NHS Fife Audit & Risk Committee

Mon 12 September 2022, 14:00 - 16:00

Agenda

14:00 - 14:00
0 min

1. Apologies for Absence

Verbal *Martin Black*

14:00 - 14:00
0 min

2. Declaration of Members' Interests

Verbal *Martin Black*

14:00 - 14:00
0 min

3. Minutes of Previous Meeting held on Friday 29 July 2022

Enclosed *Martin Black*

Item 03 - Audit & Risk Committee Minutes (unconfirmed) 20220729.pdf (5 pages)

14:00 - 14:10
10 min

4. Matters Arising / Action List

Enclosed *Martin Black*

Item 04 - Audit & Risk Committee Action List 20220915.pdf (1 pages)

14:10 - 14:25
15 min

5. Introduction from Azets External Auditors'

Verbal *External Auditor*

14:25 - 14:30
5 min

6. GOVERNANCE MATTERS

6.1. Proposed Audit & Risk Committee Meeting Dates 2023/24

Enclosed *Gillian MacIntosh*

Item 06.1 - Proposed Audit & Risk Committee Meeting Dates 2023-24.pdf (1 pages)

14:30 - 15:00
30 min

7. RISK

7.1. Board Assurance Framework

Enclosed *Pauline Anne Cumming*

Item 07.1 - SBAR Board Assurance Framework.pdf (6 pages)
Item 07.1 - Appendix 1 NHS Fife BAF Financial Sustainability.pdf (1 pages)
Item 07.1 - Appendix 2 NHS Fife BAF Environmental Sustainability.pdf (1 pages)
Item 07.1 - Appendix 3 NHS Fife BAF Workforce Sustainability.pdf (2 pages)
Item 07.1 - Appendix 4 NHS Fife BAF Quality & Safety.pdf (2 pages)
Item 07.1 - Appendix 5 NHS Fife BAF Strategic Planning.pdf (1 pages)

Item 07.1 - Appendix 6 NHS Fife BAF Digital and Information.pdf (2 pages)
Item 07.1 - Appendix 7 NHS Fife BAF Integration Joint Board.pdf (1 pages)

7.2. Draft Corporate Risk Register & Dashboard

Enclosed *Margo Mcgurk*

Item 07.2- SBAR Draft Corporate Risk Register & Dashboard + Annex 1.pdf (4 pages)
Item 07.2 - Annex 2 Proposed Risks for Inclusion in the Corporate Risk Register.pdf (7 pages)

7.3. Risk Management Improvement Programme – Progress Report

Enclosed *Pauline Anne Cumming*

Item 07.3 - SBAR Risk Management Improvement Programme – Progress Report.pdf (4 pages)

15:00 - 15:40
40 min

8. GOVERNANCE – INTERNAL AUDIT

8.1. Internal Audit Progress Report 2021/22

Enclosed *Andy Brown*

Item 08.1 - SBAR Internal Audit Progress Report 2021-22.pdf (3 pages)
Item 08.1 - Appendix 1 Internal Audit Progress Report 2021-22.pdf (5 pages)

8.2. Internal Audit – Follow Up Report on Audit Recommendations 2021/22

Enclosed *Andy Brown*

Item 08.2 - SBAR Internal Audit – Follow Up Report on Audit Recommendations 2021-22.pdf (15 pages)

8.3. Internal Audit Review of Property Transactions Report 2021/22

Enclosed *Andy Brown*

Item 08.3 - SBAR Internal Audit Review of Property Transactions Report 2021-22.pdf (2 pages)
Item 08.3 - Appendix 1 Internal Audit Report B19-23 – Post Transaction Monitoring.pdf (6 pages)

8.4. External Quality Assessment (5 yearly)

Enclosed *Tony Gaskin*

Item 08.4 - SBAR External Quality Assessment (5 yearly).pdf (3 pages)
Item 08.4 - Appendix A Public Sector Internal Audit Standards – FTF Self Assessment.pdf (14 pages)

8.5. Fife IJB Draft Internal Audit Joint Working and Reporting Protocol

Enclosed *Tony Gaskin*

Item 08.5 - SBAR Fife IJB Draft Internal Audit Joint Working and Reporting Protocol.pdf (3 pages)
Item 08.5 - Appendix A Draft Internal Audit Joint Working and Reporting Protocol.pdf (6 pages)

15:40 - 15:55
15 min

9. FOR ASSURANCE

9.1. Losses & Special Payments Quarter 1

Enclosed *Kevin Booth*

Item 09.1 - SBAR Losses & Special Payments Quarter 1.pdf (4 pages)
Item 09.1 - Appendix 1 Losses & Special Payments Quarter 1.pdf (1 pages)

9.2. Audit Scotland Technical Bulletin 2022/2

Enclosed *Kevin Booth*

Item 09.2 - SBAR Audit Scotland Technical Bulletin 2022 2.pdf (3 pages)
Item 09.2 - Appendix 1 Audit Scotland Technical Bulletin 2022 2.pdf (36 pages)

9.3. Delivery of Annual Workplan

Enclosed *Gillian MacIntosh*

Item 09.3 - Delivery of Annual Workplan.pdf (5 pages)

15:55 - 16:00
5 min

10. ESCALATION OF ISSUES TO NHS FIFE BOARD

10.1. Chair’s comments on the Minutes / Any other matters for escalation toNHS Fife Board

Verbal *Martin Black*

16:00 - 16:00
0 min

11. ANY OTHER BUSINESS

16:00 - 16:00
0 min

12. DATE OF NEXT MEETING - MONDAY 5 DECEMBER 2022 AT 2PM

MINUTE OF THE AUDIT & RISK COMMITTEE MEETING HELD ON FRIDAY 29 JULY 2022 AT 2.30PM VIA MS TEAMS

Present:
M Black, Non-Executive Member (Chair)
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
P Fraser, Audit Scotland
B Howarth, Regional Audit Manager
B Hudson, Regional Audit Manager
G MacIntosh, Head of Corporate Governance & Board Secretary
M McGurk, Director of Finance & Strategy
M Michie, Deputy Director of Finance
A Mitchell, Independent Auditor - Thomson Cooper *(agenda item 7.1)*
C Potter, Chief Executive
H Thomson, Board Committee Support Officer (Minutes)

1. Welcome / Apologies for Absence

The Chair welcomed everyone to the meeting, in particular, B Howarth and P Fraser from Audit Scotland. He noted that A Mitchell, Auditor of the Patients Funds Accounts from Thomson Cooper, will be joining for specific agenda items.

The Chair expressed a warm thanks to A Wood for serving on the Committee over the last three meetings to cover the vacancy due to the recent council election process.

Apologies were received from member A Grant, Non-Executive Member and attendee T Gaskin, Chief Internal Auditor.

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minute of the last Meeting held on 16 June 2022

A slight amendment was made on page 6, paragraph 5 to read: K MacDonald advised the point was raised to gain assurance there were no quality & safety concerns arising from the delayed progress against actions on the Organisational Duty of Candour, Adverse Events and Staff Governance Standards.

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

4. Action List / Matters Arising

The Audit & Risk Committee **noted** the updates provided and the closed items on the Action List.

5. GOVERNANCE MATTERS

5.1 Fife Integration Joint Board (IJB) Annual Statement of Assurance 2021/22

The Regional Audit Manager provided background to the IJB Annual Statement of Assurance and highlighted the key points from the Annual Internal Audit Report, including workforce pressures which is reflected across the Health and Care system generally.

A Wood, Non-Executive Member queried 'no other significant control weaknesses or issues have arisen', under point 12 on page 3. Clarification was provided that this is a standard statement within the Report, and that the main recommendations detailed at the end of the Report covers this point.

A Wood, Non-Executive Member queried the locus of the 'Finance Governance Board' mentioned on page 15 of the report. The Regional Audit Manager agreed to clarify outwith the meeting.

Action: Regional Audit Manager

The Audit & Risk Committee took **assurance** from the conclusion of the Annual Internal Audit Report on the Fife Integration Joint Board.

5.2 Audit & Risk Committee Final Annual Statement of Assurance 2021/22

The Head of Corporate Governance and Board Secretary provided background to the Audit & Risk Committee Final Annual Statement of Assurance 2021/22 and advised that this final draft now reflects the content within the IJB Statement of Assurance. It was noted the Committee had previously scrutinised the Annual Statement of Assurance in depth.

The Audit & Risk Committee **approved** the Draft Audit & Risk Committee Final Annual Statement of Assurance, for onward submission to the Board.

6. ANNUAL ACCOUNTS

6.1 Patients' Private Funds – Receipts and Payments Accounts 2021/22 & Audit Report

A Mitchell, Auditor of the Patients Funds Accounts from Thomson Cooper, joined the meeting for this item.

The Head of Financial Services & Procurement introduced the Patients' Private Funds – Receipts and Payment Accounts 2020/21 and highlighted that there was a significant

reduction in the final value of the Patients' Private Funds, due to a number of patients moving in-year from health services to services operated by Fife Council.

The Independent Auditor advised that an Audit Planning Memorandum was issued to the Audit & Risk Committee at the start of the Audit process, which highlighted the main areas of risk: the security of assets and compliance with operating procedures for patients' private funds.

The Audit Completion Memorandum reports an Audit visit was carried out, followed up with Ward visits at Lynebank and Stratheden, and no restrictions were reported in the scope of the Audit work carried out. It was highlighted that there was a restriction at one of the Wards selected at Stratheden, due to an operational incident that had occurred, and that an alternative Ward was selected.

It was advised the Audit Completion Memorandum reports no significant issues identified throughout the Audit, and noted the main issues were minor in terms of compliance with the financial operating procedures.

A clean Audit report will be provided subject to the approval of the Annual Accounts by the NHS Fife Board for year ended 31 March 2022.

Following a question from A Lawrie, Non-Executive Member, the Independent Auditor advised that the Auditors set levels of materiality for the patients' private funds, and any breaches would be highlighted during the Audit process.

The Audit & Risk Committee:

- took assurance from the Independent Auditor Report on the Patients' Private Funds Accounts; and
- **recommended** that the accounts for approval by the NHS Board.

6.2 NHS Fife Annual Accounts for the Year Ended 31 March 2022

The Director of Finance & Strategy introduced the Annual Accounts for the Year Ended 31 March 2022.

Key areas of the Annual Report were highlighted. The Performance Report confirms that NHS Fife and partners delivered significant new services and priority projects throughout 2021/22: Early Diagnostic Centre, expanding scope and range of day activity at Queen Margaret Hospital, introduction of international recruits and the development of the outline business cases to deliver the new Health Centres at Kincardine and Lochgelly.

The Director of Finance & Strategy confirmed NHS Fife met all key statutory financial targets for 2021/22.

The Director of Finance & Strategy highlighted the importance of the Governance Statement and the role of the Audit & Risk Committee review of this aspect of the Annual Accounts.

Following a question from A Wood, Non-Executive Member, it was advised a financial risk share arrangement is in place with NHS Fife and Fife Council in relation to the Integrated Joint Board (IJB). An explanation was provided on the IJB reserves and noted that a strategy is being developed to agree the utilisation of these funds across health and social care.

The team were congratulated for all their hard work in delivering the accounts for 2021/22.

The Audit & Risk Committee:

- **reviewed** the draft Annual Accounts for the year ended 31 March 2021;
- **recommended** that the Board approve the Annual Accounts for the year ended 31 March 2021;
- **recommended** that the Board authorise the designated signatories (Chief Executive and Director of Finance) to sign the Accounts on behalf of the Board, where indicated in the document;
- **approved** the proposed arrangements for resolution of minor matters in relation to the accounts, and up to the date of submission to the Scottish Government Health and Social Care Directorate; and
- **noted** that the accounts are not placed in the public domain until they are laid in Parliament.

6.3 Draft Annual Audit Report

The Director of Finance & Strategy noted that it has been a challenging year both operationally and from a financial perspective, mainly due to the ongoing uncertainty in terms of the impact of the pandemic and the pausing and retracting of services in year.

B Howarth, Audit Scotland provided an update on the Draft Annual Audit Report.

The audit concluded with an unmodified opinion on the financial statements. It was reported that there were 2 significant adjustments made to the draft accounts; the first in relation to the IJB surplus the second to record a late notification of expenditure and matching funding for Covid testing.

It was reported that the non-adjusted misstatements mainly relate to over accrual of either capital or revenue expenditure. They have not been adjusted within the Annual Accounts and the reasons are outlined in paragraph 25 of the report which are based on materiality levels. It was advised that strengthening procedures are recommended within the report for ensuring accruals are supported going forward.

B Howarth highlighted that NHS Fife achieved its revenue resource limit. It was noted a significant element of Covid funding is held in the Integrated Joint Board (IJB) reserves

Following a question from A Wood, Non-Executive Member, it was explained that the IJB are responsible for decisions on the allocation of reserves, however it was noted that there is some ring fenced and ear marked funds within those reserves that are held to deliver aspects of Covid costs for NHS Fife. It was advised that both the Fife Council and NHS Fife report 50% of the final reserve balance in their respective consolidated Accounts.

B Howarth thanked the Chief Executive, Director of Finance & Strategy & the finance team noting that this was his last year to Audit NHS Fife.

The Director of Finance & Strategy expressed thanks to the Finance Team colleagues and Internal Auditors for all their hard work and diligence throughout the year. Thanks were also extended to the External Auditors, and they were wished well for the future. The Chair and Committee Members were also thanked for all their support throughout the year, particularly in terms of the progression of the revised risk management arrangements.

The Audit & Risk Committee took **assurance** from and **noted** the Annual Audit Report.

6.4 NHS Fife Independent Auditors Report - Including Draft Letter of Representation

B Howarth, Audit Scotland advised that the Audit work is now complete, and the revised set of Annual Accounts which are referred to in the Draft Letter of Representation, have been received and reviewed, and an unqualified audit opinion has been proposed.

6.5 Annual Assurance Statement to the NHS Board 2021/22

The Audit and Risk Committee **approved** the Chair's signed approval of the Committee's final version of the Committee Assurance Statement to the Board.

7. FOR ASSURANCE

The Committee **approved** the tracked workplan.

8. ESCALATION OF ISSUES TO NHS FIFE BOARD

There were no issues to highlight to the Board.

9. ANY OTHER BUSINESS

There was no other business.

Date of Next Meeting: Thursday 15 September 2022 at 2pm via MS Teams

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

AUDIT & RISK COMMITTEE – ACTION LIST
Meeting Date: Thursday 15 September 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**	An update will be brought back to the Committee on developments as the business case is finalised.	17/03/22 - A business case is being developed in April 2022 for NHS Fife, and the preferred upgrade package is Datix Cloud IQ. A verbal update will be provided at the September meeting.	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.	29/07/2022	**Fife Integration Joint Board (IJB) Annual Statement of Assurance 2021/22**	To clarify with A Wood, the locus of the 'Finance Governance Board' mentioned on page 15 of the report.	**BH**	September 2022	Complete.	Closed
4.	15/06/2022	**Losses & Special Payments Quarter**	To ask the Director of Finance & Strategy to provide feedback on the process from her involvement with the Central Legal Office proposed settlements at the next Committee meeting.	**KB**	September 2022	22/07/22 - An update will be incorporated into the Losses and Special Payment paper regarding assurance about lessons learned from any legal settlements made by the board to reduce the likelihood of the boards repeat exposure.	Closed

AUDIT & RISK COMMITTEE

DATES FOR FUTURE MEETINGS

Date
Thursday 18 May 2023
Thursday 15 June 2023
Thursday 31 August 2023
Thursday 14 December 2023
Thursday 14 March 2024

Please note that all meetings take place via **MS Teams** / in the **Staff Club** (TBC) and start at **1.30pm**

A pre-meeting of Non-Executive Members is routinely held, beginning at **2pm**

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NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**12 September 2022**
Title:	**Board Assurance Framework**
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:

- NHS Board/Integration Joint Board Strategy or Direction
- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Board Assurance Framework (BAF) identifies risks to the delivery of NHS Fife's strategic objectives and priorities, including the NHS Fife Strategic Framework, the NHS Fife Clinical Strategy and the Fife Health & Social Care Integration Strategic Plan. It integrates information on strategic risks, related operational risks, controls, assurances, mitigating actions and an assessment of current performance.

This is an update on the BAF to the Committee since the last report on 18 May 2022. It summarises the position on the BAF components that will be reported to the governance committees in September 2022.

Members are aware, that as part of the refresh of the Risk Management Framework, it was agreed that the BAF would be replaced with a renewed NHS Fife Corporate Risk Register

and Dashboard by 31 July 2022. The timescale for concluding this work is now 30 September 2022.

Each risk will be assigned to a governance committee; this will be noted on the register.

Details of the Draft Corporate Risk Register & Dashboard are being shared with all governance committees during August and September, and will then be presented for approval at the September 2022 Board meeting. If approved, formal reporting on risks assigned to the respective governance committees will commence during the November 2022 round of meetings.

This will therefore be the final report on the BAF to this committee.

2.2 Background

This paper fulfils the requirement to report to the Committee on the status of the BAF and any relevant developments.

2.3 Assessment

The current BAF risk levels and ratings are summarised in Table 1.

Table 1 - Risk Level and Rating over time

Risk ID	Risk Title	Initial Risk Level & Rating Likelihood (L) x Consequence (C)	Current Level & Rating Aug/ Sep 2021	Current Level & Rating Oct / Nov 2021	Current Level & Rating Jan / Feb 2022	Current Level & Rating Mar / Apr 2022	Current Level & Rating May / June 2022	Current Level & Rating July / Aug 2022
1671	**Financial Sustainability**	Likely 4 x Major 4 = 16 High	16 (4x 4) High	16 (4x 4) High	9 (3x3) Mod	9 (3x3) Mod	16 (4x4) High	16 (4x4) High
1672	**Environmental Sustainability**	Likely 4 x Extreme 5 =20 High	20 (4x 5) High	20 (4x 5) High	20 (4x5) High	20 (4x5) High	20 (4x5) High	20 (4x5) High
1673	**Workforce Sustainability**	Almost Certain 5 x Major 4= 20 High	16 (4x 4) High	16 (4x 4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High	16 (4x4) High
1674	**Quality & Safety**	Likely 4 x Extreme 5 = 20 High	15 (3x 5) High	15 (3x 5) High	15 (3x5) High	15 (3x5) High	15 (3x5) High	15 (3x5) High
1675	**Strategic Planning**	Likely 4x Major 4 = 16 High	16 (4 x 4) High	16 (4 x 4) High	12 (3x4) Mod	12 (3x4) Mod	12 (3x4) Mod	12 (3x4) Mod
1676	**Integration Joint Board**	Likely 4 x Major 4 =16 High	12 (3x4)) Mod	12 (3x4)) Mod	12 (3x4) Mod	12 (3x4) Mod	4 (1x4) Low	**Closed**
1677	**Digital and Information**	Likely 4 x Extreme 5 = 20 High	15 (3x5) High	15 (3x5) High	15 (3x5) High	15 (3x5) High	15 (3x5) High	15 (3x5) High

Key points from updates to be provided to Committees in September 2022

The BAF components are provided separately in Appendices 1-7.

Financial Sustainability

The Director of Finance & Strategy reported on the above component of the BAF to the Finance, Performance & Resources Committee (F, P&RC) on 10 May and 12 July 2022, and will report on the current position to the Committee on 13 September 2022. Members will be asked to take assurance that there is mitigation in place for risks associated with financial sustainability.

Since the last update, the current risk level has been reviewed twice and assessed as **High.** The linked Risk 522 - Prescribing and Medicines Management - Prescribing Budget is unchanged at High 15.

It is proposed that as we transition from the BAF, this risk is closed and replaced with the following strategic risks for inclusion in the Corporate Risk Register:

- Delivery of a balanced in-year financial position
- Delivery of recurring financial balance over the medium-term

Environmental Sustainability

The Director of Property & Asset Management reported on the above component of the BAF to the F, P & R C on 10 May and 12 July 2022, and will report on the current position to the Committee on 13 September 2022. Members will be asked to take assurance that there is mitigation in place for risks associated with environmental sustainability.

Since the last update, the current risk level has been reviewed and it remains **High**. There are no changes to report in relation to the linked risks.

It is proposed that as we transition from the BAF, this risk is closed and replaced with the following strategic risks for inclusion in the Corporate Risk Register:

- Policy obligations in relation to environmental management and climate change
- Prioritisation & Management of Capital Funding

Workforce Sustainability

The Director of Workforce reported on the above component of the BAF to the Staff Governance (SG) Committee on 12 May 2022, and 14 July 2022, and will report on the current position to the Committee on 1 September 2022. Members will be asked to take assurance that there is mitigation in place for risks associated with Workforce Sustainability.

Since the last update, the current risk level has been reviewed and remains **High**. Changes to the BAF are highlighted in Appendix 3. There are no changes to report in relation to linked risks.

It is proposed that as we transition from the BAF, this risk is closed and replaced with the following strategic risks for inclusion in the Corporate Risk Register:

- Workforce: Planning and Delivery
- Staff Health & Wellbeing

Quality & Safety

The Medical Director and the Director of Nursing reported on the above component of the BAF to the Clinical Governance Committee (CGC) on 29 April and 1 July 2022 respectively, and will report on the current position to the committee on 2 September 2022. Members will be asked to take assurance that there is mitigation in place for risks associated with Quality and Safety.

Since the last update, the current risk level has been reviewed and remains at **High**. There are no changes to report in relation to linked risks.

It is proposed that as we transition from the BAF, this risk is closed and replaced with a new strategic risk for inclusion in the Corporate Risk Register:

- Quality & Safety: Control, Assurance and Improvement

It was previously reported to the Committee, that consideration was being given to adding a risk to the BAF around Unscheduled Care. This has been superseded by the development of a draft strategic risk associated with whole system capacity which is being proposed for inclusion in the new Corporate Risk Register.

Strategic Planning

The Director of Finance & Strategy reported on the above component of the BAF to the F, P&RC on 10 May 2022 and CGC on 1 July 2022, and will report on the current position to the CGC on 2 September 2022. Members will be asked to take assurance that there is mitigation in place for risks associated with strategic planning.

Since the last update, the current risk level has been reviewed and remains at **Moderate**.

Work is progressing in the development of the Population Health and Wellbeing Strategy with revised timescales. Further engagement work has been commissioned and will take place over the next few months. A Milestone plan to December 2022 has been produced.

The Annual Delivery Plan (ADP) 2022/23 was submitted on 29 July 2022 and a feedback meeting with the Scottish Government took place on 22 August 2022. The Planned Care section of the ADP was submitted on 12 August 2022 with a financial template supporting the long waiting times recovery plan.

It is proposed that as we transition from the BAF, this risk is closed and replaced with a new strategic risk for inclusion in the Corporate Risk Register:

- Population Health and Wellbeing Strategy

Digital and Information (D&I)

The Associate Director of Digital & Information reported on the above component of the BAF to the CGC on 29 April and 1 July 2022, and will report on the current position to the Committee on 2 September 2022. Members will be asked to take assurance that there is mitigation in place for D&I risks.

New Linked Risk
Since the last update, Risk 1500 - Cyber Resilience, has been added as a linked risk. This risk represents the overarching corporate risk and is underpinned by 4 additional risks that have been updated to align with the 4 Objectives of the Cyber Resilience Framework and the Network and Information Security Directive.

Previously Linked Risks
There are no changes to those linked risks.

Since the last update, the BAF's current risk level has been assessed and remains **High**.

It is proposed that as we transition from the BAF, the extant D&I BAF Risk 1677 and linked Risk 1500, are included in the Corporate Risk Register.

Integration Joint Board (IJB)

The IJB component of the BAF was discussed at EDG on 16 June 2022. In light of the completion of the Integration Scheme review, and approval by Scottish Ministers in March 2022, and the work to strengthen governance arrangements, the risk as stated in the BAF, had considerably reduced in terms of likelihood. The Director of Health and Social Care proposed that consideration should be given to closing this risk.

EDG noted the work that had been completed, agreed the risk had reduced to its target risk level, and supported closure of the IJB component.

2.3.1 Quality/ Patient Care

Risks to quality and safety are detailed in Appendix 4.

2.3.2 Workforce

Risks to workforce sustainability are detailed in Appendix 3.

2.3.3 Financial

Risks to financial sustainability are detailed in Appendix 1.

2.3.4 Risk Assessment/Management

Risk management is a key component of the Board's Code of Corporate Governance, a fundamental part of each committee's remit and intrinsic to the BAF.

2.3.5 Equality and Diversity, including health inequalities

It is expected, that the assessment of equality or diversity implications is intrinsic to the analysis of the BAF risks and thus reflected in the content of the appendices.

2.3.6 Other impact

Appendices 2, 5, 6 and 7 describe impacts relating to Environmental Sustainability, Strategic Planning, Digital & Information, and the Integration Joint Board.

2.3.7 Communication, involvement, engagement and consultation

This paper reflects the engagement of Executive Directors, Non Executives, the Associate Director of Quality and Clinical Governance, and other key stakeholders.

2.3.8 Route to the Meeting

Via Margo McGurk, Director of Finance and Strategy on 31 August 2022

2.4 Recommendation

The Committee is asked to:

- take **assurance** from the update on the BAF; and
- **comment on** and take **assurance** from the approach to transitioning from the BAF to a Corporate Risk Register

3 List of appendices

The following appendices are included with this report:

- Appendix 1, NHS Fife BAF Financial Sustainability for FP& RC on 130922
- Appendix 2, NHS Fife BAF Environmental Sustainability for FP& RC on 130922
- Appendix 3, NHS Fife BAF Workforce Sustainability for SGC on 010922
- Appendix 4, NHS Fife BAF Quality & Safety for CGC on 020922
- Appendix 5, NHS Fife BAF Strategic Planning for CGC on 020922
- Appendix 6, NHS Fife BAF Digital and Information for CGC on 020922
- Appendix 7, NHS Fife BAF Integration Joint Board (IJB) as at 160622

Report Contact
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Risk Manager, NHS Fife
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NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Financial Sustainability																											
1671	Sustainable	31/05/2022	31 August 2022	There is a risk that the board will not achieve its financial targets in 2022/23 due to the inability to deliver the level of cost improvement plans required, the costs of managing the ongoing global Covid 19 pandemic exceed available funding, the increasing cost of very challenging unscheduled care service pressures and insufficient available resource to support the recovery of elective care services.	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	Although agreement has been reached with IJB CFO in relation to partnership approach to funding support from Covid reserve carried forward by the IJB for both partnership and health delegated services and a further COVID financial envelope made available by SG to support health non delegated services, there remains the risk that the cost of manging the pandemic will exceed the available funding. The challenges involved with managing increasing services pressures could impede the achievement of cost improvement plans.	Margo McGurk Director of Finance and Strategy	Finance, Performance & Resources (F,P&R) Rona Laing	*Ongoing actions designed to mitigate the risk including:* 2022/23 Financial Plan approved by NHS Board in March 2022. Cost improvement plans of £11.7m and capital to revenue transfer of £2m approved to mitigate the initial funding gap of £24m. Remaining Funding gap of £10.4m with plans to mitigate over the medium term. Financial Improvement and Sustainability Programme (FIS) board established to provide oversight to the delivery of Cost Improvements Plans and approve pipeline schemes to be taken to implementation. Capacity within the Corporate Programme Management office has been increased to provide support to deliver on the FIS programme. Agreement has been reached with IJB CFO on partnership approach to the use of the Covid reserve carried forward by the IJB to support Covid expenditure across the partnership and Health delegated Services. Covid financial envelope to support non delegated Health services has been provided by Scottish Government Covid expenditure to be mitigated wherever possible either by stopping spend or absorbing into business as usual resources. All cost improvement opportunities to be shared by and with all NHS boards across Scotland through the establishment of national cost improvement workstreams	Nil	1. Continue to develop all opportunities identified through the FIS programme cost improvement pipeline tracker in the context of sustainability & value. 2. Continue to maintain an active overview of national funding streams to ensure all NHS Fife receives a share of all possible allocations. 3. Continue to scrutinise and review any potential financial flexibility. 4. Engage with H&SC / Council colleagues on the risk share methodology and in particular ensure that EDG, FP&R and the Board are appropriately advised on the options available to manage any overspend within the IJB prior to the application of the risk share arrangement	1. Produce monthly reports capturing and monitoring progress against financial targets and efficiency savings for scrutiny by all responsible managers and those charged with governance and delivery. 2. Undertake regular monitoring of expenditure levels through managers, Executive Directors' Group (EDG), Finance, Performance & Resources (F,P&R) Committee and Board. As this will be done in parallel with the wider Integrated Performance Reporting approach, this will take cognisance of activity and operational performance against the financial performance.	1. Internal audit reviews on controls and process; including Departmental reviews. 2. External audit review of year end accounts and governance framework.	1. Enhanced reporting on various metrics in relation to supplementary staffing. 2. Confirmation via the Director of Health & Social Care on the social care forecasts and the likely outturn at year end.	Current performance very challenging with ongoing financial consequences of Covid 19, significant cost pressures associated with workforce and medicines due to high levels of unscheduled care activity, enhanced costs of recruitment and retention issues and rising inflationary costs. Cost improvement plans continue to be developed with 6.4% of approved CIP target delivered to end of May 2022.	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	Financial risks will always be prevalent within the NHS / public sector and it would be reasonable to aim for a position where these risks can be mitigated to an extent. However, SG have indicated significant financial challenge in year which requires robust mitigation and may impact availability of SG funding allocations.

