and relevant External audit recommendations. ***Action Owner:*** **Director of Finance and Strategy** ***Original date of expected completion for all of the above is the 31 March 2022.***	An Improvement Plan has been developed and was agreed with EDG in February 2022 and the March 2022 FPRC. This sets out the further work required to complete and embed the changes required. Concluding this recommendation has clear links to the ongoing requirements of Risk Management Improvement Plan. The development of the Financial Improvement/Sustainability (FIS) Programme will support the delivery of efficiency savings and closing significant external audit recommendations. ***Date Expected Completed – 31 July 2022***	 **Minor slippage on agreed timelines**
8. Property & Asset Management Strategy (PAMS) • The risks around delivery of the PAMs and capital programme would benefit from having a BAF or operational risk which would aid and support the delivery of the future Health and Wellbeing Strategy. ***Action Owner: Director of Property and Asset Management*** ***Original date of expected completion for all of the above is the 31 March 2022.***	The Environmental Sustainability BAF presented to the FPRC in May 2022 has committed to a new corporate risk related to the Capital Programme and Property Strategy to be developed within the revised Risk Management Framework. ***Date Expected Completed – 31 July 2022***	 **Minor slippage on agreed timelines**
9. IG&S Assurance Reporting to CGC • Regular assurance reporting from the IG&SSG to CGC should be scheduled in the workplan of CGC for 2021/22 and future years. • This should include a regular Assurance Report as well as IG&SSG minutes. • The Assurance report should include clear, sufficient and reliable assurance on the key aspects of IG&S so that the CGC can conclude on the adequacy and effectiveness of Information Governance arrangements at year end. ***Action Owner: Associate Director of Digital and Information*** ***Original date of expected completion for all of the above is the*** **28 April 2022**	Activity Tracker report provided IG&S assurance to CGC at their meeting on 10 March 2022 and updates are scheduled in the committee's 2022/23 workplan for September 2022 and March 2023.	 **Complete and Validated**

10. Information Governance and Security Policies • Assurance provided regarding Information Governance Policies and Procedures should be improved so that a list of all policies and procedures and their review dates is provided to the IG&S Operational Group and percentage compliance, regarding reviewed within scheduled review date, figures are reported to the IG&S Steering Group. • Progress towards mitigating the risk regarding lack of resources for Information Governance and Security Policy Management should also be reported to the IG&S Steering Group. • The NHS Fife Information Security Policy [GP/I5] and NHS Fife Data Protection and Confidentiality Policy [GP/D3] must be reviewed at the earliest opportunity. The review should specifically consider the impact of the pandemic and the increase in fraud risk and remote working implications. ***Action Owner: Associate Director of Digital and Information*** ***Original date of expected completion for all of the above is the* 14 February 2022**	The IG&S Key Measures Report to March 2022 IG&SSG includes an update on policies at section 5. Reporting on how the required level of resources was being provided was included in section 4.5 of the IG&SSG Annual Assurance Statement. Revised Information Security Policy (GP/I5) is published on Stafflink with a scheduled review date of January 2025. Although we are advised that the NHS Fife Data Protection and Confidentiality Policy [GP/D3] has been reviewed, and is being presented to the General Policies Group and EDG for approval, the version of the policy published on Stafflink is the old version which had a scheduled review date of 1 June 2021.	 **Minor slippage on agreed timelines**
11. Information Governance Incident Management • The assurance route for reporting of assurances on Information Governance incidents needs to be clarified and streamlined to provide sufficient assurance to CGC. ***Action Owner: Associate Director of Digital and Information*** ***Original date of expected completion for all of the above is the* 31 March 2022**	Section 6.1 of the IG&SSG Annual Assurance Report includes the recommended details regarding IG&S incidents. This was considered by IG&S Steering Group following cancellation of scheduled meeting on 8 April 2022 and then by CGC 29 April 2022.	 **Complete and Validated**
12. Digital and Information Risk Management • It is important that the processes for recording and managing risks related to Digital and Information are sufficient to provide CGC with assurance regarding these risks at year end on the accuracy of risk ratings, and the adequacy and effectiveness of key controls and actions. • The impact of the pandemic on Digital and Information risks should be considered and specific assurance on this should be	The risk reports presented to IG&SSG and Digital & Information Board have been updated in format throughout 2021/22 and a review of all risks was undertaken which included revisiting the scoring and considered the impact of the pandemic. The new format includes graphical representation to highlight risks with improved or deteriorating ratings and provides	 **Complete and Validated**

provided to CGC. ***Action Owner: Associate Director of Digital and Information*** ***Original date of expected completion for all of the above is the* 31 May 2022**	detailed analysis on the highest ranked risks which provided the Group with additional understanding of the risk and allowed them to consider if the management actions would mitigate the risk within a suitable timescale. To date the Group has been able to provide that assurance for the highest ranked risks.	
ICE Report 2020/21 – B08/21		
1. Long term Strategy • The EDG should jointly agree how the various strands of work to inform and deliver the long term strategy for NHS Fife will be analysed and translated into a co-ordinated programme, building on the progress already made through the Strategic Planning and Resource Allocation (SPRA) as well as remobilisation planning, considering how best use can be made of existing expertise and data and understanding constraints on resources. • This review should also consider how best to ensure effective governance and oversight of this key area in advance of the Board Development Session • A timetable for development of the new Strategy and supporting strategies should be reported to the NHS Board. Reporting on progress should be clearly assigned to an Assurance Committee or the NHS Board and should include a broad overview of whether Recovery, Remobilisation and strategy development is on track, key achievements, challenges and risks and any significant implications for strategy and priorities. ***Action Owner: Chief Executive*** ***Original date of expected completion for all of the above is the 31 March 2022.***	The recommendation was integrated with the plan to develop the new Population Health and Wellbeing Strategy. Progress was made during 2021/22 on a number of key stages however the ongoing impact of the pandemic has led to delays. A paper detailing the re-phasing of this work was approved by the Public Health and Wellbeing Committee on 8 March 2022 and the NHS Fife Board at the end of March. The paper includes a milestone plan to deliver the new strategy by the end of December 2022, with Board approval by the end of March 2023. The paper also sets out the Portfolio Board arrangements to support the development of the strategy work and the governance route for each activity as the plan is developed. ***Date Expected Completed – 31 March 2023***	**Pausing of development activities as a consequence of the pandemic.**  **Minor slippage on agreed timelines**
3. Clinical Governance Framework • Development of the Clinical Governance Strategy and Clinical Governance Assurance Framework with a focus on risk, informed by Committee Assurance and Integration	Progress has slipped slightly from original targets to allow further engagement with staff which has been taking place taking place regarding a draft version of the NHS Fife Clinical and	 **Minor slippage on agreed timelines**

Principles. ***Action Owner: Medical Director*** ***Original date of expected completion for all of the above is the 31 March 2022.***	Care Governance Strategic Framework 2022-2025. It has been agreed with the Chair of the CGC, the Medical Director and Nursing Director that the Framework will be presented to CGC for approval at their meeting on 1 July 2022. The Medical Director advised that due to unforeseen circumstances a further extension has been deemed necessary.	
5. Property Management Strategy • The Property Management Strategy should be reviewed and revised to align it to updated NHS Fife Strategies and future sustainability and should specifically consider the impact of Covid19 around the property infrastructure going forward. ***Action Owner: Director of Property and Asset Management*** ***Original date of expected completion for all of the above is the 30 August 2021***	The paper considered by Fife NHS Board on 29 March 2022 on the plan for the Population Health and Wellbeing Strategy included the further development of the PAMS strategy. ***Date Expected Completed – 30 November 2022***	 **Minor slippage on agreed timelines**
6. Information Governance and Security • Establishment of IG&S Operational Group and Steering Group Terms of Reference (ToR) • Digital and Information (D&I) Board to provide additional support and assurance to IG&S and its alignment to strategy and operational performance **– April 2021** • IG&S Assurance Report and Framework – **March 2021** • Assurance report will be made available for consideration at the next Clinical Governance Meeting, following the IG&S Steering Group meeting on 23 March 2021. • Risk associated with resources and requirement for business cases when delivering the Digital and Information Strategy will be documented within the related BAF – **April 2021** ***Action Owner: Associate Director of Digital*** ***Original date of expected completion for all of the above is the 30 April 2021***	IG&SSG and IG&SOG ToRs agreed and meetings taking place. Reporting through Activity Tracker to IG&S Steering Groups and to CGC: •To 4 March IG&SSG – Tracker & Performance •To 10 March CGC – SBAR & Tracker Board Assurance Framework for D&I Strategy Delivery reporting including linked risks provided to CGC via EDG (September 2021, November 2021, and March 2022). Risk Reports including performance analysis and detailed root cause analysis and risk proximity reported to D&I Board and IG&S Steering Group.	 **Complete and Validated**

Annual Report 2020/21 – B06/22		
1. Increased Risk of Harm • A specific risk should be recorded, delegated to the CGC, to capture the clinical implications of Covid19 on waiting times and the associated impact on patient safety, clinical effectiveness and strategic prioritisation. The risk should include clear controls and assurance sources looking at reducing avoidable harm caused by delays in diagnoses and treatment and should reflect: • The key priorities and aims for 2021/22 within the current remobilisation plan. • Other relevant controls, such as implementation of Royal College of Surgeons guidelines • A description of controls to address the current pressure on scheduled care as a result of imbalance in demand and capacity; additional pressures due to Covid19; possible pent up demand due to reduction in referral rates. • Identified requirements to redesign services. ***Action Owner: Medical Director*** ***Original date of expected completion for all of the above is the 30 November 2021.***	The change to the Quality & Safety BAF was proposed and agreed by CGC at their meeting on 3 November 2021 and the was presented again to CGC at their meeting on 10 March 2022 and the revised risk description is reflected in the version of the BAF presented to CGC on 29 April 2022. The Quality and Safety BAF Risk description now reflects risk to patients from reprioritisation associated with the pandemic and linked risks include pandemic related risks.	 **Complete and Validated**

Corporate Governance

BAF risks:

Risk 1675 - Strategic Planning – Moderate (12)

- There is a risk that the development and the delivery of the new NHS Fife Population Health and Wellbeing strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements.

Risk 1676 – Integration Joint Board –Moderate (12)

- There is a risk that the Fife Integration Scheme does not clearly define operational responsibilities of the Health Board, Council and Integration Joint Board (IJB) resulting in a lack of clarity on ownership for risk management, governance and assurance.

Strategy

The ICE report highlighted positive progress on the plans to develop the Population and Wellbeing Strategy (PWS) and welcomed NHS Fife's intention to have an approved Strategy in place by 31 March 2022. This was delayed by the ongoing impact of Covid19; a revised timetable was approved by Standing Committees and the Board in March 2022. Consequently with a one year Transitional Strategic Plan will be submitted in line with the Scottish Government (SG) deadline of 31 July 2022. A one year financial plan for 2022/23 was approved by the Board and submitted to Scottish Government in March 2022.

The approved timetable details a route map for the development of the medium to long term Population Health and Wellbeing Strategy, with a draft Strategy and associated Delivery plan to be presented to the NHS Fife Board by December 2022. The route map provides key steps and dates, with dates established for Standing Committees and the Board to review and influence the work.

The SGHSCD issued the NHS Recovery plan on 25 August 2021. The recent Audit Scotland report NHS in Scotland 2021 stated that '*The ambitions in the plan will be stretching and difficult to deliver against the competing demands of the pandemic and an increasing number of other policy initiatives. The recovery plan will involve new ways of delivering services and these will take a lot of work. There is not enough detail in the plan to determine whether ambitions can be achieved in the timescales set out.*' The SGHSCD have subsequently issued further guidance reiterating its intention for NHS Boards to deliver the objectives within the NHS Recovery Plan. However, it is clear that the workforce and financial assumptions underlying both the NHS Recovery Plan and the Health and social care: national workforce strategy would require very careful risk assessment, before they could be relied upon in local planning.

Whilst the Board will need to be cognisant of SGHSCD ambitions, its priority must be the production of a realistic, achievable strategy which addresses the needs of the local population post-covid within the parameters of available resources, most particularly financial, digital and workforce. This will almost inevitably involve extremely difficult decisions, which may not fully align with public or SGHSCD expectations.

During the Covid pandemic, there was a necessary shift of focus towards operational priorities, which reflected the extreme risks in those areas as well as an influx of Covid related funding which lessened the immediate financial risk. In future, the risks related to financial sustainability are likely to rise sharply and rapidly, with the acute sector in particular facing very significant financial challenges. Consideration of the changes in culture required to adapt to this change should start now. The implementation of the Financial

Improvement and Sustainability Programme in November 2021 will be a key enabler to securing recurring financial balance and sustainability. In March 2022, the Finance, Performance & Resources Committee (FPRC) were provided an update on the Operational Pressures Escalation Levels (OPEL) process, which aims to manage day-to-day pressures, with clear triggers for action and escalation. We commend this development and note the Scottish Government interest in the overall tool. An update report on how the OPEL process is working in practice would be a useful future assurance report to the FPRC.

Covid19 & Governance

NHS Fife has continued to monitor and adapt arrangements to maintain an appropriate level of governance, whilst taking account of the pressures on management and the need to free operational staff to deal with Covid19.

On 20 May 2020 the Board ratified revised governance arrangements for the Board's Standing Committees whereby meetings were to be undertaken by TEAMs. The command structure which was stood down from 31 March 2021 was reinstated in July 2021 due to resurgence in Covid19 cases.

Given the lifting of Covid19 restrictions during April 2022, NHS Fife successfully tested its first face to face meeting for two years at a Board Development session in April 2022.

Covid19 reporting to Board has continued and covers: Covid19 Vaccination, Test and Protect and Covid19 Testing in Fife.

Assurance Mapping

The Chief Internal Auditor, working with officers from NHS Fife and other client Health Boards, developed a set of Committee Assurance principles, together with a series of questions which would help Standing Committees assess the assurances they receive on risks delegated to them. These were considered and endorsed by the NHS Fife Audit & Risk Committee at its meeting in May 2021.

The Board Secretary is working with Standing Committee Chairs to ensure these are embedded within the Board's formal assurance processes and Internal Audit continue to liaise with management on the application of the principles.

Remobilisation

The draft Remobilisation Plan 4 (RMP4) was considered and approved by the NHS Fife Board in private session on 28 September 2021 prior to submission to the SG, with positive feedback received on 19 November 2021.

An action tracker, outlining key actions and progress on deliverables, has helped support the delivery of the RMP and provided scrutiny of its achievements against target dates. The update to 31 March 2022 was provided to the FPRC on 10 May 2022, with:

- 52 actions completed
- 61 on track
- 20 at risk – require attention
- 12 unlikely to meet target

Actions that are unlikely to be completed are delivery of elective care and diagnostics, and improvements in cancer performance and early diagnosis. Incomplete actions will be carried over into the 2022/23 Annual Delivery Plan.

Risk Management

During 2021/22, the 7 BAFs were reported bi-monthly to standing committees, and

subsequently to the Audit & Risk Committee and the Board. The majority of these BAFs have been updated in year, including updates to reflect Covid19, and have shown positive score changes towards target, albeit Environmental Sustainability and IJB have remained static.

The Risk Management Framework update to the March 2022 NHS Board meeting included the development of the risk profile against the NHS Fife Strategic Priorities/Objectives as follows:

- To improve health and wellbeing
- To improve the quality of health and care services
- To improve staff experience and wellbeing
- To deliver value and sustainability

Various risks were identified under each priority/objective and following feedback further risks have been identified for Climate Change and Health Inequalities.

A risk management improvement programme was approved by the NHS Fife Board in March 2022. A comprehensive update was provided to the May Audit & Risk Committee including aims and required actions.

A Board-wide review of risk reporting is currently underway and, when concluded, will make recommendations for the reporting of relevant risks to the Standing committees. It is likely that stand-alone Board Assurance Frameworks (BAFs) in use at present will be replaced by a refreshed Corporate Risk Register, with sections pertinent to each standing committee. This will help each Committee define and monitor risks relevant to their remit once the process becomes fully established. This should help improve the consideration of risk within SBARs to the Board and Standing Committees, which still requires considerable development.

Supporting the Board Strategic Risks will be a Corporate Risk Register, featuring risks that have the potential to affect the whole organisation, or escalated operational split into: Clinical Quality and Safety, Property and Infrastructure (including Digital and Information), Workforce and Finance. In addition, a Risk Dashboard will be developed to enable oversight of the risk level of corporate risks, provide assurance that adequate controls are in place to proactively manage risks, align to improvement actions contained within the Integrated Performance & Quality Report (IPQR) and integrate with Key Performance Indicators (KPIs) and Quality Performance Indicators (QPIs). We also note the intention to refresh the Board Risk Appetite Statement, which should be an important feature of the new system.

Given operational pressures, a Covid19 strategic risk was not included in NHS Fife's extant BAF risk profile. A high level Covid19 risk register is maintained via the Emergency Command structures, which are considered by EDG. At the EDG on 5 May 2022, it was agreed that while some elements of these risks, such as workforce pressures, may remain, they are no longer primarily linked to the pandemic and will now be managed as business as usual, included in the operational risk registers or escalated to the corporate risk register as required.

Performance

NHS Fife has achieved financial breakeven position with non recurring funding of £13.7m received to bridge the financial gap.

The IPQR was presented to each Standing Committee and Board meeting as per each work plan. The IPQR reports on a range of measures covering financial and clinical delivery, with significant challenges highlighted in year.

A review of the IPQR's content and format is currently underway, to address actions from

the Board's Active Governance session and to ensure it remains relevant and clear to Board members.

The IPQR to the May 2022 FPRC provided the latest reported performance for 2021/2022, with data provided to end of March 2022 for Remobilisation Activity and all other targets to February 2022.

Cancer 31-Day Diagnostic Decision to first Treatment (DTT), Inpatient Falls, SABs - HAI and Antenatal are meeting target, with six indicators not achieving target but performing well above the Scotland average: C-Diff Community; 4- Hour Emergency Access; Cancer 62 Day RTT; Patient TTG; New Outpatients; Delayed discharge – Standard Delays.

A further eight areas are neither meeting the target nor the Scotland average: Diagnostics; 18 week RTT; Detect Cancer early; Cancer 62 Day RTT; Delayed Discharge (% bed days lost); Smoking Cessation; CAHMS Waiting Times; Psychological Therapies. Improvement actions to address these areas are included in the IPQR and will take time to embed, and we note that many of these areas are still performing well against the Scottish average.