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
522	Prescribing and Medicines Management - Prescribing Budget	Active Risk	High Risk	15	McKenna, Christopher

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1357	Financial Planning, Management and Performance	Active Risk	Moderate	12	McGurk, Margo
1363	Health and Social Care Integration	Active Risk	Moderate	9	McGurk, Margo
1513	Financial and Economic impact of Brexit	Active Risk	Low Risk	6	McCormick, Neil
1364	Efficiency Savings	Closed Risk	High Risk	16	McGurk, Margo
1784	Finance (Short Term/Immediate)	Closed Risk	Moderate	8	Connor, Nicky
1846	Test and Protect/Covid Vaccination	Closed Risk	Low Risk	6	Connor, Nicky

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Environmental Sustainability																											
1672	Clinically Excellent, Sustainable	01/08/2022	30 September 2022	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.	4 – Likely – Strong possibility this could occur	5 - Extreme	20	High Risk	4 – Likely – Strong possibility this could occur	5 - Extreme	20	High Risk	Estates currently have significant high risks on the E&F risk register; until these have been eradicated this risk will remain. Action plans have been prepared and assuming capital is available these will be reduced in the near future.	Neil McCormick Director of Property & Asset Management	Finance, Performance & Resources (F,P&R). Rona Laing.	*Ongoing actions designed to mitigate the risk including:* 1. Operational Planned Preventative Maintenance (PPM) systems in place 2. Systems in place to comply with NHS Estates 3. Action plans have been prepared for the risks on the estates & facilities risk register. These are reviewed and updated at the monthly risk management meetings. The highest risks are prioritised and allocated the appropriate capital funding. 4. The SCART (Statutory Compliance Audit & Risk Tool) and EAMS (Estates Asset Management System) systems record and track estates & facilities compliance. 5. Sustainability Group manages environmental issues and Carbon Reduction Commitment(CRC) process is audited annually. 6. Externally appointed Authorising Engineers carry out audits for all of the major services i.e. water safety, electrical systems, pressure systems, decontamination and so on.	Nil	1. Capital funding is allocated depending on the E&F risks rating Responsible person: Director of Estates, Facilities & Capital Services Timescale: Ongoing as limited funding available 2. Increase number of site audits Responsible person: Estates Compliance Manager Timescale: Ongoing	1. Capital Investment delivered in line with budgets 2. Sustainability Group minutes. 3. Estates & Facilities risk registers. 4. SCART & EAMS. 5. Adverse Event reports..	1. Internal audits 2. External audits by Authorising Engineers 3. Peer reviews.	None.	High risks still exist until remedial works have been undertaken, but action plans and processes are in place to mitigate these risks.	1 – Remote – Can't believe this event would happen	5 - Extreme	5	Low Risk	All estates & facilities risk can be eradicated with the appropriate resources but there will always be a potential for failure i.e. component failure or human error hence the target figure of 5..

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1007	Theatre Phase 2 Remedial work	Active Risk	High Risk	15	Cross, Murray
1252	Flexible PEX hoses in PHASE 3 VHK	Active Risk	High Risk	15	McCormick, Neil
1296	Emergency Evacuation, VHK Phase 2 Tower Block	Active Risk	High Risk	15	McCormick, Neil

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1207	Water system Contamination STACH	Active Risk	Moderate Risk	10	McCormick, Neil
1275	South Labs Plantroom	Active Risk	Moderate Risk	8	Lowe, David
1306	Risk of pigeon guano on VHK Ph2 Tower Windows	Active Risk	Moderate Risk	12	Lowe, David
1316	Inadequate Compartmentation VHK Phase 1, Phase 2 floors B-1st	Active Risk	Moderate Risk	8	McCormick, Neil
1341	Oil Storage - Fuel Tanks - Central/NEF	Active Risk	Moderate Risk	10	Keatings, Gordon
1342	Oil Storage - Fuel Tanks - QMH/DWF	Active Risk	Low Risk	5	Wishart, James
735	Medical Equipment Register	Closed Risk	Moderate Risk	10	Lowe, David
749	836 - VHK Ph.2 Main Foul Drainage Tower Block	Closed Risk	High Risk	15	Lowe, David
1083	VHK CLO2 Generator (Legionella Control)	Closed Risk	High Risk	15	GRB
1312	Vertical Evacuation - VHK Phase 2 Tower Block	Closed Risk	Moderate Risk	10	Fairgrieve, Andrew
1314	Inadequate Compartmentation of Escape Stairs and Lift Enclosures	Closed Risk	Low Risk	6	Fairgrieve, Andrew
1315	Vertical Evacuation - VHK Phases 1 and 2 (excluding Tower Block)	Closed Risk	Moderate Risk	8	BAN
1335	FCON Fire alarm potential faiure	Closed Risk	High Risk	15	GRB
1352	Pinpoint malfunction	Closed Risk	High Risk	16	Pirie, Margaret
1384	Microbiologist Vacancy	Closed Risk	High Risk	20	JGARDN
1473	Stratheden Hospital Fire Alarm System	Closed Risk	High Risk	20	Keatings, Gordon

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Workforce Sustainability																											
1673	Exemplar Employer	05/08/2022	3 October 2022	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 COVID-19 pandemic.	ALCERT	MAJORR	20	1_HIGH	LIKELY	MAJORR	16	1_HIGH	Workforce failures may have consequences for patients' health outcomes. NHS Fife has an ageing workforce, with recruitment challenges in many disciplines. Failure to ensure the right composition of workforce with the right skills and competencies continues to give rise to a number of organisational risks including: reputational and financial risk; a potential adverse impact on the safety and quality of care provision; staff engagement, staff absence, staff attrition and morale. Failure may also adversely impact on the implementation of the current Clinical Strategy and the future NHS Fife Population Health & Wellbeing Strategy. The current scores reflect the existing controls and mitigating actions in	Linda Douglas Director of Workforce	Sinead Braiden Staff Governance	*Ongoing actions designed to mitigate the risk including:* **WORKFORCE – GENERAL** • Development and implementation of the Workforce Strategy to support the Clinical Strategy, workforce elements of the Annual Delivery Plan, Population Health & Wellbeing Strategy and Strategic Framework; alongside the Workforce Plan for 2022 to 2025. The Workforce Plan for 2022 to 2025 has been developed partnership with Trade Union / Professional Body representatives and submitted to the Scottish Government in July 2022• Implementation of the Health & Social Care Workforce Strategy to support the Health & Social Care Strategic Plan for 2019 to 2022, the integration agenda and the development of the H&SCP Workforce Strategy and Workforce Plan for 2022 to 2025. • Implementation of the NHS Fife Board Strategic and Corporate Objectives, particularly the "exemplar employer / employer of choice" and the associated values and behaviours and aligned to the ambitions of an anchor institution. • Implementation of the NHS Fife / H&SCP Joint Interim Workforce Plan for 2021/2022. • Workforce Plans to align to and take account of the National Workforce Strategy for Health & Social Care. **WORKFORCE CAPACITY** • Current resourcing actions include: active local and international recruitment campaigns and continued expansion of bank and supplementary staffing resources, including recruitment of newly qualified nurse practitioners in all disciplines, Band 4 Assistant Practitioners, additional Band 2 bank HCSWs, fast track process to support appointable candidates being appointed to other vacancies and admin support roles as part of a commitment to support Senior Charge Nurses and nursing teams. NHS Fife has been successfully recruiting international recruits for Nursing and Radiology roles. Our first group commenced on the 28 February 2022 and we have welcomed our 5th group on 27 June 2022. To date we have recruited 21 Staff Nurses within Acute and 2 Radiographers. 2 staff Nurses will join us in September 2022 and a further 2 Radiographers and 6 Staff Nurses are within the recruitment pipeline to join NHS Fife. We are building a strong working relationship with Yeovil District Hospital NHS Foundation Trust who conduct the recruitment process for Fife. This has been a positive experience for both NHS Fife and the candidates and it is hoped that international recruitment will increase and expand to other professions over 2022/2023. Pastoral support of overseas recruits and the welcome to Fife is crucial to the success of this initiative, and a package of support, including practice development to facilitate on the job learning and skills development, is in place for each international recruit who joins NHS Fife. • Planning and delivery of actions undertaken by respective COVID-19 and Workforce Groups at various levels,(now moving into business as usual with the emergency footing ending in NHS Scotland in April 2022), including inter alia local workforce groups, workstreams associated with new programmes of work, for example, Community Care and Treatment, Vaccination Transformation and Implementation of the General Medical Services contract. • Planning to meet future service needs, applying workforce planning and forecasting skills in support of service delivery, using the workforce modelling and abstraction techniques learned during the pandemic and managing staff availability to respond to escalation requirements. The impact of these actions will be reflected in the annual workforce projections exercise, when re-introduced, to determine future capacity requirements • Supporting service delivery through implementation and integration of systems and joint working with services on redesign of services to mitigate shortfalls in staff availability. • The first fourteen young people took up paid placements on our Kickstart Programme at the end of March 2022. Thirteen young people remain in post, the intention of the programme is to improve employment opportunities for those at risk of long-term unemployment. They have been provided with development opportunities, and employability support, with the aim of supporting them to a positive work destination. We have identified and secured funding to support the implementation and sustainability of future programmes including several 'No one left behind' programmes. **WORKFORCE CAPABILITY** • eLearning and training offers aligned to current work modes • Continuation of fast track induction and related activity, including new welcome and orientation package. • Implementation of Practice Development initiatives to support changes in service delivery and preparation for further escalation requirements, for example training resources for non-clinical staff to support clinical service delivery. • Ensuring managers and staff are prepared for the implementation of and compliance with the Health & Care (Staffing) (Scotland) legislation within the clinical workforce. • Develop and deliver Phase 1 of the framework to improve leadership capability and embed talent management and succession planning. • To prioritise staff personal / professional development needs that have been delayed or restricted due to COVID-19 response as restrictions are eased, through Directorate development delivery plans. • To progress actions in support of the employability agenda. • To progress actions in support of the equality, diversity and human rights agenda. **WORKFORCE ENGAGEMENT** • Working in partnership with staff side and professional organisations across all sectors of NHS Fife to ensure staff engagement opportunities are maximised. • iMatter – supporting action planning and Board actions arising from the 2021 cycle of feedback and reporting,. Our 2022 cycle of iMatter has just concluded and we achieved a higher response rate, Fife achieved a higher response rate (60%) than the NHS Scotland average (56%) attributed to the NHS Fife iMatter Roadhshow 'lets have a natter because iMatter' We are now providing support to the action planning piece. • Supporting staff through changes in ways of working and providing access to new and different career opportunities. • Realising the benefits of the Internal (Staff) Communication Strategy and ensuring that StaffLink and other mediums for example the weekly Team and Chief Executive Briefings, joint managerial / partnership walkabouts support	Nil	**WORKFORCE – GENERAL** • Implementation and review of workforce plans and strategies to ensure that these support service delivery and the provision of appropriate and safe care to the population of Fife. • Ensuring workforce preparedness for any further COVID-19 escalation requirements and the legacy of the pandemic, working in partnership through the respective Workforce Groups and command structure. • Support for capacity building within and across the organisation to make sure we make the best use of the skills of all of our workforce and to foster an environment for staff development. **WORKFORCE CAPACITY** • Consideration of redesign of roles and services, for example: expansion of Health Care Support Worker and Assistant Practitioner roles, Advanced Practitioners, Pharmacy Technicians and Physicians Associates, combined with targetted ward administrative support, to enable clinical time to be released. • Consideration of alternative ways to attract and recruit staff, or redesign of job roles to support service delivery models and the future supply pool. • Realising the benefits of implementation of the regional recruitment model from July 2022. • Harnessing the benefits of digital technology and automation to support service delivery and the commitments within the Recovery Plan / Clinical Strategy, for example within Laboratory Services, to compensate for shortfalls in current staff / future pipeline and complement recruitment and the introduction of advanced practice. • Create a pathway for young people with barriers to employment to gain paid work experience with us, with the aim of securing future employment via the Kickstart and Long Term Unemployed Programme. • Continue with plans to develop and implement an Apprenticeship programme starting in August 2022, in collaboration with the Nursing Team and Digital and information colleagues. **WORKFORCE CAPABILITY** • Consideration of and implementation of learning and development activities in support of skill mix and associated actions. • Contributing to NHS Scotland developments in Learning and Development. • Realising benefits from the implementation of and compliance with the Health & Care (Staffing) (Scotland) legislation within the clinical workforce. • Supporting managers to harness the benefits of Tableau, TURAS and other systems integration aligned to workforce planning. • Provision of workforce planning training and support for managers. • Develop and deliver further phases of the framework to improve leadership capability and embed talent management and succession planning. • Consideration of the functionality of TURAS Learn to support capture and to facilitate reporting and analysis of training and development data. **WORKFORCE ENGAGEMENT** • Continuation of active partnership working through APF and LPFs, with staff side colleagues key stakeholders in the development of the Workforce Strategy, future Workforce Plan's and associated Action Plans. • Continue to promote NHS Fife as an employer to enhance our ability to recruit and retain staff, utilising positive Communication support and social media, alongside participation in careers events. We have very recently supported two careers events (one in partnership with our pharmacy colleagues where we have posted the success of the events on LinkedIn). • To develop mechanisms which enable everyone to feel more valued and involved on a collaborative basis throughout health and social care. •Review of alternative workforce infomatics to widen the current range of workforce egagement indicators. **WORKFORCE SUPPORT & WELLBEING** • Review of Staff Health & Wellbeing Framework to take account of COVID-19 lessons learned and evaluation of activities to establish which are most appreciated by staff. • Provision of additional staff support and wellbeing initiatives which contribute to staff health and wellbeing, staff resilience and staff retention, showcasing NHS Fife as an exemplar employer in the local labour market. • Continue to hold Gold HWL Award status and deliver on Health Promoting Health Service commitments. • Consideration of support for the ageing workforce and other disadvantaged groups and opportunities for	1. Regular performance monitoring and reports to Executive Directors Group, Area Partnership Forum, Local Partnership Fora and Staff Governance Committee 2. Staff Governance activities are reported to EDG, APF, LPFs and Staff Governance Committee	1. Use of national data for comparative purposes 2. Internal Audit reports 3. Audit Scotland reports 4. Bench marking comparison with other NHS Boards	Full implementation and utilisation of eESS, Job Train, Tableau and TURAS will provide integrated workforce systems which, alongside access to national data via the NES Portal will capture and facilitate reporting, including all learning and development activity.	Overall NHS Fife has robust workforce planning, learning and development, governance and risk systems and processes in place. Continuation of the current controls and full implementation of mitigating actions, in particular the Workforce Strategy supporting the Clinical Strategy and the future Population Health and Wellbeing Strategy for Fife and full implementation and use of eESS, should provide appropriate levels of control.	UNLIKE	MAJORR	8	2_MOD/	Continuing improvements in current controls, ongoing review and full implementation of mitigating actions will reduce both the likelihood and consequence of the risk to moderate, taking account of current and potential future workforce challenges.

													place.			organisational objectives. • Scoping a Staff Experience and Engagement Framework that sets out our key ambitions and commitments for improving staff experience, which will help to develop a culture that values and supports our workforce. **WORKFORCE SUPPORT & WELLBEING** • Provision of support and wellbeing initiatives which contribute to staff maintaining and enhancing their personal health and wellbeing at work and creating a great place to work. Staff Wellbeing Framework developed to align to Board aims and national commitments. • Access to OH,(including self referral access to Counselling and Physiotherapy) H&S, Peer Support, Psychology, Spiritual Care and Staff Listening Services. • Integration of Mindfulness, Good Conversations and Our Space support and Outdoor sessions for staff as part of Going Beyond Gold Programme, contributing to a culture of kindness and staff recovery. • Consistent application of NHS Fife and Once for Scotland employment policies • Provision of a healthy and safe working environment, including access to refreshments in the workplace and ongoing development of Staff Hubs, Pause Pods and rest areas. Management of leave and encouraging rest and recuperation.		job redesign. Responsible Person/s: Director of Workforce									

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
2214	Nursing and Midwifery Staffing Levels	Active Risk	High Risk	20	Owens, Janette
90	National Shortage of Radiologists	Active Risk	High Risk	16	Dobson, Claire
1420	Loss of consultants	Active Risk	High Risk	15	Bett, Heather

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1324	Medical staff recruitment and retention	Active Risk	Moderate Risk	12	Kennedy, John
1375	Breast Radiology Service	Active Risk	High Risk	16	Cross, Murray
1652	Medical Capacity in Community Paediatric Service	Active Risk	Moderate Risk	12	Dobson, Claire
503	Diabetes	Closed Risk	Moderate Risk	9	CHE
1042	Staffing Levels	Closed Risk	Moderate Risk	12	Nolan, Karen
1349	Service Provision - GP locums may no longer wish to work for NHS Fife Salaried Practices	Closed Risk	Moderate Risk	8	Dobson, Claire
1353	Service Provision - Shortfall in GP Cover will limit service provision	Closed Risk	Moderate Risk	9	Dobson, Claire
1846	Test and Protect/Covid Vaccination	Closed Risk	Low Risk	6	Connor, Nicky
1858	workload resulting from deterioration in mental health	Closed Risk	Moderate Risk	10	JTORRN

NHS Fife Board Assurance Framework (BAF)

Risk ID	Corporate Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Quality & Safety																											
1674	Clinically Excellent, Person Centred	01 July 2022	02 September 2022	There is a risk that due to failure of clinical governance, performance and management systems (incluing 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.	4 – Likely – Strong possibility this could occur	5 - Extreme	20	High Risk	3 – Possible – May occur occasionally – reasonable chance	5 - Extreme	15	High Risk	Failure in this area could have a direct impact on patients' health, organisational reputation and exposure to legal action. While it is recognised that several adverse events ranging from minor to extreme harm can occur daily, the proportion of these in relation to overall patient activity is very small.	Christopher McKenna Medical Director	Clinical Governance Christina Cooper	*Ongoing actions designed to mitigate the risk including:* Oversight and monitoring of strategy / framework / policy and procedure implementation and impact including: 1. Strategic Framework 2. Clinical Strategy 3. Clinical Governance Structures and operational governance arrangements 4. Clinical & Care Governance Strategy 5. Participation & Engagement Strategy 6. Risk Management Framework 7. Governance arrangements established to support delivery of the UK Coronavirus (COVID-19) action plan and Scottish Government Annual Delivery Plan 2022/23 8. Processes established for reporting and escalation of COVID-19 related incidents & risks 9. NHS Recovery Plan and Remobilisation These are supported by the following: 10. Risk Registers 11. Integrated Performance and Quality Report (IPQR), Performance reports dashboard data 12. Performance Reviews 13. Adverse Events Policy 14. Acute Adult Programme (formerly Scottish Patient Safety Programme (SPSP) 15. Implementation of SIGN and other evidence based guidance 16. Staff Learning & Development 17. System of governance arrangements for all clinical policies and procedures 18. Participation in relevant national and local audit 19. Complaints handling process 20. Using data to enhance quality control 21. HIS Quality of Care Approach & Framework, Sept 2018 22. Implementing Organisational Duty of Candour legislation 23. Adverse event management process 24. Sharing of learning summaries from adverse event reviews 25. Implementing Excellence in Care 26. Using Care Opinion feedback 27. Acting on recommendations from internal & external agencies 28. Revalidation programmes for professional staff 29. Electronic dissemination of safety alerts 30.Organisational Learning Group established in August 2021. 31.Implementiing the Adverse Event improvement Programme. 32. Reviewing and updating the Clinical and Care Governance Framework for delivery by 31/10/22. 33.Review of the Risk Management Framework and development of improvement programme is underway. 34. The Child and Young People Death Review Commissioning Group is well	1.Reviewing together of patient experience, complaints, adverse events and risk information to provide an overview of good practice, themes, trends, and exceptions to the norm 2.Weaknesses in the process for recording completion of actions from adverse event reviews including evidence of steps taken to implement and share learning from actions. 3.Weaknesses in related oversight and monitoring processes at operational level 4. Risk Management Improvement programme to be implemented	1. Give due consideration to how to balance the stabilisation and remobilisation of clinical services and take forward improvement work while managimg staff and public expectations, as we recover from the COVID-19 pandemic. 2. Continually review the Integrated Performance and Quality (IPQR) to ensure it provides an accurate, current picture of clinical quality / performance in priority areas. To incorporate a risk component from late summer 2022. 3. Refresh the extant Clinical Governance structures and arrangements to ensure these are current and fit for purpose as part of the review of the Clinical & Care Governance Framewrok. 4..Review the coverage of mortality & morbidity meetings in line with national developments and HIS guidance. 5. Review and refresh the current content and delivery models for key areas of training and development e.g. corporate induction, in house core, quality improvement, leadership development, clinical skills, interspecialty programmes, risk management, clinical effectiveness. 6. Review annually, all technology & Digital & Information systems that support clinical governance e.g. Datix / Formic Fusion Pro./ Labs systems. 7.Estabish via HIS, the plans for Board reviews against the Quality of Care Framework in order to prepare and understand our state of readiness for a review. 8. Further develop the culture of a person centred approach to care. 9. Executive commissioning of reviews as appropriate e.g. internal audit, external peer and 'deep dives' 10. Align the developing Clinical & Care Governance Framework with the NHS Fife Strategic Priorities, Corporate Objectives and the developing Population Health & Wellbeing Strategy. 11.Identify improvements within the adverse events process taking into consideration communication, roles, use of DATIX and lines of reporting. 12. Build a risk culture which ensures that there is engaged risk leadership and proactive measures with focus in place to address risks. 13. Build a risk culture which links the identification of risk to organisational objectives and strategic priorities. 14.Identify and implement an electronic system/ quality management system for managing policy and procedures to improve efficiency and assurance of document management. 15. Use the Essentials of Safe Care framework as the basis of an organisational self assessment to understand status quo and support development of C&CG Framework .	1. Assurance statements from clinical & clinical & care governance groups and committees 2. Assurances obtained from all groups and committees that: i. they have a workplan ii. all elements of the work plan are addressed in year 3. Annual Assurance Statement 4. Annual NHS Fife CGC Self assessment 5.I Reporting bi annually on adequacy of systems & processes to Audit & Risk Committee 6. External accreditation systems e.g.. Unicef - Accredited Baby Friendly Gold. UKAS Inspection for Labs 7. External agency reports e.g. GMC 8. Quality of Care review 9. Compliance and monitoring of policies & procedures to ensure these are up to date 10. Locally designed subject specific audits 11. National audits	1. Internal Audit reviews and evaluation reports on controls and process; including annual assurance and governance review / departmental reviewsto Audit & Risk Committee 2. External Audit reviews 3. HIS visits and reviews 4. Healthcare Environment Inspectorate (HEI) visits and reports 5. Health Protection Scotland (HPS) support and feedback 6. Health & Safety Executive visits and reports 7. Acute Adult Programme (formerly SPSP) visits and reviews 8. Scottish Govt Organisational DoC Annual Report 9. Scottish Public Service Ombudsman (SPSO) reports 10. Patient Experience and Feedback (PEaF) Quarterly Report which includes Care Opinion, compliments, and complaints report KPIs. 11. Specific National reporting 12. Mental Welfare Commission (MWC) reviews	1. Key performance indicators relating to corporate objectives e.g. person centred, clinically excellent, exemplar employer & sustainable 2. We require additional assurances that there is a system in place for oversight , monitoring of actions, and disseminating learning from a variety of sources e.g. audit, adverse events, SPSO, MWC reviews 3. We require additional assurances that there are systems in place for oversight of operational and strategic risks	Overall, NHS Fife has in place sound systems of clinical governance and risk management as evidenced by Internal Audit and External Audit reports and the Statement of Annual Assurance to the Board.	2 – Unlikely – Not expected to happen – potential exists	5 - Extreme	10	Moderate Risk	The organisation can identify the actions required to strengthen the systems and processes to reduce the risk level.

																established having met monthly since October 2021 Three posts to support the infrastructure of the death reviews process have been successfully recruited to. A Child &Young People Death Governance Group is in place and meets quarterly. The Year 1 report from the Child and Young People Death Commissioning Group will be submitted to the Clinical Governance Committee in November 2022.		16..Ensure linkages with Patient Relations Team to allow for shared learning and identification of organisational themes. 17. Further embed and monitor implementation of NHS Fife governance and reporting on the reviews of deaths of children and young people.									