Integration

The final version of self-evaluation response to the Ministerial Strategic Group (MSG) Integration of Health & Social Care report was submitted by Fife IJB to Scottish Government in May 2019, and detailed areas for further work locally. An update on progress was provided to the Fife IJB Audit & Risk Committee in April 2022, which showed some progress but a number of actions still outstanding. There would be benefit in the NHS Fife Board or a Standing Committee also receiving this report, as the responsibility for implementing actions also lies with the partner bodies, who are reliant on the success of the IJB in a number of key areas.

The NHS Fife Director of Health and Social Care advised the 29 March 2022 Board Meeting that the Integration Scheme (IS) had been formally signed off by Scottish Ministers on 8 March 2022.

Internal Audit has continued to provide advice and highlight governance and assurance aspects of integration and the need for clear lines of accountability and ownership of risk. Internal Audit F05-22 - Strategic Plan is reviewing the process for developing the Fife IJB Strategic Plan. The Fife IJB Strategic Risks were reviewed, updated and presented to the January 2022 meeting of the Fife IJB.

We previously noted that the Integration BAF was significantly out of date and needed to be reviewed. This will be considered as part of the updating of the NHS Fife Risk Management Framework; with the Director of HSCP recommending that the current risk is closed as the Integration Scheme is complete.

Other Governance Areas

General Policies

As reported to the May 2022 FPRC, as at April 2022, 29 (51%) of the 57 General Policies are up to date. 10 (17%) remain beyond their due date and are presently being followed up. Work is underway for 18 (32%) of General Policies, which are either being reviewed or are out for consultation to the General Policies Group. Completion has improved since the last report in November 2021.

Corporate Objectives

During April/May 2022 the Standing Committees endorsed and the Board approved the NHS Fife Corporate Objectives which will inform the development of the Annual Delivery Plan for

2022/23.

Annual Review Letter

The outcome letter from the Scottish Government Annual Review for NHS Fife was received in February 2022 and presented to the March 2022 NHS Fife Board meeting. Overall the feedback received was positive, in particular the organisational actions to the impact of Covid19 and associated activity.

Board and Standing Committee Development Sessions

We commend the timetabling of development sessions for 2022-23 which will provide an understanding in advance of business proposals to Board members and help members to scrutinise papers and understand the topics as they arise at meetings.

Board and Standing Committee Work Plans and Annual Reports

The Audit & Risk Committee will present its annual work plan to each meeting in 2022/23 which will enable the Committee to monitor items that have been completed, carried forward to a future meeting or removed. We recommend that this good practice is extended to all Standing Committees and the Board.

All standing committees' draft annual reports are broadly in line with the FTF Committee Assurance Principles and will be presented to the 16 June 2022 Audit & Risk Committee.

Blueprint for Good Governance and Active Governance

An update was presented to the NHS Fife Board in January 2022 reporting all actions from the initial assessment against the Blueprint for Good Governance as complete.

A Board Development session was held on 2 November 2021 on Active Governance, with a focus on improving how data is presented to the Board and Standing Committees, and how insights from intelligence can be used to assure quality and performance. A plan including a number of actions to improve reporting was agreed. The action plan is due to be completed during the summer of 2022 and then reported to the Board, and will include the recently updated Blue Print for Good Governance.

Code of Corporate Governance

An update to the NHS Fife Code of Corporate Governance was due to be presented to the Audit & Risk Committee in May 2022, but has been delayed to allow the recently issued Model Code of Conduct to be included in the next iteration.

Action Point Reference 1 – MSG Report	
Finding:	
Over the last few years a number of the MSG indicators have progressed but due to Covid there are a number outstanding. An update was provided to the Fife IJB Audit and Risk Committee in April 2022 but no update has been provided to the NHS Fife Board.	
Audit Recommendation:	
NHS Fife should be provided with an update/precis on work being undertaken to foster closer working relationships with colleagues in local authorities and IJBs.	
Assessment of Risk:	
Moderate 	Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**
Management Response/Action:	
A report on the MSG indicators will be presented to the Finance and Performance Committee as a standing committee of NHS Fife Board.	
Action by:	**Date of expected completion:**
Director of HSCP	**September 2022**

Clinical Governance

BAF Risk:

Risk 1674 – Quality & Safety – High Risk (15)

- There is a risk that due to failure of clinical governance, performance, and management systems (including information and information systems), NHS Fife may be unable to provide safe, effective, person centred care. Additionally, there is a risk that the effects of the COVID – 19 pandemic, including restricted capacity, reduced elective & non urgent services, and workforce pressures, will impact on the quality & safety of patient care and service delivery

Risk 1677 – Digital & Information – High Risk (15)

- There is a risk that the organisation will fail to recognise and afford the financial investment necessary to deliver its D&I Strategy and current operational lifecycle commitment to enable transformation across Health and Social care to deliver sustainable and integrated services that are safe, secure and compliant with governance frameworks and associated legislation.

Annual Report

The Clinical Governance Committee (CGC) annual report provided a reflective and nuanced conclusion that the Committee had fulfilled its remit and that adequate and effective clinical governance arrangements were in place throughout NHS Fife during the year. The narrative in the report includes detailed commentary on key areas including pandemic related activity, the risk based approach taken to service pause during the pandemic and mitigating action taken to minimise the impact of this on patient treatment and diagnosis. The report also highlighted business considered during the year including the establishment of the Public Health and Wellbeing Committee, Remobilisation Planning, Population Health and Wellbeing Strategy development, Primary Care Improvement Plan, Complaints Backlog and how this is being addressed, New legislative requirements, New Participation and Engagement Advisory Group, Urgent Care Redesign, East Region Formulary development, Independent review of Paediatric Audiology Services, Revised Integration Scheme, Annual Reports from supporting groups and relevant internal audit and external regulatory body reports.

Pandemic & Immunisation

The CGC received updates on different aspects of work related to the pandemic including the Covid19 vaccination programme and the governance around it and the wider vaccination programme, testing and tracing, communication, infection rates, pressures on services and pausing of elective services and outpatient activity.

An external review of all immunisation programmes in NHS Fife subsequently made recommendations to allow NHS Fife to meet the increasing demands and expectations for childhood and adult immunisation programmes. Recommendations were approved by the EDG at their 6 May 2021 meeting and the Fife Immunisation Strategic Framework 2021-24 was considered and supported by the CGC in September 2021 along with the flu and Covid19 booster immunisation programmes.

Clinical and Care Governance Strategy and Framework

Engagement with staff throughout NHS Fife and the Health and Social Care Partnership has

taken place regarding the draft NHS Fife Clinical and Care Governance Strategic Framework which is to be finalised and presented to the Clinical Governance Committee for endorsement at their meeting on 1 July 2022, later than expected due to service pressures associated with the pandemic. Internal Audit have been consulted on the strategy and have provided comment on governance, integration and assurance aspects as well as on the extent to which the strategy meets the requirements of previous internal audit recommendations.

CGC Governance and Assurance

A Public Health and Wellbeing standing committee has been established with responsibilities related to public health and wellbeing strategy development and assurances regarding this and public health initiatives that were previously within the remit of the CGC. Although terms of reference and workplans have been reviewed, the CGC annual assurance report acknowledges the need for further work to avoid unnecessary duplication and ensure clarity over the different roles and responsibilities of standing committees.

The Clinical Governance Oversight Group has merged with the Duty of Candour and Adverse Events Group and has a revised Terms of Reference which include responsibility for provision of an annual assurance report to the CGC. A newly formed Organisational Learning Group reports to the Clinical Governance Oversight Group, with one of its duties being to review the consistency of external and internal reports.

Risk Management

In response to our finding and recommendation in our 2020/21 Internal Audit Annual Report (B06/22 - pt 1) the Quality and Safety BAF risk was updated by the CGC to reflect the increased risk of morbidity/mortality as a result of necessary reprioritisation of service provision associated with the response to the pandemic as follows: '*There is a risk that due to failure of clinical governance, performance and management systems (including information and information systems), NHS Fife may be unable to provide safe, effective, person centred care. Additionally, there is a risk that the effects of the Covid 19 pandemic, including restricted capacity, reduced elective & non urgent services, and workforce pressures, will impact on the quality & safety of patient care and service delivery*'. The Quality and Safety BAF is linked to relevant operational risks including risks 2214 (staffing levels), 1904 (pandemic associated increased morbidity, mortality and reduced capacity), 1907 (Pandemic associated oversight of Care Homes).

External Review

The NHS Fife CGC Annual Assurance Report referred to the reviews undertaken by regulatory bodies which were reported to CGC during the year along with assurance regarding action being taken to address recommendations made in the reports. The following reports were considered by CGC in 2021/22:

- Healthcare Improvement Scotland (HIS) Healthcare Associated Infection (HAI) inspection - Glenrothes Hospital (7-8 July 2020)
- HIS HAI inspection - Adamson Hospital (28 October 2020)
- HIS Covid focused inspection – Victoria Hospital (May 2021)

In addition the Clinical Governance Oversight Group considered the following additional reports as well as routinely considering the activity tracker including inspection reports. Consultations, reports and publications for awareness and published standards:

- Multi-agency Adult Support and Protection inspection was carried out in Fife between May and August 2021 to provide assurance to the Scottish Government about local partnership areas effective operation of adult support and protection processes and leadership for adult support and protection services

The following reports were referred to in Executive Director Letters but were not reported to the CGC or CGOG:

- Mental Welfare Commission Inspection of Ravenscraig Ward, Whytemans Brae, on 30 September 2021 (update provided to Clinical & Care Governance Committee on 20 April 2022)
- Mental Welfare Commission Inspection of Dunino Ward, Stratheden on 2 November 2021.

Significant Adverse Events

A new post of Lead for Adverse Events has been recruited to and the Lead is co-ordinating the implementation of the Adverse Events improvement plan which includes the review and revision of the Adverse Events Policy. We have been advised that the revised policy will address relevant recommendations in internal audit reports (B08/22, B20/21 & B14/21).

Organisational Duty of Candour

The Annual Duty of Candour (DoC) report covering the 2020/21 financial year was presented to Fife NHS Board at their 29 March 2022 meeting. Neither CGC nor Fife NHS Board have received any information on the application of DoC during 2021/22. The Medical Director has informed us that delays to the adverse event process in its entirety are a known consequence of the impact of the Covid-19 pandemic on service pressures. Recovery to a state where more timely reporting is heavily dependent on the recovery of the backlog of closure of adverse event reviews. .

Clinical Policies and Procedures

The latest report to the Clinical Governance Oversight Group in April 2022 indicated that 97% of Clinical Policies and Procedures had been reviewed by their scheduled review date.

Health and Safety

The 2021/22 Health & Safety Sub-Committee Annual Report confirmed that there were no significant control weaknesses or issues at the year-end which it considered should be escalated to the Clinical Governance Committee or disclosed in the Board's Governance Statement.

Staff Governance

BAF Risks:

- **Risk 1673 - Workforce sustainability - There is a risk that failure to ensure the right composition of workforce, with the right skills and competencies will adversely affect the provision of services and quality patient care and impact on organisational capability to implement the new clinical and care models and service delivery set out in the Clinical Strategy and the future population Health & Wellbeing Strategy and the challenges and demands associated with the current COVID-19 pandemic.**

Workforce Planning and Risk Assurance

The Staff Governance Committee (SGC) considered the draft Interim Workforce Plan on 20 April 2021 prior to submission to SG by the deadline; with final endorsement by the Committee on 15 June 2021. The Interim Workforce Plan complied with the Scottish Governance guidance and template, and reflected workforce elements of the RMP4. No specific update on delivery of the Workforce Plan for 2021/22 has been provided to the SGC; instead the SGC has been advised of its implementation via updates on the RMP4. Whilst this enables the SGC to be kept informed of the workforce actions taken, it does not provide a conclusion on the success in implementing the Workforce Plan for 2021/22 or of its impact on the key workforce risks facing the Board. Whilst compliant with SG direction and timetables, workforce planning remains an area of high risk which is fundamental to the achievement of NHS Fife's strategic objectives and will be integral to the design and delivery of a sustainable Population Health and Wellbeing Strategy.

The National Workforce Strategy for Health and Social Care in Scotland was published in March 2022, and on 1 April 2022, the SG issued associated guidance which required Boards to submit three year integrated health and social care Workforce Plans by 31 July 2022. The risk profile of the national strategy is not available, but our assessment would be that a number of assumptions within the document are very high risk.

The NHS Fife Workforce Strategy will need to inform and be informed by the overall strategy of the Board. When the new Workforce Strategy is presented to the SGC, there would therefore be considerable benefit in a companion paper which describes how it will be monitored by the SGC, how it fits in with Population Health and Wellbeing Strategy and is connected to the developing IJB Strategic Plan e.g. delegated health services, how the associated risks will be identified and consolidated within the new risk register and how assurance will be provided on progress.

The SGC continued to receive regular assurance reports on the strategic workforce risks and received a detailed review of the Workforce Sustainability BAF in October 2021. The workforce risks remained at high; but with greater consideration to workforce sustainability risks relating to service delivery as set out in the Clinical Strategy and the future Health and Wellbeing Strategy, plus the impact of the Covid19 pandemic.

Internal Audit is completing a review of the processes relating to the development of the 2022-25 Workforce Strategy and Workforce plan, using the Workforce Sustainability BAF as the basis to evaluate the design and operation of the controls to inform the Workforce Plan.

Staff Governance Assurances

Reports, such as the Health and Wellbeing Update, indicate that a lot of work is ongoing to meet the Staff Governance Standards (SGS), but there is no reference within such reports as to the specific strands of the SGS that they are addressing or to the resulting outcomes. The SGC also did not receive comprehensive assurance on compliance with the SGS throughout

the year, with only verbal updates on the action taken to meet the SGS being provided at the September 2021 and March 2022 SGC meetings.

The SGC annual report 2021/22 reported that the committee received individual papers to demonstrate that the five strands of the SGS are being met. More detailed, written assurances are required in future to evidence such a conclusion.

Remuneration Committee (RC)

The RC completed an annual assessment of its performance for 2021/22 at its April 2022 meeting. No issues were identified for improvement, with a training session being arranged to further enhance members understanding of their responsibilities. The RC now keeps an Action List to ensure matters carried forward from each meeting are actioned.

Promoting Health and Wellbeing, Appropriately Trained & Developed, and COVID-19 Response

Regular reports have been made to SGC meetings on the impact of the Covid19 pandemic and provision of assurance on the evolving measures being taken to ensure NHS Fife's workforce is being supported during the pandemic. Our review of the Staff Health and Wellbeing update reports presented to the SGC evidenced a good level of detail and showed that NHS Fife continues to respond to the workforce issues presented by the Covid19 pandemic.

The draft Workforce Plan 2022-25 includes an action to consider succession planning implications for critical roles, including advanced practitioners grades and above. It also includes a workforce profile overview for the different medical specialities and each includes a number of actions to sustain each speciality or professional group e.g. Pharmacy Workforce, including training and development.

The sickness absence statistic for March 2022 was 5.59%, which although still high is showing a downward trend since December 2021, when it was 6.98%. For 2021/22, it is reported that there was a staffing reduction of 1.87% due to Covid19.

Appraisal

TURAS appraisal completion continues to be impacted by the Covid19 pandemic, with a 31% completion rate at the end of March 2022. The Area Partnership Forum, which supports partnership working to improve performance, receives updates on both TURAS appraisal and training arrangements, with the SGC receiving copies of its minutes. Arrangements are proposed to include TURAS appraisal performance reporting as part of the IPQR reporting cycle for 2022/23, with reporting to each SGC meeting.

As at 31 March 2022, Medical Appraisal and Revalidation data shows that of 302 Primary Care doctors, 96.7% were appraised and out of 330 Secondary Care doctors 88.8% were appraised. Internal Audit was informed that although appraisals are slowly getting back to normal, there is still a shortage of appraisers in Secondary Care, which has resulted in some being delayed in addition to the existing pressures resulting from Covid19. An update on the appraisal process has recently been issued by the Scottish Government, confirming that the more flexible approach to appraisal recommended over the previous two years should be continued at present. This includes flexibility regarding the amount of supporting information required.

Staff Governance Annual Monitoring Return

The SG advised all health boards in April 2022 that a different approach was being taken to the review of the monitoring return for 2020/21 in recognition of the continuing pressures faced by Boards. As a consequence no further actions/recommendations are being made by

the SG, based on the 2020/21 monitoring return. Although a more streamlined exercise was completed, NHS Fife was advised that the exercise will still allow the SG to measure the application of the SGS and to identify areas of good practice that will be shared to help drive continuous improvement across all NHSScotland Health Boards. The SGC will be advised of the outcome of this exercise once confirmation of the 2021/22 monitoring return format is received from the SG.

Whistleblowing

The SGC and NHS Fife Board were previously advised of the launch of the National Whistleblowing Standards from 1 April 2021 and during 2021/22 it has received updates on how the new standards were being rolled out, including Quarterly Reports detailing the number of concerns raised. Consideration is still being given to the level of detail provided to the SGC to keep it informed on the action taken to address concerns raised. A Whistleblowing Annual Report for 2021/22 will be presented to the September 2022 SGC meeting and thereafter to NHS Fife Board.

Action Point Reference 2: Staff Governance Assurances	
Finding:	
Reports provided to the SGC detailing the actions taken to meet the SGS do not specify which strand they are addressing. In addition, the SGC also did not receive comprehensive assurance on compliance with the SGSs throughout the year, with only verbal updates on the action taken to meet the SGSs being provided at the September 2021 and March 2022 SGC meetings. The SGC annual report 2021/22 reported that the committee received individual papers to demonstrate that the five strands of the SGSs are being met. More detailed, written assurances are required in future to evidence such a conclusion.	
Audit Recommendation:	
To enable the SGC to fully conclude that the SGSs are being met, written reports indicating how ongoing workstream and other activity meets the appropriate SGS(s) should be presented to it in accordance with its Workplan. Any related reports, such as the Health and Wellbeing Update, should also state which strands they provide assurance on and where possible report on the impact as well as the implementation of any actions taken.	
Assessment of Risk:	
Moderate 	Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**
Management Response/Action:	
Work is already underway to respond to this assessment and recommendations **In future all reports to Staff Governance Committee will, where appropriate, include an explicit reference to the SGS(s) the paper meets.**	
Action by:	**Date of expected completion:**
Director of Workforce, with specific action taken by the authors of papers to SGC	**November 2022**

Financial Governance

BAF Risk:

Risk 1671 – Financial Sustainability – Moderate Risk (9)

- There is a risk that the funding required to deliver the current and anticipated future service models, particularly in the context of the COVID 19 pandemic, will not match costs incurred.
- There is a risk that the organisation may not fully identify the level of savings required to achieve recurring financial balance.
- Thereafter there is a risk that failure to implement, monitor and review an effective financial planning, management and performance framework would result in the Board being unable to deliver on its required financial targets.