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
2214	Nursing and Midwifery Staffing Levels	Active Risk	High Risk	20	Owens, Janette
1904	Coronavirus Disease 2019 (COVID-19) Pandemic	Active Risk	High Risk	16	Tomlinson, Joy
2297	Cancer Waiting Times Access Standards	Active Risk	High Risk	15	Dobson, Claire
1296	Emergency Evacuation, VHK Phase 2 Tower Block	Active Risk	High Risk	15	McCormick, Neil
1907	Public Health Oversight of COVID-19 in Care Homes	Active Risk	High Risk	15	Tomlinson, Joy

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
43	Vascular access for haematology/Oncology	Active Risk	High Risk	16	Shirley - Anne Savage
528	Pandemic Flu Planning	Active Risk	Moderate Risk	12	Brown, George
637	SAB LDP standard	Active Risk	Moderate Risk	9	Cook, Julia
1652	Medical Capacity in Community Paediatric Service	Active Risk	Moderate Risk	12	Dobson, Claire
1670	Temperature within fluid storage room within critical care	Active Risk	Moderate Risk	12	Morgan, Belinda
356	Clinical Pharmacy Input	Closed Risk	High Risk	15	McKenna, Christopher
521	Capacity Planning	Closed Risk	Very Low Risk	1	Watts, Miriam
529	Information Security Risk	Closed Risk	High Risk	16	McGurk, Margo
1287	Overcapacity in AU1 Assessment Unit	Closed Risk	Very Low Risk	3	Shepherd, Angie
1297	Obsolete Equipment In Use – No Replacement Plan In Place (Graseby 3000 Series)	Closed Risk	Moderate Risk	10	Lowe, David
1366	T34 syringe drivers in the Acute Division	Closed Risk	Low Risk	6	Savage, Shirley-Anne
1502	3D Temperature Monitoring System (South Lab)	Closed Risk	Moderate Risk	12	Campbell, Ken
1514	Impact of the UK's withdrawal from the EU on the availability and cost of medicines and medical devices	Closed Risk	High Risk	15	Garden, Scott
1515	Impact of the UK's withdrawal from the EU on Nuclear Medicine and the ability to provide diagnostic and treatment service(s)	Closed Risk	High Risk	15	Anderson, Jane
1524	Oxygen Driven Suction	Closed Risk	High Risk	20	McKenna, Christopher
1667	Infusion pumps, volumisers and Syringe Divers in Paediatrics and Neonatal Units	Closed Risk	High Risk	25	Dobson, Claire

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Strategic Planning																											
1675	Clinically Excellent, Exemplar Employer, Person Centred, Sustainable	03/10/2022	3 October 2022	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. Key Risks from previous BAFs will remain until committees are content they are covered in renewed PHW Strategy. 1. Community/Mental Health redesign is the responsibility of the H&SCP/IJB which hold the operational plans, delivery measures and timescales 2. Governance of the transformation programmes remains between IJB and NHS Fife. 3. Regional Planning - risks around alignment with regional plans are currently reduced as regional work is focussed on specific workstreams 4. Clinical Strategy does not reflect that the strategic direction of the organisation following the COVID-19 pandemic.	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	3 – Possible – May occur occasionally – reasonable chance	4 – Major	12	Moderate Risk	Following period of COVID-19, portfolio management is being put in place. Programme management approach being refreshed through Strategic Planning Resource Allocation (SPRA) process.	Margo McGurk	Director of Finance and Strategy Clinical Governance. Christina Cooper.	*Ongoing actions designed to mitigate the risk including:* 11/8/22 1. Workshop has been held with PH to discuss DoPH report and focus for NHS Fife strategy. Next step is Grand Round on 31/8/22 with clinicians from across Fife to discuss next steps. Supported by MD, DoP and DoN 2. Joint engagement progressing with focus groups being planned. Opportunity to benefit from wider engagement process in HSCP. 3. Annual Delivery Plan submitted to SG but still in draft form.	EDG Portfolio Board will provide the required leadership and executive support to enable strategy development - now in place.	PHW Portfolio Board is now meeting monthly. TOR signed off. Governance route will be Public Health and Wellbeing Committee Time period for Strategy has been amended to start from 23/24 rather than 22/23. Annual Delivery Plan for 22/23 providing interim strategic direction. Work will continue during 2022 to ensure delivery of Strategy for 23/24. Responsible Person: Director of Finance Timescale: 31/03/2023	1. Minutes of meetings record attendance, agenda and outcomes. 2. Reporting of key priorities to governance groups from the SPRA process. .	1. Internal Audit Report on Strategic Planning (no. B10/17) 2. Governance committee scrutiny and reporting. .	Governance of new arrangements will be agreed to deliver the required assurance. This gap have now been closed.	Corporate Objectives now finalised for 22/23. Draft Annual Delivery Plan has been submitted in July 22 with draft Planned Care plan submitted on 12/8/22. ADP Q2 update on deliverables to be submitted in October 22.	2 – Unlikely – Not expected to happen – potential exists	4 – Major	8	Moderate Risk	Position is improving as Portfolio Board and Public Health and Wellbeing Committee is in place.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
	Nil currently identified				

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
	Nil applicable				

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Digital & Information																											
1677	Clinically Excellent, Exemplar Employer, Person Centred, Sustainable	08/08/2022	3 October 2022	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.	4 – Likely – Strong possibility this could occur	5 - Extreme	20	High Risk	3 – Possible – May occur occasionally – reasonable chance	5 - Extreme	15	High Risk	Failure in this area could have a direct impact on patients care, organisational reputation and exposure to legal action. While it is recognised that several adverse events ranging from minor to extreme can occur daily, the proportion of these in relation to overall activity is very small and reporting to competent authorities is minimal.	CMK Medical Director	Clinical Governance Christina Cooper (CGC)	*Ongoing actions designed to mitigate the risk including:* 1. Consistent alignment of the D&I Strategy with the NHS Fife Corporate Objectives and developing Health & Wellbeing Strategy 2. Digital & Information Board Governance established and supporting prioritisation with ongoing review 3. Information Governance & Security Governance Groups implemented with improvement and assurance activity plans reviewed and monitored by Steering Group. 4. Caldicott - register maintained and reviewed 5. Review of financial impact of D&I Strategy as part of annual deliver planning and areas of exposure quantified and presented via SPRA process 6. Operational governance lead through SLT focusing on operation controls (finance & resource), lifecycle management, policy/procedure implementation a workforce development 7. Risk management arrangements underpinned by: Policy & Process, Adverse event management, Asset Management Controls, Monitoring and Detection, Defence in Depth security measures and technology; all of which are receiving a higher percentage of budget allocation. 8. Directive on security of network and information systems (NIS) & Cyber Essentials Compliance – Action Plan developed prioritising a series of Cyber workshops informing technical controls and organisational response to Cyber attacks 9. Additional resilience planning and disaster recovery work underway to update alignment to current operating priorities 10. FOI, SAR, records management, DPA improvements being lead through IG&S Steering and Operational Groups 11. Senior Management Team consideration of policy and procedure impact and associated implementation 12. Monthly risk reviews with Operational Leads and escalation/reporting to Governance Groups as necessary 13. Performance Review 14. Participation in national and local audit e.g. NISD Audit 15. Commitment to ensure appropriate implementation of Cyber Defence Measures, including support of national centralised cyber incident reporting and coordination protocols. 16. Staff Learning & Development, both Digital staff and the wider organisation including leadership skills. 17. Business Case development to include costed resilience by design and ongoing support activities. 18. Enhancing monitoring of our digital systems.	Lack of formal quantification of the financial impact of the remaining items associated with the Digital Strategy, Business Cases in development. Level of financial and resource exposure linked to COVID response items. Lack of long term financial, lifecycle and workforce planning. Lack of evidence of assurance now that systems to maintain ongoing monitoring of compliance and control are established: GDPR/DPA 2018 - Improvements noted in IG&S Assurance Report (Target March 2022) Lack of consideration and commitment to unification of business process on strategic applications and the associated remove of duplicate or legacy systems Lack of training and education resource to ensure our staff and patients are digitally ready - Business Case in consideration Lack of resilience of key digital systems and technical recovery procedures and regular failover (DR) testing. - Plan to address agreed with EDG - April 2021- project now in initiation – Oct 2021 Governance and procedures do not fully follow ITIL professional standards - Internal Audit Findings responded to	1. Improving and maintaining strong governance, risk management and operating procedures following Information Technology Infrastructure Library (ITIL) professional standards within early adoption of continuous improvement assessment. (ITIL implementation - Phase 1 Agreed - Phase 2 underway) 2. Organisation to consider the gaps in current operating financial commitments as a result of COVID response and assessment of financial implementation of Digital Strategy presented through SPRA process. 3. Develop long term financial, lifecycle and workforce planning - plan to address is in development 4. Work to become fully compliant with GDPR, DPA 2018, NIS Directive, Information Security Policy Framework and thereafter maintain compliance.	Second line of Assurance: 1. Reporting to D&I SLT, D&I Board, Information Governance & Security Steering Group (IG&SG), EDG & Clinical Governance groups and committees. 2. Annual Assurance Statements for the D&I Board and IG&S Steering Group. 3. Locally designed subject specific audits. 4. Compliance and monitoring of policies & procedures to ensure these are up to date via D&I Senior Management Team. 5. Reporting bi annually on adequacy of risk management systems and processes to Audit & Risk Committee. 6. Monthly SIRO report 7. SGHSCD Annual review 8. SG Resilience Group Annual report on NIS & Cyber compliance 9. External Assurance on Delivery Plan by Scottish Government 10. Update to Assessment following June 2019- Digital Maturity Assessment 11 Periodic Benchmarking for areas of focus	Third line of Assurance : 1. Internal Audit reviews and reports on controls and process; including annual assurance and governance review / departmental reviews. 2. External Audit reviews. 3. Formal resilience testing / DR testing using an approved scope and measured success and mechanism for lessons learned and action plans. 4. Alignment to Cyber Resilience Framework 5. NISD Audit Commissioned by the Competent Authority for Health. 6. Benchmarking with NHS Scotland's Boards	1. The remaining deliverables as stated in the D&I Strategy have yet to undergone business case assessment against delivery. Findings presented via SPRA and FCIG. 2. Continual development of data assured performance is ongoing across all D&I Domains. Development of workplans aligned to risk continually developed. 3. Assurance reports are consistently provided to D&I SLT monthly and development of data/KPI reports to Governance Groups continue to be developed. These reports will ensure trend and analysis to highlight potential vulnerabilities and provide assurances (including assurances that confirm compliance with GDPR, DPA 2018, NIS Directive, the Information Security Policy Framework is being maintained). 4. Implementation of improvements as recommended in Internal and external Audit ongoing. Adverse Events review to be included 5. Improvements to SLA's (in line with 'affordable performance')is that output still awaited from 4 to provide assurance or otherwise 6. Assurance on patients' readiness/equality impact in the adoption of digital care provision 6. Assurance on organisational readiness for further Digital Adoption	Overall, NHS Fife Digital has in place a sound systems of 1. Governance - agreed ToR and reporting 2. Improving security defences and risk management as evidenced by Internal Audit and External Audit reports 3. Investment has been made to support NIS, GDPR and Cyber resilience and some tools which will improve visibility of the Network. 4. Clear articulation of digital aspiration via the Digital Strategy 2019-2024 5. Extended corporate governance including EDG attendance 6. Meeting visibility through provision of minutes and delivery plans to EDG/CGC 7. Investment in substantive resources for IG&S, Programme Management office and architecture service.	2 – Unlikely – Not expected to happen – potential exists	5 - Extreme	10	Moderate Risk	1. Difficulty in securing investment in people, tools and maintaining systems that are resilient and always within support cycles. 2. Fully implementing resistance to attack through 'resilience by design', well practised response plans and recovery procedures. 3. Reduce the 'human factor' through ongoing 'user base education' and improving organisational digital readiness. 4. Enhanced controls and continuing improvements to systems and processes for improved usage, monitoring, reporting and learning are continually being put in place. Aim for Moderate Risk as target rather than Low Risk is due to the fact that likelihood whilst unlikely may still happen and consequence will be extreme due to level of fines that may be imposed, reputational damage and patient harm.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
2192	Risk that Digital & Information Service Management activities are not aligned to ITIL	Active Risk	High Risk	20	Graham, Alistair
1422	Unable to meet NIS & Cyber Resilience Framework compliance	Active Risk	High Risk	16	Graham, Alistair
1500	Cyber Resilience Risk	Active Risk	High Risk	16	Potter, Carol
1934	Loss of Cloud based Email & Collaboration Services	Active Risk	High Risk	16	Young, Allan
537	Failure of the Network causing widespread loss of access to IT systems	Active Risk	High Risk	15	Young, Allan
885	Digital & Information Financial Position	Active Risk	High Risk	15	Graham, Alistair

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
226	Security of data being transferred off/on site	Active Risk	High Risk	16	Graham, Alistair
1338	NHS Fife at increased cyber attack risk due to legacy systems / application versions	Active Risk	Moderate Risk	12	Graham, Alistair
1393	Patch Management Risk	Active Risk	Moderate Risk	8	Young, Allan
1504	Lack of a central IT location to store guidance documents	Active Risk	High Risk	20	McKenna, Christopher
1576	Risk of not meeting Software as a Medical Device full compliance	Active Risk	Moderate Risk	9	McKenna, Christopher
1746	O365 May Cause Disruptive Network Overhead	Active Risk	Moderate Risk	9	Young, Allan
1932	T4 - User error in use of O365 products (including those supporting system)	Active Risk	Moderate Risk	12	Fowles, Malcolm
1996	Office 365 - Unknown Financial Consequence and so risk to licence availability	Active Risk	Moderate Risk	12	Graham, Alistair
529	Information Security Risk	Closed Risk	High Risk	16	McGurk, Margo
913	MIDIS replacement	Closed Risk	Moderate Risk	9	Donovan, Lesly
1424	End of support lifecycle for Microsoft Server Products	Closed Risk	High Risk	16	Young, Allan
1927	Deliberate unauthorised data access or misuse by insiders (staff, contractors etc.)	Closed Risk	Moderate Risk	12	Fowles, Malcolm
1928	T2 - Deliberate unauthorised access or misuse of O365 Email by outsiders (e.g. hackers)	Closed Risk	Moderate Risk	12	Young, Allan
1929	T7 - Inadequate or absent audit trail	Closed Risk	High Risk	25	Young, Allan

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Integration Joint Board																											
1676	Sustainable	31/05/2022	10 June 2022	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.	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	1 – Remote – Can't believe this event would happen	4 – Major	4	Low Risk	In light of the completion of the Integration Scheme review and the work to strengthen governance arrangements consider reducing risk score to target score and closing this risk	Nicky Connor Director of HSCP	NHS Fife Board. Tricia Marwick.	*Ongoing actions designed to mitigate the risk including:* May 22 1. The partner bodies, NHS Fife and Fife Council, developed the Fife IJB Integration Scheme in 2015 and it received Scottish Ministers' approval in October of that year. 2. The Integration Scheme was reviewed in March 2018 to reflect the implementation of the Carers (Scotland) Act 2016 as required by the Scottish Government. 3. The Audit Scotland report, Health and Social Care Integration – Update on Progress, published on 15 November 2018, was the second in a series of three national performance audits following the introduction of the Public Bodies (Joint Working) (Scotland) Act, 2014. It examined the impact public bodies are having as they integrate health and social care services. The report set out six areas which needed to be addressed if integration is to make a meaningful difference to Scotland. 4. This report was followed by the Ministerial Strategic Group for Health and Community Care's report – Review of Progress with Integration of Health and Social Care published in February 2019 which set out a number of proposals in each of the six key areas and allocated a timescale for completion of these. These were reviewed by Fife IJB and its partners to ensure they were incorporated into the work that was ongoing within Fife and an action plan was produced to drive forward changes. This was submitted to the Scottish Government in August 2019. The action plan set out actions to improve governance arrangements including the need to provide further clarity on the Integration Scheme. 5. All Integration Schemes are scheduled to be reviewed every five years, however, Scottish Government have allowed additional time for the review to take cognisance of the disruption caused by the coronavirus outbreak. 6. The review of the Fife Integration Scheme concluded through NHS Fife and Fife Council governance structures in September 2021. Thereafter it was submitted to Scottish Government for approval which was received on 9 March 2022. The revised IS was then signed off by NHS Fife, Fife Council and the IJB. 7. Following the approval of the revised Integration Scheme work continues to strengthen governance arrangements to ensure these reflect the position set out in the Integration Scheme. Work is concluding on review of the IJB Governance Manual and review of risk management arrangements within NHS Fife and the IJB is being progressed.	Nil	Nothing more to be done than the ongoing actions set out. Responsible Person: Director of Health & Social Care	1. Through regular updates to SLT and EDG about the progress of the reviews. 2. Updates to Audit & Risk Committees, the Integration Joint Board (IJB) and NHS Fife. .	1. • The views of auditors will be the key independent assurance mechanism around this risk. We will involve them in the work to clarify governance arrangements as it progresses. 2. • Scottish Government will also provide useful advice and an independent perspective on the work to be carried out.	None.	The problem should be largely resolved with the action taken.	1 – Remote – Can't believe this event would happen	4 – Major	4	Low Risk	Once resolved and given effect to in IJB integration scheme and NHS Fife corporate governance arrangements, the issue should largely be resolved. But given maturity of relationships and dynamics around regional approaches a remaining risk will remain..

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
	Nil currently identified				

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
	Nil applicable				

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**12 September 2022**
Title:	**Draft Corporate Risk Register & Dashboard**
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:

- Discussion
- Assurance

This report relates to a:

- Annual Operational Plan
- Government policy/directive
- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

As part of the refresh of the Risk Management Framework, it was agreed that the Board Assurance Framework (BAF) would be replaced with a renewed NHS Fife Corporate Risk Register (CRR).

2.2 Background

An iterative process to agree the content of the CRR has been underway over recent months. This has involved:

- reviews of risks on the extant Corporate Risk Register
- reviews of other active risks, including those linked to the BAF
- discussion within EDG, the governance committees and the Board
- engagement with Senior Leadership Teams and Operational Teams
- identification of new risks that require to be considered for inclusion

Risk Categorisation

It has been agreed that risks on the Corporate Risk Register will be categorised by mapping across to the 4 strategic priorities 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

2.3 Assessment

Proposed Corporate Risks

The aim has been to draw out and refocus the presentation of the corporate risks with the mitigation in place at a strategic level. Annex 1 presents a draft of the strategic risk profile as a dashboard set in the context of the risk appetite of the Board. Annex 2 sets out the draft Corporate Risk Register for review.

The plan is to create opportunities at each committee and Board session to carry out deep dives into high risks which are deteriorating or not improving over time. The dashboard will also feature in the executive summary of the IPQR.

It is recognised that the CRR must be dynamic and act as a tool to enable the management of risks that may affect delivery of our strategic priorities. Frequent review of existing risks and monitoring of the environment is necessary to ensure the risks captured represent the current profile of the organisation. Continual communication of risks within the organisation, with the Board and other stakeholders, is essential to allow for informed decision-making, to enable appropriate scrutiny and to provide assurance that the risk profile is being effectively managed. In this way, the corporate risk register content will be subject to continuing refinement and development.

The Risks and Opportunities Group will play a key role in supporting the development, monitoring and review of the corporate risk register, identifying risks and opportunities to the strategic priorities, and ensuring continuous improvement of the organisation's control environment, including appropriate containment of risks.

2.3.1 Quality/ Patient Care

Effective risk management enables risks to quality and patient care to be identified and appropriately managed.

2.3.2 Workforce

Effective management of workforce risks supports delivery of quality and patient care.

2.3.3 Financial

Effective management of financial risks supports delivery of quality and patient care.

2.3.4 Risk Assessment/Management

As detailed in the paper.

2.3.5 Equality and Diversity, including health inequalities
An impact assessment will be conducted.

2.3.6 Other impact
None

2.3.7 Communication, involvement, engagement and consultation
This paper has been developed following the range of engagement over time with EDG, SLTs, governance committees and Board.

2.3.8 Route to the Meeting
EDG 18/08/22.
The paper will be shared with all governance committees during September then a final version will be presented for approval at the September Board meeting.

2.4 Recommendation

The Committee is asked to:

- **comment** and **take assurance** from the work to date on developing the Corporate Risk Register and Dashboard reporting.

Report Contact
Pauline Cumming
Risk Manager
Email pauline.cumming@nhs.scot

Working examples for discussion

Strategic Risk Profile

Strategic Priority	Total Risks	Current Strategic Risk Profile				Risk Movement	Risk Appetite
To improve health and wellbeing	5	3	2	-	-	◀ ▶	High
To improve the quality of health and care services	5	4	1	-	-	◀ ▶	Moderate
To improve staff experience and wellbeing	2	2	-	-	-	◀ ▶	Moderate
To deliver value and sustainability	6	4	2	-	-	◀ ▶	Moderate
Total	18	13	5	0	0	◀ ▶	Moderate

Summary Statement on Risk Profile

Current assessment indicates delivery against 3 of the 4 strategic priorities facing a risk profile in excess of risk appetite.

Mitigations in place to support management of risk over time with some risks requiring daily assessment.

Risk Improvement Trajectory for high risks and Corporate Risk Register assessment in place.

Risk Key

High Risk	15 - 25
Moderate Risk	8 - 12
Low Risk	4 - 6
Very Low Risk	1 - 3

Movement Key

Improved - Risk Decreased

No Change

Deteriorated - Risk Increased

Risk Improvement Trajectory & Deep Dive into deteriorating risks *(1 for each strategic objective)*

To improve health and wellbeing	Risk Improvement Trajectory
Risks which have improved	
Risks which have deteriorated	
Risks which have not moved	
Risks which have reached acceptable level of tolerance	
Total	

Deep Dive

Risk

Risk Level and Score

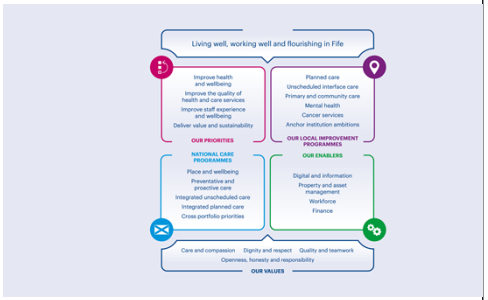
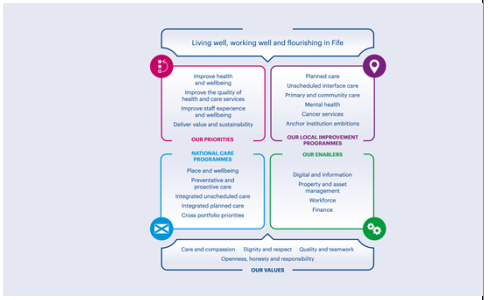
Risk Mitigation

Anticipated Timeline to Risk Reduction / Tolerate and Monitor

Corporate Risk Register contains individual risk details

M	Strategic Priority	Risk	Mitigation	Risk Level	Target Risk / Date	Risk Level Trend	Risk Owner	Primary Committee
1		**Population Health and Wellbeing Strategy** There is a risk that the ambitions and delivery of the new organisational Strategy do not deliver the most effective health and wellbeing and clinical services for the population of Fife.	EDG has established a Portfolio Board, reporting to the Pubic Health and Wellbeing Committee to deliver the required system leadership and executive support to enable effective strategy development. The Portfolio Board commissions and monitors the delivery of key mielstone activity associated with the delivery of an effective new strategy.	Mod 12	Mod 8		Chief Executive	Public Health & Wellbeing
2		**Health Inequalities** There is a risk that if NHS Fife does not develop and implement an effective strategic approach to contribute to reducing health inequalities and their causes, health and wellbeing outcomes will continue to be poorer, and lives cut short in the most deprived areas of Fife compared to the least deprived areas, representing huge disparities in health and wellbeing between Fife communities.	Public Health and Wellbeing Committee established, with the aim of providing assurance that NHS Fife is fully engaged in supporting wider population health and wellbeing for the local population. Public health department and wider partners ongoing programme of work on reducing health inequalities relating to Public Health Priorities, Health Promotion, Vaccination, Screening, and Dental Public Health (ongoing). Leadership and partnership working to influence policies to 'undo' the causes of health inequalities in Fife.	High 20	Mod 10		Director of Public Health	Public Health & Wellbeing
3		**COVID 19 Pandemic** There is an ongoing risk to the health of the population, particularly the clinically vulnerable, the elderly and those living in care homes, that if we are unable to protect people through vaccination and other public health control measures to break the chain of transmission or to respond to a new variant, this will result in mild-to-moderate illness in the majority of the population, but complications requiring hospital care and severe disease ,including death in a minority of the population.	Delivery plans are being developed for the autumn/winter vaccination campaign. The proposed start date is early September 2022; some planning is pending JCVI decisions. Implementation of new treatments for individuals at higher risk of adverse outcomes. Public communications programme to raise awareness of infection prevention and control measures across the region population cross the population.	High 16	Mod 12		Director of Public Health	Clinical Governance

4		**Policy obligations in relation to environmental management and climate change** There is a risk that if we do not put in place robust management arrangements and the necessary resources, we will not meet the requirements of the 'Policy for NHS Scotland on the Global Climate Emergency and Sustainable Development, Nov 2021.'	Robust governance arrangements have been put in place including an Executive Lead and Board Champion appointed Regional working group and representation on the National Board Active participation in Plan 4 Fife	Mod 12	Mod 10		Director of Property & Asset Management	Public Health & Wellbeing
5		**Optimal Clinical Outcomes** There is a risk that recovering from the legacy impact of the ongoing pandemic, combined with the impact of the cost-of-living crisis on citizens, will increase the level of challenge in meeting the health and care needs of the population both in the immediate and medium-term.	The Board has agreed a suite of local improvement programmes, as detailed in the diagram below to frame and plan our approach to meeting the challenges associated with this risk. The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and reduce the level of risk over time. 	High 15	Mod 10		Medical Director/ Director of Public Health	Clinical Governance

6		**Whole System Capacity** There is a risk that significant and sustained admission activity to acute services, combined with challenges in achieving timely discharge to downstream wards and/or provision of social care packages, that the management of Acute hospital capacity and flow will be severely compromised.	The combination of application of our OPEL process on a daily basis and the improvement work through our Integrated Unscheduled Integrated Care and Planned Care programmes provides the operational and strategic response to the challenges posed through this risk. 	High 20	Mod 9		Director of Acute Services	Clinical Governance
7		**Access to outpatient, diagnostic and treatment services** There is a risk that due to demand exceeding capacity, compounded by COVID -19 related disruption and stepping down of some non-urgent services, NHS Fife will see a deterioration in achieving waiting time standards. This time delay could impact clinical outcomes for the population of Fife.	Recovery Plans developed outlining additional activity and resources required to reduce backlog and meet ongoing demand. Speciality level plans in place outlining local actions to mitigate the most significant areas of risk. The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and reduce the level of risk over time. 	High 16	Low 4 3-4 years		Director of Acute Services	Clinical Governance

8		**Cancer Waiting Times** There is a risk that due to increasing patient referrals and complex cancer pathways, NHS Fife will see further deterioration of Cancer Waiting Times (CWT) 62-day performance.	Effective Cancer Management Framework Action plan agreed both locally and by Scottish Government and actions identified. A national Short Life Working Group (SLWG) is being set up to develop a 'Once for Scotland' approach to management of breaches standard operating procedure. This will be led by the NHS Fife Cancer Transformation Manager (Chair of National Cancer Managers' Forum). The Cancer Framework and delivery plan is almost complete. Optimal Pathways and integrated care are included in the framework along with viewing CWT targets as a minimum standard. The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and reduce the level of risk over time.	High 15	Mod 12		Director of Acute Services	Clinical Governance
9		**Quality & Safety** There is a risk that if our governance, arrangements are ineffective, we may be unable to recognise a risk to the quality of services provided thereby being unable to provide adequate assurance and possible impact to the quality of care delivered to the population of Fife.	Effective governance is in place and operating through the clinical Governance Oversight Group (CGOG) providing the mechanism for assurance and escalation of clinical governance (CG) issues to Clinical Governance Committee(CGC). This is further supported by the organisational Learning Group to ensure that learning is used to optimise patient safety, outcomes and experience, and to enhance staff wellbeing and job satisfaction. There are also effective systems & processes to ensure oversight and monitoring of national & local strategy / framework / policy /audit implementation and impact.	High 15	Mod 10		Medical Director	Clinical Governance
10		**Primary Care Services** There is a risk that due to a combination of the demand on services, workforce availability and current funding and resourcing of Primary Care, it may not be possible to deliver sustainable quality	A Primary Care Governance and Strategy Oversight Group has been established. The group brings together both the transformation and sustainability initiatives for all four of the independent primary care contractors, whilst also overseeing any critical aspects of	High 16	Mod 8		Medical Director/ Director of Health & Social Care	Clinical Governance

		services to the population of Fife into the medium-term.	governance. It is co-chaired by the Medical Director and the Director of Health and Social Care. The group will provide assurance to NHS Fife Board and the Integration Joint board through the appropriate sub committees. The establishment of this group will allow governance and scrutiny of all aspects of primary care delivery and to provide a focus for improving patient care for the population of Fife					
11		**Workforce Planning and Delivery** There is a risk that if we do not implement effective strategic and operational workforce planning, we will not deliver the capacity and capability required to effectively deliver services.	Development and implementation of the Workforce Strategy to support the Clinical Strategy, workforce elements of the Annual Delivery Plan, Population Health & Wellbeing Strategy and Strategic Framework; alongside the Workforce Plan for 2022 to 2025. Implementation of the Health & Social Care Workforce Strategy to support the Health & Social Care Strategic Plan for 2019 to 2022, the integration agenda and the development of the H&SCP Workforce Strategy and Workforce Plan for 2022 to 2025. Implementation of the NHS Fife Board Strategic and Corporate Objectives, particularly the "exemplar employer / employer of choice" and the associated values and behaviours and aligned to the ambitions of an anchor institution.	High 16	Mod 8		Director of Workforce	Staff Governance
12		**Staff Health and Wellbeing** There is a risk that if due to a limited workforce supply and system pressure, we are unable to maintain the health and wellbeing of our existing staff we will fail to retain and develop a skilled and sustainable workforce to deliver services now and in the future.	Working in partnership with staff side and professional organisations across all sectors of NHS Fife to ensure staff engagement opportunities are maximised. Scoping a Staff Experience and Engagement Framework that sets out our key ambitions and commitments for improving staff experience, which will help to develop a culture that values and supports our workforce.	High 16	Mod 8		Director of Workforce	Staff Governance

13		**Delivery of a balanced in-year financial position.** There is a risk that the Board may not achieve its statutory financial targets in 2022/23 due to the ongoing impact of the pandemic combined with the very challenging financial context both locally and nationally.	Financial Improvement and Sustainability Programme (FIS) board established to provide oversight to the delivery of Cost Improvements Plans and approve pipeline schemes to be taken to implementation.	High 15	Mod 8		Director of Finance & Strategy	Finance, Performance & Resources
14		**Delivery of recurring financial balance over the medium-term** There is a risk that NHS Fife will not deliver the financial improvement and sustainability programme actions required to ensure sustainable financial balance over the medium-term.	Strategic Planning and Resource Allocation process will continue to operate and support financial planning The FIS Programme will focus on medium-term productive opportunities and cash releasing savings The Board will maintain its focus on reaching the full National Resource Allocation (NRAC) allocation over the medium- term	High 15	Mod 8		Director of Finance & Strategy	Finance, Performance & Resources
15		**Prioritisation & Management of Capital funding** There is a risk that lack of prioritisation and control around the utilisation of limited capital and staffing resources will affect our ability to deliver the PAMS and to support the developing Population Health and Wellbeing Strategy.	Infrastructure developments prioritised and funded through the NHS Board capital plan. Regular Property and Asset Management Strategy (PAMS) report submitted to FP&R, NHS Board and Government.	Mod 12	Low 6		Director of Property & Asset Management	Finance, Performance & Resources
16		**Off-Site Area Sterilisation and Disinfection Unit Service** There is a risk that by continuing to use a single off-site service Area Sterilisation Disinfection Unit (ASDU), our ability to control the supply and standard of equipment required to deliver a safe and effective service will deteriorate.	Monitoring and review through Decontamination Group Establishment of local SSD for robotic being planned	Mod 12	Low 6		Director of Property & Asset Management	Clinical Governance
17		**Cyber Resilience** There is a risk that NHS Fife will be overcome by a targeted and sustained cyber attack that may impact the availability and / or	Considerable focus continues in 2022 with heightened threat level to improve our resilience to attack and ability to recover quickly.	High 16	Low 6		Medical Director	Clinical Governance

		integrity of digital and information required to operate a full health service.						
18		**Digital & Information** 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.	Consistent alignment of the D&I Strategy with the NHS Fife Corporate Objectives and developing Health & Wellbeing Strategy Digital & Information Board Governance established and supporting prioritisation with ongoing review.	High 15	Mod 10		Medical Director	Clinical Governance

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**12 September 2022**
Title:	**Risk Management Improvement Programme - Progress Report**
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:

- Annual Operational Plan
- Government policy/directive
- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper provides an update on the progress made since the last report to the Committee on 18 May 2022.