Risk 1672 – Environmental sustainability – High Risk (20)

- There is a risk that Environmental & Sustainability legislation is breached which impacts negatively on the safety and health of patients, staff and the public and the organisation's reputation

Financial Performance

The draft financial outturn position to 31 March 2022, subject to external audit review, was:

- A £0.380 million under spend on the core Revenue Resource Limit (RRL) of £920.02 million
- A break-even position against the core Capital Resources Limit (CRL) of £32.389 million
- 2021/22 savings delivered of £9.618 million, of which £5.779 million (60%) was recurring,

Total additional Covid19 funding of £95.189m was received from SG in 2021/22. Board Directed Services accounted for £36.464m of the Covid19 costs, and the balance of £58.725m was allocated to the HSCP.

The draft year-end figures for the Health and Social Care Partnership were breakeven for Health delegated, a £1.690m under spend for Social Care with the Fife IJB having a reserve balance of £78.843m.

Financial reporting throughout the year to the FPRC and Board remained consistent and the position was clearly presented, along with the impact of Covid19. Financial forecasts during the year provided an accurate outcome of the year-end position.

Efficiency Savings

The 2021/22 financial plan reflected an overall savings target of £21.7m and assumed £8m was achievable in-year with £4m on a recurring basis and £4m on a nonrecurring basis. Throughout 2021-22 the savings shortfall of £13.7m, as identified in the financial plan, remained a risk to financial balance and Scottish Government (SG) assistance was required. The SG required NHS Fife to deliver a series of actions prior to providing £13.7m to enable NHS Fife to break even for 2021-22.

Significant financial challenges remain as NHS Fife emerges from emergency footing and the Financial Improvement and Sustainability Programme (FISP) will require to ensure there is the required capacity to deliver substantial cost reduction to achieve financial balance in 2022-23 and beyond. The FISP has now been established and its remit endorsed at the January 2022 FPRC. The programme aims to develop and agree productive opportunities and savings targets for 2022/23 and plans for the more medium-term. The Programme will

report directly into the Portfolio Board with governance reporting in place to other Standing Committees and the Board.

Financial Planning 2022/23 and Covid Funding

The Strategic financial plan 2022/23 was approved by the Board on 28 March 2022. This identified a projected budget gap for 2022/23 of £24.1m with plans for this to be mitigated in part through a range of cost improvement plans and a significant capital to revenue transfer. The forecast financial position after the application of these proposed actions is a deficit of £10.4m. A 3-year medium-term plan is being developed to identify a range of cost improvement activity to ensure recurring financial balance at the end of that 3 year period. NHS Fife remain within 0.8% from the full NRAC share.

The Strategic Financial Plan highlighted the risk that Covid19 funding would not match additional costs, but did include provision for Covid consequentials. Subsequently, the SG have advised that "*the UK Government has indicated that in 2022-23 there will be no further specific consequentials to meet the ongoing cost pressures with managing Covid19*."

This guidance was highlighted in a paper to the May FP&R on the budgetary process. However, the paper also stated that '*The financial plan does not assume the continuation of SG funding for Covid19 costs*', which is not necessarily consistent with the information presented in the March budget. The Director of Finance & Strategy has advised Internal Audit that *"the inconsistency arose due to the timing of the recent notification from Scottish Government that there would be no further Covid consequentials, prior to that i.e., in March 2022 the assumption all Boards had made was that Covid consequentials would continue into 2022/23, albeit at a reduced rate. The IJB Covid reserve is earmarked to cover health delegated budget costs which include acute set aside and therefore that aspect of Covid cost will be funded from that source. The Scottish Government also advised on 1 June 2022 that an additional £7.5m for health board retained acute Covid costs will be allocated*."

Now that this risk has crystallised, the financial impact on NHS Fife budgets for 2022/23 is being fully quantified, as it may lead to an increase in the year-end deficit which will generate the need for even more savings in future years. This aspect of financial planning is currently being reviewed and will be reported to the FPRC and the Board by the end of Quarter 1.

We have been informed that the current Financial Sustainability BAF will be split into two new corporate risks. One will focus on in year delivery of the current financial plan and the second will consider the wider delivery of the 3 year financial plan. This approach should provide a more detailed and focussed management of financial risks as part of the updating of the NHS Fife Risk Framework. The Financial Plan did list a number of constituent risks to financial balance, not all of which were reflected in the BAF; these should be assigned to the relevant strategic financial risk in future where that is deemed appropriate.

Capital Planning and Asset Management

The Five Year Capital Plan 2022/23 was endorsed at the March 2022 FPRC and approved at the NHS Fife Board meeting.

The November 2021 FPRC received the Property and Asset Management Strategy (PAMS) report for the year to 31 March 2021, which is not mandatory but good practice. The PAMS itself was largely retrospective but emphasised the need for a revised NHS Fife Property & Asset Management Strategy to support the development and deliver the objectives of the future Health & Wellbeing Strategy.

Within the 2021/22 ICE report we highlighted the ambition for an NHS Fife PAMS Implementation Action Plan to be developed for 2021/22 and onwards, which will include

actions and outcomes. The development of this plan will be included as part of the process to develop the 2022 PAMS.

The PAMS and Capital Programme will be a vital enabler of the Health and Wellbeing Strategy. Internal Audit previously highlighted the absence of a BAF or operational risk for the Capital Programme and Property Strategy and is pleased to note that the intention is to develop a Property Corporate Risk.

The FPRC receive regular updates on current major capital projects. The Fife Elective Orthopaedic Centre (FEOC) Project is on track and due for completion in October 2022 and plans to be operational in January 2023, with progress regularly reported to the FPRC. Updates to the FPRC highlight the need for an additional 38.5WTE staff above the numbers originally envisaged to allow the FEOC to be fully operational by end of 2022. The reason for this increase was fully reviewed with the Scottish Government who approved additional Scottish Government funding to cover it.

BAF – Financial Sustainability – Moderate Risk

The Financial Sustainability BAF, as reported to the FPRC during 2021/22, recognises the ongoing financial challenges facing the Board, in particular Covid19 funding and savings gaps. The risk score has reduced in year with the confirmation of non repayable funding support from the SG. The BAF risk remains as Moderate, reflecting the underlying financial gap going into 2022/23. We would expect the absence of funding for net additional costs for Covid 19 to be reflected in the risk score.

We note the future ambition that the Financial Sustainability BAF would be split with one part focusing on financial performance and the other would be a risk on financial improvement and sustainability for the medium-term. This approach will allow for clearer linkages to strategy and savings programme.

BAF – Environmental Sustainability – High Risk and Environmental Reporting

A paper was presented to the September 2021 FPRC detailing NHS Fife's ambition to improve the energy efficiency of its buildings, as part of the health sector's drive towards 'net zero carbon' and with funding available from the SG as part of the Low Carbon Infrastructure Programme.

A Policy For NHS Scotland on the Climate Emergency and Sustainable Development - DL (2021) 38, was issued on 10 November 2021, setting out mandatory requirements with immediate effect. A briefing paper for the DL was taken to the Board and Public Health and Wellbeing Committee in May 2022. The DL requirements will almost certainly impact on all NHS Fife Board decision making.

The extant BAF has not materially changed during 2021/22 as the major risk is contingent on the delivery of the Fife Elective Orthopaedic Centre (FEOC) to remove inpatients from the tower block at the Victoria Hospital. As noted above, the Director of Property & Asset Management will develop an appropriate corporate risk including the impact of the net-zero requirement.

Best Value

The draft FPRC Annual Report was presented to the FPRC in May 2022. The report concludes on the NHS Fife Best Value arrangements and reflects on the introduction of both the SPRA and FISP which overall "*facilitates a more effective triangulation of workforce, operational and financial planning*" to supporting the delivery of best value across its resource allocations. The FPRC Annual Report also considered the achievement of Best Value characteristic.

Action Point Reference 3: NHS Fife PAMS Implementation Action Plan	
Finding:	
The ICE highlighted the ambition for an NHS Fife PAMS Implementation Action Plan to be developed for 2021/22 and onwards, to include actions and outcomes and be used by the Capital Groups to assess progress in achieving PAMS outcomes and objectives. We have been informed by management this is not an actual document, but is a 'living plan' that is evidenced by discussions at various Capital Groups.	
Audit Recommendation:	
The Implementation Plan for delivering the PAMS should be properly documented, approved and monitored to ensure the delivery of actions and outcomes and provide assurance to the Board that the PAMS is being delivered.	
Assessment of Risk:	
Moderate 	Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**
Management Response/Action:	
An Implementation Action Plan will be developed as part of the 2022 PAMS.	
Action by:	**Date of expected completion:**
Director of Property & Asset Management	**30 November 2022**

Information Governance

BAF Risk:

Risk 1677 – Digital & Information – High Risk (15)

- There is a risk that the organisation will fail to recognise and afford the financial investment necessary to deliver its D&I Strategy and current operational lifecycle commitment to enable transformation across Health and Social care to deliver sustainable and integrated services that are safe, secure and compliant with governance frameworks and associated legislation.

Governance Arrangements and Assurance Reporting

Reporting to the Digital and Information Group has been consistent throughout the year; both groups provided update reports to the Clinical Governance Committee during the year and Annual Assurance Reports/Statements at year-end.

In 2021/22 the format of reporting to the Information Governance and Security Steering Group improved and is now standardised with an Activity Tracker and Assessment against key measures now being provided to each meeting. Improvements have also been made to the quality and availability of data for the key measures report, albeit data is not yet available for some measures such as training/education and records management.