2.2 Background

NHS Fife is committed to delivering this risk management improvement programme.

2.3 Assessment

NHS Fife is refreshing its Risk Management Framework in order to develop and implement the following:

- Update of the Annual Risk Appetite Statement
- A Board Strategic Risk Profile
- A Corporate Risk Register to replace the current Board Assurance Framework

- 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

Update of Annual Risk Appetite Statement

A risk appetite statement details the type and amount of risk the organisation is willing to take and underpins effective risk management. NHS Fife's risk appetite statement was last considered by the Board in 2019, prior to the COVID-19 pandemic. Considering our recovery, and the development of our Population Health and Wellbeing Strategy, work has been undertaken to review NHS Fife's risk appetite and update the statement.

Through meetings of the executive directors, and a Board Development Session on 28 June 2022, consideration was given to how risk appetite is described in the organisation. A refreshed risk appetite statement has been developed which was approved by Fife NHS Board on 26 July 2022. A plan will be taken forward to support implementation.

Board Strategic Risk Profile

The profile will be informed by the updated Risk Appetite and Corporate Risk Register. It will include the development of a risk component within the refreshed Integrated Performance & Quality Report (IPQR); this will incorporate:

- a dashboard with key metrics on corporate risks; risk level, progress towards target i.e. improvement or deterioration, and the assigned assurance committee
- risk narrative aligned to the respective sections of the report

Corporate Risk Register to replace the current Board Assurance Framework

Following an iterative process over several months involving engagement with EDG, Senior Leadership Teams (SLTs) and the Board, a draft Corporate Risk Register has been developed. The draft reflects the need to ensure that:

- the substance and content of the register is pitched at a corporate level to support delivery of our strategic priorities
- risks are presented succinctly and to ensure focus

A paper presenting both the strategic risk profile as a dashboard set in the context of the Board's risk appetite, and the draft Corporate Risk Register, is provided separately for members' information.

This paper is being shared with all governance committees during September and will then be presented for approval at the September 2022 Board meeting.

Risk Escalation

A proposed risk escalation process was considered by EDG on 18 August 2022.The process was approved in principle and the appropriate systems and processes will now be

further developed to deliver it, including visuals to support implementation. These will be shared with the Risks and Opportunities Group on 14 September 2022.

Risks & Opportunities Group
The establishment of a Risks and Opportunities Group is a vital element of our Risk Management Improvement Programme. The Associate Director of Quality and Clinical Governance, and the Associate Director of Digital & Information, will co-chair the group. The membership will largely comprise Associate and Deputy Directors. A member of the Internal Audit team will be in attendance at meetings.

The Group's purpose will be to provide leadership across respective areas of responsibility to promote and embed an effective risk management culture. This will include development of a work-plan which effectively embeds the NHS Fife Risk Management Framework.

The Terms of Reference are to be agreed, but the following will be proposed:

- Meetings will be held bi-monthly.
- The reporting line will be into EDG.
- Individual members will report into respective local governance groups to ensure a focus on effective risk management arrangements. These groups include: e.g. Senior Leadership Teams (SLTs), Clinical Governance Oversight Group, Public Health Assurance Committee.

The Group's first meeting is scheduled for **14 September 2022**.

2.3.1 Quality/ Patient Care
Effective risk management enables risks to quality and patient care to be identified and appropriately managed.

2.3.2 Workforce
To support effective implementation of the refreshed Framework, an education and training programme and resources will be developed.

2.3.3 Financial
Any financial impact associated with changes to the framework will be identified and communicated as appropriate.

2.3.4 Risk Assessment/Management
As detailed in the paper.

2.3.5 Equality and Diversity, including health inequalities
An impact assessment has not been conducted.

2.3.6 Other impact
None

2.3.7 Communication, involvement, engagement and consultation

This paper has been informed by a range of engagement over time with EDG, SLTs, governance committees and the Board, and through discussion with Gemma Couser, Associate Director of Quality & Clinical Governance.

2.3.8 Route to the Meeting

Via Margo McGurk, Director of Finance & Strategy on 31 August 2022, following presentation of an earlier version of the paper to EDG on 18 August 2022.

2.4 Recommendation

The Committee is invited to

- **take assurance** from this update on the Risk Management Improvement Programme

Report Contact
Pauline Cumming
Risk Manager
Email pauline.cumming@nhs.scot

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**12 September 2022**
Title:	**Internal Audit Progress Report**
Responsible Executive/Non-Executive:	**M McGurk, Director of Finance & Strategy**
Report Author:	**B Hudson – Regional Audit Manager / A Brown – Principal Auditor**

1 Purpose

This is presented to the Audit and Risk Committee for:

- Assurance
- Discussion

This report relates to a:

- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to:

- Provide the Audit and Risk Committee with assurance on the one remaining review from the 2021/22 Internal Audit Plan and the progress of the 2022/23 plan.

2.2 Background

The Internal Audit year runs from May to April. The Internal Audit team is progressing the 2022/23 Annual Internal Audit Plan under the supervision of the Chief Internal Auditor. Audit work completed allows the Chief Internal Auditor to provide the necessary assurances prior to the signing of the annual accounts.

The work of Internal Audit and the assurances provided by the Chief Internal Auditor in relation to internal control are key assurance sources taken into account when the Chief Executive undertakes the annual review of internal controls, and forms part of the consideration of the Audit and Risk Committee and the Board prior to finalising the Governance Statement which is included and published in the Board's Annual Accounts.

2.3 Assessment

Each audit report includes an action plan that contains prioritised actions, associated lead officers and timescales. Progress on implementation of agreed actions is monitored through the Audit Follow-up System, which is maintained and reported to the Audit and Risk Committee by Internal Audit.

Appendix A shows:

- Finalised Internal Audit Reports
- Internal Audit Reports issued in draft at the time of submission of papers for the Audit and Risk Committee
- Internal Audit Work in Progress and Planned
- Summary of Internal Audit Findings in Final Internal Audit Reports issued since the last Audit and Risk Committee
- Internal Audit Performance against Service Specification Key Performance Indicators.

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 Principal Auditor and the Regional Audit Manager and reviewed by the Chief Internal Auditor.

2.4 Recommendation

The Audit and Risk Committee is asked to:

- **Discuss** and take **assurance** from the progress on the delivery of the Internal Audit Plans

3 List of appendices

The following appendices are included with this report:

- Appendix A – Internal Audit Progress Report

Internal Audit Progress Report

Introduction

This report presents the progress of internal audit activity up to 2 September 2022.

Internal Audit Activity

NHS Fife Completed Audit Work

The following audit products, with the audit opinion shown, have been issued since the last Audit and Risk Committee meeting on 18 May 2022. Each review completed has been categorised within one of the five strands of corporate governance. A summary of each report is included for information within the 'Summary of Audit findings' section.

Audit 2022/23	Opinion on Assurance	Recommendations	Draft issued	Finalised
Corporate Governance				
B06-23 - Annual Internal Audit Report / B07-23 Governance Statement	N/A	Four Moderate	2 June 2022	13 June 2022
B09/23 – Audit Follow Up	N/A	N/A	N/A	Report provided to each Audit and Risk Committee and a yearend summary will be presented to May 2023 Audit and Risk Committee.
B19/23 Post Transaction Monitoring (PTM)	As per PTM Handbook – 'A' Grade	None	28 July 2022	22 August 2022
Fife Integration Joint Board				
Annual Internal Audit Report	N/A	One Significant Three Moderate Two Merits Attention	8 July 2022	12 July 2022

NHS Fife Draft Reports Issued

Audit 2022/22	Draft issued
B13/22 Strategic Planning	9 September 2022

NHS Fife Work in Progress and Planned:

Audit 2022/23		Status	Target Audit and Risk Committee
B10/23	Attendance at meetings/ Ad-hoc Advice provided by Chief Internal Auditor, Audit Manager and Principal Auditors	WIP	A yearend summary will be presented to May 2023 Audit and Risk Committee.
B11/23	Assurance Framework	Planned	TBC
B12/23	Risk Management	Planned	TBC
B16/23	Health and Social Care Integration	WIP	Contribution to deliver Fife IJB audit plans. IJB reports will be shared with the NHSF Audit and Risk Committee.
B18/23	Workforce Planning	WIP	8 December 2022
B20/23	Whistleblowing	WIP	8 December 2022
B21/23	Financial Process Compliance[1]	WIP	March 2023
B22/23	Patients Funds[1]	WIP	March 2023

[1] Target Audit and Risk Committee date extended – staff member will be off work for approximately a 6 week period.

The following were reported to the May 2022 Audit and Risk Committee as planned reviews and have now been included in the Internal Audit plan for 2022-23:

B12-22 Risk Management (now under B12-23)

NHS Fife is progressing the development of its approach to Risk Management. A review of the process and output was due to be undertaken in the 2021/22 Internal Audit plan, however this will now be undertaken as part of the 2022/23 Internal Audit plan.

B17-22 Workforce Planning (now under B18-23)

The Scottish Government required the submission of the Workforce Plan by 31 July 2022. The Internal audit review, to be undertaken under B18-23, includes review of processes to develop the workforce plan.

Summary of Audit Findings

This section provides a summary of the findings of internal audit reviews concluded since the previous Audit and Risk Committee meeting of March 2022 where a progress report was considered.

1. B06-23 - Annual Internal Audit Report / B07-23 Governance Statement

Full report presented to the June 2022 Audit and Risk Committee

2. B09-23 Audit Follow Up

See separate agenda item 7.2

3. B19-23 Post Transaction Monitoring

See separate agenda item 7.3

4. Fife IJB – Annual Internal Audit Report

Report was considered in full at the 29 July 2022 Audit and Risk Committee meeting.

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**12 September 2022**
Title:	**Internal Audit – Follow Up Report on Audit Recommendations 2021/22**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Barry Hudson, Regional Audit Manager/ A Brown, Principal Auditor**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to the:

- Audit Follow up Protocol

This aligns to the following NHSScotland quality ambition:

- Effective

2 Report summary

2.1 Situation

Good practice guidance, as laid out in the Audit Committee Handbook, emphasises the importance of effective follow up processes to ensure that the actions agreed by management to address control weaknesses identified by the work of Internal and External Audit are actually implemented.

2.2 Background

The EDG now consider the progress on internal audit actions quarterly with Directors being reminded of the need to ensure good progress is made in clearing outstanding issues.

External Audit recommendations will continue to be followed up through NHS Fife Finance Directorate and Internal Audit will continue to review progress against External Audit recommendations where relevant to internal audit fieldwork.

Internal Audit will validate the evidence supplied by responding officers for actions they are declaring as completed to confirm that those actions address the recommendations made.

2.3 Assessment

We include reports which have actions with a status of Extended, Outstanding or Not Yet Due. Reports with all actions either completed and validated or superseded are not included. This is to promote focus on addressing the remaining recommendations.

The table below shows the status of all remaining internal audit recommendations as at 31 August 2022, with comparable figures from the last Audit Follow-Up (AFU) report as at 28 February 2022.

	August 2022	February 2022
Remaining Recommendations	**48**	**37**
Extended with revised dates (agreed by Responding Officer) *(Appendix C)*	30	34
Outstanding – Date passed *(Appendix D)*	0	0
Not yet due	18	3

Progress summary

The following reports, featured in our March 2022 report, but have either been completed and validated or superseded by recommendations in more recent reports:

Report	Remaining Actions Status
B23a/20 Attendance Management	Final recommendation (4) completed and validated.
B28/21 Digital and Information Governance Arrangements	Final recommendations (1 & 3) completed and validated.
B19/22 Post Transaction Monitoring	Final recommendation (2) completed and validated.

The status of actions to address recommendations arising from the Internal Audit Annual Report and Internal Control Evaluation Report are now being followed up as part of the follow-up system with status update request forms having been issued to the relevant Executive Directors in March 2022 and most recently in August 2022. The status of these actions will be included in the next ICE report (B08/23) and in the next iteration of this report.

The role of Internal Audit in the follow-up process is to maintain a record of responses received by management and to assess and validate responses. Appendix F records where we have concluded evidence provided was insufficient to allow us to validate that action as complete, and where further information has been requested.

We have assessed progress to date for responses in relation to those remaining recommendations with extended target implementation dates and a RAG status is included to aid prioritisation.

Where no appropriate or sufficient response is received from the responsible officer we liaise with the Director of Finance and Strategy and the Board Secretary to escalate.

2.3.1 Quality/ Patient Care

There are no direct implications for Quality/Patient Care as a result of this report.

2.3.2 Workforce

There are no workforce implications arising from this report.

2.3.2 Financial

There are no direct financial implications arising from this report.

2.3.3 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.

2.3.4 Equality and Diversity, including health inequalities

Not applicable

2.3.5 Other impacts

Not applicable

2.3.6 Communication, involvement, engagement and consultation

The content of the report was discussed with the Chief Internal Auditor and the Director of Finance and Strategy ahead of submission to the Audit and Risk Committee.

2.3.7 Route to the Meeting

Not applicable

2.4 Recommendation

The Audit & Risk Committee is asked to:-

- **Note** and take **assurance** of the current status of Internal Audit recommendations recorded within the AFU system.

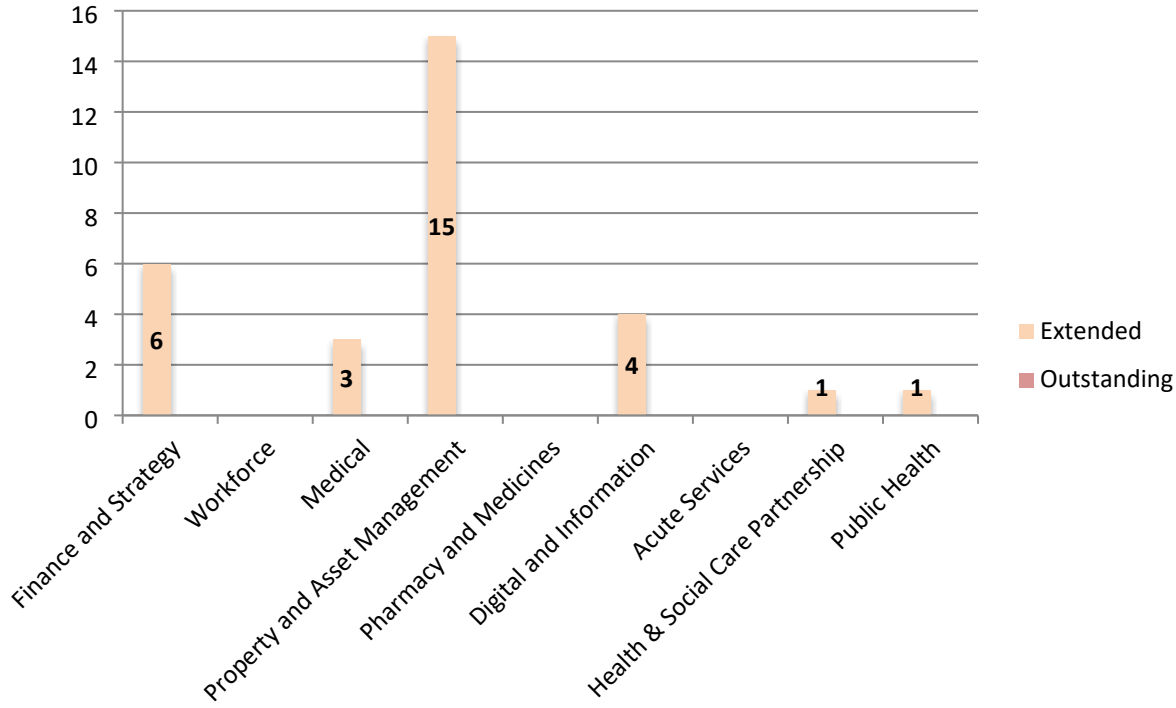
3. List of appendices

The following appendices are included with this report:

Report Contact

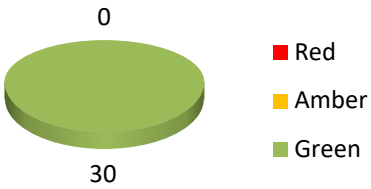
Barry Hudson, Regional Audit Manager, Email: barry.hudson@nhs.scot

Outstanding and Extended by Directorate

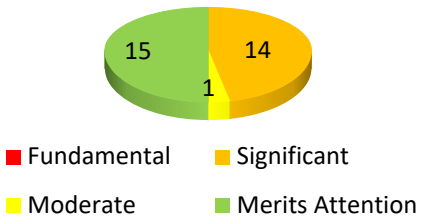


Extended Recommendations RAG Status and Priority

RAG Status



Priority



	Date of Issue	Total Recs.	Complete	Superseded	Remaining		Extended	Outstanding	Not Yet Due		Not Validated
Appendix							*C*	*D*			*E*
2019/20											
B17/20 Organisational Performance Management	Oct-20	6	1	0	5		5	0	0		-
2019/20 Totals		**6**	**1**	**0**	**5**		**5**	**0**	**0**		**-**
2020/21											
B13/21 Risk Management Strategy	Sep 21	5	4	0	1		1	0	0		-
B14/21 Sharps Management	Dec-21	14	9	0	5		5	0	0		-
B19/21 Clinical Governance Strategy and Assurance	Sep-21	2	1	0	1		1	0	0		-
B20/21 Adverse Events Management	Mar-21	1	0	0	1		1	0	0		-
B21/21 Medical Equipment and Devices	Nov-21	4	0	0	4		4	0	0		-
B22/21 Manual Handling Training	Jun-21	7	0	0	7		7	0	0		-
B23/21 ITIL Processes	Jul-21	6	2	0	4		4	0	0		-
2020/21 Totals		**39**	**16**	**0**	**23**		**23**	**0**	**0**		**0**
2021/22											
B16/22 Prescription Stationery Security	May-22	11	0	0	11		0	0	11		-
B18/22 Procurement Governance Board	May-22	5	0	0	5		0	0	5		-
B20/22 Financial Process Compliance	May-22	1	0	0	1		1	0	0		-
B23/22 Resilience	Apr-22	5	2	0	3		1	0	2		-
2021/22 Totals		**22**	**2**	**0**	**20**		**2**	**0**	**18**		**0**
Overall Totals **(Actions from reports where recommendations remain unaddressed)**		**67**	**19**	**0**	**48**		**30**	**0**	**18**		**0**

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2019/20							
B17/20 Organisational Performance Management	1	M A	A revised schedule for the Performance and Accountability Review Framework (P&ARFF) meetings and the submission of a timetable for key documents should be agreed at the Executive Directors Group	Director of Finance & Strategy **Chief Executive**	~~01 Apr 21~~ ~~30 Apr 22~~ 31 Oct 22		Following Emergency planning measure ceasing at end of March 2022 the reconstitution of the P&ARFF has been reconsidered and it is likely that it will not be reintroduced. This will be determined by 31 October 2022.
	3	M A	The KSF/TURAS/appraal performance completion rate should be included within the Workforce section of the report used for the P&ARFF.	Director of Finance & Strategy **Chief Executive**	~~30 Apr 21~~ ~~30 Apr 22~~ 31 Oct 22		The revised IPQR includes provision for information on KSF/TURAS/appraisal performance, but data is not yet available.
	4	M A	Directorates and Departments should be reminded to include the links to strategic objectives and corporate objectives within the reports used for submission to the P&ARFF.	Director of Finance & Strategy **Chief Executive**	~~01 Apr 21~~ ~~30 Apr 22~~ 31 Oct 22		Links to corporate objectives are already in place to key programmes and as part of the SPRA process. As per point 1 it is likely that the P&ARFF meetings will not be reintroduced.
	5	M A	Officers should be reminded to include the responsible officer and completion dates on action trackers. The action tracker should be amended to monitor attendance at the P&ARFF meetings.	Director of Finance & Strategy **Chief Executive**	~~01 Apr 21~~ ~~30 Apr 22~~ 31 Oct 22		As per point 1 it is likely that the P&ARFF meetings will not be reintroduced.

	6	M A	The P&ARFF should be further enhanced by including risk management	Director of Finance & Strategy **Chief Executive**	~~26 Feb 21~~ ~~30 Apr 22~~ 31 Oct 22		As per point 1 it is likely that the P&ARFF meetings will not be reintroduced. All aspects of strategic and performance work will include identification of risks and mitigations.
19/20 Sub Total	**5**						

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2020/21							
B13/21 Risk Management Strategy	3	S	Now that there is clarity around responsibility for operations, an IJB Risk Management Strategy should be produced and formally agreed with the parties as soon as possible and incorporated into the NHS Fife Framework. More detailed aspects of the risk management arrangements between NHS Fife and Fife IJB should be included in GP/R7 - Risk Register and Risk Assessment policy.	**Director of Health & Social Care**	~~31 Mar 22~~ 30 Sep 22		The Integration Scheme was approved by the Scottish Government on 9 March 2022. Work has begun on the review of the IJB Risk Management Policy and Strategy. Further sessions are to be scheduled for the Senior Leadership Team to consider the policy and strategy and the Risk appetite for the IJB. H&SCP Risk Management continue to engage with EDG and the Risk Management team to support review of the NHS Fife risk management arrangements. Realistically there is significant work to do to achieve all the required outcomes. An extension has been agreed with auditors for the work on the IJB Risk Management Policy and Strategy and the IJB Risk Appetite (which form part of other audits) to 30 Sept 2022, so the same timescale is appropriate for this action.
B14/21 Sharps Management	2f	M A	Update the Adverse Events Policy to: • clearly outline processes for review and analysis of Health and Safety Incidents related to staff • refer to lessons learned needing to be applied across the organisations to all departments and wards that they are applicable to.	Associate Director of Quality and Clinical Governance **Medical Director**	~~26 Mar 21~~ ~~30 Apr 22~~ 31 Oct 22		An extension is requested to do the time taken for the Lead for Adverse Events to commence in post. Preparatory work has commenced however due to the system pressures there has been a delay to proceeding.

	3a 3b 3c 3d	S	Action plan to address issues raised in report (section 3 - Control 2) and appendix 1 to be developed and implementation progress to be reported to the Sharps Strategy Group and the Health and Safety Sub-Committee. The Health and Safety Sub-Committee to be reminded of their responsibility to escalate issues to the Clinical Governance Committee when required.	H&S Manager **Director of Property and Asset Management**	~~a. 3-Feb-21~~ ~~b. 3-Feb-21~~ ~~c. 10-Feb-21~~ ~~d. 30-Dec-20~~ all: ~~30-Jun-21~~ ~~28-Feb-22~~ 31-Jul-22		The impact of the pandemic on workload and senior staff being seconded to other roles has delayed progress in addressing these actions. A new Health and Safety Manager commenced working for NHS Fife in August 2022 and Internal Audit are to meet them to bring them up to date with the background to these recommendations and to discuss the efforts that have been made to address them which included attempts to reconvene the Sharps Strategy Group and the escalation of this issue to the Health & Safety Sub Committee. Revised implementation dates for these actions will be agreed at this meeting.
B19/21 Clinical Governance Strategy and Assurance	1	S	Revision of Clinical and Care Governance Strategy addressing recommendations made in Internal Audit report B15/17 & B18/18 – Clinical Governance Strategy & Assurance.	Associate Director of Quality and Clinical Governance **Medical Director**	~~31 Jan 22~~ ~~31 May 22~~ 31 Oct 22		To allow for the Clinical Governance Framework and Delivery Plan to be approved by CGC and for related Terms of Reference to be updated and approved by the relevant groups and committees.
B20/21 Adverse Events Management	1	M A	Address concerns of DATIX Action Module users expressed by the comments made in this review regarding unfamiliarity with the DATIX Action Module and the lack of a full understanding of users' individual responsibilities Based on the findings of the initial review in B19/20 – Adverse Event Management, plus the additional comments made by users in this review, consideration should be given to a review of the framework and processes currently in place, to determine if any system changes could result in benefits and improvements, which would reduce the number of actions actually outstanding and those incorrectly recorded as outstanding.	Associate Director of Quality and Clinical Governance **Medical Director**	~~31-May-21~~ ~~30-Apr-22~~ 31 Oct 22		Extension agreed to allow Adverse Event Improvement action plan to be completed including approval and publication of revised Adverse Events Policy.

B21/21 Medical Equipment and Devices	1	M A	Updates required to both the GP/E4 – Medical Equipment Management Policy (including related appendices) and E14.1 - Equipment Procurement Operational Policy and these require to be authorised by the Capital Equipment Management Group.	Head of Estates **Director of Property and Asset Management**	~~31 Jan 22~~ ~~31 Jul 22~~ 31 Dec 22		We are advised that the revised policies have been approved by the Capital Equipment Management Group and have been submitted to the General Policies Group for approval and publication on Stafflink. Extension required to allow time for approval by the General Policies Group and publication on Stafflink.
	2	M A	Equipment Request Form (ERF) requires updating to include prompts for sufficient detail to be recorded regarding consultation, training requirements, maintenance costs and needs assessment.	Head of Estates **Director of Property and Asset Management**	~~31 Jan 22~~ ~~31 Jul 22~~ 31 Dec 22		As per 1 above – We are advised that the revised form is included in the revised policy. Extension required to allow time for approval by the General Policies Group and publication on Stafflink.
	3	M A	As per 2 above.	Head of Estates **Director of Property and Asset Management**	~~31 Jan 22~~ ~~31 Jul 22~~ 31 Dec 22		As per 2 above.
	4	M A	The CEMG should review the KPIs within Annex 2 of CEL 35 (2010) and consider whether receipt of these would benefit its decision making process and arrange for the receipt of such information in future. In addition it terms of reference (currently being reviewed) should be updated to note the monitoring of such KPIs.	Head of Estates **Director of Property and Asset Management**	~~31 Jan 22~~ ~~31 Jul 22~~ 31 Dec 22		Extension required to allow consideration of KPIs by CEMG.
B22/21 Manual Handling Training	1	S	An annual manual handling training plan should be put in place to ensure that NHS Fife can effectively deliver manual handling training to all the necessary staff in line with government requirements.	H&S Manager **Director of Property and Asset Management**	~~27-Aug-21~~ 31-Mar-22		The organisation of the Manual Handling Training Team is being reconfigured, but we are advised that progress has been made in the provision of training and in planning how the restructured team will deliver training once up to its full complement of staff. A new Health and Safety Manager commenced working for NHS Fife in August 2022 for NHS Fife and a meeting has been arranged with them to bring them up to date with the background to these recommendations and the efforts that have been made to address them and to agree the actions that remain to be addressed and revised implementation dates for these.
	2	S	A training needs exercise should be undertaken to determine manual handling training requirement.	H&S Manager **Director of Property and Asset Management**	~~27-Aug-21~~ 31-Mar-22		As per recommendation 1 above.