We commend the work of the Director of Finance and Strategy, Medical Director and Associate Director of Digital and Information in driving and supporting the considerable improvements made to assurance reporting, particularly to IG&SSG.

The IG&S Operational Group has not met as often as intended in 2021/22 due to service pressures and staffing resource issues in the IG&S Team and as a result the relationship between the Operational Group and the Steering Group is not yet fully resolved.

The improvements in the assurance reporting and governance arrangements, and scheduling of reporting throughout 2022/23 to the CGC in its annual workplan, have completed recommendations made in previous internal audit reports (B08/21, B28/21 & B08/22).

Digital and Information Strategy

Updates on the NHS Fife Digital and Information Strategy 2019-2024 were provided to the September 2021 and March 2022 Clinical Governance Committee meetings. The latest update recognised that '*the Digital strategy would have benefited from a resourcing and financial assessment to achieve the stated ambitions*' and '*noted the impact of the COVID-19 pandemic response and the requirement to align activities to the evolving risk profile within the Digital and Information domains*'. The CGC have been informed of a new prioritisation process launched in February 2022 in order to align the digital deliverables to their operational and strategic requirements and agree a prioritised workplan consistent with available resources, including the use of a revised prioritisation matrix to balance the adoption of existing digital capabilities with the implementation of new ones.

Whilst resources have increased, and there is now a clearer view of how the remaining two years of the Digital and Information Strategy will be delivered, it is clear that elements of the strategy will not be delivered by the end date of 31 March 2024. The CGC should therefore be notified of these changes, and informed of the impact that this will have on the strategic objectives of the Board.

Risk Management

The format of risk reports presented to IG&SSG and D&I Board have improved throughout 2021/22 and all risks were reviewed to ensure the scores reflected the impact of the pandemic. The new format includes graphical representation to highlight risks with improved or deteriorating ratings and provides detailed analysis on the highest ranked risks which provided the Group with additional understanding of the risk and allowed them to provide assurance on whether management actions would mitigate the risk within a suitable timescale.

The latest Digital and Information BAF presented to CGC on 29 April 2022 highlighted the increased threat of cyber attack due to the war in Ukraine.

External Review

The IG&SSG received detailed update on the NIS Audit throughout the year, with the in March 2022 estimating current compliance of 73% with additional assurance that evidence to demonstrate implementation of previous recommendations was underway, ahead of the review audit to be undertaken by the Competent Authority in April 2022. The review audit was completed for 2022 and the report received detailing an overall compliance status of 76%, an increase from 69% achieved in 2021.

IG&SSG await final feedback from the Keeper of the National Records of Scotland on NHS Fife's draft Records Management Plan submitted in February 2021.

The Information Commissioners Office (ICO) will be auditing Boards in NHS Scotland against its accountability framework; NHS Fife is due late summer 2022. In preparation, a self assessment was presented to CGC on 10 March 2022 which considered the 343 activities associated with the 10 categories and 77 expectations in the framework and concluded that:

- 84 activities had yet to start
- 146 activities had been started but were not complete
- 113 activities had been completed and can be evidenced as such.

Information Governance Incidents

Through the year, 14 incidents were reported to the ICO, an increase of 3 on the previous year. Of the 14, 9 (64%) were reported within the 72-hour requirement. Of the 14 incidents, 13 have been confirmed not to require any further follow up and 1 item rejected as it was deemed to not meet the criteria. At present there is no requirement for these to be disclosed in the Board's annual Governance Statement.

ITIL Processes

In response to internal audit B23-21 – ITIL Processes, the D&I Board supported the introduction of Information Technology Infrastructure Library (ITIL) Version 4 to support strategic planning, design, build activities and the efficient running of operations and service management to further enhance the availability of systems and digital capability.

Action Point Reference 4: Delivery of D&I Strategy 2019/24	
Finding:	
Whilst resources have increased, and there is now a clearer view of how the remaining two years of the Digital and Information Strategy will be delivered, it is clear that elements of the strategy will not be delivered by the end date of 31 March 2024.	
Audit Recommendation:	
The CGC should be notified in 2022/23 of any elements of the D&I Strategy that will not be delivered by 31 March 2024 and the impact that this will have on the strategic objectives of the Board.	
Assessment of Risk:	
Moderate 	Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**
Management Response/Action:	
The element of digital strategy that will not be delivered in full or in part will be identified to the CGC. The initial identification will take place for the 1 July meeting; with the fuller impact assessment being presented as part of the strategy update report on 13 January 2023, as per the Committee's work plan. **This will be evidenced through the committee's minutes.**	
Action by:	**Date of expected completion:**
Associate Director of Digital & Information	**March 2023**

Key Performance Indicators – Performance against Service Specification

	Planning	Target	2021/22	2020/21
1	Strategic/Annual Plan presented to Audit & Risk Committee by 30 June.	Yes	Draft presented May 2022	No (July 21)
2	Annual Internal Audit Report presented to Audit & Risk Committee by June	Yes	Presented Audit & Risk Committee – June 2022	No
3	Audit assignment plans for planned audits issued to the responsible Director at least 2 weeks before commencement of audit	75%	100%	79%
4	Draft reports issued by target date	75%	67%	59%
5	Responses received from client within timescale defined in reporting protocol	75%	100%	68%
6	Final reports presented to target Audit & Risk Committee	75%	67%	47%
7	Number of days delivered against plan	100% at year-end	67%	93%
8	Number of audits delivered to planned number of days (within 10%)	75%	91%	77%
9	Skill mix	50%	80%	77%
10	Staff provision by category	As per SSA/Spec	Pie chart	
	Effectiveness			
11	Client satisfaction surveys	Average score of 3.5	Bar chart	

Assessment of Risk

To assist management in assessing each audit finding and recommendation, we have assessed the risk of each of the weaknesses identified and categorised each finding according to the following criteria:

Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	None
Significant		Weaknesses in design or implementation of key controls i.e. those which individually reduce the risk scores. **Requires action to avoid exposure to significant risks to achieving the objectives for area under review.**	None
Moderate		Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**	Four (Ref 1,2,3,4)
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	None

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**16 June 2022**
Title:	**Draft Annual Internal Audit Plan 2022/23**
Responsible Executive:	**Margo McGurk – Director of Finance and Strategy**
Report Author:	**Tony Gaskin – Chief Internal Auditor**

1 Purpose

This is presented to the Audit and Risk Committee for:

- Assurance

This report relates to a:

- Legal requirement

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The draft Internal Audit plan was presented to the May 2022 Audit and Risk Committee. This updated plan incorporates the comments and suggestions made at that meeting.

As previously reported, a further updated version of the plan will be provided to the Audit and Risk Committee once the Strategic Priorities and Corporate Risk Register are approved.

2.2 Background

> ***"Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, internal control and governance processes."***
>
> Public Sector Internal Audit Standards (PSIAS) – Section 3, Definition of Internal Auditing

The Operational Plan 2022/23 will be developed in accordance with Public Sector Internal Audit Standard 2010 – Planning, to enable the Chief Internal Auditor to meet the following key objectives:

- The need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- Provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- Audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;
- Improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- Effective co-operation with external auditors and other review bodies functioning in the organisation.

The internal audit service will be delivered in accordance with the Internal Audit Charter.

Our Strategic Internal Audit Plan is designed to provide NHS Fife, through the Audit and Risk Committee, with the assurance it needs to prepare an annual Governance Statement that complies with best practice in corporate governance. We also support the continuous improvement of governance, risk management and internal control processes by using a systematic and disciplined evaluation approach.

The objective of audit planning is to direct audit resources in the most efficient manner to provide sufficient assurance that key risks are being managed effectively.

2.3 Assessment

The draft Internal Audit Plan was considered by the Audit and Risk Committee at its meeting in May 2022. The plan will require to be updated further once the Corporate Risk Register (CRR) has been introduced in June 2022. The May Audit and Risk Committee the following requests for inclusion to the draft plan and scopes for 2022-23 as follows:

- Delayed Discharge Management
- Strategic Planning
- Workforce Planning

An updated version of the Annual Internal Audit Plan for 2022-23 is provided at Appendix A. Changes are shown in red.

2.3.1 Quality/ Patient Care

The Triple Aim is a core consideration in planning all internal audit reviews.

2.3.2 Workforce

Management responsibilities, skill sets and structures are a core consideration in planning all internal audit reviews.

2.3.3 Financial

Financial Governance is a key pillar of the Annual Internal Audit Plan and value for money is a core consideration in planning all internal audit reviews.

2.3.4 Risk Assessment/Management

Whilst a detailed mapping has not been undertaken this year, the plan is cognisant of NHS Fife's risk profile as identified through the BAF and through our detailed ICE review. Individual internal audit assignments identify the key risks at the planning stage and our work is designed to evaluate whether appropriate systems are in place and operating effectively to mitigate the risks identified. Legal requirements are a core consideration in planning all internal audit reviews.

2.3.5 Equality and Diversity, including health inequalities

All internal audit reviews which involve review of policies and procedures examine the way in which equality and diversity is incorporated in Board documentation.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

See timetable above.

2.3.8 Route to the Meeting

Executive Directors Group – 21 April 2022
Audit and Risk Committee – 18 May 2022

2.4 Recommendation

The Audit and Risk Committee are asked to:

- Decision – approve the partial audit plan for 2022/23 (Appendix A) and support the approach to further developing the Internal Audit Plan for 2022/23 once the Strategic Priorities and Corporate Risk Register are approved.