	3	S	Routine manual handling training management reports should be prepared detailing the number of courses held in comparison with the planned number, with explanations being provided for significant variations. High level reporting on this should be reported to the Clinical Governance Committee.	H&S Manager **Director of Property and Asset Management**	~~30-Sep-21~~ 31-Mar-22		As per recommendation 1 above.
	4	M A	Consideration should be given to changing the way courses are advertised, so that availability is more accessible and potentially a greater uptake in attendance.	H&S Manager **Director of Property and Asset Management**	~~30-Jul-21~~ 31-Mar-22		As per recommendation 1 above.
	5	M A	The introduction of the self-accreditation scheme should be revisited.	H&S Manager **Director of Property and Asset Management**	~~30-Aug-21~~ 31-Mar-22		As per recommendation 1 above.
	6	M A	Lesson plans should be created for all areas of manual handling training to ensure the content and suitability of each is considered.	H&S Manager **Director of Property and Asset Management**	~~30-Jul-21~~ 31-Mar-22		As per recommendation 1 above.
	7	M A	The risk assessment for manual handling training should be finalised to ensure that correct actions are in place to deal with the associated risks.	H&S Manager **Director of Property and Asset Management**	~~30-Jun-21~~ 31-Mar-22		As per recommendation 1 above.
B23/21 ITIL Processes	3	S	Digital and Information should engage with other services undertaking IT service management roles to assess their ITIL compliance and to offer assistance in introducing further ITIL processes to improve the efficiency of IT Service management in these areas. The timing of these actions will need to follow the cost benefit analysis and outcome referred to in action plan point 1 above and will also need to be sensitive to the impact the pandemic continues to have on the operation of other services.	Head of Digital Operations **Associate Director - Digital and Information**	~~31-Aug-21~~ ~~31-Mar-22~~ ~~30-Jun-22~~ 31-Mar-23		Cost / Benefit paper presented to D&I Board 19/10/21. Time to allow for engagement with other services regarding introducing ITIL practices Recruitment now completed and lead resource starting on 5th September 2022. Further resource is at preferred candidate stage. Then initial engagement can begin. Extension required due to delays in recruitment.

	4	S	The NHS Fife Policy and Procedure for Change Management should be reviewed prior to the forthcoming change of IT Service Management software from Cherwell to ServiceNow. Part of this review should include determination of mandatory fields to be completed for all changes. Recording of risks related to changes should be undertaken in a consistent manner and should always include scoring of the risks based on impact and likelihood. The relevant staff should be reminded of the need to complete and attach the appropriate checklist for changes associated with server decommissioning.	Service Delivery Manager **Associate Director - Digital and Information**	~~30-Sep-21~~ ~~31-Dec-21~~ ~~31-Mar-22~~ ~~30-Jun-22~~ 31-Mar-23		Extension required to allow migration of change management process from Cherwell to ServiceNow which is now possible following technical difficulties.
	5	S	The setting of required approvals should not be undertaken by the change requester. This should be automated as far as possible based on the type of change and its impacts and where the change is exceptional the approval requirements should be set by another member of the Digital and Information Team (eg the Change Manager). The move from Cherwell to ServiceNow should include determination of how approvals for changes are recorded so that this is clear and does not result in any doubt over whether the change has been appropriately authorised. Brief minutes of each Change Advisory Board meeting held should be recorded including listing those in attendance and decisions made.	Service Delivery Manager **Associate Director - Digital and Information**	~~31-Aug-21~~ ~~31-Mar-22~~ ~~30-Jun-22~~ 31-Mar-23		As per 4 above.
	6	S	A section should be added to the Service Management application (ServiceNow) to indicate whether the change falls into one or more of the 3 criteria listed in the Change Management Procedure as requiring the emergency change process to be invoked. A review of changes processed as emergency changes should be undertaken to identify changes that have been processed as such but do not meet the criteria for invoking the emergency change	Service Delivery Manager **Associate Director - Digital and Information**	~~31-Aug-21~~ ~~31-Mar-22~~ ~~30-Jun-22~~ 31-Mar-23		As per 4 above.

			procedure. The IT Service Management application (ServiceNow) should include provision for the recording of approval by the D&I General Manager or their Deputy for emergency changes classified as high risk.				
20/21 Sub Total	**23**						

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2021/22							
B20/22 Financial Process Compliance	1	M	Providing EDG with regular Invoice Register reports including commentary on progress to reduce the number of disputed invoices.	Head of Financial Services and Procurement **Director of Finance and Strategy**	~~31 Aug 22~~ 31 Oct 22		Capacity challenges as a result of Staff Absence in Accounts Payable Team. A Paper has been drafted for EDG and will be shared once the current numbers are updated. And will be presented to EDG in September.
B23/22 Resilience	1c	S	Presenting finalised Major Incident Operational Plan to CGC and providing an update on Action Cards stakeholder testing to the Resilience Forum.	Head of Resilience **Director of Public Health**	~~30 Sep 22~~ 30 Nov 22		The Major Incident Operational Plan was ratified at the Resilience Forum on 25 August 2022 and will be presented to CGC on 4 November 2022. Action Cards were presented to the Resilience Forum on 25 August 2022 and feedback on stakeholder testing of these will be reported to their next meeting on 24 November 2022. Extension required to allow relevant papers to be presented to CGC on 4 November 2022 and the Resilience Forum on 24 November 2022.
21/22 Sub Total	**2**						
Total	**30**						

Report	Issue Date	Rec Ref.	Audit Finding & Recommendation	Responsible Officer & Executive Director	Original Management Response	Priority	Original Due Date
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sub Total		**0**					
Total		**0**					

Audit Year/Report	Rec. Ref.	Finding & Recommendation	Priority	Responsible Officer, Executive Director & Action by Date	Follow-up Response	Internal Audit Opinion on Further Evidence Required to Allow Action to be Recorded as Complete [*This further evidence will be requested from the Responsible Officers through the Follow-up Process*]
N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total						

Action Status	
Term	**Definition**
Complete	Client has informed Internal Audit that the action has been implemented
Superseded	Action has been updated within a further audit report
Extended	Client has requested further time to implement the action (see A**ppendix D**)
Outstanding	The original, or extended, due date has passed, and the client has not provided an update or requested an extension to the due date (see A**ppendix E**)
Not Yet Due	Original action by date has not yet occurred
Not Validated	Client has informed Internal Audit that the action has been implemented but our validation process found that further evidence is required to support this conclusion (see A**ppendix F**)

Recommendation Priority	
Term	**Definition**
Fundamental (F)	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.
Significant (S)	Weaknesses in control or design in some areas of established controls. Requires action to avoid exposure to significant risks in achieving the objectives for area under review.
Moderate (M)	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.
Merits Attention (MA)	There are generally areas of good practice. Action may be advised to enhance control or improve operational efficiency.

RAG Status Definitions for Importance of Extended and Outstanding Recommendations		
RAG Status		**Definition**
Red		**Action is imperative to ensure that the objectives for the area under review are met and risks are mitigated.**
Amber		**Stated actions have not been progressed sufficiently to mitigate the identified risk. Completion of updated actions should ensure objectives are achieved.**
Green		**Good progress is being made and completion of updated actions will achieve objectives and mitigate identified risks.**

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**12 September 2022**
Title:	**Internal Audit Review of Property Transactions Report 2021/22**
Responsible Executive:	**Tony Gaskin, Chief Internal Auditor**
Report Author:	**Barry Hudson, Regional Audit Manager/A Brown, Principal Auditor**

1 Purpose

This is presented to the Audit and Risk Committee for:

- Assurance

This report relates to a:

Government Directive

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

- Safe
- Effective
- Efficient

2 Report summary

2.1 Situation

In return for operational independence in respect of property transactions that NHS Boards are allowed, Scottish Government Health and Social Care Directorate (SGHSCD) now Scottish Government Finance, Corporate Governance and Value Directorate (SGFCGVD) require the procedures laid out in the NHS Scotland Property Transactions Handbook (PTH) to be followed.

2.2 Background

The purpose of this report is to advise the Audit and Risk Committee of the internal audit of the property transactions completed in 2021/22, which provides assurance that the required procedures have been followed.

2.3 Assessment

Under the PTH regulations, the Audit and Risk Committee is charged with oversight of the monitoring of the process of property transactions. The monitoring process is a cyclical exercise and Internal Audit reviewed the two transactions completed in 2020/21 to ensure the requirements of the PTH were followed.

The audit report assessed both transactions at grade A, i.e. transaction is properly completed. No recommendations were made.

A clean property transaction return in respect of 2021/22 can therefore be submitted to the SGHSCD by the 31 October 2022 deadline.

2.3.1 Quality/ Patient Care

There are no direct implications for Quality/Patient Care as a result of this report.

2.3.2 Workforce

There are no workforce implications arising from this report.

2.3.3 Financial

The PTH is intended to ensure that NHS property is bought, sold and leased at a price and on other conditions which are the best obtainable for the public interest at that time. This post transaction monitoring process considers compliance with the PTH including the requirements associated with finance.

2.3.4 Risk Assessment/Management

The post transaction monitoring process considers the control objectives and processes in place to mitigate against the risk of non compliance with the PTH.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed because it is not applicable for this report.

2.3.6 Other impact

Not applicable

2.3.7 Communication, involvement, engagement and consultation

The content of the report was discussed with the Chief Internal Auditor, Director of Finance and Director of Property and Asset Management ahead of submission to the Audit and Risk Committee.

2.3.8 Route to the Meeting

Not applicable

2.4 Recommendation

The Audit and Risk Committee is requested to take **assurance** that:

1. The requirements of the PTH have been complied with;
2. The internal audit report is attached at Appendix 1, and
3. Arrangements are in place to issue the Board's Annual Property Transactions Return to SGHSCD by the deadline of 31 October 2022, and that the return be submitted with no significant issues identified.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Internal Audit Report B19/23 – Post Transaction Monitoring

Report Contact

Tony Gaskin
Chief Internal Auditor
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FTF Internal Audit Service

Post Transaction Monitoring

Report No. B19/23

Issued To: **Carol Potter, Chief Executive**
Margo McGurk, Director of Finance and Strategy

Neil McCormick, Director of Property and Asset Management
Paul Bishop, Head of Estates
Nicola Swan, Projects & Property Administration Manager

Gillian MacIntosh, Head of Corporate Governance/Board Secretary
Hazel Thomson, Board Committee Support Officer

Audit and Risk Committee
External Audit

Contents

Draft Report Issued	28 July 2022
Management Responses Received	N/A
Target Audit & Risk Committee Date	15 September 2022
Final Report Issued	**22 August 2022**

CONTEXT AND SCOPE

1. NHS Boards have operational independence in relation to property transactions. In return for this independence the Scottish Government Health & Social Care Directorates (SGHSCD) require that Boards follow procedures laid out in the Property Transactions Handbook (the Handbook). The NHS Scotland Property Transactions Handbook provides guidance on the responsibility and procedures to be followed by Holding Bodies, i.e. Fife NHS Board, to ensure that property is bought, sold and leased at a price, and on other conditions, which are the best obtainable for the public interest at that time.

2. It is a requirement of Part A Section 6.3 of the Handbook that: '*Post-transaction monitoring must be an integral part of the internal audit programme. The Audit Committees of the Boards of Holding Bodies are responsible for the oversight of the programme. The Internal Auditor reports his/her findings to the Audit Committee. The Audit Committee's oversight of the work of the Internal Auditor includes reporting to the Board.'*

3. The following transactions meet the criteria set out in the NHS Property Transaction Handbook for 2021/22.

Transaction Type	**Transaction Description**
Acquisition by Lease	Unit 5 Hayfield Industrial Estate, Kirkcaldy – 5 Year Lease
Acquisition by Transfer of Lease	Auchtermuchty Health Centre – Transfer of lease to NHS Fife as per PCA (2018) 08 (by short term licence until standard sub lease is finalised by Central Legal Office in conjunction with the British Medical Association)

4. The Audit and Risk Committee meeting on 16 June 2022 agreed the Internal Audit Annual Plan for 2022/23 which includes the mandatory review - Post Transaction Monitoring. We agreed with client management that both transactions would be reviewed.

5. Transaction files were examined to ensure that:

   ◊ Property needs are appropriately identified and suitable action taken

   ◊ Transactions are properly managed

   ◊ Certificates are completed as required.

AUDIT OPINION

6. As the audit opinions categories for post transaction monitoring are pre-defined within the Handbook we have not stated an overall opinion on the system but have provided an opinion on each transaction using the Handbook categories.

7. In accordance with the requirements of Part A Section 6.9 of the Handbook each transaction must be categorised as:

   A Transaction has been properly conducted, or

   B There are reservations on how the transaction was conducted, or

   C A serious error of judgment has occurred in the handling of the transaction.

The audit opinions for the transactions concluded in 2021/22 are:

Transaction	Lease P/A	Lease Term	Category
Unit 5 Hayfield Industrial Estate, Kirkcaldy	£35,714	**5 Years**	**A**
Auchtermuchty Health Centre	£102,700	**25 Years**	**A**

Checklists

8. In response to our findings and recommendations in last year's post transaction monitoring report (B19/22) Internal Audit provided post transaction monitoring checklists to the Projects & Property Administration Manager for transactions related to disposal by sale, acquisition by purchase and acquisition by lease. The checklists were provided in April 2022. The use of the checklists should help to prevent administrative issues highlighted around the timing of certification sign off, as identified in this report.

Unit 5 Hayfield Industrial Estate, Kirkcaldy

9. The monitoring pro forma was completed and the certification was signed off following completion of the transaction but was not signed off at offer stage as is required by the handbook and sign off at settlement stage was completed 33 working days after the date of settlement. The Director of Property & Asset Management advised that this, and the delay to signing the certification following the date of settlement, was related to Covid 19 working arrangements and periods of annual leave.

10. Property Advisors have been appointed by completive tender and evidence provided that the advice of the Property Advisor was acted upon for this transaction.

11. The need for the lease of the property was outlined in an SBAR to the Fife Capital Investment Group on 27 January 2022. The SBAR noted that the current estate had no suitable accommodation and due to NHS procurement guidelines accommodation was required urgently to house two CT scanners prior to 31 March 2022. Other large equipment purchases which will require storage have also been identified and this lease of a warehouse will assist with the delivery of potential and proposed equipment for Fife wide capital schemes in terms of storage for both the short, medium, and long term.

12. The SBAR refers to the suitability of the property eventually leased in terms of its good access, good size, proximity to VHK and its instant availability. As we were advised that no other suitable property was identified for the storage of the equipment no contingency alternative was identified in case negotiations on the preferred option failed.

13. We are advised by the Projects & Property Administration Manager that review of availability of suitable property from other Holding Bodies, from within the Scottish Government Estate or the Government's Civil Estate was undertaken but no documentary evidence was available for this.

14. Approval of the proposal was obtained from the Director of Finance and Strategy and the Chief Executive, in line with scheme of delegation financial limits, and was approved by the Fife Capital Investment Group on 1 February 2022.

15. Legal advice was taken from the Central Legal Office (CLO) on the proposed terms of the lease. The CLO advised that the lease is for a sufficient time period and includes appropriate break clauses.

16. Schedule of condition was prepared and responsibilities for maintenance of the leased property were clarified and agreed. Minimal fit-out requirements were agreed prior to agreement of the lease.

Auchtermuchty Health Centre

17. The monitoring pro forma was completed and the certification was signed off at the offer stage by the Legal Advisor and In House Property Manager but was not signed off at this stage by the Chief Executive or the Property Advisor. The certification was fully signed off at the completion stages of the transaction. The handbook requires that certification is signed off on the day of settlement, but the certificate was fully signed off 28 working days following the date of settlement.

18. The Scottish Government letter PCA (2018) 08 - National Code of Practice for GP Premises - GP Premises Leased from Private Landlords states that the Code of Practice sets out that the Scottish Government's long-term strategy is, '*that no GP contractor will need to enter a lease with a private landlord. Health Boards will, over the course of the next fifteen years, take on the responsibility for negotiating and entering into leases with private landlords and the subsequent obligations for maintaining the premises from GP contractors who no longer want to lease privately*.'

19. An SBAR was presented to EDG 20 May 2021 explaining the situation regarding the general background regarding transfer of primary care third party leases to Health Boards in general and specifically regarding the proposed transfer of the lease for the Auchtermuchty Health Centre. As NHS Fife is the first NHS Board to reach this stage of negotiation with a GP practice and national guidance regarding the sub-lease element of the transaction was not yet available from CLO at the time two options were outlined:

    - enter a short-term licence until the sub lease is developed
    - wait until the sub lease has been developed

20. The Finance, Performance and Resources Committee endorsed the first option, and the overall approach regarding Primary Care Premises, on 13 July 2021. The SBAR also explained that the lease for the buildings occupied by the Auchtermuchty Health Centre expires in 2023 and therefore time was of the essence to avoid any risk of disruption to services.

21. Property Advisors have been appointed by completive tender and evidence provided that the advice of the Property Advisor was acted upon for this transaction.

22. An enquiry was made with Fife Council as to whether they held any other suitable accommodation in Auchtermuchty, but this was not fruitful.

23. Due diligence was undertaken regarding the condition of the property prior to agreeing the lease with a schedule of condition being issued by professional building surveyors on 8 November 2021 which concluded that the inspected areas were in fair or good condition.

24. Legal advice was taken from the CLO on the proposed terms of the lease. The CLO advised that the lease is for a sufficient time period and includes appropriate break clauses.

ACTION

25. There were no recommendations resulting from this review.

ACKNOWLEDGEMENT

26. We would like to thank all members of staff for the help and co-operation received during the course of the audit.

Barry Hudson BAcc CA
Regional Audit Manager

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**12 September 2022**
Title:	**External Quality Assessment (5 yearly)**
Responsible Executive:	**M McGurk, Director of Finance and Strategy**
Report Author:	**A Gaskin, Chief Internal Auditor**

1 Purpose

This is presented to the Audit and Risk Committee for:

- Assurance

This report relates to:

- Legal requirement

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The **Public Sector Internal Audit Standards (PSIAS)** requires the following:

> "***the chief audit executive must develop and maintain a quality assurance and improvement programme that covers all aspects of the internal audit activity***"

PSIAS requires internal audit providers to have a quality assurance and improvement programme, which must include both internal and external assessments.

This report details the FTF Self Assessment and provides assurance that FTF Internal Audit complies with PSIAS, and is being presented to the Audit and Risk Committee for awareness. The FTF Partnership Board approved this report at its meeting on 2 August 2022.

2.2 Background

Within the FTF Consortium, two External Quality Assessments (EQAs) were completed early in 2018. The NHS Fife, NHS Forth Valley and NHS Lanarkshire part of the FTF Internal Audit service was independently reviewed as part of a peer review arrangement with Lothian Council auditors. NHS Tayside was reviewed by the Institute of Internal Auditors (IIA). The respective reports were presented to the relevant client Audit and Risk Committees.

The quality assurance and improvement programme must include both internal and external assessments. The attached paper is the FTF internal assessment carried out during 2021/22, which includes follow up of all previous EQA recommendations.

2.3 Assessment

The table below provides a summary of the FTF Self Assessment against the requirements of the PSIAS. Figures in brackets represent the position from the previous EQA.

Summary of IIA Conformance	Standards	Generally Conforms	Partially Conforms	Does not Conform	
Definition of IA and Code of Ethics – **Section 3**	Rules of conduct	12 (12)	-	-	**12 (12)**
Purpose – **Section 4**	1000 – 1130	8 (8)	-	-	**8 (8)**
Proficiency and Due Professional Care (People) – **Section 5**	1200 – 1230	7 (4)	1	-	**8 (4)**
Quality Assurance and Improvement Programme – **Section 6**	1300 – 1322	7 (4)	- (3)	-	**7 (7)**
Managing the Internal Audit Activity – **Section 7**	2000 – 2130	12 (8)	- (4)	-	**12 (12)**
Engagement Planning – **Section 8**	2200 - 2600	25 (17)	- (4)	-	**25 (21)**
	Total	**71 (54)**	**1 (10)**		**72 (64)**

2.3.1 Quality/Patient Care

PSIAS requires internal audit providers to have a quality assurance and improvement programme, which must include both internal and external assessments.

2.3.2 Workforce

Management responsibilities, skill sets and structures are a core consideration in planning all internal audit reviews and delivering the service.

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 and delivering the FTF service.

2.3.4 Risk Assessment/Management

The PSIAS require risk assessment to be at the core of all audit activity, which is considered as part of the EQA Self Assessment.

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

This paper has been produced by the Regional Audit Manager – NHS Fife/Tayside, with the paper approved by the FTF Management Team.

2.3.8 Route to the Meeting

This paper has been previously considered by the FTF Partnership Board on 2 August 2022.

2.4 Recommendation

This Audit and Risk Committee is asked to:

- Note the **assurance** provided within the FTF Self Assessment.

3 List of appendices

The following appendices are included with this report:

- Appendix A – Public Sector Internal Audit Standards – FTF Self Assessment

Report Contact

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FTF Internal Audit and Management Service

Public Sector Internal Audit Standards – FTF Self Assessment:

- *NHS Fife*
- *NHS Tayside*
- *NHS Forth Valley*

Issued To: **FTF Partnership Board**
M McGurk, Director of Finance and Strategy, NHS Fife
S Lyall, Director of Finance, NHS Tayside
S Urquhart, Director of Finance, NHS Forth Valley

Audit and Risk Committee – NHS Fife
Audit and Risk Committee – NHS Tayside
Audit and Risk Committee – NHS Forth Valley

Contents

SECTION 1 - INTRODUCTION

1. A professional, independent and objective internal audit service is one of the key elements of good governance, as recognised throughout the UK public sector. The Public Sector Internal Audit Standards (PSIAS) were last updated in March 2017. These standards include a requirement for internal audit providers to have a quality assurance and improvement programme.
2. In 2018 two External Quality Assessments (EQAs) were completed. The NHS Tayside part of the FTF Audit Service was independently reviewed by the Institute of Internal Auditors. NHS Fife, NHS Forth Valley and NHS Lanarkshire were reviewed as part of a peer review arrangement with Lothian Council auditors. The respective reports were presented to the relevant client Audit and Risk Committee.
3. This report provides the outcomes of the FTF self-assessment completed in 2021/22.
4. The recommendations from both the EQAs undertaken in 2018 are included at Section 3. All the recommendations have been completed with evidence documented.
5. Links to the previous EQA reports and the PSIAS as follows:

Public Sector Internal Audit Standards	 PSAIS_1_April_2017.pdf
EQA – NHS Tayside	 201806NHSTaysideEQAFinalReport2.docx
EQA – NHS Fife and NHS Forth Valley	 NHS Fife and Forth Valley EQA 2018.doc

SECTION 2 – EXECUTIVE SUMMARY

6. FTF comply fully with professional best practice, internal audit standards and legal requirements. This includes guidelines issued by the Auditing Practice Board, professional bodies and the Institute of Internal Auditors. The Public Sector Internal Audit Standards and our operational Internal Audit guidance documents are central and support the requirements for external quality accreditation (BS EN ISO 9001:2000).
7. FTF prides itself in exceeding the basic standards, in particular the quality of our staff, qualifications and provision of an exceptional skill mix recognising the need for this to match the complexity of the Clients with which we work. The table below demonstrates FTF's continued compliance with Public Sector Internal Audit Standards.

Public Sector Internal Audit Standards	**FTF Compliance**
1000 – Purpose, Authority & Responsibility	For each of our clients we have an Internal Audit Charter, approved by each Audit and Risk Committee, which sets out the purpose and nature of internal audit, including the ethical standards which underpin our service.
1100 – Independence & Objectivity	FTF is operationally managed independently from each audited body. The FTF Partnership Board oversees the FTF consortium from a budget and strategy perspective, and has agreed terms of reference. FTF have direct access to the Audit and Risk Committee Chairs of each client and are represented at each Client Audit and Risk Committee. All FTF staff complete an annual declaration of interests for NHS Fife, who host the FTF consortium.
1200 – Proficiency & Due Professional Care	Professional care is monitored and achieved through supervision and through our quality assurance process as defined internally within our audit methodology and external audit reviews of FTF. The CIA is a CCAB Qualified accountant and FTF's staff are either fully or part qualified (including CCAB, CIIA, CISA, QICA and ACIS) and undertake continuing professional development. Specialist expertise is used within our core delivery, e.g. IM & T.
1300 – Quality Assurance & Improvement	All audit reviews are subject to strict quality assurance process. External accreditations through External Quality Assessments were completed in 2018. The next External Quality Assessment will be undertaken in 2023.
2000 – Managing the Internal Audit Activity	FTF have a clearly defined approach for risk assessment, planning, resourcing, performance and reporting to ensure we add value through our work. We work in partnership with our clients to develop a 5 year risk based audit plan with regular progress against annual plans reported to each Audit and Risk Committee, along with outcomes.
2100 – Nature of Work	FTF internal audit activity evaluates and contributes to the improvement of governance, risk management and internal control through reports, recommendations and development support, across both Health Board and

SECTION 2 – EXECUTIVE SUMMARY

	Integrated Joint Board Clients. Where required we liaise with other review bodies, for example external audit, to facilitate effective coordination of work.
2200 – Engagement Planning	Assignment plans are established and agreed for each review, including scope, risks, timing and resource allocations.
2300 – Performing the Engagement	FTF staff identify, analyse, evaluate and document sufficient information to achieve the assignment objectives. All assignments are properly supervised and subject to robust quality assurance processes. All our records are electronic and these are retained in line with policy.
2400 – Communication Results	FTF communicates the results of each assignment to management, Directors and to the respective Audit and Risk Committees, including Integrated Joint Boards. As part of the report clearance process, we work with each organisation to ensure our reports are accurate, objective, clear, concise, constructive, complete and timely. An annual opinion for each client, is provided by the Chief Internal Auditor (CIA) as part of the year end Annual Internal Audit Report
2500 – Monitoring Progress	Audit Follow Up processes are either managed by the Client organisations or by Internal Audit, who report to Audit and Risk Committees the extent to which management actions have been implemented etc.
2600 – Communicating the Existence of Risk	FTF recognise the professional role of Internal Audit to challenge the level of risk accepted by management, support resolution and ensure transparency in reporting to each Audit and Risk Committee and this is incorporated within our working papers and audit methodology.

8. The Institute of Internal Audit (IIA) International Professional Practice Framework (IPPF) includes the Definition of Internal Auditing, Code of Ethics, Core Principles and International Standards. Within PSIAS, there are 72 fundamental ***principles*** to achieve the recommended practice. For FTF Audit, we have aggregated our assessment for FTF as one organisation, with detailed evidence available for each client.
9. The External assessment undertaken in 2018 has been included in the table below for comparative purposes. This EQA was the routine 5 yearly review of the NHS Tayside (NHST) Internal Audit Service.
10. FTF have identified further conformance requirements from PSIAS which explains the difference in the total standards and conformance requirements from the 2018 External Assessment. Compliance with the 2018 External Assessment is included in brackets.
11. The only PARTIALLY CONFORMS relates to "***exercising due professional care internal auditors must consider the use of technology-based audit and other data analysis techniques.***" Over the last three years FTF have focussed their audit resource towards strategic reviews where data analysis techniques were not appropriate. We are now undertaking more operational reviews within our audit plans. The CIA is the Data analysis/statistical lead for FTF and future arrangements will be combined with succession planning in advance of his retiral in 2023.

SECTION 2 – EXECUTIVE SUMMARY

12. A detailed assessment with each standard, conformance assessment and FTF evidence is available on request.

Summary of IIA Conformance	Standards	Generally Conforms	Partially Conforms	Does not Conform	
Definition of IA and Code of Ethics – **Section 3**	Rules of conduct	12 (12)	-	-	**12 (12)**
Purpose – **Section 4**	1000 – 1130	8 (8)	-	-	**8 (8)**
Proficiency and Due Professional Care (People) – **Section 5**	1200 – 1230	7 (4)	1	-	**8 (4)**
Quality Assurance and Improvement Programme – **Section 6**	1300 – 1322	7 (4)	- (3)	-	**7 (7)**
Managing the Internal Audit Activity – **Section 7**	2000 – 2130	12 (8)	- (4)	-	**12 (12)**
Engagement Planning – **Section 8**	2200 - 2600	25 (17)	- (4)	-	**25 (21)**
	Total	**71 (54)**	**1 (10)**		**72 (64)**

SECTION 3 – FOLLOW-UP OF PREVIOUS RECOMMENDATIONS

Status of Recommendations for further development from 2018 External Assessment

IIA Review of NHS Tayside

Recommendation	Complete / In Progress	Evidence and Update
Purpose, authority and responsibility		
The updated Internal Audit Charter clearly sets out the purpose, authority and responsibility of Internal Audit. To reinforce the key messages and raise Internal Audit's profile we recommend the Chief Internal Auditor should organise a series of short meetings across the organisation to explain the role of internal audit in the governance process. Emphasis should be placed upon how internal audit provides assurance on the management of strategic risks and other ways internal audit adds value to the organisation. **Action** A) The Chief Internal Auditor and Director of Finance will organise a series of briefings across the organisation to explain the role of internal audit and promote the Board's governance arrangements. B) The Chief Internal Auditor has also agreed to develop an electronic briefing to be made available on the Intranet for managers, with particular reference to internal audit's role in relation to risk management and added value.	**A) Complete** **B) Complete**	A) Briefings were held across each FTF client and continue to be reinforced as required. B) FTF Website completed and web link provided to each FTF client

SECTION 3 – FOLLOW-UP OF PREVIOUS RECOMMENDATIONS

Planning		
The existing internal audit plan is based upon a corporate governance framework that enables an annual opinion on the control environment. It incorporates specific audits of risk management and includes references to specific strategic risks to approach the requirement for a risk based plan. Although, the information is available within the detail of the strategic IA plan, it is difficult for readers to understand why some audits have been chosen compared to possible others derived from the strategic risk register, what individual audit priorities are in terms of their alignment to defined risk mitigation and there is no information provided on how all of this fits in with Audit Committee priorities and with other assurance work around the Transformation programme, the Assurance & Advisory group and the work arising from Grant Thornton. To enable collective ownership of the annual internal audit plan we recommend a planning meeting, sometime between December and January each year. This could be, led by the CIA and involve the Audit Committee and senior management (including the chair of strategic risk management groups) to discuss the alignment of audit priorities to strategic and emerging risks. Immediate objectives of the meeting should include:	**Complete**	**Standard process – Previous Years** Our Strategic Internal Audit planning process is normally structured around an audit universe based on a 5 year cycle which links to the Strategic Risk Register and objectives. The process overtly demonstrates cyclical coverage of all strategic risks and is designed to allow Executive Directors and the Audit and Risk Committee to contribute their views on areas for inclusion. The resultant operational plan is again overtly linked to the relevant strategic risk, which will still be the focus of our work, together with any key governance or assurance elements required in order to provide a view on the overall adequacy and effectiveness of internal controls. **Current year process – 2022/23** As was the case for 2021/22, due to the significant and ongoing impact of Covid-19 on the risk profile of the organisation, a planning process which relied on a relatively static risk environment and change generally occurring in the medium to long term was no longer viable. As such, our view is very much that the plan will need to be flexible, responsive to the requirements of senior management and non executive directors and, to a certain extent, emergent as the risk profile changes. In order to provide a starting point for discussion, we will ask for the views of Directors with greater emphasis on the organisations current rather than cyclical needs, focusing on emergent risks and those with most immediacy, as the basis for a first draft plan. However, we know that the organisational risk profile is changing rapidly, as is organisational understanding of those risks and we will present an updated plan later in the audit year.

SECTION 3 – FOLLOW-UP OF PREVIOUS RECOMMENDATIONS

• Refinement and simplification of the internal audit plan format. • Clearer linkage between strategic risks, the controls that mitigate risks and the focus of individual audits. • Identifying internal audit priorities – 'must do' audits and their timing. • A more holistic annual review of risk management. • Visibility of the strategic risks not being audited in the year by FTF to enable a discussion about coverage and the level of audit resource. **Action** Whilst the detail is available either within the plan or in our background processes, the internal audit progress reports to the Audit Committee will set out the: • linkages between the Internal Audit plan and the Board's strategic risks • identify those the priorities that the Chief Internal Auditor believes are 'must do' reviews • Strategic risks not covered by the internal audit plan to enable the Committee to have a discussion about coverage. The alignment of the internal audit plan and strategic risks will be kept under review by the Audit Committee throughout the year using the information within the regular progress reports.		
Risk Management		

SECTION 3 – FOLLOW-UP OF PREVIOUS RECOMMENDATIONS

Linked to the above recommendation and the growing commitment to effective risk management at NHST we recommend that a wider, holistic review of risk management be embedded within the Annual Internal Audit Plan for the foreseeable future. Circumstances will vary from year to year but we recommend internal audit could embrace some or all of the following options : • Validation of the Strategic Risk Management Group assurances. • Validation of the CIPFA or equivalent risk management self-assessment. • Verification of the accuracy of risk KPI reporting. • Verifying the application of the risk management processes across the organisation either through a specific audit or by reviewing this as part of every audit. • Reviewing the effectiveness of risk management training. In formulating ideas we suggest the overall expectations of Internal Audit in relation to risk management could be specified within the Internal Audit Charter. **Action** The Executive Leadership Team are undertaking a review of the Board risk management arrangements in response to the findings in the Internal Audit Annual report. Internal Audit will follow up the implementation of the actions	**Complete**	Risk Management is included in every FTF Client Internal Audit plan as a "statutory audit", and includes cyclical reviews of all the options highlighted, amongst others. Our Audit Charters with each Client include specific reference to Risk Management, and are reviewed and approved annually by each Client Audit and Risk Committee.

agreed within the Annual Report during 2018/19 and complete a detailed organisation wide review of risk management during the first quarter of 2019/20. It would be the intention that a review of risk management would be included in each year's annual programme.		
Coordination and reliance		
NHST, having been placed under special measures, is undergoing a high level of scrutiny from a variety of external agencies. There is also a wide range of internal assurance providers including the strategic risk management group, clinical audit and health & safety. While there is some coordination with Audit Scotland there is much greater scope for Internal Audit to review and perhaps work with other assurance providers to avoid potential duplication and gaps. We recommend Internal Audit work with risk management to revisit the Board Assurance Framework with a view to ensuring there is clarity upon: • The identification and definition of the key controls that mitigate strategic risks. • Understanding who will provide assurance (2nd and 3rd lines of defence) these key controls are actually working and where appropriate how this assurance is provided. • Assess the extent of any duplication or gaps in assurance and how these might impact future IA plans, including the potential for internal	**Complete**	Assurance Mapping Principles have been developed by a working group across the FTF Client base, with the principles now adopted by each FTF Client. These have been reinforced by the work of the Assurance Mapping Group, consisting of Risk Managers and Board Secretaries across our Client base. Members of the group have been adopting different strategies to implement the principles within each Client, supported by detailed internal audit reviews.

SECTION 3 – FOLLOW-UP OF PREVIOUS RECOMMENDATIONS

audit to rely upon the assurance of others. • Where internal audit and other assurance providers might work together on joint audits to marry audit and technical skills. Ultimately work on coordination will inform the planning process and should form significant input into the annual planning meeting suggested earlier. **Action** Internal Audit last conducted a detailed review of the BAF in 2015, and this will be revisited during 2018/19. The Chief Internal Auditor will liaise with Audit Scotland as part of this review to ensure that the review of the Board Assurance Framework will support management in implementing the controls and mitigations required in response to the external reports and recommendations that have been highlighted and to minimise the risk of such events occurring in the future.		

SECTION 3 – FOLLOW-UP OF PREVIOUS RECOMMENDATIONS

EQA of NHS Fife and NHS Forth Valley

Ref. No.	Finding	Recommendation	Complete/In Progress	Evidence and Update
1	Approval of resource to the FTF Internal Audit Service is made by the Partnership Board comprising the Directors of Finance of NHS Fife, Tayside and Forth Valley. The Charter does not specify how the Chief Executives and Audit Committees contribute to the CIA's appraisal.	The Partnership Board should review the requirements of PSIAS standard 1100 with Senior Management, Chairs of the Audit Committee, and the Chief Internal Auditor, with a view to improving compliance, in line with local circumstances. The Charter should specify how the Chief Executives and Committees contribute to the CIA's appraisal.	Complete	Client Directors of Finance already contributed to the CIA's appraisal through the NHS Fife Director of Finance. These contributions are now informed by discussions between the Director of Finance and Audit Committee Chair.
2	The training budget for FTF's internal audit service is relatively small considering the number of auditors employed, and there is no resource for appointment of short-term specialist auditors.	The level of resource put aside for training and development for specialist audits should be reviewed to ensure the skill set of auditors remains appropriate for the organisations.	Complete	This is considered by the Partnership Board as part of discussions around the FTF budget.
3	FTF currently do not explicitly report to the Audit and Risk Committees on progress in implementing the Quality Assurance Improvement Programme.	In future, within the Annual Internal Audit Report, or through periodic update of the Audit Charter, the Quality Assurance Improvement Programme should be reported on to the Audit and Risk Committees.	Complete	This is included within all Internal Audit Annual reports.

SECTION 3 – FOLLOW-UP OF PREVIOUS RECOMMENDATIONS

Ref. No.	Finding	Recommendation	Complete/In Progress	Evidence and Update
4	For both NHS Fife and NHS Forth Valley's Audit Plans, there were audits carried forward from the prior year and these were reported after the prior year's Annual Internal Audit Opinion.	Consideration should be given at the time of reporting the next year's Internal Audit Plan to closing off in full the previous year's Audit Plan. Prior year audits would then either be added to the current year plan after reassessing the risk and priority of these, or dropping these audits entirely in favour of current year proposals. This would allow the plan to be more reactive to emerging risks, the views of senior management, and the Audit and Risk Committee.	Complete	FTF adopted this approach to any outstanding reviews when developing the following years audit plan. The process itself has been adapted to be more fluid given the increasing dynamism of the risk environment due to Covid-19.

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**12 September 2022**
Title:	**Fife IJB Draft Internal Audit Joint Working and Reporting Protocol**
Responsible Executive/Non-Executive:	**M McGurk, Director of Finance & Strategy**
Report Author:	**T Gaskin, Chief Internal Auditor**

1 Purpose

This is presented to the Audit and Risk Committee for:

- Approval
- Discussion

This report relates to a:

- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to provide the draft Fife Integration Joint Board (IJB) – Internal Audit Joint Working Protocol to the NHS Fife Audit and Risk Committee for approval. The Fife IJB Audit and Risk Committee endorsed the Protocol at its meeting of 9 March 2022.

2.2 Background

In order to work efficiently with our partner bodies and to allow the appropriate sharing of information and assurances, we have updated and expanded the information sharing protocol previously approved by the NHSF Audit and Risk Committee and those of the partner bodies.

This will enable sharing of relevant internal audit outputs, ensures compliance with the spirit of the Due Diligence guidance, recognises the complex inter-relationships between the governance of all parties and allows Chief Internal Auditors for each organisation to produce comprehensive reports for their respective Audit Committees.

The new Joint Working and Reporting protocol also sets out the working relationships between the Internal Audit Departments and thereby assures this Audit and Risk Committee that the arrangements are well-structured and efficient.

2.3 Assessment

The protocol sets out the following principles in relation to the sharing of internal audit outputs and granting of access to information:

- the Internal Audit plans of Fife Council and NHS Fife will be presented to the IJB Audit and Risk Committee for noting to allow identification of any relevant audits which they may wish to receive assurance from and issues relevant to the Fife IJB which they may wish to be considered during a relevant audit. For these audits and others where the IJB Chief Internal Auditor believes there are relevant issues, summaries of the final reports will be presented to the IJB Audit and Assurance Committee at the meeting following presentation at the parent body Audit Committee.
- An agreed standard report format will be used for all IJB Internal Audit Reports, with all work conducted within the terms of the Internal Audit Charter approved by the IJB Audit and Assurance Committee and the requirements of PSIAS. A summary of IJB reports will be presented to the IJB Audit and Assurance Committee, with a full copy available to IJB Audit and Risk Committee members on request. These summaries shall also be shared with the Fife Council and NHS Fife Audit and Risk Committees.
- The IJB Internal Audit Annual Report, prepared by IJB Chief Internal Auditor, will be shared with the parent bodies and reported through their own internal audit reporting procedures. In return, Fife Council and NHS Fife Internal Audit Annual Reports will be presented to the IJB Audit and Assurance Committee for noting, as part of the overall assurance portfolio in support of the governance statement. This information sharing protocol will provide the basis of an assurance framework to meet the assurance needs of all partners.

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

There are no financial impacts arising directly from this report.

2.3.4 Risk Assessment/Management

There are no risk implications. The draft Internal Audit Joint Working and Reporting Protocol has been prepared in accordance with the General Data Protection Regulation principles and seeks to ensure that information required for assurance purposes is shared appropriately within the partnership.

2.3.5 Equality and Diversity, including health inequalities

There are no implications arising directly from this report.

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

All papers have been produced by Internal Audit.

2.3.8 Route to the Meeting

The IJB Chief Finance Officer was consulted on the contents of this protocol which has also been shared with the Fife Council Chief Internal Auditor. The Fife IJB Audit and Risk Committee endorsed the protocol at its meeting on 9 March 2022.

2.4 Recommendation

The Audit and Risk Committee is asked to:

- **Approve** the draft Internal Audit Joint Working and Reporting Protocol

3 List of appendices

The following appendices are included with this report:

- Appendix A – Draft Internal Audit Joint Working and Reporting Protocol

Appendix A

Internal Audit Joint Working and Reporting Protocol

1. Introduction

1.1 This paper is intended to provide the protocol by which Internal Audit will conduct their work during the year including planning, conducting and reporting on audit assignments. It clarifies the roles and responsibilities of all relevant parties, including the IJB Chief Internal Auditor, partner body internal audit teams and the officer designated by the Chief Accountable Officer as being responsible for liaising with Internal Audit regarding each individual audit assignment (hereafter referred to as the Responding Officer).

1.2 In order that all parts of the system receive appropriate information on the adequacy and effectiveness of internal control within their purview, including controls operated by other bodies which impact on their control environment, this protocol also covers the need to share internal audit outputs beyond the organisation that commissioned the work. This will apply for all internal audit output (e.g. internal audit reports, follow-up reports, internal audit plans and internal audit annual report / opinion).

1.3 An Internal Audit Charter has been agreed separately to define Internal Audit's purpose, authority, responsibility and position.

2. Audit Planning - Annual

2.1 The Annual Internal Audit Plan details the audit reviews to be carried out for the financial year ahead and will be presented by the Chief Internal Auditor to the Audit & Assurance Committee for approval by end September, following consultation between the parties' Internal Audit Teams. Prior to finalising their audit plans, the Chief Internal Auditor of the Local Authority, Health Board and IJB will meet to ensure that the Internal Audit plans of both parties provide appropriate coverage of functions delegated to the IJB.

2.2 Once the audit plan is agreed, the two Internal Audit teams will agree audits to be assigned to either the Health Board or Local Authority Internal Audit team to lead, or, where appropriate, audits will be conducted jointly by both Internal Audit teams. The Audit & Assurance Committee date for the final report to be presented to will also be agreed.

2.3 IRAG guidance states that '*The risk based audit plan should be developed by the Chief Internal Auditor of the Integration Joint Board and approved by the Integration Joint Board or other committee (see 2.6 Audit & Assurance Committees). It is recommended that it is shared with the relevant committees of the Health Board and Local Authority.'* This principle is agreed and the approved IJB annual internal audit plans will be shared with the relevant committees of NHS Fife and the Fife Council.

2.4 Given that the IJBs are reliant on assurances provided by the parties on their systems and also to ensure that plans can be seen to be coherent over the whole system, the Internal Audit plans of the Health Board and Fife Council will also be presented to the IJB Audit & Assurance Committee for noting. This will provide each Audit & Assurance Committee, whilst respecting the primacy of the organisation for whom the report is prepared, with the opportunity to identify any relevant audits from another body which they may wish to receive assurance from, and highlight any areas where they might wish to ensure that particular issues, relevant to their IJB are taken into account.

2.5 At the beginning of each audit year, and on an ongoing basis, the respective internal auditors, taking into account the views of the IJB Chief Officer, IJB Chief Internal Auditor and IJB Audit & Assurance Committee, will review their audit plans to identify any audits of the parent bodies (NHS Fife and Fife Council) that may be of relevance to the IJB. For these audits, summaries of the final reports, or relevant issues from within those reports, will be presented to the IJB Audit & Assurance Committee.

2.6 If, for any other completed audits across NHS Fife and Fife Council, the auditor believes there may be issues which impact on the IJB control environment, the IJB Chief Internal Auditor will be notified so that arrangements can be made to report the relevant findings to the IJB Audit & Assurance Committee.

2.7 The final audit reports issued shall follow the normal reporting routes established for internal audit reports within the parent bodies; this shall include being presented to their respective Audit & Assurance Committees. The parent body Audit & Assurance Committee shall be advised if the report, or any part thereof, is to be shared with the IJB Audit & Assurance Committee.

2.8 When either an NHS Fife or Fife Council final internal audit report has been identified as relevant to the IJB, the audit report shall be presented in summary at the next meeting of the IJB Audit & Assurance Committee. These summary reports shall also be shared between NHS Fife and the Fife Council internal audit services.

3. Planning Individual Assignments

3.1 Prior to the commencement of the audit, the Chief Accountable Officer and Chief Finance Officer will be contacted to ascertain the appropriate Responding Officer for the review being undertaken. The Responding Officer will be responsible for agreeing the key risks relevant to the audit and reviewing the Assignment Terms of Reference and will later be responsible for agreeing the draft report, including the provision of the management response to the action plan.

3.2 The draft Assignment Terms of Reference for each audit will be prepared by the team leading the audit, in an agreed standard format, for approval by the Lead Chief Internal Auditor.

3.3 The Assignment Terms of Reference will then be agreed with the Chief Officer or Chief Finance Officer and the nominated Responding Officer prior to the commencement of the audit.

3.4 The Chief Officers will also identify any partner body officers who should be consulted as part of the audit. The Assignment Terms of Reference will be shared with these individuals for information/comment before final approval by the Responding Officer(s).

3.5 The finalised Assignment Terms of Reference will be issued to all relevant parties, including the Chief Accountable Officer, the Chief Finance Officer and the Responding Officer(s). The Assignment Terms of Reference will be issued in advance of the assignment and include the indicative timing of the audit.

4. Audit Assignment Fieldwork

4.1 Assignments will be conducted in accordance with the normal audit approach adopted by the allocated internal audit team, including appropriate quality assurance processes. An exit meeting to discuss findings with staff including the Responding Officer will be arranged prior to preparation of the draft report as required.

5. Audit Reports

5.1 The template of the lead CIA's organisation will be used for audit reports. Any request for changes to this format by IJB management or members will be taken into consideration. The Internal Audit team leading the assignment will produce a draft report, or, in the case of jointly conducted audits, relevant staff from both Internal Audit teams will liaise to compile a joint draft report. The draft will be reviewed by the Lead Chief Internal Auditor, prior to formal issue to the client.

5.2 All draft reports will be issued to the relevant Responding Officer(s) for agreement regarding the accuracy of the findings and consideration of the audit opinion and the recommendations detailed in the Action Plan appended to the draft report.

5.3 The target date for issue of the draft and final report will be in line with timescales governing the target Audit & Assurance Committee meeting as detailed in the Assignment Terms of Reference.

5.4 Opportunity will be given to the Responding Officer to discuss any issues with the auditors prior to submission of the written management response for inclusion in the final report. Any officers of the partner bodies named under Para 2.5 will receive a copy of the draft report and be given the opportunity to

comment in time for their contribution to be taken into account by the Responding Officer.

5.5 The Responding Officer(s) should provide a formal response detailing agreement or otherwise regarding all recommendations included in the Action Plan, together with any related comments, details of the responsible officer for actions and a timescale for implementation of the proposed action.

5.6 It is the responsibility of the Responding Officer(s) to ensure that the response accurately reflects the official position of the Integration Joint Board and takes into account comments received from partner officers. They should also ensure that the proposed action and timescale for completion is appropriate to the risk and is achievable. The target deadline for this stage will be intimated on issuing the draft report and be based on a 3 week deadline.

5.7 The finalisation process for audit reports will be undertaken by the Internal Audit team which issued the draft report and include follow up of any late replies and discussion with the Responding Officer(s) regarding any 'disagreed' recommendations including the underlying reasons, clarification of any management comments which do not appear to fully address the recommendation made and clarification of any timescales which appear overly extended.

5.8 In the event of a failure to receive a suitable response from the Responding Officer within the required timescale, or to reach agreement on a fundamental recommendation, the matter will be referred to the Chief Finance Officer. Any residual risk associated with not agreeing to implement a recommendation should be clearly communicated to management.

5.9 Where assignments are conducted jointly by both Internal Audit teams, the finalisation process will include appropriate liaison between both teams.

5.10 Following management responses as above, the Chief Internal Auditor will review all draft final reports prior to issue to the Chief Officer. Once agreed, final reports will then be issued by the Chief Internal Auditor to the distribution list shown at the front of the report, agreed as part of the finalisation process, including as a minimum IJB Members, the Chief Officer, the Chief Finance Officer, the Responding Officer, named partner body officers, External Audit and any officers responsible for implementing agreed actions.

5.11 The full report will be presented to the next Audit & Assurance Committee, together with a report showing progress against the agreed Annual Internal Audit Plan.

5.12 The full final report for each audit assignment will be presented to the IJB Audit & Assurance Committee for scrutiny purposes, with a full copy available to all IJB members on request. A summary of the report shall also be shared with the NHS Fife and relevant Fife Council Audit & Assurance Committee). The sequence will depend on the timing of the meetings.

5.13 Progress on delivering the Internal Audit Plan will be reported to each Audit & Assurance Committee. The Chief Internal Auditor will maintain regular contact with the Chief Finance Officer to discuss progress.

6. Annual Internal Audit Reports

6.1 The principal report to be produced by Internal Audit will be the Annual Internal Audit Report for each audit year. This needs be prepared in time for submission to the Audit & Assurance Committee in June. The Annual Internal Audit Report should contain:

- An opinion on whether:
  - Subject to any issues highlighted in the Governance Statement, reliance can be placed on the IJBs governance arrangements and systems of internal controls for the year
- Any concerns over the following:
  - Consistency of the Governance Statement with information that we are aware of from our work;
  - The format and content of the Governance Statement in relation to the relevant guidance;
  - The disclosure of all relevant issues.
- comment on the key elements of the control environment
- analysis of any changes in control requirements during the year
- make recommendations on any gaps identified in the control environment

6.2 IRAG guidance states that '*It is recommended that the Integration Joint Board annual internal audit report is shared with the partner Health Board and Local Authority through the reporting arrangements in those bodies for internal audit.*' The IJB Chief Internal Auditor shall prepare an IJB Internal Audit Annual Report and opinion and in accordance with IRAG guidance, it will be shared with the parent bodies and reported through their own internal audit reporting procedures. Again, this principle will be extended and reciprocated so that Local Authority and Health Board Annual Internal Audit Reports are presented to the IJB Audit & Assurance Committee for noting as part of the overall assurance portfolio in support of the governance statement.

6.3 Each IJB has put in place Audit Follow Up processes reporting to their Audit & Assurance Committee on progress against previous audit recommendations. Each year, Internal Audit will set aside time to for detailed testing of a sample of responses to confirm accuracy.

6.4 An Internal Audit Charter has been agreed separately to define Internal Audit's purpose, authority, responsibility and position.

6.5 To ensure coordination of work, An indicative timeline for standard output during the audit year is included below, noting that the timescales will move forward in future years:

April	**May**	**July**	**September**	**January**	**March**
Deadline for receipt of completed governance checklists. Follow up of previous audit recommendations	Issue draft Annual IA report. Preparation of audit plan for following year including meetings with CO and CFO	Present IA Annual reports to Audit & Assurance Committee	Approval of IJB Audit Plan	Review and agree governance checklists	Issue governance checklists to CFO for completion
	Ongoing: Audit assignments and reporting Ongoing ad hoc governance advice IA progress reports to the Audit & Assurance Committee				

Last reviewed: August 2022

Next Review Date: August 2024

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**12 September 2022**
Title:	**Losses and Special Payments Quarter 1**
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 01/04/22 – 30/06/22. 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 any legal claims that are negotiated and settled 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 paperwork is then provided to the Deputy Director of Finance for final approval. The ex-gratia compensation payments for both clinical and non-clinical legal claims, following

consultation and agreement with the Director of Finance & Strategy 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 processed accordingly. Any Losses and Special Payments for the quarter 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 01/04/22 – 30/06/22. The reports categorise the types of losses and special payments made in the period whilst also quantifying the number of cases of each and the total monetary value.

There were 221 Losses and Special Payments in the quarter which were broadly in line with the previous 12-month figure of 841. The cost however was significantly higher this quarter in comparison to the fourth quarter of 2021/22 (£644,321 compared to £136,736), as a result of a significant increase in value of both clinical ex-gratia compensation payments (£529,045 up from £73,251) and Non-Clinical ex-gratia compensation payments (£99,008 up from £11,292). It should be noted that the quarter four 2021/22 total for Losses and Special Payments were historically low and the overall position in quarter one is a return towards the historically anticipated level.

The Losses and Special Payments out-with the Clinical and Non-Clinical Legal settlements were significantly down in comparison to quarter 4 (2021/22), however this can be attributed to the Year End process where the Financial Services Debtors Review resulted in a £41,244 write off. There was a noticeable increase in quarter 1 identified with regards to compensation payments for financial Loss suffered by patients (£9,715 in Quarter 1 up from £1,791 in Quarter 4) and this will be carefully monitored as the year progresses.

Update to Action Log item 1 (15/06/22)

Following the Action Raised at the Audit and Risk committee on the 16th June 2022, and in relation to any legal settlements made by the board, assurance is provided that all adverse events, including those which lead to a clinical negligence compensation payment go through a series of local reviews following national and local guidance and protocols. Systems learning from adverse advents is a critical part of the review process which is applied rigorously by NHS Fife and contributes to ensuring lessons are learned and services continually improve to deliver person-centred, safe and effective delivery of care.

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 are 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 presented to the Head of Financial Services and Procurement ahead of the annual submission to the Scottish Government. The losses and Special Payments included in the report have 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 provision of the Losses and special payments report follows on from the 2021/22 Financial Year where each quarter was presented for oversight to the Audit and Risk Committee.

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 30st June 2022.

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Summary of Losses and Special Payments 01/04/22 – 30/06/22

Report Contact
Kevin Booth
Head of Financial Services & Procurement
Email kevin.booth@nhs.scot

FIFE HEALTH BOARD

SUMMARY OF LOSSES AND SPECIAL PAYMENTS

ITEM NO.	CATEGORY	APR - JUN'22		APR'21 - MAR'22	
	Miscellaneous / Theft / Arson / Wilful Damage				
1	Cash	2	170		
2	Stores/procurement				
3	Equipment			2	492
4	Contracts				
5	Payroll *Salary Overpayment Debtors Invoices*			16	13230
6	Buildings & Fixtures *Vandalis*	21	2196	66	6475
7	Other			4	276
	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 *Hardship Accounts*	168	1686	637	42672
	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 *Loss / Damaged E*	5	2301	25	8564
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	6	529045	30	3913335
27	Compensation Payments - ex	8	99008	21	297923
28	Compensation Payments - ex	10	9715	31	7930
29	Other Payments				
	Damage to Buildings and Fixtures:				
30	Incidents of the Service :				
	- Fire				
	- Flood				
	- Accident *Vehicle Expenditu*	1	200	9	1696
	- Other Causes				
31	**Extra-Statutory & Extra-regulationary Payments**				
32	**Gifts in cash or kind**				
33	**Other Losses**				
		221	644321	841	4292593

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**12 September 2022**
Title:	**Audit Scotland Technical Bulletin 2022/2**
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:

- Assurance

This report relates to a:

- Emerging issue
- Government policy/directive
- Legal requirement

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

- Effective

2 Report summary

2.1 Situation

The Audit Scotland Technical Bulletin 2022/2 is a resource shared across members of the Finance Directorate and is provided to the Audit and Risk Committee to raise awareness of emerging developments from an Audit perspective.