Report Contact
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Appendix A – Draft Operational Internal Audit Plan 2022-23

Audit Process	Scope	Days
AUDIT MANAGEMENT		***55***
Audit Risk Assessment & Planning	Audit Risk Assessment & Operational Planning	8
Audit Management & Liaison with Directors	Audit Management, liaison with Director of Finance and other officers	15
Liaison with External Auditors	Liaison and co-ordination with External Audit	4
Audit Committee	Briefing, preparation of papers, attendance and action points	18
Clearance of Prior Year	Provision for clearance and reporting of 2020/21 audit reports	10
CORPORATE GOVERNANCE		
Accountability and Assurance		***105***
Annual Internal Audit Report	CIA annual assurance to Audit Committee	15
Governance Statement	Preparation of portfolio of evidence to support	15
Interim Control Evaluation	Mid-year assurance for Audit and Risk Committee on specific agreed governance areas	35
Audit Follow Up	Undertaking the follow up of audit action points and provision of related reports to the Audit and Risk Committee	40
Control Environment		***10***
Board, Operational Committees and Accountable	Attendance and input / provision of advice at Standing Committees and other Groups.	5

Audit Process	Scope	Days
Officer		
Assurance Framework	Continuation of assurance mapping work across FTF Clients – CIA leading	5
Risk Management		***30***
Risk Management Strategy, Standards and Operations	Yearly review of strategy and supporting structures in order to conclude on risk maturity. This review is a requirement of the Public Sector Internal Audit Standards.	15
Resilience and Business Continuity	Further review of Resilience following on from Interim Report T29/21	15
Health Planning		***95***
Strategic Planning	Review of service capacity and delivery plans post Covid.	20
	Review of NHSF's progress in delivering the Health and Wellbeing Strategy in line with its agreed timetable	10
Operational Service Planning	Review of the management of delayed discharges	30
Health & Social Care Integration	Deliver Fife IJB Internal Audit Plans.	35
CLINICAL GOVERNANCE		***10***
Medicines Management	Follow-up audit of the Transportation of Medicines audit (B21/20) – Request from Director of Pharmacy (previous)	10
STAFF GOVERNANCE		***35***
Workforce Planning	Review of aspects of Medical workforce planning.	25

Audit Process	Scope	Days
Whistle blowing	Compliance with Whistle blowing Standards	10
FINANCIAL GOVERNANCE		
Capital Investment		***15***
Property Transaction Monitoring	Post transaction monitoring	15
Transaction Systems		***35***
Financial Process Compliance	To be selected from: Central, payroll, travel, accounts payable, accounts receivable, banking arrangements.	15
Patients Funds/Endowments	Focus on the ward controls – Request from Kevin Booth	20
Total Days Allocated		***390***
To be allocated during year – approx 4 reviews		***73***
Total Days for 2022/23 Internal Audit Plan		***463***

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**16 June 2022**
Title:	**Losses and Special Payments Quarter 4**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

- National policy

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

- Effective

2 Report summary

2.1 Situation

This paper presents a summary of the Board's Losses and Special Payments covering the period 01/01/22 – 31/03/22. The attached appendix quantifies the Board's Losses and Special payments into categories defined by the requirements of the Scottish Government. These categories include losses relating to fraud, damage to buildings/equipment, Debtors balances written off, damage/loss of equipment and stock, Vehicle accident and insurance excess payments and compensation payments covering financial losses suffered by patients amongst others. The report also quantifies both the clinical and non-clinical ex-gratia compensation payments for legal claims that are negotiated on the Board's behalf by the Central Legal Office.

2.2 Background

The Losses and Special Payments are controlled by the Financial Services Department and are reported to the Scottish Government as part of the Annual Accounts process. All losses and Special Payments as per section 16 of the Financial Operating Procedures are approved by the relevant Directorate/Department Head. The Loss, theft or damage forms are then provided to the Deputy Director of Finance for final approval. The ex-gratia compensation payments for both clinical and non-clinical legal claims are agreed on the

Boards behalf by the Central Legal Office. The Finance Business Partner for Corporate Services liaises with the Central Legal Office to ensure that settlements are as communicated and recharged accordingly. The Losses and Special Payments are then collated in the prescribed categories/format presented as per the requirements of the Scottish Government.

2.3 Assessment

The attached appendix summarises the Boards losses and Special Payments for the period 01/01/22 – 31/03/22. The reports categorise the types of losses and special payments made in the period while also quantifying the number of cases of each and the total monetary value.

There were 195 losses and special payments in the quarter which was in line with the 12-month figure of 826. The cost however was significantly lower this quarter than in the third quarter (£136,736 compared to £3,025,449), as a result of a significant reduction in value of both clinical ex-gratia compensation payments (£73,251 down from £2,856,232) and Non-Clinical ex-gratia compensation payments (£11,292 down from £160,593).

There were increases in the period relating to Payroll write offs (£11,625) and General Debtor write offs (£29,619) , which are carried out as part of the Year End process. The other categories were in line with historical spend.

A Year End review was also carried out by the Financial Services to identify any significant increases or emerging patterns across the last twelve months losses and special payments. This review (see Appendix 2) did not identify any areas of concern, with the only point to note being that the Debtors review carried out at the end of 2021/22 was the first for two years and thus the cumulative balance was higher. The Head of Financial Services will assure the Audit and Risk committee that the Debtors review will be carried out on an annual basis going forward.

In addition, whilst the Central Legal Office negotiate any legal settlements on behalf of NHS Fife, the Legal Services Manager confirmed that the Legal Services Team carry out analysis on potential claimants to alert the Central Legal Office to any consistencies identified.

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

N/A

2.3.3 Financial

The Losses and Special Payments require to be tightly controlled as they can have a material impact on the Boards financial position.

2.3.4 Risk Assessment/Management

The level of the Board's Losses and Special Payments is monitored to minimise any potential reoccurrence and future exposure to the Board.

2.3.5 Equality and Diversity, including health inequalities

The Board's treatment of its losses and special Payments is consistently applied and follows the Financial Operating Procedures where relevant to ensure equity of treatment.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The Boards quarterly Losses and Special Payments are compiled by the Treasury Team and are provided to the Head of Financial Services and Procurement. These losses and Special Payments have already been approved by the appropriate Directorate/Department Head or in the case of legal settlements have come through following agreement/notification by the Central Legal Office.

2.3.8 Route to the Meeting

The Quarters 1 & 2 Losses and Special Payments were previously brought to the Audit and Risk Committee on the 9th of December 2021, whilst the Quarter 3 were brought to the committee on 17th March 2022

2.4 Recommendation

- **Assurance**

This paper is brought to the members attention to give visibility of the Board's losses and special payments in the quarter to 31st March 2022.

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Summary of Losses and Special Payments 01/01/22 – 31/03/22
- Appendix No 2, 2021/22 Year End Losses and Special Payments Review

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FIFE HEALTH BOARD

FOR THE PERIOD 01.01.22 - 31.03.22

SUMMARY OF LOSSES AND SPECIAL PAYMENTS

ITEM NO.	CATEGORY	NO. OF CASES	TOTAL £
	Miscellaneous / Theft / Arson / Wilful Damage		
1	Cash		
2	Stores/procurement		
3	Equipment	1	250.00
4	Contracts		
5	Payroll	15	11,625.73
6	Buildings & Fixtures	26	2,782.39
7	Other	3	36.00
	Fraud, Embezzlement & other irregularities (inc. attempted fraud-		
8	Cash		
9	Stores/procurement		
10	Equipment		
11	Contracts		
12	Payroll		
13	Other		
14	**Nugatory & Fruitless Payments**		
	Claims Abandoned:		
15	(a) Private Accommodation		
	(c) Other	129	33,419.37
	Stores Losses:		
16	Incidents of the Service :		
	- Fire		
	- Flood		
	- Accident		
17	Deterioration in Store		
18	Stocktaking Discrepancies		
19	Other Causes		
	Losses of Furniture & Equipment		
	and Bedding & Linen in circulation:		
20	Incidents of the Service :		
	- Fire		
	- Flood		
	- Accident	5	2,088.14
21	Disclosed at physical check		
22	Other Causes		
	Compensation Payments - legal obligation		
23	Clinical		
24	Non-clinical		
	Ex-gratia payments:		
25	Extra-contractual Payments		
26	Compensation Payments - ex-gratia - Clinical	3	73,251.44
27	Compensation Payments - ex-gratia - Non Clinical	4	11,292.07
28	Compensation Payments - ex-gratia - Financial Loss	8	1,791.75
29	Other Payments		
	Damage to Buildings and Fixtures:		
30	Incidents of the Service :		
	- Fire		
	- Flood		
	- Accident	1	200.00
	- Other Causes		
31	**Extra-Statutory & Extra-regulationary Payments**		
32	**Gifts in cash or kind**		
33	**Other Losses**		
		195	136,736.89

FIFE HEALTH BOARD - SUMMARY OF 2021/22 REVIEW OF LOSSES AND SPECIAL PAYMENTS

			20 / 21			21 / 22	
ITEM	CATEGORY	NO.	£	CASES	NO.	£	DETAILS	COMMENT
	Miscellaneous / Theft / Arson / Wilful Damage							
1	Cash	1	10	*Cameron Petty Cash*	-	-	*-*	*21/22 All Petty Cash confirmed*
2	Stores/procurement							
3	Equipment	-	-		2	492	*(T) Lynebank Phone 07813724372 £242* *(T) Stratheden OTMH Workshop Drill & Sander £250*	*(L) Department unable to locate phone or identify user* *(S) Police informed of Workhop Break-in*
4	Contracts							
5	Payroll	-	-		16	13230	*Historic Superannuation £1604 Salary Debtor W.O'ffs (15) £11626*	*(D) 20/21 no review done*
6	Buildings & Fixtures	31	13042	*Vandalism: Kennoway x1 - Kirkcaldy x1 - Leven x4 (4) - QMH x3 - WBH x4 (1) - VHK x1 (1) - Stratheden x15 (6) - Lynebank x2*	66	6475	*Vandalism: Oakley x1 - Glenrothes x3 (3) RWM x2 - QMH x3 - WBH x11 (8) - VHK x3 - Stratheden x42 (36) - Lynebank x1*	*(IJR) Internal - presumably damaged by Patient.* *(Invoice) External - insufficient Order detail to verify if non-patient related*
7	Other	-	-		4	276	*(T) Lynebank Phone 07813724372 charges £240* *Patient Balances (3) £36*	*(L) Ascertained as personal charges - user not identified* *(PB) Considered probable at year end*
	Fraud, Embezzlement & other irregularities (incl. attempted fraud)							
8	Cash							
9	Stores/procurement							
10	Equipment							
11	Contracts							
12	Payroll							
13	Other							
14	Nugatory & Fruitless Payments							
	Claims Abandoned:							
15	(a) Private Accommodation							
	(b) Other	667	7818	*Hardship Accounts (656 cases) £5618* *Insurance Excess (11 individuals) £2200*	622	39672	*Hardship Accounts (547 cases) £4749* *Debtors W.Off's (75 various) £34923*	*(HA) Report to 05/03/22 - Deemed consistent* *(IE) 21/22 to be confirmed (DWO) 20/21 no review done*
	Stores Losses:							
16	Incidents of the Service :							
	- Fire							
	- Flood							
	- Accident							
17	Deterioration in Store							
18	Stocktaking Discrepancies							
19	Other Causes							
	Losses of Furniture & Equipment and Bedding & Linen in circulation:							
20	Incidents of the Service :							
	- Fire							
	- Flood							
	- Accident	16	6534	*Loss / Damaged Equipment - Individual x4 - VHK x9 - QMH x3*	25	8564	*Loss / Damaged Equipment - Individual x8 - VHK x6 - QMH x4 - Cameron x7*	*Typically Laptops / Ipads / Phones - 21/22 includes other equipment plus 133% increase in loss of Phones*
21	Disclosed at physical check							
22	Other Causes							
	Compensation Payments - legal obligation							
23	Clinical							
24	Non-clinical							
	Ex-gratia payments:							
25	Extra-contractual Payments							
26	Compensation Payments	45	4680487	*Ex-gratia - Clinical*	30	3913335	*Ex-gratia - Clinical*	*20/21 HPO £1.5m (+£250k x4) - 21/22 HPO £2m (+250k x3)*
27	Compensation Payments	16	119417	*Ex-gratia - Non Clinical*	21	297923	*Ex-gratia - Non Clinical*	*20/21 HPO £25.5k - 21/22 HPO £85k*

FIFE HEALTH BOARD - SUMMARY OF 2021/22 REVIEW OF LOSSES AND SPECIAL PAYMENTS

			20 / 21			21 / 22		
ITEM	**CATEGORY**	**NO.**	**£**	**CASES**	**NO.**	**£**	**DETAILS**	**COMMENT**
28	Compensation Payments	42	6588	*Ex-gratia - Financial Loss: Carnegie x1 - Adamson x1 - Valleyfield x1 - Glenrothes x1 - QMH x2 - VHK x22 - Stratheden x3 - Lynebank x2 - Cameron x9*	31	7930	*Ex-gratia - Financial Loss: Glenrothes x1 - St.Andrews x3 - QMH x4 - WBH x1 - VHK x16 - Stratheden x2 - Lynebank x1 - Cameron x3*	*Predominantly Clothing, Spectacles, Dentures, Hearing Aids Average Claims are less in items and amount in 21/22 20/21 upto £1k (x3) - 21/22 upto £1k (x3) £2k (x1)*
29	Other Payments							
	Damage to Buildings and Fixtures:							
30	Incidents of the Service :							
	- Fire							
	- Flood							
	- Accident	3	518	*Vehicle Expenditure*	9	1696	*Vehicle Expenditure*	*No obvious reoccurence*
	- Other Causes							
31	Extra-Statutory & Extra-regulationary Payments							
32	Gifts in cash or kind							
33	Other Losses							
		821	4834413		826	4289593		

AUDIT & RISK COMMITTEE

ANNUAL WORKPLAN 2022 / 2023

Governance - General							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Minutes of Previous Meetings	**Chair**	✓	✓	✓	✓	✓	✓
Action Plan	**Chair**	✓	✓	✓	✓	✓	✓
Escalation of Issues to NHS Board	**Chair**	✓	✓	✓	✓	✓	✓
Governance Matters							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Committee Self-Assessment	**Board Secretary**						✓
Corporate Calendar / Committee Dates	**Board Secretary**				✓		
Review of Annual Workplan	**Board Secretary**	✓	✓	✓	✓	✓	✓ Approval
Review of Terms of Reference	**Board Secretary**						✓ Approval
Annual Review of Code of Corporate Governance	**Board Secretary**	**Deferred to next mtg**	✓				
Annual Assurance Statement 2021/22	**Board Secretary**		✓ Draft	✓			
Annual Assurance Statements from Standing Committees 2021/22	**Board Secretary**		✓				
IJB Annual Assurance Statement 2021/22	**Board Secretary**		**Deferred to next mtg**	✓			
Significant Issues of Wider Interest	**Director of Finance & Strategy**		✓ Draft	✓			
Governance Statement	**Director of Finance & Strategy**	✓ Draft	**Deferred to next mtg**	✓			
Internal Audit Review of Property Transactions Report 2021/22	**Internal Audit**				✓		

Governance Matters (cont.)							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Losses & Special Payments	**Head of Financial Services**		✓		✓	✓	✓
Risk							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Annual Risk Management Report 2021/22	**Risk Manager**	✓ Draft	✓				
Risk Management Key Performance Indicators 2021/22	**Risk Manager**	**Deferred until work on framework concluded**			✓	✓	✓
Board Assurance Framework (BAF)	**Risk Manager**	✓			✓	✓	✓
Risk Management Improvement Programme – Progress Report	**Risk Manager**	✓			✓	✓	✓
Governance – Internal Audit							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Internal Audit Progress Report 2021/22	**Internal Audit**	✓			✓	✓	✓
Internal Audit Annual Report 2021/22	**Internal Audit**	**Draft not available due to timings**	✓				
Internal Audit – Follow Up Report on Audit Recommendations 2021/22	**Internal Audit**				✓	✓	✓
Annual Internal Audit Plan 2022/23	**Internal Audit**	✓ Draft	✓ Draft				
FTF Shared Service Agreement / Service Specification	**Internal Audit**					✓	
External Quality Assessment (5 yearly)	**Internal Audit**				✓		

Governance – External Audit							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Annual Audit Plan 2022/23	**External Audit**						✓
Patients' Private Funds - Audit Planning Memorandum	**Director of Finance & Strategy**	✓					
Governance – External Audit (cont.)							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
External Audit – Follow Up Report on Audit Recommendations	**Director of Finance & Strategy**					✓	✓
Service Auditor Reports on Third Party Services	**Director of Finance & Strategy**		✓				
Annual Accounts							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Annual Accounts & Financial Statements 2021/22	**Director of Finance & Strategy / External Audit**			✓			
Annual Audit Report (including ISA 260) 2021/22	**External Audit**			✓			
Letter of Representation (ISA 580) 2021/22	**Director of Finance & Strategy / External Audit**			✓			
Patients' Funds Accounts 2021/22	**Head of Financial Services**			✓			
Annual Statement of Assurance to the NHS Board 2021/22	**Board Secretary**			✓			

Counter Fraud							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Counter Fraud Service – Quarterly Report (Alerts & Referrals)	**Head of Financial Services**	Private Session			Private Session	Private Session	Private Session
Counter Fraud Standards Update	**Head of Financial Services**	Private Session					
Adhoc							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Private Meeting with Internal / External Auditors	**Committee**				✓		✓
Adhoc (cont.)							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Appointment of Patients' Funds Auditor	**Director of Finance & Strategy**	**As required**					
Progress on National Fraud Initiative (NFI)	**Head of Financial Services**	**As required**					
Legal & regulatory updates (e.g. Audit Scotland reports; Technical Bulletin etc)	**Head of Financial Services**						
Additional Agenda Items (Not on the Workplan e.g. Actions from Committee)							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Annual Accounts Preparation Timeline	**Head of Financial Services**	✓					

Additional Agenda Items (Not on the Workplan e.g. Actions from Committee) (Cont.)							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Internal Audit Framework	**Chief Internal Auditor**	✓ **Deferred from 17/03/22**					
Notification of External Audit Appointment from 2022/2023	**Director of Finance & Strategy**	✓					
Partnership Agreement between Health Boards & Counter Fraud – Update	**Head of Financial Services**	Private Session					
Training Sessions Delivered							
	Lead		**16/06/22**				
Members' Training Session – the Annual Accounts: The Role & Function of the Audit & Risk Committee	**External Auditors**		✓				