2.2 Background

The Audit Scotland Technical Bulletins are prepared on a quarterly basis and are provided to support auditors appointed by the Auditor General for Scotland and Accounts Commission for Scotland with:

- Information on the main technical developments across the public sector in the quarter.
- Information on professional matters during the quarter that are expected to have applicability to the public sector.
- Summaries of responses to any requests from auditors for technical consultations with Audit Scotland Professional Support.

2.3 Assessment

The Audit Scotland Technical Bulletin 2022/2 is arranged by sector with content applicable to each sector and across the public sector as a whole.

From a Health Board perspective, guidance is provided within section 2 relating to the Annual accounts Process, on the Whole of Government Accounts consolidation process and the identification of audited sections within the remuneration report. Section 5 relates specifically to the health sector and again clarifies a number of matters relating to the Annual accounts process.

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

The Technical Bulletin is shared widely across the Finance Directorate.

2.3.3 Financial

Technical and Financial developments are addressed from Audit Scotland's perspective.

2.3.4 Risk Assessment/Management

Emerging Risks relating to the Health Sector are addressed from Audit Scotland's perspective.

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 Audit Scotland Technical Bulletins are provided to Boards through the TAG meetings.

2.3.8 Route to the Meeting

This paper has been provided following discussions between the Head of Corporate Governance and the Head of Financial Services & Procurement

2.4 Recommendation

- **Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix, Audit Scotland Technical Bulletin 2022/2

Report Contact
Kevin Booth
Head of Financial Services & Procurement
Email kevin.booth@nhs.scot

Technical Bulletin 2022/2

Technical developments and emerging risks from April to June 2022

AUDIT SCOTLAND

Prepared by Audit Scotland for appointed auditors and audited bodies in all sectors

22 June 2022

Contents

1: Introduction

Purpose

The purpose of Technical Bulletins from Audit Scotland's Professional Support is to provide auditors appointed by the Auditor General for Scotland and Accounts Commission for Scotland with:

- information on the main technical developments in each sector during the quarter
- information on professional matters during the quarter that are expected to have applicability to the public sector
- summaries of responses to any requests from auditors for technical consultations with Professional Support.

Appointed auditors are required by the Code of Audit Practice to pay due regard to Technical Bulletins. The information on technical developments is aimed at highlighting the key points that Professional Support considers auditors in the Scottish public sector require generally to be aware of. It may still be necessary for auditors to read the source material if greater detail is required in the circumstances of a specific audited body. Source material can be accessed by using the hyperlinks.

Any specific actions that Professional Support recommends that auditors take are highlighted in green.

Technical Bulletins are also published on the Audit Scotland website and therefore are available for audited bodies and other stakeholders to access. However, hyperlinks to source material indicated with an asterisk (*) link to files on Audit Scotland's SharePoint* and are only accessible by auditors.

Highlighted items

Professional Support highlights in the following table a selection of the items in this Technical Bulletin that are of particular importance:

Highlighted items		
Treasury has issued guidance on preparing the 2020/21 WGA [**paragraph 1**]	Professional Support has provided guidance on the audited part of the Remuneration Report [**paragraph 9**]	CIPFA/LASAAC has issued proposed revisions to the accounting code in respect of infrastructure assets [**paragraph 17**]
CIPFA has issued a draft bulletin on accounting for infrastructure assets in local government [**paragraph 24**]	Professional Support has issued a briefing on preparing IARs for 2021/22 [**paragraph 31**]	The Scottish Government has issued statutory guidance on disclosures where a local authority defers loans fund repayments [**paragraph 35**]
LASAAC has issued guidance on COVID-19 related grants in 2021/22. [**paragraph 39**]	CIPFA has issued guidance on 2021/22 financial statements [**paragraph 47**]	PWC has issued a report for auditors on IAS 19 reporting [**paragraph 60**]
Professional Support has published guidance on inspections and objections to 2021/22 local government annual accounts [**paragraph 66**]	The Scottish Government has guidance on the approval and publication dates for the 2021/22 annual accounts of local government bodies [**paragraph 69**]	The NAO has published a disclosure guide on the 2021/22 financial Statements [**paragraph 77**]
Professional Support has provided auditors with advice on issues arising from 2021/22 audits [**paragraph 81**]	The Scottish Government has issued health boards with revised accounts directions from 2021/22 [**paragraph 82**]	The Scottish Government has issued a letter on year-end arrangements for health boards in 2021/22 [**paragraph 86**]
Professional Support has issued an assurance report CNORIS for 2021/22 [**paragraph 92**]	The PAF has issued proposed revisions to PN 10 [**paragraph 94**]	BEIS has issued a response to its consultation on restoring trust in audit and corporate governance [**paragraph 98**]
The FRC has issued reports on its 2020/21 audit quality inspections [**paragraph 116**]	The FRC has issued proposed revisions to ISA (UK) 600 [**paragraph 119**]	The ISSB has issued draft standards on sustainability [**paragraphs 122 and 128**]

Contact point

The main contact point for this Technical Bulletin is Paul O'Brien, Senior Manager (Professional Support) – Pobrien@audit-scotland.gov.uk.

2: All sectors

Contact: Paul O'Brien, Pobrien@audit-scotland.gov.uk

Guidance on 2020/21 WGA

1. HM Treasury has issued guidance on preparing the 2020/21 Whole of Government Accounts (WGA) for local government and for central government bodies. WGA is prepared by Treasury and consolidates bodies in the UK that exercise functions of a public nature or are funded from public money.

2. Data is collected for the 2020/21 WGA by bodies inputting information directly to the Online System for Central Accounting and Reporting (OSCAR II). Bodies are exempt from the WGA process if their gross expenditure, gross income, gross assets, and gross liabilities are below £30 million for both 2019/20 and 2020/21.

3. Paragraph 1.7.1 sets out the key dates for 2020/21 WGA as summarised in the following table:

Cycle	Return	Submission date
1	Unaudited	31 July
2	Audited	31 August

4. A diagram at paragraph 4.2.2 of the guidance sets out the steps involved in the WGA submission process. The steps depend on whether the body is above the audit threshold. Paragraph 1.7.2 advises that the threshold for audit is breached if any of total assets (excluding property, plant and equipment), total liabilities (less pension liabilities), total income or total expenditure is above £2 billion.

5. Although the guidance states that the deadlines and thresholds may be different in Scotland, the Scottish Government subsequently confirmed that they apply unchanged.

6. Annex A provides a summary of the proforma tabs used to input data. Chapter 7 provides more detailed guidance on inputting data into the tabs. Paragraph 7.2.7 explains that the Audit Report is a view of all data submitted which can be shared with auditors. It may be appropriate, as a new facility for 2020/21, to download the individual tabs instead, and also run the new primary financial statements report.

7. A key part of the WGA process is the elimination of transactions and balances between WGA bodies. Recording complete and accurate counter-party identifier (CPID) information is the only way in which transactions and balances between WGA bodies can be identified and eliminated. Paragraph

6.3.4 explains how bodies can run a Matches Analysis Tool which allows them to see ‘live’ published data from other bodies. Central government bodies are required to formally agree transaction streams and balances that are above £5 million with central government counterparties.

8. A TGN on the evaluation by auditors of the 2020/21 WGA submissions will be provided by Professional Support in due course.

Identification of audited part of Remuneration Report

9. Professional Support has identified that some audited bodies may not be clearly and accurately identifying the part of the Remuneration (and Staff) Report that is subject to audit. The following guidance is intended to assist in that regard.

10. For local government bodies, the Schedule to The Local Authority Accounts (Scotland) Regulations 2014 (accounts regulations) is the main reference source for the Remuneration Report. In summary:

- the items set out at paragraphs 4 to 12 of the Schedule are subject to audit
- the narrative information on remuneration arrangements required by paragraphs 2 and 3 are not audited.

11. In addition, The Trade Union (Facility Time Publication Requirements) Regulations 2017 require employers to publish information in relation to trade union facility time. Guidance from the Cabinet Office indicates that disclosure should be in the Remuneration Report. This information is not subject to audit.

12. The Code of Practice for Local Authority Accounting in the UK (accounting code) requires local authorities to disclose members' salaries, allowances and expenses. Some authorities choose to make the disclosure in the Remuneration Report while others include it as a note to the financial statements. Regardless of where it is disclosed, the information requires to be audited.

13. Finance Circular 8/2011 (paragraph 5) requires local authorities to clearly identify those parts of the Remuneration Report that are subject to audit, and provides illustrative wording. It should be noted that the wording:

- used in the unaudited financial statements should state that the information ‘will be audited’ but the tense should be updated to ‘has been audited’ in the audited financial statements
- needs to reflect that any disclosure of members' salaries, allowances and expenses requires to be audited.

14. For central government bodies and health boards, the requirements for a Remuneration and Staff Report are set out at section 6.5 of the FReM. Information subject to audit is set out at paragraphs 6.5.8 to 6.5.30, and 6.5.31 b) and l). The FReM requires bodies to clearly identify the information as audited. The part of the Remuneration Report that is audited is covered by the opinion on the Remuneration Report.

15. The items required by FReM paragraph 6.5.7 and the other elements of paragraph 6.5.31 are not audited. The unaudited part is statutory other information and should be treated and reported on accordingly.

16. Auditors should check that bodies have correctly and clearly identified the part of the Remuneration Report that is subject to audit, and request amendments where necessary.

3: Local government sector

Contact: Paul O'Brien, Pobrien@audit-scotland.gov.uk

Proposed revisions to accounting code

17. The CIPFA/LASAAC Code Board has issued an Invitation to Comment (ITC) that sets out proposed revisions to the accounting code in respect of infrastructure assets.

18. The proposed revisions would apply on a temporary basis up to and including 2022/23, pending a longer-term solution. Responses were required by 14 June 2022.

19. The proposed temporary revisions are in response to issues relating to the derecognition of replaced parts of infrastructure assets. The specific issue is whether local authorities are assessing any undepreciated cost remaining in the replaced parts at the point the replacement parts are added. There are concerns that assessment may not be happening for infrastructure assets due to significant practical difficulties such as:

- it not generally being possible to identify parts of infrastructure assets as the engineering records were not designed to map against identifiable parts
- information on previous historical repairs not being available in a meaningful or identifiable way
- information deficits in relation to historical expenditure on assets created before 1994/95, which were measured on recognition at 'capital undischarged' rather than at historical cost
- issues where assets have been transferred to local authorities on reorganisation.

20. The ITC proposes a temporary adaptation to IAS 16 Property, Plant and Equipment to the effect that it is reasonable to assume that the net book value of replaced parts of infrastructure assets is zero. This is on the basis that parts are rarely replaced before they are fully consumed.

21. The adaptation, however, does not address the overstatement of gross book value and accumulated depreciation of infrastructure assets caused by the failure to derecognise the cost and accumulated depreciation of replaced parts. A second temporary adaptation to IAS 16 is proposed therefore to remove the requirement for those amounts to be disclosed in the financial statements. This is considered to be justified on the basis that this information is not useful to users of the financial statements.

22. In light of the challenges of developing an effective depreciation policy for infrastructure assets, the ITC also proposes that the accounting code should provide guidance to assist in this area. There is a proposed interpretation indicating that it may be appropriate for the pattern of consumption of economic benefits to be reflected by means of weighted average useful lives of the different parts of the asset.

23. CIPFA/LASAAC is considering longer-term solutions to these issues and will consult on proposals in due course.

Draft bulletin on infrastructure assets

24. The Chartered Institute of Public Finance and Accountancy (CIPFA) has issued a draft bulletin which is intended to accompany the proposed changes to the accounting code in relation to infrastructure assets. Responses were also required by 14 June 2022.

25. Section 2 of the draft bulletin is on materiality and is intended to help local authorities in making estimations. It advises authorities to consider the information which will be useful to the users of the financial statements for taking economic decisions. Paragraph 31 states that, although the cost of infrastructure assets will be material, for most authorities the incomplete data held on infrastructure assets will limit the usefulness of the figures.

26. Paragraph 34 expands on the proposed adaptation that the net book value of replaced parts of infrastructure assets may be zero. Local authorities have generally applied the accounting code in such a way that, where expenditure has taken place to replace a part of the infrastructure assets, the carrying amount of the replaced part of the asset derecognised is in effect derecognised at a zero amount. This is consistent with the approach that authorities only replace parts of infrastructure assets when they have been fully consumed.

27. If applied by a local authority, the proposed adaptation will need to be carefully reported in the accounting policies. This will need to:

- set out the measurement base for infrastructure assets and the changes in place as a result of the temporary changes to the accounting code
- note the adaptation for derecognition when replacement/renewals expenditure has taken place, except where there has been a disposal of a part of the infrastructure
- reflect accounting policies which effectively measure the consumption pattern of the economic benefits of the parts of the infrastructure asset
- note that gross historical cost or accumulated depreciation has not been reported (where the authority uses that option).

28. An illustrative accounting policy is included in Annex A to the draft bulletin.

29. Section 5 provides guidance on the depreciation of infrastructure assets to support the proposal for a weighted average useful life approach. Determining the depreciation charge for infrastructure assets is difficult as these take the form of a network of assets where there are many different components working as a part of a continuous network maintained in a relatively steady state.

30. The bulletin states that it would be reasonable to use the parts of the network which were defined in the Code of Practice on the Highways Network Asset, i.e., carriageways, footways and cycle tracks, structures, street lighting, street furniture and traffic management systems. The methodology set out in sections 5.2 to 5.8 of the draft bulletin illustrates how weighted averages might be calculated for each. They provide examples where the local authority has information on gross historical cost for different parts of the highways network, or may be able to estimate it on a reasonable basis.

Learning points for 2021/22 IARs

31. Professional Support has issued a briefing* to set out learning points for auditors when preparing Independent Auditors' Report (IARs) for 2021/22. The points arose from a review of the 2020/21 IARs of local authorities which evaluated compliance with the model forms of IAR and auditor actions set out in TGN 2021/5(LG).

32. A summary of findings is provided at section 1 of the briefing with specific areas for improvement highlighted at section 2. The review found a very good level of compliance with the auditor actions set out in the TGN. However, two significant areas for improvement were identified by the review:

- At one local authority, the auditor did not use the wording specified to explain the extent to which the audit is considered capable of detecting irregularities including fraud.
- At another authority, the auditor failed to report that a significant trading operation had failed to meet the prescribed financial objective.

33. The review also identified other issues where it may not have been clear to users what statements had been audited. For example, in half of IARs auditors did not:

- use the precise titles of the financial statements used by the local authority
- ensure that the local authority had properly described the parts of the Remuneration Report that had been audited.

34. Auditors should ensure the areas for improvement are addressed for their IARs in 2021/22.

New statutory Guidance on deferring loans fund repayments

35. The Scottish Government has issued Finance Circular 5/2022 which provides statutory guidance that sets out disclosure requirements where a local authority defers loans fund repayments.

36. Technical Bulletin 2022/1 (paragraph 20) highlighted that The Local Authority (Capital Finance and Accounting) (Scotland) Regulations 2016 had been amended to permit a local authority to reduce the statutory repayments of loans fund advances in any one of the financial years 2020/21, 2021/22 or 2022/23. If an authority adopts that option, repayment of the reduced amount requires to be repaid within the shorter of:

- the remaining period of the loans fund advance
- twenty years.

37. The statutory guidance requires a local authority to disclose in a note to the financial statements:

- the amount of the repayment that has been deferred. This should be disclosed in the year of deferral, but any deferral in 2020/21 should be disclosed in 2021/22.
- the term over which the deferred repayments will be repaid.

38. Where a local authority deferred loans fund repayment in either 2020/21 or 2021/22, auditors should evaluate whether the disclosures required by the statutory guidance have been properly made in the 2021/22 financial statements.

2021/22 guidance on accounting for COVID-19 grants

39. The Local Authority (Scotland) Accounts Advisory Committee (LASAAC) has issued guidance on the classification between agency and principal for COVID-19 related grants in 2021/22.

40. Appendix 1 of the guidance includes an assessment of the appropriate classification to inform the judgements of local authorities and integration joint boards (IJBs). The guidance advises that local authorities should apply Appendix 1 on a 'comply or explain' basis.

41. In Professional Support's view, a 'comply or explain' basis means that any local authority that does not follow the classification in Appendix 1 should disclose that fact and the reason why in a note to the financial statements. Professional Support also considers that the same basis should apply to IJBs for consistency.

42. Appendix 1 advises that local authorities are the principal for most funding stream elements of General Revenue Grant (GRG) in Finance Circulars 5/2021 and 1/2022. However, the following two elements of GRG should be classified as agency transactions because the Scottish Government set the amounts and criteria for payment:

- Low Income Pandemic Payments
- Scottish Child Payment Bridging Payments.

43. Local authorities act as agents for the Scottish Government for most specific COVID-related grants. The details for these are set out in various letters from the Scottish Government.

44. As with the guidance for 2020/21, local authorities are considered to be acting as agents when making the £500 payments to health and social care staff, including to their own staff.

45. Appendix 1 advises that IJBs, with the exception of hospice funding, are usually the principal for COVID funding. This classification includes supplier sustainability payments to social care providers as IJBs have a significant degree of discretion.

46. Auditors should evaluate whether:

- local authorities have appropriately classified COVID-19 related grants in 2021/22 between those where the authority is acting as the agent of the Scottish Government and those where the authority is the principal in the transaction
- and explanation has been disclosed where the authority's classification differs from that set out at Appendix 1 of the guidance.

Guidance on 2021/22 financial statements

47. CIPFA has issued Bulletin 10 which provides guidance on the 2021/22 financial statements. The guidance is intended to be best practice, but it does not have the formal status of the accounting code.

48. The following items in the guidance are relevant to Scottish local government:

- Adoption of IFRS 16 Leases before 2024/25
- Valuation of operational property assets
- Critical judgements and estimation uncertainty
- Financial reporting deadlines for 2021/22
- Working papers
- Accounting standards issued but not yet adopted
- Accruals for pay awards in 2021/22
- Infrastructure assets.

Adoption of IFRS 16 before 2024/25

49. Section 1 of the bulletin refers to the latest statement from CIPFA/LASAAC on its decision to defer the mandatory implementation of IFRS 16 until 1 April 2024 (and therefore in the 2024/25 accounting code).

50. However, the accounting code will allow for adoption before 2024/25. The bulletin provides guidance for authorities intending to adopt the standard in 2022/23. Those authorities should:

- advise CIPFA of their intention to adopt (paragraph 1.4)
- disclose IFRS 16 in 2021/22 as a standard issued but not yet adopted (paragraph 1.5)
- follow the provisions for adoption before 2024/25 that will shortly be set out in the 2022/23 accounting code (paragraph 1.7).

Valuation of operational property assets

51. Section 2 of the bulletin reminds local authorities of the key requirements of the accounting code in respect of the valuation of operational property. These include the following:

- The accounting code requires revaluations to be made with sufficient regularity to ensure that the carrying amount of an asset does not differ materially from current value (paragraph 2.2).
- Local authorities need to determine a valuation frequency for operational property based on the expected significance and volatility of changes in current value The accounting code sets five years as the maximum interval between formal valuations. However, where a property experiences significant and volatile changes in current value, an annual revaluation is required (paragraphs 2.3 to 2.5).
- Where a local authority uses 1 April 2021 as the valuation date for 2021/22, the authority needs to consider any movements in value during the year that should be reflected in the 31 March 2022 carrying amount. Where a valuation has been carried out as at 1 April 2022, local authorities should consider this an adjusting event in 2021/22 on the basis that it provides evidence of conditions that existed at 31 March 2022 (paragraph 2.6).

Critical judgements and estimation uncertainty

52. Section 3 provides good practice guidance on meeting the requirements of the accounting code for disclosing critical judgements and sources of estimation uncertainty.

53. Key aspects of the guidance include the following:

- The following two separate notes are required:
  - one that details the decisions taken (i.e. judgements) in applying accounting policies
  - a second note that sets out the assumptions made in calculating estimates that have the greatest risk of being materially incorrect in the next 12 months.

- Only the most significant judgements require to be disclosed (paragraph 3.8), e.g:
  - where the matter was complicated
  - a different conclusion would have resulted in a material difference in the financial statements; and
  - the final assessment finely balanced.
- Judgements not to take action also need to be covered, e.g. a decision that group accounts are not required where they could reasonably be expected (paragraph 3.9).
- Disclosure is only required in relation to assumptions that have a significant risk of resulting in material adjustments to the estimate in the next financial year, not to all assumptions that involve material balances of assets or liabilities (paragraph 3.14).
- The estimates note does not cover those that are not based on attempting to see into the future. For example, estimates that are made for reasons of efficiency (e.g. property valuations using beacon principles) are excluded (paragraph 3.15).

Working papers

54. Section 13 highlights that some local authorities have diverted staff resources away from completing working papers and preparing the financial statements, while the quality of processes within the finance functions has affected their preparedness for audit.

55. The bulletin reminds authorities of the recent CIPFA guidance on streamlining the annual accounts, which includes advice on preparing good quality working papers. Paragraph 13.4 of the bulletin provides a summary of the advice, which includes the following points:

- Spreadsheets, ledger reports and journal postings are unlikely to be sufficient without additional explanations of where the information has come from and what the preparer was trying to achieve.
- All working papers should be internally consistent and agree with the amounts in the financial statements submitted for audit.
- Reconciling items, mis-postings and suspense account items should all be resolved pre-audit.

Accounting standards issued but not yet adopted

56. Paragraph 15.3 lists the following standards introduced by the 2022/23 accounting code which may require to be disclosed in 2021/22 as standards issued but not yet adopted:

- IFRS 16 (for those authorities planning on a 2022/23 adoption).

- Annual Improvements to IFRS Standards 2018-2020, but it is not expected that any of the improvements will have a significant effect on a local authority's financial statements.

- An amendment to IAS 16 which prohibits an entity from deducting from the cost of property, plant and equipment amounts received from selling items produced while the asset is under construction.

Accruals for pay awards in 2021/22

57. Paragraph 16.1 confirms that any amounts unpaid at 31 March 2022 in relation to agreed pay awards for the 2021/22 year will need to be accrued in the 2021/22 financial statements.

58. Paragraph 16.2 clarifies that the accrual should include employers' on-cost (i.e. employers' national insurance contributions and employers' pension contributions).

Infrastructure assets

59. Section 17 of the bulletin refers to the derecognition of parts of infrastructure assets described earlier in this section. Paragraph 17.8 of the bulletin encourages local authorities to:

- consider in detail the financial information they hold on their infrastructure assets

- ensure they have an effective depreciation policy for those assets.

2021/22 report on actuarial information

60. Professional Support has arranged for PWC to provide a report* to support auditors when assessing the competence and objectivity of, and assumptions and approach adopted by, actuaries producing information required by IAS 19 figures in respect of the Local Government Pension scheme (LGPS) as at 31 March 2022. Auditors should refer to paragraphs 15 to 27 in Module 4 of TGN 2021/8(LG) for guidance on using the report and further information.

61. PWC have confirmed the competence and objectivity of the actuaries involved in valuations for the LGPS in Scotland. They are also comfortable that in aggregate the assumptions adopted by all actuaries will lead to liabilities falling within their expected ranges for a typical employer at 31 March 2022.

62. However, the report advises auditors to consider whether:

- local issues have been adequately covered in instructions issued by employers to actuaries (page 3)

- to subject the source data provided to the actuaries by employers to further audit procedures as discussed in section 4 of the report

- to establish actual asset returns and compare them with expected returns arrived at using market indices (see page 22).

63. Page 17 of the report addresses accounting for plan amendments, curtailments, and settlements (special events) under IAS 19. Auditors need to understand whether any significant special events have occurred, and whether profit and loss items have been remeasured from the date of the event for the remainder of the accounting period. This entails remeasuring both the assets and liabilities using assumptions set at this date. The report confirms that all actuaries are aware of the IAS 19 requirement.

64. Page 18 of the report provides an update on Guaranteed Minimum Pension (GMP) indexation and equalisation, the McCloud judgement and other legal cases. In summary:

- There have been no relevant developments related to GMP and all actuaries are following an approach in 2021/22 consistent with 2020/21
- The only relevant development in respect of McCloud was confirmation that the remedy set out in the consultation paper would be adopted. The actuaries had followed the consultation in making adjustments in 2020/21, and therefore no further change is required.
- Actuaries do not intend making any specific allowance for the Goodwin, O'Brien or similar cases, unless requested to do so.

65. Page 19 highlights the issue of pay awards that have been backdated to 1 January 2021. If the backdated pay award has been paid before 31 March 2022, it may affect the following three areas:

- Auditors need to consider any actions where contribution figures for February and March are based on estimated figures, as the overall contribution figure could be understated if they do not include the backdated pay award.
- Similarly, auditors need to consider whether pensionable pay figures are based on estimated figures
- Although there may be an impact on past service final salary benefits and the McCloud allowance, actuaries do not ordinarily allow for salary experience differences between triennial valuations. Any impact will therefore come through when the IAS 19 figures are based on a new triennial valuation as at 31 March 2024.

Guidance on objections to 2020/21 annual accounts

66. Professional Support has published TGN 2022/3(LG) to provide auditors with guidance on the right of an interested person under section 101 of the Local Government (Scotland) Act 1973 to:

- inspect the unaudited 2021/22 annual accounts of a local government body

- object to those accounts.

67. The TGN is available with supporting material to auditors on SharePoint* and is also freely available from the Audit Scotland website.

68. Auditors should:

- evaluate whether the public inspection notice for 2021/22 is in accordance with applicable legislation
- carry out the actions set out in the TGN for any objections received.

Guidance on 2021/22 accounts approval and publication dates

69. The Scottish Government has issued Finance Circular 6/2022 to provide guidance on the extension to the approval and publication dates for the 2021/22 annual accounts of local government bodies due to the amendments to the accounts regulations (explained at paragraph 20 of Technical Bulletin 2022/1).

70. In summary, the dates have been amended as follows:

- Regulation 10(1) requires a local authority to aim to approve the audited annual accounts no later than 30 November 2022 (deferred from 30 September)
- Regulation 11(3) requires the approved audited annual accounts to be published no later than 15 December 2022 (deferred from 31 October)

71. The circular confirms that there is no date set in the regulations for audit completion but reiterates that Audit Scotland has set a completion date of 31 October 2022 for 2021/22 audits. This is earlier than the extended statutory deadline to commence the transition back to regular timescales.

2021/22 NDR return and guidance

72. The Scottish Government has issued the 2021/22 Non-domestic rates notified return and guidance*. The most significant changes for 2021/22 are summarised in the following table:

Line	Relief	Change
N/A	General relief	The general relief that was introduced in 2020/21 has been removed.
	Subsidy control	State Aid is now Subsidy Control and the cap on the aggregate amount that can be awarded in specified non-domestic rates relief is 325,000 Special Drawing Rights (which are units of account maintained by the International Monetary Fund).
8	Fresh start relief	The threshold has increased to £95,000 (from £65,000).

Line	Relief	Change
16	District heating relief	A new relief of 90% has been introduced for premises used for a district heating network installed on or after 1 April 2021 powered by renewables
21 to 22	Business growth accelerator relief	The relief is now available where there is an increase in rateable value due to a change in the way the property is being used.
27	Retail, hospitality, leisure and airport relief	An application is required for 2021/22
30 to 31a	Sports club discretionary relief	A new requirement that the relief supports affordable community-based facilities, rather than members' clubs with significant assets.

73. Professional Support has published TGN/NDR/22 on certifying the 2021/22 non-domestic rates return. The TGN is provided with supporting material to auditors on SharePoint* and also on the Audit Scotland website.

74. Auditors should certify 2021/22 NDR returns using TGN/NDR/22.

Housing benefit subsidy

75. The Department for Work and Pensions (DWP) has issued the following modules of the Housing Benefit Assurance Process (HBAP):

- Module 2* uprating checklist to help auditors ensure that the authority's system is using the correct benefit parameters to calculate benefit entitlement and for the authority to claim the correct amount of subsidy.
- Module 3* comprising workbooks to be completed for detailed testing.

76. Professional Support has been discussing with the DWP changes to the testing required for the certification of the subsidy claim. This has delayed the production of the TGN. The DWP submission deadline for the HB subsidy certification is 31 January 2023.

4: Central government sector

Contact: Neil Cameron, Ncameron@audit-scotland.gov.uk

Disclosure guide for 201/22 financial statements

77. The National Audit Office has published a disclosure guide on the 2021/22 financial Statements for bodies covered by the Government Financial Reporting Manual (FReM).

78. The guide is designed to ensure that bodies covered by the FReM have prepared their 2021/22 financial statements in the appropriate form and have complied with all disclosure requirements. The guide is cross-referenced to the 2021/22 FReM, individual financial reporting standards, and the Companies Act 2006. A tailored checklist can be generated by selecting the criteria that are material to the body.

79. When checking that the FReM's disclosure requirements have been met, auditors should in accordance with the Overview Module of TGN 2022/1:

- consider requesting that the body completes the disclosure checklist
- investigate the reasons for any non-compliance that the guide highlights
- evaluate whether the body's responses in the checklist are consistent with auditor's knowledge.

Amendments to SPFM

80. The Scottish Government has issued Finance Guidance Note 2022/02 to announce amendments to the borrowing, lending and investment chapter in the Scottish Public Finance Manual (SPFM). The guidance in respect of investment in private businesses by Scottish Ministers contained in Annex A has been strengthened based on recent experience of interventions in private companies. The amendments include:

- outlining the overarching principles which any investment proposal should take into account. Any proposal must be contingent upon the completion of satisfactory due diligence and demonstrate a clear policy rationale
- additional guidance on commercial risk and the importance of considering individual transaction risk
- more prescriptive language where appropriate, balanced against the aspects of the framework that are principles-based.

Technical consultations with auditors

Professional Support responds to requests from auditors for technical consultations

81. The following tables summarise requests from auditors for technical consultations with Professional Support in respect of issues arising from the audit of the 2021/22 annual accounts of central government bodies, along with the advice offered:

How should a negative pension benefit be treated in a director's total remuneration figure? How should any negative components in the pension benefit calculation be treated?

The increase in value of pension benefit is a component of the total remuneration figure. The FReM requires bodies to use the methodology for calculating remuneration set out in the relevant Employer Pension Notice (EPN). EPN 647 provides an explanation of where an increase could be negative and states that the scheme administrator will explain the reasons where that is the case. The EPN is silent on whether the negative pension element should be included in remuneration in the relevant column in the remuneration table or be replaced with a zero. However, the FReM's requirements are based on The Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008 which explicitly require that, where calculations (other than in respect of a recovery or withholding) result in a negative value, the result should be expressed as zero in the relevant column in the remuneration table. Professional Support would therefore expect central government bodies to adopt the same treatment but there does not appear to be an explicit requirement to do so.

This approach would be consistent with health boards because, as advised in Module 13 of TGN 2022/1, the accounts manual explicitly requires health boards to express a negative pension benefit as a zero.

The replacement of a negative value with a zero applies only to the calculated result and not to individual components of the calculation. For example, if the real increase in lump sum is negative, that amount should be netted off the real increase in pension in the calculation.

In the fair pay disclosures, what is the difference in principle between (1) the average percentage change in employee salary and allowances and (2) the change in median pay ratio?

The median pay relates to the individual in the middle of the pay range for the body. The median pay ratio is the remuneration of the highest paid director relative to the median pay. Bodies are required by the FReM to make various disclosures, including the change in the median pay ratio since the previous year.

The average percentage change in employee salary and allowances is the total for all employees on an annualised basis (excluding the highest paid director) divided by the FTE number of employees (excluding the highest paid director). This is a new disclosure for 2021/22.

Should payments made in lieu of notice be included in the disclosure of exit packages?

Exit packages for the purposes of disclosure in the annual accounts relate to an individual ceasing to be an employee of a public body in exchange for compensation which requires the agreement of the body. This includes:

- settlement agreements (used to settle an employment dispute)
- voluntary severance (used where the post or skills no longer exist following a restructuring and redeployment is problematic).

The costs associated with an exit package relate to payments that are contractual (those which would be received in the normal course of employment) and non-contractual (those offered on a discretionary basis). It is expected that payment in lieu of notice would be a contractual payment. However, the SPFM expects that notice should be worked by the individual rather than a payment being made in lieu of notice. Where, exceptionally, payment in lieu of notice is made in respect of an agreed exit package, it should be included in the disclosure.

There is no requirement to disclose exit packages which do not require the agreement of the public body (such as where a person exercises a contractual right to leave employment on the grounds of ill health). Any payment in lieu of notice associated with such exit packages does not therefore require to be disclosed.

5: Health sector

Contact: Neil Cameron, Ncameron@audit-scotland.gov.uk

Revised accounts direction from 2021/22

82. The Scottish Government has issued health boards with a revised account directions which applies with effect from the 2021/22 annual report and accounts.

83. The revised direction includes specific reference to the Manual for the Annual Report and Accounts of NHS Boards, Capital Accounting Manual and the SPFM. This replaces the more general reference (to the accounts format, disclosure and accounting requirements issued by the Scottish Ministers) included in previous directions. There is, however, no change to the financial reporting framework.

84. The direction also states that boards are required to use the accounts template when preparing their accounts. However, a subsequent letter from the Scottish Government (see following item) clarifies that the requirement applies only to the Scottish Government Consolidated Accounts. Boards are still able to produce their published accounts in a different format, but they must submit the completed accounts template to the Scottish Government for consolidation purposes. Auditors are still required to complete an assurance statement stating whether the completed templates are consistent with the audited accounts.

85. The direction is required to be included in the published annual accounts. Auditors should confirm that boards include the revised version of the direction in 2021/22.

Guidance on 2021/22 arrangements

86. The Scottish Government has issued a letter* on the year-end arrangements for the 2021/22 annual report and accounts. The letter is intended to clarify certain aspects of the process.

87. The letter advises that it is too early to determine the potential implications of the legal ruling on discharging untested COVID-19 patients into care homes. Therefore, the Scottish Government do not believe that boards should be making any specific disclosures in relation to this matter in 2021/22.

88. The letter clarifies that:

- the threshold for the agreement of balances with other NHS Scotland bodies is £200,000 rather than the £100,000 specified in the accounts manual
- income from donated assets is no longer disclosed in note 7d and is instead disclosed in note 2a Summary of Revenue Outturn. The template

also includes this change in the prior year comparators. This will impact on the 2020/21 capital outturn for boards that received donated assets in 2020/21. The letter provides a suggested explanatory footnote for boards affected.

89. As stated in the previous item, the letter also explains that the reference in the revised accounts direction to boards being required to use the accounts templates applies only to the Scottish Government Consolidated Accounts.

Accounting for PPE and testing kits

90. NHS National Services Scotland (NSS) has provided health boards with estimates of the notional costs of personal protective equipment (PPE) and testing kits provided free of charge in 2021/22. This includes equipment supplied by the Scottish Government but also includes equipment from the UK Government, which should be recognised as a donation. The accounting entails recognising a non-cash grant at fair value and an equivalent amount of notional expenditure.

91. The auditor of NSS has reviewed the methodology used to arrive at the estimates provided to boards and concluded that the allocations are reasonable.

Assurance report on 2021/22 clinical negligence claims

92. Professional Support has issued a report to auditors following an examination of the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS). The purpose of the report is to:

- provide assurance on the methodology used by the Scottish Government in the calculation of the CNORIS national obligation at 31 March 2022
- inform auditors' evaluation of the role of the NHS Central Legal Office as a management expert.

93. Auditors should refer to this report when auditing the 2021/22 provisions for CNORIS.

6. Professional developments

Proposed revisions to PN 10

94. The Public Audit Forum has issued an exposure draft of proposed revisions to Practice Note 10 Audit of Financial Statements and Regularity of Public Sector Bodies in the UK (PN 10).

95. Part 1 of PN 10 sets out how auditors of public sector bodies apply auditing standards to their work on financial statements. The aim is to support consistency in the application of auditing standards while also recognising the specific legislative and regulatory frameworks that apply to the audits of public sector bodies. Part 2 provides guidance on the approach to the audit of regularity.

96. PN 10 was last revised in 2020 and there is a need to ensure it is updated to take account of changes to standards and other developments in the auditing profession. Comments on the consultation should be sent to PracticeNote10@public-audit-forum.org.uk by 16 September.

97. The main proposed changes are summarised in the following table:

Section	Pages	Summary of proposed revisions
ISQM (UK) 1	14 - 20	There are revisions to existing material on ISQC 1 to reflect its replacement by ISQM 1 in respect of systems of quality management. Most of the proposed changes apply to contracted out audits and therefore do not apply in Scotland (which uses an appointments basis). Revisions that apply in Scotland are the following: • Paragraph 1-23 has been added to advise that public sector auditors may determine that an engagement quality review is appropriate for bodies judged to have a high public profile. • Paragraph 1-27 has been added to explain that the individual assigned operational responsibility for the system of quality management in the national audit agencies may not be eligible for appointment as a statutory auditor under the Companies Act 2006. However, the national audit agencies comply with ISQM (UK) 1 by ensuring that the individuals have levels of experience, knowledge, influence and authority such that they are capable of fulfilling the role of engagement partner as defined in auditing standards. This is considered to be equivalent to the levels required to achieve eligibility for appointment as a statutory auditor.

Section	Pages	Summary of proposed revisions
ISA (UK) 240	22 - 25	Paragraphs 1-40 to 1-44 have been added to provide guidance on the interaction between fraud and regularity responsibilities. This includes the following points: • The public sector auditor's responsibilities relating to fraud under ISA (UK) 240 are interrelated with the work that underpins the regularity opinion. However, the audit of regularity is not in itself sufficient to provide reasonable assurance about whether the financial statements as a whole are free from material misstatement due to fraud. • The term 'irregularities' refers to instances of non-compliance with laws and regulations, including fraud. In the context of the regularity opinion, the term 'irregular transactions' refers to transactions not in accordance with the framework of authorities. • An irregular transaction may not be an irregularity (e.g. a breach of spending controls may not be unlawful). However, it is likely that transactions relating to an 'irregularity' would also be irregular transactions for the purpose of the regularity opinion. • Even where fraud does not result in misstatement of the financial statements, it may result in transactions that are not in accordance with the framework of authorities. The public sector auditor's responsibilities under ISA (UK) 240 in respect of reporting fraud or suspected fraud extend to such cases.
ISA (UK) 315	29 - 33	There are various proposed revisions to reflect the July 2020 revision of ISA (UK) 315. Key changes include the following: • Paragraph 1-73 explains that ownership of a public body may not have the same relevance as in the private sector because decisions related to the body may be made outside of the body as a result of political processes. Relevant matters include understanding the ability of the body to make unilateral decisions and the ability of other public sector bodies to control or influence it. • Paragraph 1-79 has been added to provide examples of inherent risk factors that may be particularly relevant to public bodies under the categories of inherent risk factors of complexity, subjectivity, change, uncertainty and management bias. • The guidance in paragraph 1-80 on the situation where public bodies are required to work to annual limits on resources has been extended. It explains that the risk of transactions being recorded in the wrong accounting period is increased due to an incentive for an entity to bring forward or delay expenditure or capital additions depending on its expected outturn against these limits. The risk of misclassification is also increased as there is an incentive to recognise items in a manner that increases outturn against limits that are underspent and reduces outturn against limits that are overspent.

Section	Pages	Summary of proposed revisions
ISA (UK) 320	34 - 35	Existing guidance at paragraphs 1-87 and 1-88 has been expanded including providing further examples for determining materiality in the public sector. Key points include: • Attention has been drawn to paragraph A20 of ISA (UK) 450 which highlights circumstances where misclassifications between balance sheet items that do not affect the performance statement may not be considered material. • In some public sector bodies, the value of gross assets and/or liabilities is much higher than the value of total expenditure and income. Where the audited body has custody of significant public assets, their service potential is an important contributor to the body's ability to deliver its services, which may make them an appropriate benchmark for setting materiality for the financial statements as a whole. • Example 5 has been added on setting materiality where the audited body's accounts include high-value property, plant and equipment, but its day-to-day decision making focuses on much lower-value expenditure and income transaction streams. Auditors may determine materiality for the financial statements as a whole using gross assets as a benchmark and also determine a lower materiality level to be applied to transaction streams.
ISA (UK) 570	46 - 56	The following additional clarification has been added for bodies where the financial reporting framework provides for the adoption of the going concern basis due to the anticipated continuation of the provision of a service in the future: • Paragraph 1-156 explains that the factor relevant to the auditor's work on going concern is whether the services will continue rather than the continued existence of the audited body itself. • Paragraph 1-162 clarifies that uncertainty regarding the future existence of the audited body does not create a material uncertainty, provided that this uncertainty does not also extend to the future delivery of the services.
ISA (UK) 600	57 - 59	Paragraph 1-195 has been added to provide guidance on cases where those charged with governance is unclear. It advises that those charged with governance are the persons or organisations with responsibility for overseeing the financial reporting process relating to the combined financial statements. This group may have responsibility for overseeing the strategic direction and obligations related to the accountability of the sector to which the financial information included in the combined financial statements relates.

Section	Pages	Summary of proposed revisions
Revised Ethical Standard	66 - 68	A new section has been added (paragraphs 1-227 to 1-233) on applying the revise ethical standard to the public sector. For example, paragraph 1-232 explains that in the public sector it may not be possible to comply strictly with the engagement partner rotation requirements envisaged for listed entities. Nonetheless it may be in the public interest for public sector organisations to establish policies and procedures to promote compliance with the spirit of rotation of engagement partner responsibility
Materiality for the audit of regularity	77 - 78	Paragraph 2.34A has been added to provide examples of situations when auditors may determine a materiality threshold for the audit of regularity that is different to that determined for the financial statements as a whole. These include where: • the audited body makes payments to individuals or other bodies that are of significantly greater public interest than the administrative functions of the body itself • the benchmark used to determine materiality for the financial statements as a whole has increased significantly but there remains user interest in the regularity of transactions at a more granular level • aspects of the audited body's framework of authorities and/or regulatory oversight regime indicate that quantitatively small non-compliance with the framework of authorities would be perceived more seriously than from assessing the amounts against materiality for the financial statements as a whole • the benchmark used to determine materiality for the financial statements as a whole is based on assets or liabilities and these amounts are out of proportion to the expenditure and income transactions that are subject to the regularity opinion.

BEIS response on restoring trust in audit consultation

98. The Department for Business Energy and Industrial Strategy (BEIS) has issued a response to its consultation on restoring trust in audit and corporate governance (explained in Technical Bulletin 2021/1 – paragraph 75).

99. The response does not set out a timetable for implementing the proposals, but rather outlines the actions to be taken, including what the UK Government intends to ask of the regulator and other stakeholders.

New regulator

100. Section 10 confirms the proposals to establish the Audit, Reporting and Governance Authority (ARGA) as a new regulator with the overarching objective to protect and promote the interests of investors, other users of corporate reporting and the wider public interest. ARGA's operational objectives will focus on quality, competition and acting as an effective 'system leader' for local public audit in England.

101. The reforms will give ARGA a range of statutory responsibilities and powers that the Financial Reporting Local authority does not have. These include:

- formalised responsibility for overseeing the accounting and actuarial professions
- a stronger role in auditor registration
- new powers to tackle breaches of company directors' duties relating to corporate reporting and audit.

102. Section 4 explains that ARGA will exercise oversight of corporate reporting to raise standards and improve the informativeness of company reports. For example, ARGA will be able to:

- direct changes to company reports and accounts
- publish summary findings following a review
- require or commission an expert review to support its corporate reporting review work
- review the entire contents of the annual report and accounts, including corporate governance statements and any voluntary reports.

Extension of PIE definition

103. Section 1.6 advises that the definition of public interest entities (PIEs) is to be extended to include large private companies which have both more than 750 employees and an annual turnover of more than £750 million. These size-based PIEs will not be required to meet all of the audit requirements as existing PIEs.

104. Public bodies such as local authorities will not become PIEs by virtue of this new size-based tests. However, those public bodies that are PIEs under existing legislation will continue to be so.

Internal controls and fraud prevention

105. The consultation proposed requiring directors to report on a company's internal controls and fraud-prevention measures, with auditors providing assurance on the latter.

106. However, section 2.1 of the response advises that the Government believes a more incremental approach to strengthening the internal control framework would be appropriate. It will therefore invite ARGA to strengthen the UK Corporate Governance Code to provide for an explicit directors' statement about the effectiveness of the company's internal controls and the basis for that assessment, and to develop appropriate guidance.

107. Section 6.2 explains that legislation will require directors of size-based PIEs to report on actions they have taken to prevent and detect fraud. Auditors will be required to fulfil the existing requirements of ISA (UK) 720 with respect to the directors' statements on fraud, and the Government considers that will be

sufficient. Before considering further action, the Government intends to wait to see if the revisions to ISA (UK) 240 have the anticipated effect in clarifying what is expected of auditors in explaining the work they have done to detect fraud.

Improving the informativeness and quality of audit

108. Section 6.1 covers the proposals in respect of improving the informativeness and quality of audits. Consultation responses suggested that improvements to current auditing standards and practice are likely to be more effective and targeted than legislative changes. The Government will therefore look to ARGA to drive improvements in audit quality, including ARGA taking on responsibility for the registration of PIE auditors.

109. The Government supports the Brydon Review's long-term vision of expanding the future scope and purpose of audit. However, it believes that the first stage should be the development of a market for assuring financial and non-financial information beyond that in the financial statements. The Government does not propose to create a legislative framework for this market at such an early stage in its development.

110. The Government will not seek to establish a new professional body or regulatory oversight of a new 'corporate auditing' framework at this stage. Instead, the Government will create the conditions for the market to develop wider external assurance services. It will also ask professional bodies to improve auditor qualifications, skills, and training in order to help create a more effective and distinctive audit profession.

111. There are no plans for any legislative changes regarding the assurance of Alternative Performance Measures and Key Performance Indicators. It will be left to directors to decide whether specific assurance is necessary.

112. The current 'true and fair' view is to be retained as the standard for financial reporting. It is considered to be functionally identical to the alternative of 'presents fairly in all material respects'.

Resilience, competition, and choice in the audit market

113. To support ARGA's objectives to promote high-quality audit and effective competition in the audit market, the Government has decided to proceed with the proposed package of measures to improve resilience in the audit market for the largest companies. This includes the introduction of a 'managed shared audit' regime which will give challenger audit firms the opportunity to audit a meaningful proportion of subsidiary audits conducted for FTSE 350 companies. There will also be powers for ARGA to:

- operate a 'market share cap' once managed shared audit is in place
- require 'operational separation' of the largest firms
- monitor the health of audit firms and to address any concerns around an audit firm's resilience.

Monitoring audit quality

114. The consultation proposed to legislate for the publication of Audit Quality Review (AQR) reports. The aim was to allow the regulator to publish its AQR reports on individual audits without the need for consent from both the audit firm and the audited entity, as is the case at present.

115. Many respondents to the consultation highlighted problems with the publication of AQR reports without prior discussion. Rather than legislating specifically for the publication of AQR responses by the regulator, the Government is asking the regulator to look at non-legislative ways of improving the AQR process and continuing to seek consent from audit firms and audited entities where possible before publication. In addition, the Government is asking the regulator to engage with investors and other users to improve the usefulness to them of the information published on AQR.

Findings from quality inspections

116. The Financial Reporting Council (FRC) has issued a report on the key findings reported in the 2020/21 audit quality inspections of private sector audits. The inspections focus on:

- the quality of the audit work performed in the areas selected for review
- the sufficiency and appropriateness of the audit evidence obtained
- the appropriateness of the key audit judgments made by the audit partner and their team.

117. Some key findings that may have relevance to public sector audits are summarised in the following table:

Area	Finding
Compliance with laws and regulations	Where issues were identified, insufficient evidence was obtained to conclude on issues identified and whether they were isolated or representative of broader concerns
Bank reconciliation testing	The audit team did not investigate a net reconciling item in the period end bank reconciliation and therefore did not consider whether it was made up of significant offsetting items.
Pension scheme assets	The audit team performed insufficient procedures over the valuation and existence of pension scheme assets. In particular, the audit team did not: • obtain service organisation control reports for investment managers, to assess whether there were appropriate controls, before placing reliance upon their confirmations • in the absence of control reports, test the valuation of harder-to-value pension scheme assets • consider additional pricing information to assess and challenge the valuation of directly held publicly traded assets.

Area	Finding
Understanding and responding to inherent risks	The audit team did not demonstrate a sufficient understanding of the entity and the underlying controls in place to minimise the inherent business risks it faced.
Impairment of non-current assets	The audit team did not obtain sufficient evidence to assess whether an impairment of assets, or additional sensitivity disclosures, were required.
Fair value of financial instruments	Deficiencies were identified in the audit team's testing of financial instrument valuation, primarily the work performed over model risk management

118. The FRC also issued a separate report on good practices reported in the audit quality inspections. Some good practices that may have relevance to public sector audits are summarised in the following tables:

Risk assessment and planning

Area	Finding
First year audit procedures	The audit team's audit procedures supported a risk-based audit. There was comprehensive evidence of review of the predecessor auditor's working papers and of the audit of opening balances.
Fraud	The group instructions included a comprehensive section on entity-specific fraud risks, to be used as part of the component team's discussions. The group audit team tailored its scoping to respond to fraud risks, making good use of the business insights gained from management and the Audit Committee. It also incorporated elements of unpredictability into the audit procedures performed.
Journal entry testing	The journal entry testing across the group was thorough and well-controlled, with the detailed selection criteria communicated as required procedures to the component audit teams.
IT general controls	The audit team planned and scoped their testing of IT general controls from both a bottom-up and top-down perspective, to ensure that all relevant applications were covered. Their plan also reconciled the scope for the current year to the prior year to confirm completeness.

Execution

Area	Finding
Other information	The audit team evidenced a clear and thorough review of the other information included in the annual report, particularly whether it was fair, balanced and understandable.

Area	Finding
Areas requiring a high level of judgement	The audit team's approach to areas requiring a high level of judgement and industry knowledge involved robust challenge of key management assumptions, including effectively utilising the firm's technical team and internal specialists.
Extent of scepticism and challenge of management	The audit team presented its audit approach and findings in a way which clearly demonstrated the effective exercise of professional scepticism and consequent challenge of management in respect of key audit areas.
Valuation of assets	The audit team prepared a comprehensive memorandum evidencing its challenge of management's key assumptions used in their impairment model.
Impact of climate change	The audit team prepared a detailed memorandum evidencing consideration of the potential impacts of climate change. This enabled the team to ensure that all relevant disclosures were included in the financial statements, and informed specific aspects of the audit testing (for example, the testing of the valuation of assets).

Completion and reporting

Area	Finding
Communications with the Audit Committee	The use of graphics in the reports to the Audit Committee, notably in relation to the valuation of assets, aided the communication of complex issues which required the exercise of significant judgement.
Correction of identified errors	The audit team identified a significant number of material errors in the financial statements, and asked management to re-perform certain key assessments.
Review of the financial statements	Documentation clearly demonstrated the extent of the audit team's review of the financial statements and how points were resolved.
Other information	The audit team prepared a comprehensive work paper for narrative disclosures, annotated with testing performed and referenced to supporting evidence.
Delaying the signing of the auditor's report	The audit partner delayed signing their report until certain audit evidence was obtained. Furthermore, there was robust reporting to the Audit Committee in relation to difficulties during the audit.

Proposed revisions to ISA on group financial statements

119. The FRC has issued proposed revisions to ISA (UK) 600 on the audit of group financial statements. The proposals reflect recent changes to the corresponding international standard made by the International Auditing and Assurance Standards Board, as well as proposed additional material to address

specific UK requirements. Comments require to be sent to AAT@frc.org.uk by 8 July 2022.

120. The revisions arising from changes in the international standard include:

- clarifying the scope and applicability of the standard
- reinforcing that all ISAs are to be applied in group audits
- focusing the group audit team's attention on the identification and assessment of risk at the group financial statement level and emphasising the importance of designing and performing appropriate procedures to respond to those risks
- reinforcing the need for robust communication and interactions between the group audit team, group audit partner and component auditors.

121. The proposed additional UK material clarifies:

- the relationship between the audit team, group auditor and component auditor (diagram at paragraph 14(h))
- the group audit partner has overall responsibility for compliance with ISAs and for ensuring that the auditor's report is appropriate, and for the design, implementation, and operation of a system of quality management (paragraph 16-1)
- the group audit partner is required to obtain confirmation from the component auditors that:
  - they are able to comply with the FRC Ethical Standard requirements (paragraph 25(b))
  - the ethical requirements have been fulfilled (paragraph 25-1).

Draft standard on disclosing sustainability-related financial information

122. The International Sustainability Standards Board (ISSB) has issued an exposure draft of a standard intended to set out general requirements for the disclosure of sustainability-related financial information.

123. The proposals in the exposure draft set out overall requirements for disclosing a complete set of sustainability-related financial information. Comments require to be sent to commentletters@ifrs.org by 29 July 2022.

124. The exposure draft sets out the objective of disclosing sustainability-related financial information that is useful to the assessment by the primary users of the financial statements of the entity's enterprise value and their decision whether to provide resources to it. The proposals would require an entity to disclose material information about all of the significant sustainability-related risks and opportunities to which it is exposed, even if such risks and opportunities are not addressed by a specific IFRS Sustainability Disclosure Standard.

125. The proposed definition of sustainability-related financial information is information that gives insight into sustainability-related risks and opportunities that affect enterprise value, and which provides a basis to assess the resources and relationships on which an entity's business model and strategy for sustaining and developing that model depend.

126. Sustainability-related financial information should therefore:

- include information about the entity's governance of, and strategy for, addressing sustainability-related risks and opportunities
- depict the reputation, performance and prospects of the entity as a consequence of actions it has undertaken.

127. The exposure draft also proposes that:

- disclosures should provide a fair presentation of an entity's sustainability-related risks and opportunities. Applying IFRS Sustainability Disclosure Standards, with additional disclosure when necessary, is presumed to result in sustainability-related financial disclosures that achieve a fair presentation.
- the definition of material information should be aligned with the definition in IAS 1
- comparative information should be restated if better information becomes available (rather than being reported as part of current year disclosures).

Draft standard on climate-related disclosures

128. The ISSB has issued an exposure draft of a standard intended to set out requirements for the disclosure of climate-related matters. The proposals set out requirements for identifying, measuring, and disclosing climate-related risks and opportunities.

129. Comments require to be sent to commentletters@ifrs.org by 29 July 2022.

130. The exposure draft would require an entity to provide information that enables users of the financial information to understand the matters summarised in the following table:

Area	Explanation
Governance	The governance processes, controls, and procedures an entity uses to monitor and manage climate-related risks and opportunities.

Area	Explanation
Strategy	The climate-related risks and opportunities that could enhance, threaten or change an entity's business model and strategy over the short, medium and long term, including: • whether and how information about climate-related risks and opportunities inform management's strategy and decision-making • the current and the anticipated effects of climate-related risks and opportunities on its business model • the effects of climate-related risks and opportunities that could reasonably be expected to affect the entity's business model, strategy and cash flows, its access to finance and its cost of capital, over the short, medium or long term • the resilience of its strategy (including its business model) to climate-related risks.
Risk management	How climate-related risks and opportunities are identified, assessed, managed and mitigated by an entity.
Metrics and targets	The metrics and targets used to manage and monitor an entity's performance in relation to climate-related risks and opportunities, including: • performance and outcome measures that support the qualitative disclosures across governance, risk management and strategy disclosure requirements • targets that an entity uses to measure its performance goals related to significant climate-related risks and opportunities.

Technical Bulletin 2022/2

Technical developments and emerging risks from April to June 2022

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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**		✓ Final				
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**			**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	✓				
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**				Private Session		✓
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					
Extract from Internal Audit Framework	**Chief Internal Auditor**		✓				
Audit Scotland Technical Bulletin	**Head of Financial Services**				✓ **2022/2**	✓ **2022/3**	✓ **2022/4**
Introduction from Azets External Auditors'	**External Auditors**				✓		
Fife IJB Draft Internal Audit Joint Working and Reporting Protocol	**Chief Internal Auditor**				✓		
Training Sessions Delivered							
	Lead		**16/06/22**				
Members' Training Session – the Annual Accounts: The Role & Function of the Audit & Risk Committee	**External Auditors**		✓				